

University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Requires improvement	
Medical care (including older people's care)	Requires improvement	
Surgery	Good	
Critical care	Good	
Maternity and gynaecology	Requires improvement	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,959 general and acute beds. 147 of these beds are maternity beds and 49 are critical care beds. 975 inpatient beds and 66 day-case beds are located at Leicester Royal Infirmary.

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

Leicester Royal Infirmary is close to Leicester city centre and provides Leicestershire's only emergency department. The hospital has approximately 975 inpatient beds and 66 day-case beds. There were 86,943 inpatient admissions, 511,864 outpatient attendances and 135,111 emergency department attendances between April 2015 and March 2016.

We inspected Leicester Royal Infirmary in January 2014 under our new inspection methodology and rated it as requiring improvement. We also undertook an unannounced focused inspection of the emergency department at Leicester Royal Infirmary on the evening of 30 November 2015 because we were concerned about potential risks to patient safety in the emergency department. Following this inspection, we undertook urgent enforcement action to protect patients from the risk of harm.

During this inspection we followed up on the identified areas that required improvement from the 2014 inspection. We looked at a wide range of data, including patient and staff surveys, hospital performance information and the views of local partner organisations. The announced part of the inspection took place between the 20 and 23 June 2016, but the critical care service was inspected between the 25 and 27 July 2016. We also carried out unannounced inspections to Leicester Royal Infirmary, the Glenfield Hospital and Leicester General Hospital on 27 June, 1 July and 7 July 2016.

Overall we found the Leicester Royal Infirmary was performing at a level which led to the judgement of requires improvement. We inspected all eight core services at this hospital; two were rated as good and six were rated as requires improvement.

Our key findings were as follows:

- There was a good incident reporting culture in the trust and systems were in place to enable staff to report incidents. Staff were aware of their responsibilities in relation to reporting incidents, managers undertook incident analyses and investigations to determine any areas of improvement and staff were provided with feedback.
- Staff had a varied understanding about the duty of candour regulation and we saw examples where duty of candour had been applied appropriately.
- Recognised staffing assessment tools were used to assess the required numbers and skill mix of staff.
- Like many trust's in England, there were staff shortages in some areas for doctors, nurses and allied health professionals. Some areas had higher vacancy levels than others. The trust had recruited a number of registered nurses from overseas. The trust also used bank and agency staff to meet the needs of patients.
- There were effective safeguarding procedures in place for both adults and children. However, staff were not always sure of the level of safeguarding children training they had received.
- Emergency equipment was checked on a daily basis. We found that relevant checks had been undertaken and documented.

Summary of findings

- We were concerned about the trust's management of deteriorating patients and those who presented with sepsis. This is a severe infection which spreads in the bloodstream and if left untreated can lead to death. Where patients had met the trust's criteria for sepsis screening, they were not all screened in accordance with national guidance. This put patients at risk of not receiving the correct treatment in a timely manner.
- Medicines in the emergency department were not always securely stored.
- Staff mostly followed infection prevention and control policies and cleansed their hands between tasks and contact with patients.
- It was not always clear to see whether equipment was cleaned following use as it was not always labelled appropriately to indicate it had been cleaned. In some areas effective cleaning would not be possible due to aging and damaged furniture.
- Until May 2016, cleaning services had been contracted out to a private provider. There had been problems with cleanliness prior to our inspection which were identified through the trusts own audits. During our inspection, we found that environmental cleanliness had not always been given sufficient priority, especially in public areas such as toilets.
- In most of the services, patients' needs were assessed and care and treatment was delivered in line with legislation, evidence based practice.
- Staff on all the wards were mostly observed to be polite and courteous to patients and saw a number of examples of good care.

We saw several areas of outstanding practice including:

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.
- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities facilitator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24-hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.
- The trust had introduced a non-religious carer to provide pastoral support in times of crisis to those patients who do not hold a particular religious affiliation. Also to provide non-religious pastoral and spiritual care to family and staff.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The maternity inpatient risk assessment booklet also included a situation, background, assessment, recommendation (SBAR) tool, a sepsis screening tool, a venous thromboembolism (VTE) assessment tool which also had a body mass index chart, a peripheral intravenous cannula care bundle, a urinary catheter care pathway and assessment tools for nutrition, manual handling and a pressure ulcer risk score. This meant that all assessment records were available together.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

However, there were also areas of poor practice where the trust needs to make improvements.

Summary of findings

Importantly, the trust must:

Urgent & emergency services

- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department. **This also applies to medical areas.**
- The trust must take action to ensure standards of cleanliness and hygiene are maintained at all times to prevent and protect people from a healthcare-associated infection. **This also applies to medical areas and outpatient and diagnostic areas.**
- The trust must ensure that patients in the emergency department have venous thromboembolism (VTE) risk assessments completed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

Medicine

- The trust must ensure patient side rooms with balconies have been risk assessed in order to protect vulnerable patients from avoidable harm.

Critical Care

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

Surgery

- The trust must ensure DNACPR decisions are documented fully in accordance with the legal framework of the Mental Capacity Act 2005.

Maternity and gynaecology

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the maternity and gynaecology service.
- The trust must ensure that midwives have the necessary training in the care of the critically ill woman and anaesthetic recovery in line with current recommendations.

Services for children and young people

- The trust must ensure at least one nurse per shift in each clinical area is trained in APLS or EPLS as identified by the RCN (2013) staffing guidance.
- The trust must ensure Neonatal staffing at the Leicester Royal Infirmary (LRI) neonatal unit is compliant with the British Association of Perinatal Medicine Guidelines (BAPM) (2011).
- The trust must ensure children under the age of 18 years are not admitted to ward areas with patients who are 18 years and above unsupervised.
- The trust must ensure nursing staff have the appropriate competence and skills to provide the required care and treatment for children who require high dependency care.

End of life

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

Outpatients & Diagnostic Imaging

Summary of findings

- The trust must ensure the waiting environment for ophthalmic patients and eye casualty is fit for purpose.
- The trust must ensure that all equipment, especially safety related equipment is regularly checked and maintained.
- The trust must ensure it has oversight of planning, delivery and monitoring of all care and treatment so it can take timely action on treatment backlogs in the outpatient departments.

In addition the trust should:

- The trust should ensure cleaning products are locked away and are not accessible to patients on Ward 23.
- The trust should ensure patient side rooms with balconies have been risk assessed in order to protect vulnerable patients from avoidable harm.
- The trust should ensure medical notes, for patients who have been discharged are locked away and are not accessible to patients or the public on Ward 23.
- The trust should ensure patient's individual care records are written and managed in a way that keeps patient's safe. This includes ensuring patient records on ward 26 are up to date.
- The trust should ensure assistance with mealtimes is carried out in a timely way and provision of food outside of mealtimes is sufficient and includes access to a hot meal.
- The trust should ensure Deprivation of Liberty Safeguards (DoLS) are always applied appropriately.
- The trust should ensure male and female patients are not occupying the same bed bay unless there is a clinical need to do so.
- The trust should consider reviewing the numbers of patients being moved between wards out of hours.
- The trust should consider reviewing the process of referral to the General Medicine Assessment Unit.
- The trust should ensure that the actions initiated after the recent never event in the critical care unit and include re-enforcing the importance of the timely reporting of all incidents.
- The trust should ensure that it works to improve the access and flow issues within critical care with focus on the high occupancy and its impact on the numbers of non-clinical transfers and cancelled elective surgical cases.
- The trust should consider how it is going to meet the existing areas of non-compliance with the D16 National Service Specification for Adult Intensive care. More specifically, the shortfall in allied health professional support and NICE guidance compliance.
- The trust should ensure that staff are aware of the level of safeguarding training they have received.
- The trust should develop a transition pathway for children from children's services to adult services.
- The trust should identify a non-executive director lead for children's services to represent the service at board level.
- The trust should improve compliance of reviewing a child within four hours of being admitted.
- The trust should improve compliance with the three non-compliant standards of the five standards of the neonatal audit programme (NNAP) 2014.
- The trust should improve staff knowledge of the duty of candour processes throughout children's services.
- The trust should continue to work with outside agencies to reduce the backlog of 4565 letters for paediatric services and closely monitor the progress.
- The trust should ensure medical records are kept securely throughout all services.
- The trust should ensure that within children's services, patient names are not visible for the public to see.
- The trust should monitor did not attends in clinics and ensure staff are aware of the policy guidance.
- The trust should audit data on the length of time children spend in the children's assessment unit.
- The trust should consider its procedures for retrieving syringe pumps from the community to ensure there are sufficient numbers for patients requiring them in the hospital.
- The trust should review the leadership arrangements and focus on end of life care to ensure it is given sufficient priority at directorate and board level.
- The trust should consider formulating an overall strategy for end of life care across the trust which is disseminated to all staff across all sites.
- The trust should consider the redesign of services to match capacity to demand and reduce in-clinic waiting times.

Summary of findings

- The trust should ensure that needs for nutrition and pain relief are acted upon in cases of patients waiting in outpatients for a delayed appointment.
- The trust should ensure governance arrangements enable services to take timely action to address delays and problems, and effectively identify risks.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement



Rating

Why have we given this rating?

We rated urgent and emergency care as requires improvement overall.

We rated the safety of urgent and emergency care as requires improvement. Where patients had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance. This put patients at risk of not receiving the correct treatment in a timely manner. Care records were not always completed or updated appropriately to minimise risks to patients in the emergency department, for example in relation to pressure ulcers. Insufficient importance had been given to the prevention and control of infection, especially within the environment. Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Monitoring whether safety systems are implemented is not robust. There are some concerns about the consistency of understanding and the number of staff who are aware of them. Staff did not always sufficiently assess, monitor and manage risks to patients in the department, especially at times when the department was busy and overcrowded. However, where incidents were reported investigations took place and learning was shared. Staff had a good understanding of how to protect patients from abuse. Staff could describe what safeguarding was in addition to the processes to follow if they were concerned.

We rated the effectiveness of urgent and emergency services as requires improvement because patients were not always receiving effective care and treatment. Patients were not assessed for their risk of developing blood clots in their leg. Nurses did not always follow best practice guidance in relation to the use of clinical risk assessment tools for managing individual patients. The risk assessment tools used to assess a patient's risk of developing pressure ulcers and care assessments did not always consider the full needs of patients. Patients were not always assessed for their requirements for pain control in a timely manner. Insufficient priority was given to the nutrition and hydration status of

Summary of findings

patients within the majors area of the department. Patients could not always get the attention of nurses to let them know they were thirsty, especially when the department was overcrowded. Mental Capacity Assessments were not always appropriately undertaken. However, we also found evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively and, staff were supported to maintain and further develop their professional skills and experience.

We rated the care provided to patients within urgent and emergency services as requires improvement because there were times when patients told us they did not feel well supported or cared for. Although staff were kind and caring and did their best to meet the care needs of patients, they did not always see people's privacy and dignity as a priority. No consideration was given to the gender or culture of patients who were being nursed in the middle area of the majors department. However, we also found that at times when the department was calmer, staff demonstrated compassion and we saw a number of examples of good care.

We rated the responsiveness of urgent and emergency care as inadequate because the service was not planned or delivered in a way that met patient's needs. Despite the demographic population of Leicester and Leicestershire, signage in different languages within the department was poor. Leaflets were printed in English, although staff told us they could be obtained in different languages, but they often found it difficult to access the translation service. Flow through the department was slow because of delays in transferring patients to ward areas, which often occurred later at night. Some patients experienced unacceptable waits to be transferred to a ward because beds were not available. Because patients remained in the department, they were unable to access the ongoing care they needed. The emergency department did not have a clear plan in place to meet the needs of patients who had long waits to be transferred to a ward as well as provide

Summary of findings

essential emergency care for patients entering the department. We observed frail elderly patients who had no pillow to rest their head on. However, we also found that staff could access specialist support services such as a learning disability nurse if they needed to.

We rated the leadership of urgent and emergency care services as requires improvement because the leadership, governance and culture did not always support the delivery of high quality person-centred care.

We found that departmental governance and risk management arrangements were not robust and as such were not effective in protecting patients from avoidable harm. Risks, issues and poor performance had not always been dealt with appropriately or in a timely way. Staff did not always raise concerns because they felt they would not be listened to or that anything would change.

Medical care (including older people's care)

Requires improvement



We rated medical care services at the Leicester Royal Infirmary as requires improvement overall. There were inconsistencies in the way that staff used safety systems and processes, staff did not always follow these procedures. Staff were not always identifying and responding appropriately to changing risks to deteriorating patients. Nursing staff did not always adhere to trust guidelines for the completion and escalation of deteriorating observations and early warning scores (EWS), the frequency of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner and in line with national and local guidelines. We saw some instances where policy was not followed by staff. Staff did not always assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care

Summary of findings

associated. Staff were not consistent in keeping side room doors closed for patients who were isolated. This posed a risk of spreading infection to others.

Hydration records were not always updated appropriately to minimise risks to patients. However, patients were protected from abuse. Staff had an understanding of how to protect patients from abuse.

Patients were at risk of not always receiving effective care and treatment. Outcomes for patients were sometimes below expectations when compared with similar services and services did not always meet national standards; patients were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week.

We saw where patient's symptoms of pain were suitably managed in both ward and department areas with good comfort outcomes for patients in endoscopy and staff were mostly proactive in assessing patient's nutrition and hydration needs. However, assistance with mealtimes was not always carried out in a timely way and provision of food outside of mealtimes was insufficient.

We observed staff responding compassionately when patients needed help, and saw a number of examples of good care.

Patients were supported emotionally and this was reflected in their care and treatment.

Patients were mostly supported and treated with dignity and respect.

NHS Friends and Family results were positive with 95% of patients recommending the NHS service they had received to friends and family who may need similar treatment or care.

Medical care services did not always meet patient's needs; the process of referral to the acute medical unit (AMU) resulted in at least one patient per day being inappropriately admitted and a high proportion of patients moved wards between the hours of midnight and 6am.

Referral to Treatment Times (RTT) for the cancer standards and access to diagnostic tests was worse than the England average.

Summary of findings

However, we did see timely access to stroke services and patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.

The leadership, governance and culture in medical care services did not always support the delivery of high quality person-centred care; department governance and risk management arrangements were not robust and as such did not always protect patients from avoidable harm.

Surgery

Good



We rated surgical care services at the Leicester Royal Infirmary as good.

On all the wards and departments we visited, we saw staff acting in a kind and caring way towards patients and the public. Relatives and carers told us they felt involved and informed.

Patients had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. For example enhanced recovery programmes.

We found nursing staff consistently followed trust guidelines for the completion and escalation of deteriorating physiological observations and early warning scores (EWS).

However;

Staff did not always recognise, concerns, incidents or near misses for example not reporting missing medical notes, or the lack of computers.

The pathway for pre-operative and high-risk anaesthesia patients was not consistently followed causing potentially avoidable delays and cancellations. Some patients were not having pre-operative assessment despite being identified as high risk for anaesthetic.

Departmental governance and risk management arrangements were not robust and as such did not always protect patients from avoidable harm.

Critical care

Good



We rated critical care services at Leicester Royal Infirmary as good overall.

There were sufficient numbers of suitably qualified staff to care for patients. We found a culture where incident reporting was encouraged and understood by staff.

Summary of findings

Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

There was strong clinical and managerial leadership at both unit and management group level. The service had a vision and strategy for the future. There was an effective governance structure in place, which ensured that the risks to the service were known, recorded on the trust risk register and discussed. The framework also enabled the dissemination of shared learning and service improvements.

However, we also found some issues with access and flow. In 2015, 47 patients had their elective surgery cancelled because there was no critical care bed available.

Bed occupancy levels were consistently higher than 90% for 2015 thus making it difficult to respond to individual needs. The trust target was 85%.

There were higher levels of non-clinical transfers when compared with similar units.

Pharmacy provision for the critical care service did not fully meet the D16 service specification, and the trust was not compliant with all aspects of NICE guidance 83 'Rehabilitation after Critical Illness'.

Maternity and gynaecology

Requires improvement



We rated maternity and gynaecology services as requires improvement overall.

Midwifery staffing levels did not always meet minimum acceptable numbers for the unit and one-to-one care in labour was not always achieved.

There was a lack of junior doctors to cover the service out of hours. Whilst the service mitigated these risks wherever possible, lack of staff, on occasion, posed a risk to patient safety.

Whilst most of the environment was visibly clean, there were some areas, which did not meet acceptable standards of infection control, and staff were not always compliant with hand hygiene standards.

Staff mostly planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation; however, they did not always follow the trust's

Summary of findings

policy on the disposal of fetal remains. Some midwifery staff did not have the competencies required when caring for women who were critically ill or following anaesthesia.

The majority of women, their partners and relatives were positive about the care they had received. Most of the women we spoke with told us staff were kind and caring and that they had been treated with dignity and respect and were happy with the emotional support they received. Staff involved patients in their care and treatment.

The trust provided an extensive range of specialist maternity and gynaecology services which included specialist midwives, 'consultant direct' and one-stop gynaecology clinics.

The service provided a cohesive and sensitive bereavement service for women experiencing pregnancy loss, including the employment of a specialist midwife, dedicated bereavement rooms and postnatal records; however, women experiencing pregnancy loss shared a ward entrance with antenatal patients, which could be distressing.

There was a clear vision and strategy for the service, which was shared by most staff, and most of the leadership team were visible and well respected. There was a clear governance structure. Some outcomes on the quality dashboard were reported trust wide and others were not RAG (red, amber, green) rated. Most outcomes were reported at service level meaning site variance could not be identified. This meant we were not assured that service leads had good oversight of trends and outcomes for women at both sites. The outcomes for women against trust targets were mixed; the normal birth rate was above the national average and rates of instrumental birth were better than trust targets but the rates for caesarean section and postpartum bleeding were worse. We were also not assured that incidents were appropriately graded following discussions at clinical governance meetings. Clinical audits were undertaken but could be delayed because of staff availability to undertake them. We were not assured that results of audit were addressed in the action plans. The risk register was regularly reviewed however not all known risks were included.

Summary of findings

Services for children and young people

Requires improvement



We rated services for children and young people at the Leicester Royal Infirmary as requires improvement overall.

Mandatory training levels for Advanced Paediatric life support, mandatory training and level three safeguarding training did not meet the trust target. The trust did not meet Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants.

The service could not provide at least one nurse per shift in each clinical area trained in Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training.

The service had a backlog of children needing to be seen for certain specialities which meant children waiting long periods of time for surgical procedures. Staff were not always trained to care for complex patients requiring high dependency care.

Medical records were not always kept safely and securely.

Learning from incidents was shared with staff through emails and team meetings. There were robust safeguarding policies and procedures in place.

Equipment was checked and available for staff to be able to carry out their role.

The service offered a holistic range of services to meet children and young people's needs.

Medication monitoring practices were effective and medications were administered safely.

Patients received evidenced based care and there was good multi-disciplinary working between nursing and medical teams.

However we also found staff were caring, compassionate and respectful to children, young people and their families.

End of life care

Requires improvement



We rated end of life care services at the Leicester Royal Infirmary as requires improvement. We rated safe, responsive and caring as good with effective and well led as requires improvement because.

The medical staffing levels were not in line with the recommendations from the National Council for Palliative Care who recommend there should be one whole time equivalent (WTE) consultant for

Summary of findings

every 250 beds. The service had 3.5 WTE consultants and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended.

The trust had 82 syringe drivers that were in line with best practice guidelines. However, only ten were ready for use. This meant the trust was reliant on using syringe drivers, which did not meet the NHS patient safety guidance.

We looked at 23 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR) across the trust and found there were inconsistencies in how these were completed. We found that out of 23 DNACPR orders, six were completed correctly (25%). We found staff had not always followed trust policy when they completed DNACPR orders.

The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust scored lower than the England average for all five Clinical KPIs. The trust had undertaken an audit in April 2016 in response to the National Care of the Dying Audit 2016, and an action plan had been developed to address the KPI's that had not been achieved.

The service did not have its own risk register and risks were not recorded on the trust wide risk register.

There was no strategic plan for end of life care throughout the trust.

The service did not have a non-executive director representing end of life care at board level.

However, we also found that care records were mostly maintained in line with trust policy.

Staff understood their responsibilities in following safeguarding procedures and care and treatment was delivered in line with recognised guidance and evidence based practice. The last days of life care plan was in use throughout the trust.

The trust had effective multidisciplinary working in place and staff were seen to be compassionate and we observed them treating patients and their families with dignity and respect.

A bereavement service was available to support family members with practical and support issues

Summary of findings

after the death of a patient. The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital, as well as their relatives.

The specialist palliative care team were committed to ensuring that patients receiving end of life care services had a positive experience.

The trust had a rapid discharge home to die pathway. Discharge in these circumstances was arranged by the specialist discharge sister and could be facilitated within a few hours for patients wishing to return home.

Staff spoke positively about the service they provided for patients. High quality, compassionate patient care was seen as a priority. Staff within the specialist palliative care team spoke positively and passionately about the service and care, they provided for patients.

The trust had recruited a bereavement nurse specialist in July 2015 who worked across the three hospital sites and closely with the specialist palliative care team (SPCT).

Outpatients and diagnostic imaging

Requires improvement



We rated outpatient services and diagnostic imaging at Leicester Royal Infirmary as requires improvement overall.

The individual patient risks associated with anticipated events were not fully recognised, assessed or managed, as the hospital did not schedule follow up appointments for eye patients. Ophthalmology and rheumatology specialities had backlogs of follow up patients. The hospital had not fully assessed their clinical priority for appointments, which meant patients were at risk of harm. Outpatient services and diagnostic imaging learned from incidents and there was an open reporting culture.

The approach to assessing and managing day-to-day risks to people who use services did not take a holistic view of patient's needs. Standards of hygiene were not met in some outpatient clinic rooms, waiting areas and toilets. Overcrowding in the eye clinic was unpleasant and unsafe for patients. There were periods of understaffing. Nurse staffing levels, at Leicester Royal Infirmary (LRI), based on information given to us by the trust, were 18.5% below the planned level.

Summary of findings

Patient care and treatment were planned and delivered in line with current evidence-based guidance, standards, and legislation. This was monitored to ensure consistency of practice. Patient privacy and dignity was not protected in the eye clinic. Overcrowding long waits and cancellations led to a poor quality outpatient experience. However, patients told us that nurses and doctors were kind, caring and courteous. The trust had backlogs of patients waiting for initial and follow up appointments. It did not meet its target for two-week cancer waits, although performance was improving. Managing outpatient capacity was complicated by overbooking and clinical schedules, which did not reflect appropriate consultation times.

Clinical outpatient services lacked regular dashboards to show performance against quality, safety activity and financial indicators. Clinical management group (CMG) level plans were not clear about how they would match capacity with demand for outpatient services. Staff spoke highly about senior leadership and there were effective staff and public engagement initiatives.

Leicester Royal Infirmary

Detailed findings

Services we looked at:

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

Detailed findings

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Background to Leicester Royal Infirmary

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

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

Leicester, Leicestershire and Rutland have a population of approximately 1.03 million, with 32% of people living in

the city, 64% in Leicestershire and 4% living in Rutland. The three areas have significant differences. The city of Leicester has a younger population and the county areas are older. The city of Leicester is an ethnically diverse population with over 37% of people being of Asian origin.

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

Our inspection team

Our inspection team was led by:

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

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

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

Two experts by experience who had personal experience of using or caring for someone who used the type of service we were inspecting also supported this inspection.

Detailed findings

How we carried out this inspection

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

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

Before our inspection, we reviewed a wide range of information about University Hospitals of Leicester NHS Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National

Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

The announced inspection took place between the 20 and 23 June 2016, with critical care being inspected between the 25 and 27 July 2016. We held focus groups with a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, consultants, administrative and clerical staff, physiotherapists and occupational therapists, porters and ancillary staff. We also spoke with staff individually.

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

Facts and data about Leicester Royal Infirmary

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,784 inpatient beds and 175 day-case beds. 937 inpatient beds and 85 day-case beds are located at Leicester Royal Infirmary.

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

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:





Detailed findings

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

Notes

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

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

Information about the service

University Hospitals of Leicester NHS Trust provides urgent and emergency care at the Leicester Royal Infirmary as part of the Emergency and Specialist Medicine Clinical Management Group (CMG).

The Emergency Department (ED) at the Leicester Royal Infirmary (LRI) is a major trauma unit, which can be used to stabilise trauma patients prior to transfer to a regional major trauma centre. The ED at Leicester Royal Infirmary consists of an ‘assessment and triage’ area which has six cubicles, a side room and four red marked out areas on which patients requiring assessment waited until a cubicle became available. There were also chairs for those patients who did not require a trolley; a ‘major injuries’ treatment area which has 15 cubicles plus five red spaces on which patients requiring a trolley waited until a cubicle became available. There was also a ‘minor injuries’ treatment area which consists of a seated waiting area plus nine cubicles and a ‘resuscitation’ room which has eight cubicles. There is also a separate ‘paediatrics’ ED with a seated child’s waiting area, a seated adolescent waiting area, six cubicles and seven trolleys. There is also a 16-bedded emergency decisions unit (EDU) where patients could be admitted if they were waiting for test results or required a short period of observation before they returned home. To the front of the emergency department there are six ambulance receiving bays.

The emergency department provides a 24-hour service, seven days a week to the local population.

In November 2015, the trust took responsibility for the Urgent Care Centre (UCC), which had previously been run by another provider. The UCC provides a triage and urgent care service for walk in patients. The UCC service assesses patients to determine the most appropriate service to meet the patients’ needs. Patients can be referred to their own GP, treated at the UCC or sent to ED.

The ED at the Leicester Royal Infirmary was originally built for 100,000 attendances per year. Between April 2015 and March 2016, 155,736 patients were seen in the ED. Of these patients 38,870 were aged 16 or below and accounted for 27.5% of all attendances.

Patients presented to the department either by walking into the UCC or by arriving through a dedicated ambulance only entrance.

Before our inspection, we reviewed performance information from and about this service. We also held focus groups with nursing staff, medical staff and ancillary staff, as well as speaking to senior doctors and nurses.

During our inspection, we visited all areas of the emergency department including minor injuries, major injuries (Majors), resuscitation, the assessment area, the EDU, paediatric ED, the UCC and the ambulance bays at the entrance to the department. Throughout our inspection of urgent and emergency services at the LRI we spoke with 25 patients, and/or those accompanying them and 59 members of staff, including student nurses,

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junior and senior registered nurses, discharge co-ordinators, allied health professionals, ancillary staff and junior and senior medical staff and ambulance staff who were not directly employed by the trust.

As part of our inspection, we observed interactions between patients, those close to them and staff, considered the environment and reviewed 29 sets of patient care and treatment records.

Summary of findings

We rated urgent and emergency care as requires improvement because:

- The trust had an incident reporting policy, which included an incident grading system and requirements for reporting internally and externally. However some incidents of sub-optimal care were not being reported as culturally they had become accepted, for example missed doses of prescribed medications.
- Where patients had met the trust's criteria for sepsis screening, not all patients were screened or received treatment in accordance with national guidance. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- Care records were not always completed or updated appropriately to minimise risks to patients in the emergency department, for example in relation to pressure ulcers.
- Insufficient importance had been given to the prevention and control of infection, especially within the environment.
- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Monitoring whether safety systems are implemented is not robust. There are some concerns about the consistency of understanding and the number of staff who are aware of them
- Staff did not always sufficiently assess, monitor and manage risks to patients in the department, especially at times when the department was busy and overcrowded.
- Nurses did not always follow best practice guidance in relation to the use of individual patient risk assessment tools. The risk assessment tools used to assess a patients risk of developing pressure ulcers and care assessments did not always consider the full needs of patients.
- Patients were not always assessed for their requirements for pain control in a timely manner.
- Insufficient priority was given to the nutrition and hydration status of patients within the majors area of

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the department. Patients could not always get the attention of nurses to let them know they were thirsty, especially when the department was overcrowded.

- Mental capacity assessments were not always appropriately undertaken.
- There were times when patients told us they did not feel well supported or cared for. Although staff were kind and caring and did their best to meet the care needs of patients, they did not always see people's privacy and dignity as a priority.
- No consideration was given to the gender or culture of patients who were being nursed in the middle area of the majors department.
- The service was not planned or delivered in a way that met the needs of the local population. Despite the demographic population of Leicester and Leicestershire, signage in different languages within the department was poor. Leaflets were printed in English, although staff told us they could be obtained in different languages, but they often found it difficult to access the translation service.
- Flow through the department was slow because of delays in transferring patients to ward areas, which often occurred later at night. Some patients experienced unacceptable waits to be transferred to a ward because beds were not available.
- Patients who remained in the department were unable to access the on-going care they needed and the emergency department did not have a clear plan in place to meet the needs of patients who had long waits to be transferred to a ward as well as provide essential emergency care for patients entering the department.
- Patients, including, frail elderly patients had no pillows to rest their head on.
- The leadership, governance and culture did not always support the delivery of high quality person-centred care. Departmental governance and risk management arrangements were not robust and as such were not effective in protecting patients from avoidable harm.

- Risks, issues and poor performance had not always been dealt with appropriately or in a timely way. Staff did not always raise concerns because they felt they would not be listened to or that anything would change.

However, we also found:

- Where incidents were reported, investigations took place and learning was shared.
- Staff had a good understanding of how to protect patients from abuse. Staff could describe what safeguarding was in addition to the processes that should be followed if they were concerned.
- Effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively and, staff were supported to maintain and further develop their professional skills and experience.
- When the department was calmer, staff demonstrated compassion and we saw a number of examples of good care.
- Staff could access specialist support advice, such as a learning disability nurse if they needed to.

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Are urgent and emergency services safe?

Requires improvement 

We rated the safety of urgent and emergency services as requires improvement because:

- The trust had an incident reporting policy, which included an incident grading system and requirements for reporting internally and externally. However some incidents of sub-optimal care were not being reported as culturally they had become accepted, for example missed doses of prescribed medications.
- Where patients had met the trust criteria for sepsis screening, they were not all screened in accordance with national guidance. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- Care records were not always completed or updated appropriately to minimise risks to patients in the emergency department, for example in relation to pressure ulcers.
- Insufficient importance had been given to the prevention and control of infection, especially within the environment.
- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Monitoring whether safety systems are implemented is not robust. There are some concerns about the consistency of understanding and the number of staff who are aware of them.
- Staff did not always sufficiently assess, monitor and manage risks to patients in the department, especially at times when the department was busy and overcrowded.
- The volume of patients and pressured capacity in the department frequently resulted in delays in patients being received into the department from ambulances.

However, we also found:

- Where incidents were reported investigations took place and learning was shared.

- Staff had a good understanding of how to protect patients from abuse. Staff could describe what safeguarding was in addition to the processes they should follow if they were concerned.

Incidents

- The trust had an incident reporting policy, which included an incident grading system and requirements for reporting internally and externally. In line with the trust's incident and accident, reporting policy, incidents, accidents and near misses were reported through the trust's centralised electronic reporting system.
- Urgent and emergency care services reported 826 incidents between November 2015 and March 2016. Of these, one resulted in major harm, two in moderate harm, 78 minor harm and 745 in no harm or injury.
- The trust reported 44 serious incidents between May 2015 and April 2016. The emergency department at the Leicester Royal Infirmary between May 2015 and April 2016 had reported six of these serious incidents. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to ensure a comprehensive response (NHS England, March 2015). One serious incident related to treatment delay, whilst the others related to sub-optimal care of a deteriorating patient; a failure to act on results following a diagnostic procedure; a patient developing a pressure ulcer; failure to obtain an inpatient bed for a child; infection control and adverse media coverage about the organisation. None of these incidents were classified as never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Serious incidents were discussed at the emergency department quality and safety open meetings, which took place once every two months. We saw evidence of this in minutes provided by the trust.
- All staff we spoke with knew how to report incidents but did not routinely report delayed handover times and delays in flow through the emergency department (ED) as incidents. Staff told us if they reported all handover times and delays in flow through the ED they would not have time to do their job.

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- Staff told us they felt frustrated that flow through the department affected patient care, as the department was so busy. Medical and nursing staff told us when the department was busy, this resulted in patients receiving a poor standard of care, for example medication not being administered, comfort rounds not taking place and patients deteriorating prior to assessment. This suboptimal standard of care had to some extent been normalised and staff did not always report these sorts of harm. We observed this throughout our inspection when a patient was not prescribed or administered medication they were required to take at the same time every day. We asked to see the incident report relating to this but the incident had not been reported.
- All incidents were reviewed twice weekly by the consultant of the week, the senior sister of the week, a registrar and a matron. The team would go through each reported incident and scrutinise the information to establish whether the incident required escalation or whether any further actions were required. We saw there were cross reference checks to patient records and other relevant information.
- Following serious incidents we saw that root cause analysis investigations had taken place. Root cause analysis is an approach for identifying the underlying causes of why an incident occurred. We requested the serious investigation reports for these incidents and saw thorough and robust reviews had taken place. Learning from the incidents had been recorded along with agreed actions.
- There was no dedicated mortality and morbidity meeting for urgent and emergency services. Mortality and morbidity was however discussed at the emergency department quality and safety open meetings. We saw cases were presented and concise learning points and required changes to practice were briefly noted: however, there was no evidence to outline agreed actions and ownership going forward.
- Learning from incidents and changes to practice because of incidents was shared at handover as nurses changed shift. We saw where changes to practice had changed following incidents. For example children did not routinely have their blood pressure monitored when they came into the emergency department, but following a serious incident, changes were made to ensure all children had their blood pressure recorded as part of their assessment.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Senior staff were aware of the requirements and their responsibilities around the duty of candour regulation; however, junior staff were less confident around articulating their responsibilities. Whilst not all staff were familiar with the term 'duty of candour', staff knew of their responsibilities to be open and honest with patients when things went wrong. The trust's incident reporting form had been updated to provide a prompt for staff around duty of candour.
- Incident reports were shared with the patient and where relevant, those who were close to them when they had been adversely affected by the incident within the service. In addition, we saw evidence that patients and those close to them were given an apology and informed of any actions taken because of the incident.
- We saw examples where duty of candour had been appropriately applied, for example, where incidents had led to patient harm.

Cleanliness, infection control and hygiene

- The Department of Health's Code of Practice on the Prevention and Control of Infections was not always adhered to within the urgent and emergency care services at the Leicester Royal Infirmary. We found issues with cleanliness, infection control and maintenance throughout the emergency department. For example, during our unannounced visit, we found cleanliness issues with the toilet facilities within the paediatric emergency department and the minor injuries department despite the monitoring form indicating these toilets had undergone a full clean earlier in the day. We escalated this to a senior member of staff who took immediate action to close the toilet facility. At a further unannounced inspection, we found the trust had taken immediate steps to rectify the problems we had identified.
- We reported a dirty toilet in the minors department to a matron who noted the inadequacies and assured us action would be taken to make the toilet facility clean.
- In the adolescent's waiting area of the children's emergency department, we observed a seating area that was covered in waterproof medical tape due to

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tears and cracks in the seating. The seating area was worn, exposing the underlying foam. Effective cleaning of these areas could not be assured, increasing the risk of cross contamination. We escalated this to a matron who assured us action would be taken.

- In the plaster room, at our announced inspection, we observed the room to be covered in plaster of Paris residue and debris, the disposable curtains were covered in splashes of plaster of Paris and had not been changed since January 2016. We brought this to the attention of the most senior nurse in charge of the department who immediately arranged for the room to be cleaned. We noted the curtains were changed immediately. Within the plaster room, we also saw the chair which was used to apply plaster of Paris was worn and the arms of the chair was chipped with broken and cracked edges. Effective cleaning of this area could not be assured, increasing the risk of cross contamination. We escalated this to a matron who assured us a replacement chair would be ordered with immediate effect. At our unannounced visit, we saw the arms of the chair had been covered with waterproof medical tape and a sheet was used to cover the seat area. This was changed between patients.
- A side room was available for treating patients who may pose a risk of spreading infection, those who had an infection and patients who were at risk of infection due to low immunity.
- Leicester Royal Infirmary participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered within the NHS and independent/ private healthcare sector in England. PLACE encourages the involvement of patients, the public and bodies, both nationally and locally, with an interest in healthcare assessing the care environment. The assessment of cleanliness at the Leicester Royal Infirmary demonstrated a score of 92.9%. This was worse than the England average of 95.5%.
- The majority of staff were observed to be compliant with some of the trust's infection control policies. All staff were observed to adhere to protocols such as bare below elbows policy.
- There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. However, we observed two isolated occasions where staff were in close contact with patients, they wore gloves but did not wear a disposable

apron, for example staff supporting a patient with moving and handling and staff supporting a patient with personal care. We also observed a member of staff carry used bed linen across the department to dispose of it. This is not best practice as it increases the risk of cross contamination.

- We observed six nurses in the majors area and five nurses in the assessment area of the department. Two of these staff completed appropriate hand washing after contact with patients.
- Staff did not routinely use the green 'I am clean' stickers to indicate when equipment had been cleaned. We did however see some green 'I am clean' stickers on patient trolleys which were stored in a corridor at the back of majors. These stickers had not been dated or signed to indicate the trolleys had been cleaned and ready for use.
- The trust had a sharps management policy, which stated sharps bin closure should be left in the partial close position when not in use, especially if the bin is in an accessible patient or visitor area. Although sharps bins complied with the UN 3291 or the BS 7320 standards, we found all sharps bins regardless of their size and location were left open. This did not comply with the trust's sharps management policy and increased the risk of unauthorised access, needlestick injury and accidental skin puncture from a used needle.
- Foot-operated pedal bins were used for the disposal of waste in line with current national guidance. However we noted a bin in the resuscitation area of the department was broken and staff would be required to use their hands to open the bin to dispose of waste. We also noted clinical and domestic waste was not always segregated. Domestic waste was being disposed of in clinical waste bins and larger sharps containers.
- Infection prevention and control of infection was included in the trust's mandatory training programme. Information provided by the trust indicated 92 % of staff had completed this training, the trust target was 95%.
- There was a cleaning schedule for each area of the department; however, these had not been consistently completed.

Environment and equipment

- There were six ambulance bays located outside the emergency department at the Leicester Royal Infirmary. There was a sign for vehicles approaching the site advising the left hand lane was for ambulances,

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disabled vehicles and delivery vehicles only and the right hand lane was for the car park, drop off point and exit. In front of the ambulance bays there was red markings and notices on the road to indicate 'Ambulance parking only'.

- Outside the emergency department, we observed drivers ignoring the signs and cars were using the left hand lane to drop patients off outside the main Balmoral entrance. In doing this, they obstructed the ambulance bays, making it difficult for ambulances to enter and exit the ambulance bays. We also observed a queue of traffic blocking the road where ambulances entered the grounds of the hospital. On one occasion, an ambulance had its blue lights and siren on, indicating it required emergency access. Ambulance crews and staff at the hospital told us this happened all the time. There was a member of security staff who was in charge of ambulance flow and was attempting to stop traffic from entering the ambulance bays; however, we observed that some drivers ignored them. We raised our concerns about this with the executive team. When we undertook our unannounced inspection, we saw the member of security staff was located further down the road to ensure cars were redirected and denied access to the ambulance bays.
- When the six ambulance bays were in full use, ambulances arriving on site were redirected to one of the overflow bays. These bays were further away from the emergency department entrance and depending on flow throughout the emergency department ambulance crews held patients on ambulances until they could enter the department, then had to transport patients across the road.
- Staff expressed some concerns relating to security and access to the emergency department. There were many ways in which unauthorised people could access the department, for example through Balmoral X-ray department. Access to the majors area and resuscitation area from outside of the department was by key code. However, we noticed the doors could be opened without the code. The entrance to the children's emergency department was not locked. Staff told us this was for ease of access and there was always someone watching the door.
- Within the paediatric emergency department we found plug sockets did not have protective covers on them and as such children were not protected from avoidable harm. We escalated this to a senior nurse who assured us action would be taken. At our unannounced visit we checked to see if action had been taken and found a double plug socket with no protective cover on it. We asked a nurse about this who told us protective covers had been placed in all plug sockets but parents removed them to charge their mobile telephones.
- In 2007 and 2010, the Department of Health issued an alert to NHS trusts requiring action to reduce potential suicide risks relating to patients using curtain rails from which to hang themselves. Curtain rails within the urgent care centre were not magnetic and therefore not anti-ligature. The trust had carried out a ligature point risk assessment in June 2016, which we reviewed. The risk assessment identified the curtain rails, blood pressure monitors and fans with wires and door handles as ligature points. The risk assessment identified patients presenting with mental health conditions would not be left alone in these areas and where patients were assessed as being high risk they would not be left unattended. The risk assessment was signed as satisfactory with no changes necessary. Throughout the emergency department, we observed curtain rails to be magnetic and pull cords in toilet areas were also anti-ligature cords.
- Cubicles within the majors department had call bells, and we observed where patients did not have relatives with them could mostly reach their call bell. However, those patients who were placed on the red marked out areas in the middle of majors had no call bell. This meant they had no means of alerting staff if they required assistance.
- On the first day of our inspection, we found a fire door open in the minors area of the department. The door was labelled to indicate it was no longer in use due to building works. However, staff lockers were based in the room behind the doors and staff were still accessing the area. We were concerned because the area was accessible to the public and posed a risk of entrapment, ligature risk and a falls from height risk. We escalated this to a senior member of staff who assured us they would take action to secure the door. The next day we checked the door and found it had been padlocked and was inaccessible to the public.
- Computerised tomography (CT) and X-ray facilities were located close to the emergency department and so were suitably accessible for patients. A CT scan uses X-rays and a computer to create a detailed image of the inside of the body.

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- We checked the resuscitation equipment throughout the emergency department. The resuscitation equipment was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence to indicate the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- Within the urgent care centre, an emergency transfer bag was used to transfer patients in an emergency. There was no checklist, or list of contents for this bag and we found an endotracheal tube contained within the bag had expired. An endotracheal tube is a tube that is inserted into the trachea (wind pipe) in order to establish and maintain a clear airway. We were therefore not assured this bag had been checked or that it contained the equipment it should have contained. We escalated this to a senior nurse who assured us action would be taken to enable the bag to be replenished and checked. The following day we looked to see what action had been taken and found that no action had been taken. We escalated this again to a senior nurse who took immediate action to replace the bag and ensure a checklist was available for staff to sign to evidence the bag had been checked.
- Band one ED assistants had been employed by the department following our unannounced inspection in November 2015. Their role was to assist with administrative tasks such as photocopying and to ensure there was enough stock in each of the ED areas.
- We reviewed a sample of equipment throughout the department and found equipment had been serviced and safety tested.
- Equipment including pumps and monitors were clean and in working order. All items of equipment we examined were labelled with the last service date.
- A hoist could be used for patients throughout the emergency department. The hoist was in working order and was labelled with the last service date.
- In the resuscitation area of the department, we observed three members of staff reposition a patient in bed. We noted the staff did not use any moving and handling equipment such as slide sheets but instead used the bottom sheet to reposition the patient. This is not recommended practice and increases the risk of a sheering injury which could lead to breaks in the skin.
- Staff felt there was not enough equipment, such as blood pressure machines available, and the equipment they had was old. Although staff told us this, we

observed facilities to monitor blood pressure in each cubicle in the majors department. When staff reported faulty or missing equipment they felt the medical devices team were slow to respond.

- Although we did not see any equipment for heavier people in use, staff told us this was available on request.

Medicines

- There were four medication-dispensing units throughout the emergency department; we saw one in the majors area, one in the resuscitation area, one in the children's emergency department and one in the emergency decisions unit. These were stocked with oral medications and access was by finger print recognition, so only those people who were authorised to access the unit were able to do so. Although pharmacy provided the emergency department with a top-up service, they did not maintain or check the dispensing units. Emergency department (ED) staff were responsible for ensuring medications delivered to the department were placed in the correct compartment of the dispensing unit.
- Excess stock of oral medications and intravenous medications were stored in medicine cupboards. However, medicines at the Leicester Royal Infirmary were not always securely stored. We found a medicines cupboard in the minor's area was unlocked. We informed nursing staff of this, who immediately locked this cupboard. During our unannounced inspection, we found this medicine cupboard was again unlocked; we escalated this to a matron who locked the cupboard immediately.
- At our announced inspection, we found boxes of intravenous fluids unlocked in a corridor in the minors area. We escalated this and found the fluids had been locked away by the following day. During our unannounced inspection, we looked at this area again and found a box of intravenous fluids that again had not been locked away. This increased the risk of these fluids being accessed or tampered with by unauthorised persons.
- In the majors area of the department, intravenous fluids were kept in cupboards on the outside of the nurse's station. None of the cupboards were locked. We highlighted this to nursing staff who told us the

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cupboards were unlocked for ease of access. We escalated this to a senior member of staff who took steps to lock the cupboards. However later in the shift we found the cupboards to be unlocked again.

- In the resuscitation area of the department, we found a box containing different intravenous medications and a box containing strips of different oral medications in a locked cupboard. We highlighted this to the nurse in charge who recognised this could increase the risk of medication errors. At our unannounced inspection, we noted steps had been taken to remove these mixed boxes of medication.
- Throughout the department, we noted bottles of liquid medications that had been opened but had not been signed and dated on opening. Once opened liquid medications have to be used within a specified timeframe and if not dated and signed there would be no way of identifying when these medications had been opened. This increased the risk of patients receiving medications that had potentially passed their expiry date and may be less effective and may contain harmful bacteria.
- On the emergency decisions unit we noted the area used to store medications was very warm. There was no thermometer in there to indicate the room temperature. We escalated this to the deputy site manager on call who indicated immediate action would be taken. Following our inspection the trust submitted information which suggested our concerns had been raised with pharmacy.
- Controlled drugs (CDs) were stored appropriately and records were accurately completed. CDs are prescription medicines, which are governed by the misuse of drugs legislation. The law determines the storage, production; supply and prescribing of these medicines were stored, managed and recorded safely and appropriately.
- Medications to be administered were prescribed on the back of the emergency department record document. This gave space to prescribe one off doses of medication such as intravenous fluids, pain relief and antibiotics. Patients were not prescribed their long-standing medications as this was prescribed once patients were transferred to a ward area. Staff recognised prolonged stays in the emergency department because of delays in transferring patients meant some patients who required time critical medications such as those with Parkinson's disease would miss essential medications. These medicines are

very time sensitive and delays in administering them may cause significant patient discomfort. We saw evidence of this during our unannounced visit to the emergency department. Staff told us where patients were delayed in going to the wards this would often happen but information in relation to this was not routinely collected. We were therefore concerned that insufficient importance was given at the Leicester Royal Infirmary to patients who required time critical medications.

- Within the urgent care centre at the Leicester Royal Infirmary, we observed a number of oxygen cylinders were not stored securely. We escalated this to the nurse in charge who took steps to secure the oxygen cylinders.

Records

- There was an emergency department specific procedure for the management of patient records.
- Original paper records did not leave the emergency department. When patients were transferred to a ward, records were photocopied and taken with the patient.
- Patient care records were in paper format and used for every patient. This was an emergency department specific document known as the nursing assessment and nursing notes and included various clinical risk assessments such as cognitive functioning screening (to identify risks associated with dementia), pressure ulcers, identification of seniors (over 65 years) at risk, falls and infection control. The documentation also included assessment charts for physiological observations (e.g. blood pressure, heart rate, temperature), fluid balance, and intentional rounding (regular patient assessment). There was also a section for recording the care provided to patients in addition to the discharge and transfer of patients.
- Doctors had a separate clerking sheet, which included a page for prescribing medications and intravenous fluids.
- We reviewed 29 sets of patient records throughout the department. We found variations in the accurateness, completeness and legibility of patient records. Individual patient risk assessments had not always been completed within the appropriate timescales, for example 13 out of 29 sets of records did not have a pressure ulcer risk assessment documented and 10 sets of records did not contain evidence of hourly intentional rounding.
- All patients should receive hourly comfort rounds. Comfort rounding is a scheduled check on each patients

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comfort every hour and to establish if they require anything for example whether patients require repositioning, need the toilet or require something to eat and drink. We looked at 29 sets of records and found that 12 of them had documented that hourly comfort rounds had taken place.

- Records on the emergency decisions unit (EDU) were securely stored in lockable trolleys. However, in the majors area of the department, patient records were stored in mesh racks on the outside of the nurse's station. We observed patient identifiable information was on view and although nurses and medical staff were usually around the nurses' station, at times, when staff were busy, the area was not supervised. This could increase the risk of records being accessed and seen by unauthorised persons.
- In the majors area of the department we observed a laptop, which was regularly updated by staff. The laptop displayed the names of all patients in the department as well as their presenting complaint. The screen was not concealed and staff did not monitor the laptops all of the time. This increased the risk of patient identifiable information being viewed by unauthorised persons, and we witness a relative of one patient reading the information on the screen.
- Locked confidential waste bins were available to dispose of confidential information and records; however, in the majors area and the resuscitation area of the department we found patient identifiable information in clinical waste bins and in a sharps bin. This meant confidential and patient identifiable information was not always protected or correctly disposed of in line with the requirements of the Data Protection Act 1998. We escalated this to the nurse in charge who briefed staff on our findings and the correct way to dispose of patient identifiable information.

Safeguarding

- There was a dedicated executive level safeguarding lead in addition to local named safeguarding leads for children and adults at the trust. All staff throughout the department were aware of the safeguarding leads and knew how to contact them if they required their input.
- Out of hours, staff told us they would raise safeguarding concerns with the nurse in charge of the department.
- The trust had a dedicated PREVENT lead and PREVENT e-learning was being rolled out to staff. The aim of PREVENT is to recognise people who are at risk of becoming radicalised and to stop them from supporting terrorism or becoming terrorists.
- Safeguarding policies for adults and children were up-to-date and included relevant guidance and legislation for staff to follow. All of the staff we spoke with understood their responsibilities to adhere to safeguarding policies and procedures and could articulate the circumstances under which they would need to make a safeguarding referral.
- The trust had a standalone female genital mutilation (FGM) guideline. All staff we spoke with were aware of their responsibilities to adhere to the FGM guideline and the actions to take if they had concerns about a woman or child in relation to FGM.
- The trust had a safeguarding assurance committee who had met once every other month, until March 2016 when they had started to meet on a monthly basis. This was chaired by the deputy chief nurse and was attended by safeguarding leads as well as key senior staff from the various Clinical Management Groups.
- Staff followed specific guidelines and care pathways where concerns around safeguarding children and young people were identified, for example in instances of self-harm.
- None of the staff we spoke with were able to tell us to what level of safeguarding training they had received. We spoke with a matron who told us all staff had received level three safeguarding of children training and they had personally delivered the training. We also spoke with the department's professional development lead who told us not all staff were trained to level three.
- We asked the trust to share with us the percentage of staff who had undertaken level three safeguarding training within urgent and emergency care services. The trust shared with us a table of the numbers of staff who had attended the emergency department raising awareness of vulnerable patients study day since June 2013. We saw 80% of nurses, 68% of consultants and 18% of trainees had undertaken this training. The trust sent us 17 separate documents, which indicated not all staff had received level three safeguarding of children training. This was not in line with intercollegiate guidance which states all clinical staff working with children, young people and/or their parents or carers and who could potentially contribute to assessing,

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planning, intervening or evaluating to the needs of a child or young person should receive level three safeguarding training. We were therefore not assured staff had sufficient knowledge and skills to safeguard children.

- Reception staff checked the demographic details of children attending the emergency department and confirmed the relationship of the person who was accompanying the child or young person. This is considered good practice.
- There was a safeguarding link nurse in each area of the emergency department.
- The safeguarding status of each child or young person was assessed on their arrival to the emergency department. If a child or young person presented as a safeguarding concern they would be admitted to the children's assessment ward.

Mandatory training

- All staff we spoke with told us they attended mandatory training on an annual basis. Mandatory training for all staff groups included fire safety, moving and handling, infection prevention and control, equality and diversity, information governance, safeguarding children, conflict resolution, safeguarding adults and basic life support.
- Information provided by the trust following our inspection in June 2016 demonstrated training compliance in urgent and emergency care services was variable against the trust's target of 95%.
- The trust had a sepsis management protocol and all staff we spoke with throughout the ED were aware of this.

Assessing and responding to patient risk

- In November 2015, we undertook an unannounced inspection of the emergency department where we raised concerns about the timeliness in which patients arriving to the department by ambulance were assessed. Since then, the trust has been reporting to us on a weekly basis.
- The trust had a target for 90% of patients to be assessed with a Dynamic Priority Score (DPS) on arrival at the ED. DPS is a triage tool to assess which patients need more urgent care.
- At the beginning of October 2016 the trust provided data which showed overall 88% of patients received a DPS

score within 15 minutes of arrival at the ED. When broken down, 98% of category one patients received a DPS against a target of 100%. Category one patients are those that require the most urgent care.

- At our previous unannounced inspection in November 2015, we found patients were at risk of avoidable harm because staff were failing to ensure all patients received adequate care and treatment in accordance with the trust's sepsis pathway. We placed conditions on the trust's registration, which meant the trust had to ensure there was an effective system in place to deliver sepsis management, in line with relevant national clinical guidelines. In addition, there was a requirement for the trust to report to the Care Quality Commission (CQC) describing the actions taken and how the clinical outcomes were being audited, monitored and acted upon on a weekly basis. The weekly reports indicated the trust was making some progress in the management of patients presenting to the emergency department with sepsis.
- According to the trust's guideline for the recognition and treatment of adult patients with sepsis and septic shock, patients with two or more systemic inflammatory response syndrome (SIRS) criteria, and signs of infection which could develop into sepsis should be screened for sepsis using the trust's 'Adult Sepsis Screening and Immediate Action Tool'. In addition, the emergency department observation chart indicated patients who had a EWS of three or more should be considered for sepsis screening. Sepsis is a potentially life threatening condition, which can be triggered by an infection or an injury.
- The number of patients screened for sepsis throughout June 2016 varied between 86% and 100%, however, the number of patients who received intravenous antibiotics within an hour was variable. Throughout June 2016, there were 13 days where 100% of patients received their intravenous antibiotics within an hour. For the rest of the month between 33% and 78% of patients received their intravenous antibiotics within an hour. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- During the week 3-9 October 2016, there were eleven patients with red flag sepsis identified in ED. Of these, 82% of patients received Intra venous antibiotics (IV)

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antibiotics within an hour, with a mean time of 44 minutes. The trust carried out reviews on patients who did not get their antibiotics within the hour so that any lessons could be identified.

- Throughout our announced and unannounced inspection, we reviewed the medical and nursing care records of 29 patients throughout the ED. We found three patients had not been screened for sepsis when they should have been, and of these three patients antibiotics had not been administered within an hour for two of them .
- We did however, observe good practices in relation to the management of a patient who developed sepsis whilst being nursed on the emergency decisions unit, where medical staff had assessed the patient and recognised the patient's EWS had deteriorated. The medical staff acted promptly to ensure the patient was screened and treatment was promptly started. This was a good example of how sepsis management should be delivered.
- Patients arriving by ambulance would directly enter the assessment area where the ambulance crew would hand over to the nurse in charge or they would proceed directly to the resuscitation area if the patient had been assessed as having a life threatening condition. At times when the assessment area was overcrowded, patients remained on the back of ambulances. Under these circumstances a registrar or an advanced nurse practitioner assessed these patients and they received a dynamic priority score (DPS) to establish their level of priority. Leicester emergency department were funded for a private company to provide the department with two paramedics who worked from 12pm to 12am seven days a week. They were trained to take the handover within the department from incoming paramedic crews. If a patient had not received an initial assessment after 15 minutes the service manager would escalate this to the hospital duty manager and the nurse in charge of the department.
- Over the winter period, from November 2014 to March 2015, there had been 4,501 ambulance hand-overs delayed for over 30 minutes. University Hospitals of Leicester NHS Trust is in the upper quartile of all trusts in England for numbers of delayed handovers.
- Between September 2015 and March 2016 there had been 3,297 delays over 60 minutes (black breaches) between ambulance arrival and patient handover to the Emergency Department (ED) at the Leicester Royal Infirmary. The reason given behind the number of black breaches was bed capacity within the trust and ED occupancy.
- There had been an agreement in place since 2012 that patients requiring admission to medical wards would be admitted to the medical speciality within 30 minutes of referral, this would increase the capacity in the emergency department, however medical wards had been unable to facilitate this and large numbers of medical patients were experiencing prolonged waits in the emergency department. We were told concerns had been escalated at a high level within the trust but it is still a recurrent problem.
- Children arriving by ambulance, which required a pre-alert, were taken straight to the resuscitation area of the department. A pre-alert is where the ambulance alert the resuscitation department of their imminent arrival, giving details of the patient's condition and an estimated time of arrival. Children who did not require a pre alert were taken straight to the paediatric reception area where they were triaged and assessed. Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 state that children should have an initial clinical assessment within 15 minutes of arrival to the department. Information submitted by the trust indicated the trust did not always achieve this, with some children waiting longer to be assessed. Children and young people were seen in the children's emergency department; they were triaged by a suitably qualified clinician and were streamed into children's minors or majors.
- Walk in patients were initially seen and booked in at the urgent care centre (UCC). Staff told us this was now the reception area for the emergency department. They were then seen, treated and referred to the minors department or transferred to the majors or resuscitation department dependent on their presenting complaint.
- The emergency department ran an information technology (IT) system, which was compatible with the local ambulance service's IT system. This enabled the emergency department to access information about which patients were coming into the department in advance of their arrival.
- Nursing staff used an early warning score system (EWS), based on the National Early Warning Score, to record and monitor routine physiological observations of

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adults such as blood pressure, respiration rate, oxygen saturation levels, temperature, and heart rate. EWS was used to monitor patients and initiated escalation when required.

- A paediatric early warning score (PEWS) tool was used to monitor physiological observations of children and young people. The PEWS was adapted according to the child's age and we saw examples of these having been completed with scores accurately calculated.
- During our unannounced visit, we saw staff had not adhered to the clinical response guidelines for an adult patient in the resuscitation area of the emergency department who was triggering an early warning score of 13. We were alerted to this patient because their monitor was alarming. The monitor was alarming for more than three minutes and staff did not respond to the alarm. We asked a doctor to review the patient as the patient had removed their oxygen mask and placed this on their head. We looked at the observation chart for this patient who had been in the department for just over two hours. Observations had been recorded at 2.10pm but an EWS had not been calculated. We calculated the patient's EWS to be 13. According to the trust's escalation and reporting record, the patient's observations should have triggered a sepsis screen and should have been recorded at 15-minute intervals. The patient had not been screened for sepsis and a second set of observations was recorded at 3pm. The nurse who was caring for the patient had accompanied another patient for an investigation and had not done any further observations. At the point, we raised concerns about this patient; they were screened and treated for sepsis some two and a half hours after entering the department.
- Many staff, including doctors and nurses told us they felt the emergency department frequently became unsafe. Seven medical and nursing staff we spoke to specifically expressed concerns about the safety of patients at busy periods. We were told that the department "feels out of control, especially when there were high volumes of patients", and that the department felt "chaotic" and "stressful".
- Staff told us risk assessments for checking patients' risk of developing deep vein thrombosis (DVT), also known as blood clots were not undertaken on patients within the emergency department, even if patients were in the department for more than six hours. We asked the trust to provide us with any audits relating to the assessment

of patient risk around developing DVTs and the trust's response indicated the assessments did not take place in the emergency department but took place once the patient was admitted to a ward area.

- If a pre alert was received for a child coming into the resuscitation area of the department a paediatric team would be requested over the department's tanyo system. We observed this on several occasions where a paediatric consultant and a paediatric nurse would receive the child and assess the level of intervention required.

Nursing staffing

- An electronic rostering system was used to plan nurse staffing for each shift.
- Planned nursing staffing levels across urgent and emergency care totalled 174 full time equivalent posts. Data for March 2016 showed actual staffing levels to be 155.5 full time equivalent, giving a combined vacancy rate of 11%. There were 18.5 full time equivalent qualified nurse vacancies and 12 support staff vacancies in the emergency department at the Leicester Royal infirmary.
- Since June 2015, there had been 24 new nursing appointments within the emergency department. Of those, nine (37%) were European nurses recruited from countries such as Spain, Portugal, Italy and Greece.
- The department had used the Baseline Emergency Staffing Tool (BEST) last year to assess the acuity of their patients against their staffing establishment. Because staffing and overcrowding had been on the risk register for a long period of time, extra funding was allocated to enable the department to staff the extra resuscitation bay and a bay in the assessment area.
- Planned versus actual staffing numbers were not displayed throughout urgent and emergency services. However, they were displayed within the urgent care centre.
- The use of agency nurses ranged between 13.3% and 25.2% from April 2015 to March 2016.
- Essential information and guidance was available for staff. A specific induction folder called the 'mandatory elements of local induction for temporary staff' was used for locum staff. Areas covered on the local induction included working procedures, environmental orientation and local guidelines relevant to the area. In addition, locum staff were provided with 'flashcards'. These included prompts relating to specific conditions

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such as sepsis, fractures and dislocations and methods of referrals to specific clinics. All of the agency staff we spoke with confirmed they had received an induction and they had worked in the department on several occasions.

- The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013 state that a minimum of one paediatric trained nurses should work on each shift. We saw paediatric trained nurses were available on all shifts within the paediatric emergency department.
- At or previous unannounced inspection in November 2015 we found the trust was failing to operate effective systems to ensure appropriate nursing skill mix within the ED. However, throughout our most recent announced inspection we saw the trust had taken action to ensure nursing skill mix was appropriate in all areas of the ED. All staff we spoke with told us the skill mix was improved and leadership in each area was coordinated by a suitably skilled and qualified nurse, however there was an acknowledgement the trust was still heavily reliant on the use of agency staff.
- Nursing staff handovers occurred at each shift change and included updates to standard operating procedures and any ongoing concerns. One to one handovers were undertaken by the patient's bedside nurse to nurse.
- The trust have been reporting their ED nurse staffing levels and skill mix to us every week since December 2015. The latest data for the beginning of October 2016 showed staffing levels and skill mix were being appropriately managed. This had been a consistent picture for many weeks which meant we were assured the improvements had been sustained.
- An emergency specialist middle grade doctor covered the night shift and should the shift be uncovered, for example because of sickness, the emergency department consultant would stay on site to provide leadership.
- There were four paediatric emergency medicine trained consultants with an additional five who had sub-speciality training in paediatrics.
- There was funding for 22.8 full time equivalent consultants. At the time of our inspection, 20.8 full time equivalent consultants were employed in urgent and emergency care services. Information from the trust indicated there were two full time equivalent medical vacancies across urgent and emergency care services. However, we observed chronic medical staff shortages with a permanent requirement for the use of locum medical staff to fill middle grade rota gaps.
- The average medical locum usage for April 2015 to March 2016 throughout urgent and emergency care was noted to be between 16.9% and 29.4%.
- The department used medical locum staff that were well known to them. However, a senior consultant told us that adequate locum provision was dependent on good relationships and could not be guaranteed when crucial administrative staff were on annual leave.
- The trust have been reporting their ED medical staffing levels to us every week since December 2015. The latest data for the beginning of October 2016 showed staffing levels and skill mix were being appropriately managed. This had been a consistent picture for many weeks which meant we were assured the improvements had been sustained.
- Essential information and guidance was available for staff. A specific induction folder called the 'mandatory elements of local induction for temporary staff' was used for locum staff. Areas covered on the local induction included working procedures, environmental orientation and local guidelines relevant to the area. In addition, locum staff were provided with 'flashcards'. These included prompts relating to specific conditions such as sepsis, fractures and dislocations and methods of referrals to specific clinics. The flashcards also contained useful information such as bleep numbers, commonly used telephone numbers and door codes.

Medical staffing

- The trust had a lower percentage of consultants when compared to the England average and the percentage of junior grade staff was in line with the England average. This meant there was a shortage of consultants within the department.
- Formal medical handover took place each morning with informal and ad hoc verbal handovers taking place throughout the day.
- Consultant cover was provided between 8am and 1am seven days per week to ensure there was 17 hours of cover 365 days of the year.

Major incident awareness and training

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- Evacuation training was included as part of fire safety training. Compliance in this training across all staff groups was 93.3% against the trust's target of 95%.
- The trust had major incident, critical incident and business continuity plans in place detailing the actions to be taken by trust staff in the event of a utilities failure or major incident. The major incident plan was version controlled and reviewed on an annual basis. It had also been amended as and when required.
- Staff could access the major incident plan via the trust's intranet. However, we saw no signage in relation to major incident plans throughout the emergency department.
- The major incident plan set out the roles and responsibilities of the urgent and emergency care department in the event of a major incident. This involved multi-agency working.
- Major incident planning was part of the emergency department's annual mandatory training; however, we spoke with five members of staff who told us they did not know what their role would be in a major incident and they had never seen the major incident policy.
- The action cards for use during a major incident could be found under a table in the sister's office and decontamination suits and a tent were kept in a covered area outside. We were not able to establish when these had last been checked.
- A matron told us there was a text alert system that would be used to call staff into the department should a major incident occur.
- A member of the security team was based in the urgent care centre 24 hours a day to deal with any untoward incidents that may occur.
- Although pathways were in place, the department did not consistently follow guidance and best practice. For example, the department did not follow the Royal College of Emergency Medicine (RCEM) and National Institute of Health and Care Excellence (NICE) clinical guideline 92 for carrying out thromboprophylaxis on patients with lower limb injuries and those who required a lower leg plaster cast. Nurses did not always follow best practice guidance in relation to the use of clinical risk assessment tools for example those used to assess a patient's risk of developing pressure ulcers and care assessments did not always consider the full needs of patients.
- Patients were not always assessed for their requirements for pain control in a timely manner. We saw evidence of patients who required strong pain relief to control their symptoms of pain. These patients had not been prescribed pain relief and struggled to get the attention of nurses at a time when it was busy and overcrowded in the department.
- Insufficient priority was given to the nutrition and hydration status of patients within the majors area of the department. Patients could not always get the attention of nurses to let them know they were thirsty, especially when the department was overcrowded.
- Mental capacity assessments were not always appropriately undertaken and Deprivation of Liberty Safeguards (DoLS) were not applied appropriately. We saw evidence that a patient was being deprived of their liberty to leave the department when their mental capacity assessment stated they had the capacity to make decisions. The assessment was not decision specific and did not indicate the person was at risk of harm to themselves or others.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement 

We rated the effectiveness of urgent and emergency services as requires improvement because patients were not always receiving effective care and treatment.

We found:

However, we also found:

- Evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively and, staff were supported to maintain and further develop their professional skills and experience.

Evidence-based care and treatment

- Staff mostly provided care to patients based on national guidance such as the National Institute of Health and Care Excellence (NICE) guidelines and were aware of changes being made to guidance. Clinical guidelines

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were available in line with National Institute for Health and Care Excellence (NICE) Guidance and College of Emergency Medicine (CEM) guidelines. Clinical guidelines were available on the trust's intranet and could easily be accessed by staff. During our inspection however, we saw some guidelines for example escalating the deteriorating patient and sepsis screening were not consistently adhered to.

- Staff in the emergency department used a range of care pathways for adults and children, in line with national guidance, such as for paracetamol poisoning, management of a suspected stroke and head injuries. These care pathways were based on NICE guidance and were evidence based. Staff could access these through the trust's intranet; they were also available in paper format.
- The department did not follow the Royal College of Emergency Medicine (RCEM) and National Institute of Health and Care Excellence (NICE) clinical guideline 92 for carrying out thromboprophylaxis on patients with lower limb injuries and those who required a lower leg plaster cast. Thromboprophylaxis is the treatment given to prevent deep vein blood clots. The trust took part in the RCEM 2015 to 2016 venous thromboembolism (VTE) risk assessment in lower limb immobilisation in plaster cast clinical audit, which indicated there was no written evidence of a VTE risk assessment being undertaken for this group of patients.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care were based and aligned to best practice guidance. For example, use of pressure ulcer risk screening tools. However, at times when the department was crowded and busy, staff did not complete the risk-screening tool or ensure pressure-relieving care was undertaken.
- Procedures and policies reflected current guidelines and were easily accessible through the trust's intranet. All policies we looked at were up-to-date.
- We saw a local audit regime was planned. Audits scheduled to be carried out included consultant sign-off, (based on RCEM standards).

Pain relief

- The CQC accident and emergency survey 2014 showed that University Hospitals of Leicester NHS Trust was about the same as other trusts concerning pain relief responsiveness and staff helping with pain control.

- Ambulance crews administered pain medication prior to arrival where appropriate and patients were asked about their levels of pain on assessment. Appropriate analgesia had not always been prescribed or administered in a timely manner. Out of the 29 sets of records we reviewed analgesia was not required for 10 patients. Of the other 19 patients, 13 patients had analgesia prescribed. Five patients did not have appropriate analgesia prescribed and on three occasions, when the department was busy, a CQC inspector had to prompt staff to prescribe and administer pain control medication when patients call bells had not been answered.

Nutrition and hydration

- The trust performed 'about the same' as other trusts for the question 'Were you able to get suitable food or drink when you were in the accident and emergency department.'
- Patients who were in the emergency department for a long time were offered drinks and snacks such as sandwiches, but this depended on how busy the department was. We saw an example where a patient was asking for a drink but staff were too busy to respond. We also saw another example where a patient who was diabetic was in the department for two hours before anyone offered them a sandwich.
- Patients who were on the emergency decisions unit all had jugs of water within their reach and these were replenished throughout the day. These patients were also given three meals per day, with access to hot food, in line with patients throughout the rest of the hospital.

Patient outcomes

- There was a consultant lead for audit in the paediatric emergency department and the adult emergency department. The department participated in Royal College of Emergency Medicine (RCEM) audits so they could assess their practice and performance against best practice standards. Audits included severe sepsis and septic shock, paracetamol overdose, asthma in children, cognitive impairment in older people, initial management of the fitting child and adult mental health in the emergency department.
- The severe sepsis and septic shock audit 2013/14 results indicated the department to be performing in line with the England average for nine indicators, better than the England average for two and worse than the England

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average for one indicator. The department achieved one of the standards, which related to the administration of an intravenous fluid challenge within the emergency department, although this was not achieved within an hour. An intravenous fluid challenge is where large amounts of fluids are given over a short period and are closely monitored to assess the patient's response.

- The trust had taken actions to address the outcomes for patients with sepsis and had reviewed their sepsis care pathway. The aim was to help staff to identify when to provide treatments in line with best practice guidelines. However, during our inspection we found this was not always used.
- The asthma in children 2013/14 audit showed the emergency department scored better than the England average for seven indicators and scored in line with the England average for one indicator and better than the England average in seven. As with the majority of other emergency departments throughout England, the trust met none of the standards. The documentation of 'systolic blood pressure' and 'peak flow' readings was found to be poor. The documentation of blood pressure within 15 minutes was 8% against a national median of 19%; and peak flow documentation within 15 minutes was 4% against a national median of 17%. Documentation of the other observations was found to be good.
- The paracetamol overdose 2013/14 audit indicated the trust did not meet any of the five standards. Performance was very poor against two standards; 'staggered overdoses receiving N -acetylcysteine (NAC), an antidote, within one hour of arrival' and 'proportion that received NAC within 1 hour of arrival'. [NAC is a medication that is given to treat people who have taken a paracetamol overdose].
- The initial management of the fitting child 2014/15 audit showed the department met two of the developmental standards and one of the fundamental standard (developmental standards are requirements over and above the fundamental standards). The department performed in line with the England average for four of the five indicators and worse than the England average for one.
- The mental health in the emergency department's 2014/15 score showed the department to be performing in line with the England average for six indicators and better than the England average for two. However, the

trust did not meet any of the developmental or fundamental standards and the audit highlighted a mental health practitioner had assessed none of the audited patients within an hour.

- The assessing for cognitive impairment in older people 2014/15 audit showed the department to be performing in line with the England average for three indicators and better than the England average for three out of six indicators. The department met the target of 100% for the use of a 'structured cognitive assessment tool used'. The one fundamental standard scored in the middle 50% of English trusts and the remaining developmental standard (cognitive assessment took place) scored in the top 25% of all English trusts. The trust met one aspirational standard (standards used for setting long-term goals) showing good communication with the admitting service. Performance against the remaining two aspirational standards, relating to communication of findings with GPs and with carers, was very poor.
- The trust's unplanned re-attendance rate within seven days was higher than the England average for all 13 months between November 2014 and November 2015. The trust failed to meet the standard of 5% unplanned re-attendance between November 2014 and November 2015, and the rate of unplanned readmissions remained consistent, on average, throughout the period. In July 2015 22.1% of attendances were unplanned re-attendances within seven days of a previous attendance.

Competent staff

- Appraisal rates at Leicester Royal Infirmary for the reporting period April 2015 to March 2016 averaged 82% across all staff groups within urgent and emergency care. This was worse than the previous year's appraisal rate, which was 88% for April 2014 to March 2015. This was also below the trust's target of 90%. Senior nurses told us the appraisal process and attendance at mandatory training was now linked to pay progression and hoped this would influence future figures.
- Staff told us the appraisal process was a positive experience and a process, which gave them the opportunity to identify their learning needs for the following year. We spoke with a charge nurse who had been supported to attend two courses since discussing their development needs at their appraisal.
- The trust had systems in place to ensure the registration status of doctors and nurses had been renewed on an

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annual basis. All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC) and there was a nominated Responsible Officer who took responsibility for medical revalidation.

- Newly appointed nurses had an induction to their role in the department and had a supernumerary period.
- The trust recruited nurses from European countries, including Spain, Portugal, Italy and Greece. These nurses were given a comprehensive 12-week induction including lessons to develop their English language; within this time, they were supernumerary. This gave them the opportunity to become familiar with nursing practice in England. At the end of the induction, they had to complete and pass a medicines management assessment before being allowed to work independently.
- Patients we spoke with felt confident about the medical and nursing staff's ability to care for them appropriately.
- In order to better support patients presenting with mental health conditions, the department had recently supported one of their adult trained nurses to undertake their mental health training.
- Specialist nurses for example, tissue viability specialist nurse, discharge liaison specialist nurse and, learning disability nurse were available in the emergency department to provide face-to-face training, guidance and support to staff within these areas.
- Education fellows and consultants had created an education programme that was accessible to all emergency department staff, including doctors, nurses, advanced nurse practitioners and health care assistants through the internet. Simulation training also took place on a regular basis.
- Sepsis training throughout the emergency department was variable. Nurses told us they received weekly feedback about the sepsis audit information. Two agency nurses told us they had received no formal training for sepsis. Doctors told us that mandatory sepsis training had been introduced recently.
- All consultants working in the paediatric emergency department were advanced paediatric life support (APLS) trained. All band six and band seven nurses were APLS trained. There was always a band six or a band seven nurse on duty for every shift.

Multidisciplinary working

- We saw evidence of good multidisciplinary team work on the emergency decisions unit where nursing staff, primary care coordinators, therapists and medical staff worked together to ensure patient's needs were fully assessed.
- The emergency department had access to an emergency psychiatric team which was nurse led. However, staff told us that they had to wait extended periods for mental health assessments out of hours. This meant patients waiting for mental health assessments were kept in the Emergency Decisions Unit (EDU) for long periods whilst waiting for assessment.
- There were two porters based in the emergency department to assist with any relevant tasks as required.
- A paramedic and technician and were based in the assessment bay between the hours of 12pm and 12am to free up nurses and assist with triaging patients. The paramedic was trained to take handover from the incoming paramedic crews. The paramedics reported good working relationships.
- There were three play staff in the paediatric emergency department. These were partly funded by the children's hospital.

Seven-day services

- The emergency department was consultant led, and provided a service 24 hours a day, 365 days a year.
- Diagnostic services such as X-ray and computerised tomography (CT) scanning were available in the emergency department 24 hours a day.
- Mental health support was available 24 hours a day, 365 days a year in the emergency department and the urgent care centre. Out of hours, an on-call duty psychiatrist provided cover.
- An alcohol liaison team were available between 8am and 4pm Monday to Saturday.
- The frail older person assessment and liaison team (FOPAL) was available Monday to Friday 9am to 5pm.

Access to information

- Staff within the emergency department received a handover from ambulance staff relating to the patients they were receiving. Information was given to a care coordinator.
- Staff in the resuscitation department received a pre alert from the ambulance service through a dedicated telephone line where essential information was communicated prior to the patient's arrival.

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- All staff had access to the information they needed to deliver effective care to patients in a timely manner, including access to test results, risk assessments and medical and nursing records.
- Care and treatment pathways were available for staff to follow in all areas of the department.
- The paediatric emergency department communicated with health visitors and school nurses by letter where they were required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date Mental Capacity Act 2005 (MCA) policy and Deprivation of Liberty Safeguards (DoLS) policy. The MCA 2005 aims to empower and protect people who may not be able to make decisions for themselves. It also enables people to make advance decisions to plan in case they are unable to make important decisions in the future. DoLS are part of the MCA 2005. They aim to ensure people in care homes, hospitals and supported living are cared for in a way that does not restrict their freedom inappropriately.
- Staff working in urgent and emergency care services received MCA and DoLS training on induction and as part of their emergency department mandatory training. There was also a mental health nurse who delivered sessions on the MCA, care of the frail elderly person and dementia awareness. However, staff knowledge in relation to the requirements of the MCA and DoLS was variable. We spoke with 10 nurses about the MCA, six of which told us they did not know when the MCA should be used and thought it was the same as the Mental Health Act.
- The trust had a process in place for application of DoLS where it was considered a patient may need to be deprived of their liberty in order to receive essential treatment. At the time of our inspection we observed a patient who was living with a mental health condition and had been admitted to the emergency department. The patient was being closely monitored by Closed Circuit Television (CCTV) cameras and was under the surveillance of a security guard. We spoke with a nurse who told us this patient lacked the capacity to make decisions and was waiting for the mental health crisis team to review them. We looked at the care records for this patient. An adult mental health proforma had been completed and a mental capacity assessment had been undertaken. The mental capacity assessment indicated

the patient had capacity to make decisions and did not lack capacity. We asked to see where a further assessment had been made to indicate the patient lacked capacity to make a decision. The nurse told us this had not been completed but they could see the patient lacked capacity to make decisions concerning their safety. At the time of our inspection the patient was not subject to any powers of the Mental Health Act but was being deprived of their liberty to leave the department. Under these circumstances, according to the trust's DoLS policy a DoLS referral should have been considered. However, staff told us they did not apply for DoLS in the emergency department and they did not understand it.

- Staff sought verbal consent from patients prior to treating them. We witnessed several examples where staff appropriately gained consent, where patients were able to give consent, prior to undertaking clinical interventions. Patients' also told us that staff had asked their permission before undertaking examinations and treatment. Where patients were unable to give consent, treatment was provided in the patient's best interest.
- Staff in the children's emergency department were aware of consent requirements relating to children.
- We asked the trust to share with us any audits relating to the completion of MCAs for patients who attended the emergency department with a mental health condition; however, the trust did not audit this information as a matter of routine.

Are urgent and emergency services caring?

Requires improvement 

We rated the care provided to patients within urgent and emergency services as requires improvement because there were times when patients did not feel well supported or cared for.

We found:

- Although staff were kind and caring and did their best to meet the care needs of patients, they did not always see people's privacy and dignity as a priority. At times when the department was overcrowded staff focused on tasks rather than treating people as individuals.

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- Dignity and privacy was compromised when portering staff took patients for investigations. We followed the journey of one person who was living with dementia. We observed a situation where no conversation took place to put the patient at their ease. In addition the dignity and privacy of patients was compromised in the red areas of majors and in the assessment area of the department.
- No consideration was given to the gender or culture of patients who were being nursed in the middle area of the majors department or in the marked out areas of the assessment and triage area of the department.

However, we also found:

- At times when the department was calm, staff demonstrated compassion and we saw a number of examples of good care.

Compassionate care

- The trust used the NHS Friends and Family Test (FFT) to capture patient feedback. [The FFT is a method used to assess patients' perceptions of the care they received and how likely patients would be to recommend the service to their friends and family]. We reviewed the FFT results for urgent and emergency services between August 2014 and February 2016. During this period, the percentage of patients recommending the department ranged from 91.7% in August 2014 to 97% in February 2016. The departments FFT response rate around was around 5%.
- The trust took part in the 2014 Care Quality Commission accident and emergency survey. Results indicated the trust performed about the same as other trusts for 18 of the 29 questions, and performed worse than other trusts in the remaining five questions relating to compassionate care. We found the length of time patients had to wait to be examined was the biggest concern for people, which was scored 3.6 out of 10. The trust scored about the same as other trusts for the question 'Were you given enough privacy when being examined or treated'.
- Reception staff were very respectful and polite to patients, assisting them with any enquiries they had. We observed examples of reception staff showing sympathy and consideration for patients when they were booking into the department.
- Throughout our inspection, we observed a very busy and overcrowded environment in the majors area and

the assessment area of the emergency department. Staff did their best to provide compassionate care for patients and those close to them. However, there were times when staff were unable to check the comfort levels of patients whilst they were being cared for in each of these areas. We observed patients trying to catch the attention of nurses, who were too busy to respond to their needs.

- On two of these occasions, patients had attempted to get the attention of a nurse to ask for pain control but the nurses were too busy to respond.
- Although staff did their best to maintain the privacy and dignity of patients, this was not always possible due to overcrowding in the department. There were five red bays in the middle of the majors area on which patients requiring a trolley waited until a bay became available. There were no screens to afford the privacy of patients with male and female patients being located in very close proximity next to each other. In addition, the way the trolleys were positioned meant these patients were facing the bay opposite them and this compromised the privacy of the patient in the corresponding bay.
- Within the assessment area of the department, we observed overcrowding with patients waiting on marked out red bays whilst they waited for an assessment cubicle to become available. We observed patients being transferred from ambulance trolleys to hospital trolleys. This was done in view of other patients with no screens in place to afford the privacy and dignity of the person being transferred.
- If a patient was on a trolley in a red marked out bay required the toilet they were swapped with another patient who was in a bay, and then brought back out to the red marked out area once they had finished.
- We spoke with 25 patients and those close to them throughout the inspection and most patients told us they were happy with the care they received despite how busy the nurses and doctors were. One patient told us "The staff are very caring and respectful" another patient told us "the staff are always respectful." Not all patients however had a positive experience. One patient told us they felt neglected because they were left on their own. The patient explained that staff just walked past them.
- We also followed the journey of a patient being taken for a computerised tomography (CT) scan. The porter wheeled the patient on their bed to the department and never once spoke with the patient or the patient's

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relative. The porter left the patient in a small corridor outside the CT scan room and placed the bed directly opposite a bed with a male patient in it. This did not preserve the dignity of either of the patients. The porter did not attempt to communicate with the patient or their relative throughout their journey.

- Within the resuscitation area of the department, we observed that although staff were working under pressure they were better able to demonstrate compassionate care that afforded patient privacy and dignity. All patients were nursed in cubicles which were screened off and had curtains to ensure privacy and dignity.
- We saw a female member of security responding to a patient who had a mental health condition. The member of staff was escorting the patient back into the emergency department from the outside area. We saw the member of staff treating the patient with compassion and kindness.

Understanding and involvement of patients and those close to them

- Staff explained the treatment and care they were delivering to patients in a way patients could understand.
- There were however some patients who told us they had not been kept updated or informed about what was happening to them. For example, one patient was waiting to be transferred to the Glenfield hospital but had not been kept informed of progress relating to their transfer.

Emotional support

- The hospital had a chaplaincy service and staff told us they could request support from the chaplaincy team if this was necessary.
- Staff were able to provide emotional support but found this difficult when the department was crowded and busy.
- We observed times when patients were distressed and staff were too busy to provide emotional support, for example we heard one patient in the majors area of the department calling out for assistance because they were in pain and uncomfortable. Staff were too busy to notice. We had to intervene to get a member of staff to attend to the patient's needs.

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

Inadequate



We rated the responsiveness of urgent and emergency care as inadequate because the service was not planned or delivered in a way that met patient's needs.

We found:

- Service provision was not planned to meet the cultural needs of the local population. Despite the demographic population of Leicester, Leicestershire and Rutland, signage in different languages within the department was poor. Leaflets were predominantly printed in English, although staff told us they could be obtained leaflets in different languages, they said they often found it difficult to access translation service. We saw evidence of this throughout our inspection.
- Flow through the department was slow because of delays in transferring patients to ward areas, which often occurred later at night. Some patients experienced unacceptable waits to be transferred to a ward because beds throughout the trust were not available.
- Because patients remained in the department for long periods, they were unable to access the ongoing care they needed. The emergency department did not have the facilities or resources to meet the needs of patients who should have been cared for on a ward as well as provide essential emergency care for patients entering the department.
- Patients did not have access to pillows. We observed frail elderly patients within the emergency department who had no pillow to rest their head on.

However, we also found:

- Staff could access specialist support services such as a learning disability nurse if they needed to.

Service planning and delivery to meet the needs of local people

- From April 2015 to March 2016 there had been 155,736 patients, including children who attended the

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emergency department at the Leicester Royal Infirmary. The emergency department was often overcrowded and the environment was not sufficient to deal with the amount of patients who attended the department.

There was an escalation policy which provided guidance for staff when dealing with periods of significant demand for services and staff demonstrated an awareness of what to do in these circumstances.

- Recognising the department was not sufficient for the population of Leicester, Leicestershire and Rutland, the trust had put together a business case and were in the process of building a new emergency department, which would be purpose built and provide more space to serve the population of the surrounding area. The new emergency department was planned to open in 2017.
- In order to take more control of the flow through the emergency department, in November 2015, the trust took over the running of the emergency care centre.
- Despite the demographic population of Leicester, Leicestershire and Rutland, signage in different languages within the department was poor.
- The 8 bedded Emergency Frailty Unit (EFU) comprised half of the Emergency Decisions Unit, and provided fast track Acute Geriatric assessments for frail, elderly patients who were frequently transferred to community pathways and thus discharged without admission onto the medical unit. The Geriatrician working in EFU also undertook frailty in-reach into Majors, working collaboratively with Primary Care Coordinators, and this often resulted in admission deferral, again utilizing either community pathways or community hospitals. Over the past year, there had been an 8% increase in attendances in the Emergency Department, but only a 1% increase in admissions, reflecting the impact of both Acute Medicine and Geriatric Medicine in-reach.
- There were well developed ambulatory pathways, including GPAU, the DVT Clinic and TIA Clinic at The Leicester Royal Infirmary, and the PE and Rapid Access Chest Pain Clinics at Glenfield Hospital, thus reducing the numbers attending the Emergency Department.

Meeting people's individual needs

- The trust had an interpreting and translation policy. Staff had access to interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British

Sign Language. Staff told us the interpretation service sometimes found it difficult to allocate a translator. We saw evidence of this during our inspection where a patient required a German translator. In these circumstances, and where possible staff members would interpret information for patients, however staff told us they would also ask family members to translate if this was the only option. This is not considered good practice as family members are not trained interpreters and increases the risk of information being filtered, deliberately or because the family member cannot interpret accurately.

- Patient information leaflets were available for a wide range of injuries and illness these were only available in English. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Hearing loops were not available in the emergency department reception areas for people who had a hearing impairment.
- The trust had 2.5 full time equivalent acute liaison nurses (ALNs) that provided advice and support to patients admitted to the trust who had a learning disability. In addition to this, a flagging system linked to the Leicestershire Learning disability register alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Patients who were living with dementia were identified by a blue forget-me-not flower sticker, which was placed on their nursing records. In addition, an alert was placed on the department's electronic recording system.
- Patients presenting with a mental health condition were assessed either in the assessment bay or in the Emergency Decisions Unit, unless there was an overriding physical health condition in which case they would be treated in the most appropriate place such as the majors or resuscitation area. There was a mental health triage team on site who provided 24-hour cover, seven days a week.
- Throughout our inspection, we observed that all patients, including frail elderly patients on trolleys were without a pillow to support their head. We escalated this to a senior nurse, they told us pillows were not available

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as they were often taken to the wards. When we returned for our unannounced visit, the nurse told us they had ordered 200 pillows and we saw that every patient had a pillow.

- A pictorial pain assessment chart was used to assess pain in children and young people.
- We observed a scenario where an emergency department consultant had had trouble in getting a doctor within the organisation to support them in obtaining an out of hours scan for a patient who had cancer.
- There were two rooms at the back of the resuscitation area where relatives could go for some privacy and time on their own.
- Staff regularly offered children and their parents food and drinks within the paediatric emergency department.
- Within the children's emergency department, there was a departmental made three-dimensional poster, which depicted the amount of sugar that could be found in fizzy and sugary drinks. The visual awareness of the amount of sugar there was in drinks was intended to help parents and children to make healthier choices.
- Vending machines were available in the minors area of the emergency department, so that patients could access snacks and drinks.

Access and flow

- Walk in patients were initially seen and booked in at the urgent care centre (UCC). Staff told us this was now the reception area for the emergency department. They were then seen and treated, referred to the minors department or transferred to the majors or resuscitation department dependent on their presenting complaint.
- Patients arriving by ambulance would directly enter the assessment area where the ambulance crew would hand over to the nurse in charge or they would proceed directly to the resuscitation area if the patient had been assessed as having a life threatening condition. At times when the assessment area was overcrowded, patients remained on the back of ambulances. Under these circumstances a registrar or an advanced nurse practitioner assessed these patients and they received a dynamic priority score (DPS) to establish their level of priority.

- Children arriving by ambulance, which required a pre alert, were taken straight to the resuscitation area of the department. Children who did not require a pre alert were taken straight to the paediatric reception area where they were triaged and assessed.
- When the department was full and all overflow areas and trolleys were in use, the service manager or the coordinator for the assessment area pressed a button, which showed a red light outside the ambulance entrance. This prompted ambulance staff to enter the department to give a short handover to the coordinator. A doctor or an advanced nurse practitioner would then assess the patient on the ambulance and allocate a dynamic priority score (DPS). This would indicate the urgency with which the patient would need to be seen.
- Between January 2013 and November 2015, the median time to initial assessment had steadily increased peaking at 33 minutes in November 2015. The waiting time had been above the England median of three to six minutes since October 2013.
- The Department of Health target for emergency departments is to admit, transfer, or discharge 95% of patients within four hours of arrival at accident and emergency. Between July 2014 and February 2015, the department had consistently performed below the standard and was below the England average. The trust had a whole hospital response escalation policy, and gold command meetings took place up to four times per day to look at staffing, bed status and escalate any risks that could potentially affect patient safety, such as low staffing and bed capacity issues.
- Between January 2013 and November 2014, the percentage of patients leaving the department before being seen fluctuated around the England average. The trust performed worse than the England average between May and November 2015.
- From April 2015 to March 2016 the trust averaged around 86.9% of patients processed within 4 hours although this was a declining picture and has been consistently below the England average.
- The number of patients leaving the department without being seen had been above the England average since May 2015.
- The total amount of time spent in the department on average per patient was shorter than the England average.
- The percentage of patients who waited between four and 12 hours from the decision to admit until being

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admitted was better than the England average until November 2015 when the percentage steadily increased to be in-line with the average, exceeding it in February 2016.

- There was an urgent care centre where patients could be seen without hospital admission.
- Between January 2013 and November 2015, the median monthly time to treatment was 29 minutes. This met the standard of 60 minutes and was below the England monthly median of 53 minutes.
- The consultant or senior registrar in charge of the emergency department arranged patient flow between the emergency departments and the ward areas. There was no formal medical, surgical or specialty handover or referral of non-urgent patients who were transferred from the emergency department to a ward and there was no inreach from medical or surgical doctors to the emergency department. The consultant or senior registrar gave the patient's details to a band six or band seven bed coordinator by telephone. These patients remained under the care of the emergency department until they were transferred. There was no acute physician review prior to the patient arriving on the ward areas and ward based physicians told us there were times when they did not know patients were being transferred to their ward until they arrived. Medical and nursing staff told us this often resulted in inappropriate admissions. Staff on the medical admissions unit told us at least one patient per day would be considered an inappropriate admission or, would be discharged from the unit within one hour of a medical review. Some patients were admitted to medical admissions unit in order to receive a meal because they may have been in the emergency department for up to eight hours and not received food. Following our inspection the senior leadership team told us they were not aware of any patients being admitted to the medical admissions unit for a meal following long waits in the emergency department.
- We observed the environment within the majors area of the emergency department at the Leicester Royal Infirmary to be chaotic and overcrowded throughout our inspection. This got worse as the day progressed. Medical and nursing staff expressed that lack of space, high in-flow and delayed transfer of patients made flow through the department very difficult. There was insufficient space and bays in which patients could be assessed and treated. There were five red 'overflow' bays in the middle of majors. Patients requiring a trolley were placed on a red bay until a treatment cubicle became available. The trust did not audit number of times in which this occurred.
- We observed the review of a patient who was referred to a specialist nurse under the medical team. The doctor referring the patient was told there would be a delay of four hours or more for the transfer of the patient. The referring doctor also had a further five patients under their care who had all been referred for an inpatient bed. Medical staff in the emergency department and on the medical assessment unit told us they favoured this system of referral because it meant their time could be spent seeing patients; they did however acknowledge that discharge and flow could be improved if a medical physician from the wards came to the emergency department to review medical patients.
- On the first day of our announced inspection, there were 20 patients in the majors area of the department. 12 of these patients were waiting to be transferred to a bed on a ward.
- The department had access to an emergency psychiatric team. However, staff told us they had to wait extended periods for mental health assessments out of hours. This meant patients waiting for mental health assessments were kept in the emergency decisions unit (EDU) for long periods of time whilst waiting for assessment. We asked the trust for audit data around the response times once a mental health referral had been made, however the trust did not audit this.
- There were pathways for transferring to the EDU, for example there were pathways for patients awaiting results, patients with mental health conditions, patients experiencing a headache and patients receiving received N-acetylcysteine (NAC) following paracetamol overdose. In order to prevent inappropriate admissions to the EDU, a signature was required from a referring doctor, the doctor in charge and the nurse in charge. Staff on the EDU told us that patients transferred to them were appropriately transferred and the unit was not used inappropriately.
- The department had escalation areas, which were used to provide extra capacity space when the emergency department was crowded. There were five red marked out spaces in the middle of the majors department, an emergency department corridor that could

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accommodate four trolleys and a bay opposite the EDU, which could hold up to four trolleys or beds. There was an escalation pathway with specific criteria for using the escalation areas.

- Medical and nursing staff expressed concerns that overcrowding in the emergency department impacted on patient safety.

Learning from complaints and concerns

- There was a trust wide policy for the management of complaints.
- Systems and processes were in place to enable patients and relatives to make a complaint. Posters and leaflets were available within the department. These allowed members of the public to identify how they could raise a concern or make a formal complaint. We also saw 'message to matron' cards and boxes to allow patients and relatives to make comments or raise concerns which where possible could be dealt with locally.
- A Patient Information and Liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- Between March 2015 and March 2016, 121 complaints had been received in relation to urgent and emergency services at Leicester Royal Infirmary. The top three themes related to medical care, staff attitude and waiting times.
- Complaints were shared and discussed at team meetings and any changes to practice because of a complaint or concern were shared with all staff at the nursing handover. We attended a morning and an evening handover and saw these were discussed.

Are urgent and emergency services well-led?

Requires improvement 

We rated the leadership of urgent and emergency care services as requires improvement because the leadership, governance and culture did not always support the delivery of high quality person-centred care.

We found:

- Departmental governance and risk management arrangements were not robust and as such were not effective in protecting patients from avoidable harm.
- Risks, issues and poor performance had not always been dealt with appropriately or in a timely way.
- Staff did not always raise concerns because they felt they would not be listened to or that anything would change.
- The approach to service delivery and improvement was reactive and focused on the short-term issues.
- Staff did not always deliver care and treatment in a way that was in line with the trusts vision and values and staff did not always feel supported.

Vision and strategy for this service

- Most staff we spoke with were able to articulate the trust's vision and the values, which was to deliver 'caring at its best' for everyone who visited the trust. Underpinning this was the trust's values which were; 'We treat people how we would like to be treated'; 'We do what we say we are going to do'; 'We focus on what matters most'; 'We are one team and we are best when we work together' and; 'We are passionate and creative in our work'.
- University Hospitals of Leicester NHS Trust had a detailed five-year integrated business plan, which covered 2014 to 2019. A two-year 'Operational Plan' was in place within emergency and specialist medicine with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy.
- Leicester Royal Infirmary provided the only emergency department throughout Leicester, Leicestershire and Rutland; and there was a clear vision for the future of emergency services, which included a programme of change to redesign and rebuild the emergency floor. However, there was no vision and strategy for urgent and emergency services in the interim.
- The vision and strategy for this service was not displayed throughout the urgent and emergency care department and although staff were looking forward to the build of the new emergency floor, they conveyed concerns with the current situation. Some staff also told us they were concerned the new department would not fix many of the issues they faced.

Governance, risk management and quality measurement

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- At our last responsive inspection on 30 November 2015 we found the trust was failing to demonstrate the implementation of an effective system in place so as to ensure;
- an appropriate skill mix to provide a safe standard of care to patients who require care and treatment within the ED at the Leicester Royal Infirmary.
- patients receive an appropriate clinical assessment by appropriately qualified clinical staff within 15 minutes of presentation to the ED at the Leicester Royal Infirmary in line with best practice.
- Patients did not always receive care and treatment in accordance with the trust's sepsis clinical pathway.
- The trust had been monitoring and providing weekly reports on its performance in managing deteriorating patients and the performance on screening and managing patients with suspected sepsis. Some improvements had been made and where patients did not receive timely treatment this was explored for further learning.
- The department maintained a risk register, which contained eight risks associated with urgent and emergency services at the Leicester Royal Infirmary. These related to overcrowding, high nursing vacancies, gaps in medical rotas due to shortfalls in medical staffing, risks associated with inadequate paediatric nurse staffing and seniority levels, risk of harm to patients during inter and intra hospital transfers and the ability to provide safe, appropriate and timely care, including care to patients presenting with mental health conditions. The senior management team within the emergency department had a good knowledge of the risks identified within the risk register and cited the impact of overcrowding and risk to patient safety as the main concern and risk within the service. All risks had control measures in place and had been assigned to a named, accountable person with responsibility.
- Concerns we identified during our inspection however, had not been included on the risk register. Outside the emergency department, we observed cars dropping patients off outside the Balmoral entrance. In order to do this they obstructed the ambulance bays, making it difficult for ambulances to enter and exit the ambulance bays. In addition, part of the road had been obstructed due to the new build of the emergency department. We asked to see any risk assessments relating to this,

however a formal risk assessment had not been completed. Following asking for a risk assessment and expressing our concerns the trust took steps to undertake a formal written risk assessment.

Leadership of service

- A clinical director, a director and a deputy clinical director provided leadership of the emergency department under the acute medicine/ED and specialist medicine clinical management group (CMG). At the time of our inspection there was no head of nursing for urgent and emergency care, however the trust had recently taken steps to appoint to this role.
- There was no emergency department representation at board level.
- Locally, staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt sisters and charge nurses, matrons and heads of nursing were visible and provided a good level of support. Some staff however expressed concern that there was a disconnect between senior management and those who were working on the emergency floor.
- There was a senior shift coordinator on each shift, who managed the day-to-day running of the emergency department.
- Following our inspection we received information from the trust so say the Emergency Department medical leadership had been strengthened through the appointment of three Heads of Service in July 2016, covering Paediatric Emergency Medicine, Front Door (Urgent Care Centre, Assessment Bay and Minors) and Majors and Resuscitation. The emergency processes had substantial support from the Executive Team, including the Chief Executive and Chief Operating Officer, and this was particularly in the context of the Emergency Quality Steering Group (EQSG) and LLR A&E Improvement Board, which was preceded by the LLR Urgent Care Board.

Culture within the service

- Morale within the department was variable. Whilst senior nurses staff generally thought morale was stable, staff told us they often felt the pressure of working in an overcrowded department. They felt frustrated that safety was at times compromised.
- All of the staff we spoke with were proud to work within urgent and emergency care services, and despite the daily difficulties encountered they remained focussed

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and positive about their role and the team in which they worked. However, we noticed a culture within the organisation where patient experience and safety was compromised at times when the department was overcrowded and busy. This had become normalised.

- Staff within urgent and emergency care services spoke positively of their colleagues and the staff we spoke with within the ambulance service spoke positively of the team within the emergency department. However, all of them recognised they were working under a great deal of pressure within the department.
- Most staff we spoke with, including agency and locum staff told us they felt supported in their role. Junior doctors and nurses told us they received a good level of support from their peers and line managers.

Public engagement

- Within the urgent care centre, we observed a patient experience suggestions box and a message to matron box containing patient survey forms.
- Within the paediatric emergency department children were encouraged to give feedback by writing their thoughts on a 'shorts and t shirt' board that was attached to a washing line on the wall. The shorts and t-shirts were wipe clean and could be used again. We saw many positive comments on this board.
- Patients could give feedback by completing a friends and family feedback questionnaire.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement






- There was a 'suggestions and ideas box' in the sister's office; however, staff told us they were not assured their ideas were always actioned or discussed.

- The trust told us about their Listening into Action (LiA) programme. Staff in the emergency department told us a LiA session was going to be undertaken in relation to end of life care in the emergency department.
- Staff in the paediatric emergency department told us about the development of 'greatix', this was where staff could celebrate good things that had happened in the department. They likened it to 'Datix' where staff raised concerns. Greatix could be used to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback through greatix and told us how this made them feel proud and valued.
- The trust had a 'UHL Way Implementation Plan' 2016 to 2017 setting out how they were going to manage change, engage and empower staff which also offered a framework for patient and public involvement in the improvement of care. It consisted of three components including better engagement, better teams and better change. None of the staff we spoke with mentioned the UHL way.

Innovation, improvement and sustainability

- In May 2016, the emergency department won two Health Service Journal Awards. One for training and development and the other for workforce efficiency.
- The department had developed and introduced an educational platform called East Midlands Emergency Educational Media (EM3). This was accessible to all staff and could be accessed through the internet. Weekly real time simulations were held with members of the emergency department team. During our inspection, we observed one of the simulations, with a junior doctor, a paediatric nurse, a health care assistant and a student nurse. The emergency specialist registrar (SpR) and the emergency consultant were leading the simulation with a member from the EM3 programme. Following the simulation, a reflection and brief took place. Staff who attended these sessions received a pin badge to indicate they had been part of the training. EM3 also provided learning cards on various topics to be displayed in staff areas; these were seen in the staff toilets and staff room. This had been well received by staff in the emergency department, and there was a plan to invite staff from other specialty areas, such as intensive care and the paediatric wards.

Medical care (including older people's care)

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

Information about the service

University Hospitals of Leicester NHS Trust provides medical care (including older people's care) is part of two clinical management groups: Cancer, hematology, urology, gastroenterology and general surgery (CHUGGS) and Emergency and specialist medicine CMG. Specialities include: medical oncology, clinical hematology, gastroenterology, general medicine, geriatric medicine, neurology, stroke medicine, diabetic medicine, infectious diseases, dermatology and rheumatology.

The trust has 902 inpatient medical beds across the three sites; 525 are located within 23 wards at Leicester Royal Infirmary. During our inspection we visited 21 clinical areas. These included; wards 15. Also known as the acute medical unit (AMU), 16, 23, 24, 25, 26, 29, 30, 31, 34, 39, 40, 41, 42, 43, endoscopy, chemotherapy suite, oncology assessment unit, bone marrow transplant unit, osborne day ward and the equipment library.

Between September 2015 and May 2016 there were 44,462 medical admissions to the Leicester Royal Infirmary. Of these, 50% were emergency admissions, 48% were treated as a day cases and the remaining 2% were planned admissions. General medical admissions represented the largest number of admissions at 28%.

During our inspection of this hospital we spoke with 16 patients, four relatives and 37 staff. Staff we spoke with included junior and senior registered nurses, health care assistants, housekeeping staff, student nurses, discharge coordinators, allied health professionals and junior and senior medical staff.

As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed interactions between staff, patients, and patient's relatives, considered the environment and looked at 11 sets of medical and nursing care records and reviewed 24 patient observation / sepsis screening pathway records. Before our inspection, we reviewed performance information from, and about, the trust.

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Summary of findings

We rated medical care services as requires improvement overall.

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

- We saw some instances where policy was not followed by staff. Staff did not always assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. Staff were not consistent in keeping side room doors closed for patients who were isolated. This posed a risk of spreading infection to others
- Some patients were at risk because they did not receive treatment in a timely manner. Nursing staff did not consistently follow or adhere to trust guidelines for the completion and escalation of deteriorating physiological observations and early warning scores (EWS); frequencies of observations were not always appropriately recorded on observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. Patients were at risk of being exposed to the risk of harm, when they met the trust criteria for sepsis screening, because staff did not always screen them appropriately. The trust took action to improve their performance with this following the inspection.
- Patients were at risk of not always receiving effective care and treatment. Outcomes for patients were sometimes below expectations when compared with similar services and services did not always meet national standards.
- Patients were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week.
- Assistance with mealtimes was not always carried out in a timely way and provision of food outside of mealtimes was insufficient.
- We observed staff responding compassionately when patients needed help, and saw a number of examples of good care.
- Patients were supported emotionally and this was reflected in their care and treatment.

- Patients were mostly supported and treated with dignity and respect.
- NHS Friends and Family results were positive with 95% of patients recommending the NHS service they had received to friends and family who may need similar treatment or care.
- Medical care services did not always meet patient's needs; the process of referral to the acute medical unit (AMU) resulted in at least one patient per day being inappropriately admitted and a high proportion of patients moved wards between the hours of midnight and 6am.
- Referral to Treatment Times (RTT) for the cancer standards and access to diagnostic tests was worse than the England average.
- The leadership, governance and culture in medical care services did not always support the delivery of high quality person-centred care; departmental governance and risk management arrangements were not robust and as such did not always protect patients from avoidable harm.

However:

- Patients were protected from abuse. Staff had an understanding of how to protect patients from abuse.
- We saw where patient's symptoms of pain were suitably managed in both ward and department areas with good comfort outcomes for patients in endoscopy.
- Staff were mostly proactive in assessing patient's nutrition and hydration needs.
- There was timely access to stroke services and patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.

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Are medical care services safe?

Requires improvement 

We rated safety of medical services as requires improvement because:

- There were inconsistencies in the way that staff used safety systems and processes, staff did not always follow these procedures. Staff were not always identifying and responding appropriately to changing risks to deteriorating patients.
- Nursing staff did not always adhere to trust guidelines for the completion and escalation of deteriorating observations and early warning scores (EWS), the frequency of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated.
- Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of harm because they did not receive the correct treatment in a timely manner and in line with national and local guidelines.
- We saw some instances where policy was not followed by staff. Staff did not always assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. Staff were not consistent in keeping side room doors closed for patients who were isolated. This posed a risk of spreading infection to others.
- Hydration records were not always updated appropriately to minimise risks to patients.

However, we also found:

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

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

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- Without exception all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- There were no never events in this service between March 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- The trust reported 44 serious incidents between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Medical care had the highest number of serious incidents reported at 13 (30%) with nine serious incidents reported at this hospital. Examples included three cases of care of the deteriorating patient that fell below standard and two medication incidents meeting the serious incident criteria.
- We reviewed the full investigation reports for four serious incidents and the initial incident review, also known as a 72-hour report for one serious incident. Investigation reports were thorough and showed that robust reviews had taken place, and where relevant staff

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and patients were involved in the review or investigation. Investigation reports highlighted where lessons had been learned and actions had been identified. Patients were told when they were affected by something that had gone wrong, given an apology and informed of any actions taken as a result.

- Medical services at this hospital reported 5727 incidents between March 2015 to March 2016. Of these two were unexpected patient deaths, five resulted in major harm, 53 in moderate harm, 800 in minor harm and the majority, 4866 in no harm or injury.
- Of the 5727 incidents, 158 were reported as near misses. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so.
- The most frequently reported incident categories were pressure ulcers, which generated 2072 reports and slips, trips collisions and falls where 1062 incidents were reported.
- Staff told us they received feedback from incidents through email, staff meetings, board 'huddles' and, during handovers. All staff we spoke with were able to tell us of incidents they had reported and of more serious incidents that had occurred in other areas. A recent change that had been put in place as a direct result of a serious incident included the introduction of a safety checklist for patients being nursed in side rooms. With the exception of Ward 42, all other ward areas we visited had checklists in place where staff had signed hourly to indicate they had checked the patient in the side room. On Ward 42 this was completed two-hourly.
- Mortality and morbidity meetings were held quarterly, as a minimum, across all medical specialties to discuss patient deaths. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Minutes from the meetings held for example, within stroke medicine and, geriatric medicine showed that mortality reviews had taken place with evidence of shared learning and actions identified where appropriate.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff we spoke with had a good understanding about duty of candour. Junior staff talked of being open and transparent with the public. Senior medical and nursing staff had a full understanding and gave examples of where duty of candour had been applied appropriately.
- We saw examples of where duty of candour had been applied appropriately. These incidents included a breach of patient confidentiality and where a scan had been performed on the wrong patient, in this incident an immediate apology had been given to the patient.
- Prior to our inspection we asked the trust if they monitored the application of duty of candour to gain assurance that this process was consistently followed across all areas. Data received following our inspection showed for the reporting period April 2015 to March 2016, there had been no breaches of the duty of candour requirement.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein.
- Data for 20 medical wards from April 2015 to March 2016 showed an average harm free care rate of 90%, which was worse than the hospital average of 92%. For the same reporting period eight wards performed similar to or better than the hospital average and, six wards performed significantly worse than the hospital average with harm free care reported as being between 83% and 89%. (Wards 16, 23, 29, 33, 37, 38).

Cleanliness, infection control and hygiene

- Leicester Royal Infirmary participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 92.9% which was worse than the England average of 95.5%.

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- Trust wide there had been 61 cases of clostridium difficile (*C. difficile*) infections between March 2015 and April 2016 with 36 cases occurring at this hospital in this core service. *C. difficile* is an infective bacteria that causes diarrhoea, and can make patients very ill.
- Methicillin resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between March 2015 and April 2016 there were 1 cases of MRSA reported at this trust with none occurred this hospital in this core service.
- Methicillin sensitive Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between 1st April 2015 and 31st March 2016 there were 25 recorded cases of MSSA at this trust, of which 5 occurred at this hospital in this core service.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits against key policies. For example; hand hygiene, sharps safety and availability and appropriate use of personal protective equipment (PPE).
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for December 2015 for two elements of the audit; before patient contact and after patient contact demonstrated 67% and 68% compliance respectively across 20 clinical areas. This was better than the trusts overall compliance figures but worse than the trust target of 90%.
- Throughout medical services the majority of staff were compliant with best practice regarding hand hygiene. All but one member of staff were observed to wash their hands or use hand sanitising gel between contact with patients. There was access to hand washing facilities and a supply of PPE, which included gloves and aprons.
- We saw some instances where policy was not followed by staff. Staff did not always assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated.
- Staff were not consistent in keep side room doors closed for patients who were isolated. This posed a risk of spreading infection to others. On Wards 23, 24, 31, 42 and 43, during our announced inspection, doors were left open to side rooms where it had been identified patients might present a risk of spreading infections to others. We raised this with staff on the ward to determine if risk assessments had been carried out. Staff confirmed that risk assessments had not been undertaken and immediately closed the doors. During our unannounced visit to this hospital we saw a door to a side room left open on Ward 16.
- We saw a wheelchair in use on Ward 23. The wheelchair appeared dirty and the seat cover was torn. Effective cleaning of the seat could not be assured, therefore increasing the risk of cross contamination and spread of infection. Dirt and dust was visible around the wheels and foot plate areas indicating the wheelchair had not recently been cleaned. We raised this with the nurse in charge and the wheelchair was taken out of use immediately.
- On Ward 24 we saw three commodes and four bedpans stored in the sluice. We could not see if these were ready for patient use as they did not have an 'I am clean sticker' in place in line with trust policy. On Ward 42 we could not see any evidence to suggest the ward had been cleaned in accordance with their cleaning schedule for example although the ward was visibly clean, the cleaning schedule had not been signed.
- On Ward 31 part of the nurses station work surface was cracked and damaged. This meant this area could not be cleaned effectively. On the same ward we saw two nurses not adhering to the trust infection prevention control policy. Hair was long and not tied up. During our unannounced visit to this hospital we saw three members of staff on ward 23 not adhering to the dress code, which was to be 'bare below elbows'.
- In Endoscopy we observed a member of the medical staff entering the clinical area in day clothes not 'scrubs'. Scrubs are the sanitary clothing worn by surgeons, nurses, physicians and other workers involved in patient care in hospitals, particularly in areas such as endoscopy, theatres and high dependency areas. We raised this with the Matron and Charge Nurse of the area, who stated this was not the normal procedure, all other staff were in scrubs.

Environment and equipment

- We checked the resuscitation equipment on five ward areas. The resuscitation equipment we checked appeared clean. Single-use items were sealed and in date, and emergency equipment had been serviced. Resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency.

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- A medical equipment library was available on this hospital site. The equipment library responded to ward requests for equipment in hours. Out of hours wards had access to 'satellite' stores maintained by the equipment library. The equipment library was responsible for cleaning, checking and servicing equipment to ensure it was ready for patient use. None of the staff we spoke with raised concerns regarding provision and access of equipment.
- We reviewed 16 items of patient-care equipment. All were clean and ready for use. Most patient-care equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service. However on Wards 29 and 30 we observed an enteral feeding pump in both areas that had no sticker to indicate when it was next due for a service. This meant we could not be assured these pumps had been safety checked or when they were due their next service. We raised this with the nurse in charge and both items were removed from use. An enteral feeding pump is an electronic medical device that controls the timing and amount of nutrition delivered to a patient during enteral feeding. Enteral feeding is a procedure in which the doctor inserts a tube into the patient's digestive tract to deliver liquid nutrients and medicines to the body.
- Arrangements for the storage of cleaning materials did not always keep people safe. On Ward 23 we saw where cleaning products were stored in unlocked cupboards within the sluice area. In the same ward area the cleaning cupboard that also contained cleaning products, was not locked. This increased the risk of unauthorised people being able to access these storage areas.
- The Endoscopy environment lacked space; as a result endoscope cupboards were in an accessible area to the public, the cupboards were open and unlocked. Geographically the endoscopy suite did not allow for continuous patient observation from a central point. However, the Trust had addressed this by ensuring that a nurse was present in this area and this was observed by the inspection team.
- The main doors to the chemotherapy suite opened directly in to a patient area where patients were receiving treatment. The patient treatment area had limited space and as such it was difficult for friends and family to accompany the patient throughout their time on the suite. Further refurbishment was planned and involved the upgrading of two small consulting rooms to provide more patient privacy during assessment and cannulation. However, as funding for this refurbishment was from a local charity staff did not have a timescale for completion.
- On Ward 40 the patient side rooms had balconies. The ward sister told us during spells of warmer weather the balconies would remain unlocked and patients would have direct access outside. We raised concerns about the types of patients who would be in these side rooms and were assured patients who may become confused would not be placed in these areas or, access to the balconies would be restricted. We were concerned however, that should side rooms be empty and balcony doors unlocked could patients who may be wandering and / or cognitively impaired access these areas. We raised this with senior staff in the trust who assured us the policy for leaving doors to balconies unlocked would be immediately reviewed and the doors would be locked.
- In January 2015, the Department of Health issued an alert to NHS trusts requiring action to reduce the risk of strangulation in children and vulnerable adults from loop cords and chains on window blinds. During a night time inspection visit we noted window blinds with loop cords on Ward 43. During our inspection we were unable to access all windows but saw three looped chains were not secured to a fixing point and all had tape mending them with no visible break point. Despite considerable pressure we could not break the loop cords. This was escalated to the ward staff. We were assured the maintenance department would attend the ward to ensure loop cords did not pose a future risk to vulnerable patients. During our unannounced inspection of the hospital on 30 June 2016 we visited Ward 43 to ensure this work had been carried out. Bays one, two and three, and side rooms two, five and seven had loop cords. The loop cords had not been addressed, we escalated this immediately to the ward sister who contacted the maintenance department whilst we were there. We contacted the trust after the unannounced visit to check if the work had been carried out. We received confirmation from the trust that our concerns had been addressed on 7 July 2016.

Medicines

- We looked at the prescription and medicine administration records for 24 patients across four wards

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and the acute medical unit (AMU). We saw appropriate arrangements were in place for recording the administration of medicines. The hospital used an electronic prescribing and medication administration (EPMA) record system for patients which facilitated the safe administration of medicines. Records were clear and fully completed. The records showed patients were getting their medicines when they needed them. Allergies to any medicines were recorded on the EPMA system.

- There were local microbiology protocols for the administration of antibiotics and we saw where these were followed. An antimicrobial pharmacist was also available to offer support and guidance.
- A pharmacist visited all wards each weekday and an on-call service was available out of hours. AMU had a clinical pharmacy service 8am to 8pm 7 days a week. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines. Patients told us they did not always receive information about changes to their medicines whilst they were on the wards.
- Medicines, including intravenous fluids were stored securely and we saw controlled drugs were stored and managed appropriately. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs
- We did not see records to assure us that medicines requiring refrigerated storage were stored at the correct temperatures to ensure they would be fit for use. Action was taken at the time of the visit to address deficiencies in monitoring (and confirmed in place on unannounced visits)
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.

Records

- During our inspection we reviewed 11 medical and nursing care records and, 24 patient observation / sepsis screening pathways. Records were paper-based and held at the patient's bedside and, in notes trolleys in the main ward corridors. We observed notes trolleys were

stored securely and were in an area where they could be seen at all times by a member of trust staff. However, during an evening visit to Ward 23 we observed 13 sets of medical notes, for discharged patients, stored in an unlocked cupboard. We raised this with ward staff who indicated this was normal practice. This meant that there was a risk of access to a patient's medical notes by an unauthorised person. The ward staff assured us they would ensure this area was secured.

- Locked confidential waste bins were available in all clinical areas. However, on Wards 42 and 43 these were stored by the main entrance to the ward. Bins were not secured to the wall. This meant they could be removed from the ward by an unauthorised person.
- Records were mostly legible, accurately completed and up to date. Nursing care records included care plans for; breathing and circulation, pain, communication, pressure area / wound care, mobility, elimination and continence, nutrition and fluid balance, personal hygiene, rest and sleep, psychological and emotional well-being, promoting health and safe care and discharge. However we saw examples where care records were not always completed or updated appropriately. For example, on Ward 26 a patient had not had an assessment of their risk of pressure ulcer damage. On Ward 23 a patient's fluid balance chart and food chart had not been updated since the morning, we reviewed the records after 8.50pm. This patient had a clostridium difficile (c. diff) infection and as such was at risk of severe dehydration. On the same ward a wound care plan had not been updated sufficiently to inform staff of any improvement or deterioration in the wound.
- Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and, dietetics staff.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. All staff we spoke with were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads.
- Information received after our inspection showed as of June 2016 training compliance in safeguarding children

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was 94% and, safeguarding adults 98%. The level of safeguarding training was predetermined by the Trust based on individual staff member's role and responsibilities within UHL.

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

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (level one and two), conflict resolution, safeguarding adults (level one), health and safety and, basic life support.
- Information received after our inspection showed as at June 2016 training compliance in medical services was greater than 90% across all subject areas. The trust target for mandatory training was 95%, however the data was not split into specific staff groups.

Assessing and responding to patient risk

- We reviewed 11 sets of medical care records. Where patients were admitted as an emergency medical admission they were seen and assessed by a consultant within 12 hours of admission and assessed by a member of the medical team within 30 minutes.
- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required.
- Patients with a suspected infection or an EWS of three or more, or those for whom staff or relatives had expressed concern were to be screened for sepsis, a severe infection which spreads in the bloodstream, using an 'Adult Sepsis Screening and Immediate Action Tool'.
- Patients being treated for sepsis, were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic'

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

- During our inspection of this hospital we reviewed 24 patient observation charts across 10 wards. We found nursing staff did not always adhere to trust guidelines for the completion and escalation of EWS, frequencies of observations were not always appropriately recorded on the observation charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. The trust were rolling out an electronic track and trigger system (e-obs) which would enable the trust to ensure that EWS scores were correctly calculated, frequency of observations correctly set and the correct escalation response requested.
- Only four of the 24 observation charts had the frequency of observations recorded. 21 out of 24 charts had full observations recorded (blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Two of the 24 observation charts; one on the acute medical unit (AMU) and one on ward 39, did not have the patient's urine output recorded and one observation chart on ward 29 did not have a temperature recorded.
- EWS had been completed at each time of recording the patient's observations on all 24 charts we reviewed with the exception of one chart on AMU which had three sets of observations recorded and no EWS calculated.
- EWS scores had been calculated correctly in all of the 24 charts we reviewed with the exception of one chart on ward 29 which had no temperature recorded and two charts on AMU and ward 39 which did not have a urine output recorded.
- Two of the 24 charts had a documented agreement not to escalate if a patient had triggered on their EWS. This had been written by the medical staff. This allowed nursing staff to make decisions about escalating the deteriorating patients. However, where agreements were not in place EWS scoring did not always take place in line with trust policy.
- Patients triggering on their EWS were required to have a further set of observations recorded within a set timescale; for example from four hourly to half hourly. Of the 24 charts we reviewed 10 patients had not had

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observations repeated in line with the trust's escalation of EWS monitoring in adult patients policy. This increased the risk of further deterioration for these patients.

- On Ward 34 we saw a patient had triggered an EWS of seven at 8:25am with no evidence that the trust's response to clinical deterioration policy had been followed. The patient had previously scored an EWS of seven at 2:17am and was reviewed by a doctor at 3:30am. The review stated the patient was already on antibiotics, so sepsis screening was not required at this point. We did not see documented evidence of a change of plan or specific parameter escalation nor did we see a further medical review documented in the patient's notes until 10am. This was not in line with trust's response to clinical deterioration policy which stated patients with an EWS of six or more should have a management plan documented detailing physiological parameters and interventions required. At 12pm, two hours after a medical review had taken place, blood results became available which indicated the patient had sepsis.
- On AMU a patient scored an EWS of six at 12:40pm. A further set of observations was not recorded until 2:10pm, this was not in line with trust's response to clinical deterioration policy. A patient with an EWS of six should have observations recorded half hourly. This patient's fluid balance chart was incomplete, an entry was recorded at 2:15am stating 1000mls of normal saline, and there were no further entries on the chart until 2pm when 100mls of water was recorded as input. No urine output was recorded on the chart, despite the patient having a urinary catheter. We took the opportunity to review the medical notes and saw that the doctors had written at 10:40am. Despite the patient scoring six there had not been another review by the doctors and we could not find any evidence that the doctors were aware of the EWS. We escalated our concerns to the nurse caring for the patient who said they would get a doctor to review the patient, but they were not worried about the patient's condition. A short time after this the patient left the ward to attend for an ultrasound scan. We were not assured that the nursing staff were taking appropriate action and were concerned that they may not understand the severity of the patient's condition. There was no evidence that the patient had received any interventions in line with the trust's response to clinical deterioration policy. For example, the patient had not been referred to the critical care team, and there was not a registered nurse remaining with the patient at all times; however there was a nurse present in the bay. This patient had been diagnosed with sepsis and was receiving antibiotics. However, we saw no evidence that the remaining interventions of the Sepsis Six Bundle had been followed for example blood cultures.
- On AMU a patient had scored an EWS of four at 8:20am and did not have another set of observations recorded until 11:05am. This was over two hours later than instructed in the trust's response to clinical deterioration policy; there was not a documented agreement not to escalate if a patient had triggered on their EWS. Staff had not followed the trust's response to clinical deterioration policy or guidance relating to screening patients for sepsis in line with the trust's sepsis pathway, which states patients scoring an EWS of three or more should be screened for sepsis.
- On AMU a patient had scored an EWS of four at 10:30am; a further set of observations were not recorded until 12:30pm which showed a repeat EWS of four. A further set of observations were recorded at 2:40pm. We did not see any evidence that the escalation or the trust's response to clinical deterioration policy or sepsis guidance had been followed. For example there was no evidence to indicate the patient had been reviewed medically at the time of our visit to the ward area at 4:13pm despite the trust's response to clinical deterioration policy stating that a management plan should be documented outlining interventions and physiological parameters for the patient. In addition, there was no evidence that the patient had been screened for sepsis.
- On Ward 29 a patient had scored four at 7:15am; no further observations were recorded until 10:05am. There was no evidence that the trust's response to clinical deterioration policy had been followed and the patient had not been screened for sepsis in line with the trust's sepsis pathway.
- On AMU a patient had scored an EWS of three at 9:40am and was not screened for sepsis in line with the trust's sepsis pathway. Observation frequency was not recorded in line with the trust's response to clinical deterioration policy. This patient should have had observations recorded hourly for a minimum of two hours. However, the patient had observations recorded at 12:50pm and 4pm.

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- On AMU a patient had scored an EWS of two at 11:05am, a further set of observations should have been recorded within one hour. On our visit to the ward the patient had still not had a set of observations recorded at 3:50pm. This was not in line with the trust's response to clinical deterioration policy. The patient had however had temperatures recorded at 12:05pm, 1:05pm, 1:20pm and 2:00pm.
- On Ward 25 a patient had triggered an EWS of two at 4:20pm, a further set of observations were not recorded until 7:20pm which triggered an EWS of two. Subsequent observations were carried out at 00:15am and 4am both with an EWS of two. However, the trust's escalation policy had not been followed, no frequency of observations were recorded and there was no evidence that the nurse in charge had been made aware of the patient's EWS, as this should be recorded on the back of the observation chart in the summary of intervention section. Observations had not been recorded from 4am to the point that we reviewed the chart at 9:30am, we informed the nurse in charge, who was unaware of the patient's previous EWS of two.
- On Ward 30 a patient had scored an EWS of two at 4:15pm. No further observations had been recorded until 6:15am the following morning despite the trust's response to clinical deterioration policy stating that all patients should have at least 12 hourly observations, and patients with an EWS of two should receive hourly observations for a minimum of two hours. The trust's response to clinical deterioration policy had not been followed for this patient.
- On Ward 30 a patient scoring an EWS of two at 6:00am did not have observations recorded within the timescales laid down in the trust's response to clinical deterioration policy, further observations were recorded at 2:45pm and 9pm when the patient was still triggering an EWS of two.
- On the oncology assessment unit a patient had scored an EWS of six at 7pm. This patient had all the appropriate interventions carried out in line with the trust's clinical deterioration interventions policy, this included the documentation of specific patient parameters and the patient was screened for sepsis in line with the trust's sepsis pathway.
- Compliance with EWS scoring and escalation of patients who triggered or were deteriorating was incorporated into the Clinical Management Groups (CMGs) nursing metrics data. We reviewed the nursing metrics data specifically for the six wards where EWS and/or sepsis screening had not been managed in line with trust's response to clinical deterioration policy and sepsis guidelines. Data from September 2015 to February 2016 demonstrated an overall average compliance score of 86%. This was worse than the overall average compliance score for all medicine wards which was 92%. One of the six wards had scored better than the 92% average with a compliance score of 96%; this was ward 34.
- Following the inspection, we asked the trust to provide more information about their plans to improve performance on the management of deteriorating patients as well as sepsis. The trust had a plan in place to improve their performance and they voluntarily offered to report this to us every week. We were satisfied they had adequate plans and governance processes in place to monitor and act on their data.
- Since our inspection the trust has been providing data on how deteriorating patients were being managed. At the beginning of October 2016 the trust had 95% of patients who had an EWS score of 0-2 and were appropriately managed; 90% of patients with an EWS of 3 or more were appropriately managed. Ninety two percent of patients with an EWS of 3 or more were appropriately screened for sepsis. The percentage of patients with red flag sepsis who received antibiotics within one hour was 46%, so many patients were still not receiving timely treatment.
- A critical care outreach team (CCOT) was available to the wards 24 hours a day, seven days a week. The team worked closely with the nursing and medical teams in the intensive care units within the trust and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Nursing staffing

- Across UHL since September 2014 all clinical areas had collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the

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Chief Nursing Officer for England. It is important to note that this tool is only applicable to acute adult ward areas. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically and matrons and the senior nursing teams confirmed this data on board rounds as well as unannounced visits to clinical areas. The data was considered alongside staffing information from the electronic rostering system and patient information including admissions and discharges and additional tasks undertaken in different clinical areas

- Staffing levels were displayed in all the clinical areas we visited and information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were 'gaps' in staffing bank and agency staff had been requested.
- During our inspection we found staffing levels in most areas were sufficient to deliver safe patient care. However, nursing staff on Wards 15 and 39 raised concerns. We saw from ward staffing rotas and trust wide vacancy data that there were vacancies within these areas of 4.6 whole time equivalent (WTE) and 1.3 WTE respectively. Ward sisters told us where there were vacancies these had been addressed and wards were at various stages of the recruitment process. Staffing vacancies had also been raised as a concern by the senior leads within medicine and had been identified on their risk register.
- On Ward 16 there were two 'acute care bays' and two 'acute side rooms', this totalled 10 beds for those patients deemed as requiring 'Level one' and 'Level two' care. Level two care is defined by the Guidelines for Provision of Intensive Care Services (GPICS) as; patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. GPICS standards suggest 'level two' patients require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care. If there were 10 level two patients being cared for on ward 16 then the nurse to patient ratio would be one nurse to three patients and would not meet the GPICS guidelines. At the time of our inspection, eight beds were in use giving a nurse to patient ratio of 1:2.6. Staffing levels were raised with the ward sister of this unit who did not feel this was a problem, nor did we see where patient care and safety had been compromised.
- Planned nursing staffing levels across the 23 clinical areas totalled 605.8 whole time equivalents (WTE). Data for March 2016 showed actual staffing levels to be 526.8 WTE giving a combined vacancy rate of 13%. Vacancies varied across clinical areas with vacancy figures of between 0.2 WTE and 13.4 WTE. The three areas with the highest vacancy rates were; ward 43 (13.4 WTE), wards 25 and 26 (5.9 WTE) and ward 24 (5.2 WTE).
- The average nursing agency usage for April 2015 to March 2016 across medicine was between 5.1% and 22.7%. However, agency use in neurology was between 6.3% and 35.1% for the same reporting period. Agency staffing was managed on a day to day basis with agency use 'shared out' across the clinical management groups to mitigate the risk of high numbers of agency staff in any one ward area.
- A specific induction folder was used on the wards for bank and agency staff; 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration. However, the log book was not always completed sufficiently to indicate bank and agency staff had been orientated to the ward or clinical area. On Ward 42 since 1 April 2016 there were 74 agency/bank staff recorded in the log book all signed by the agency/bank nurse, on 44 occasions there was no record completed for which member of ward staff had conducted the induction process. On Ward 23 there had been 65 entries from 1 April 2016, all signed by agency staff, with six occasions where there was no record completed for which member of ward staff had conducted the induction process.
- At the time of our inspection agency staff working on Wards 15 and 23 both confirmed to us they had undertaken the trust induction process with a member of ward staff.
- During our inspection we observed a shift handover taking place by the patient's bedside. Handover involved the named staff identified to care for a group of patients, and included half of the staff on duty for the shift. This ensured a significant number of staff had an appropriate awareness of each patient on the ward.

Allied Health Professional staffing

- Physiotherapy and Occupational therapy (AHP) support was available on the acute medical unit (AMU) 9am to 5pm seven days a week. Where support was required

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from physiotherapy out of these hours an on-call system was in place. Nursing staff told us the on-call system worked well with no difficulty getting physiotherapy support at night.

- Within stroke services staff reported good access to AHPs Monday to Friday with on-call access out of hours and weekends. For non-urgent patients, plans were completed by the AHPs on Friday for the nurses to follow over the weekend.
- Speech and Language Therapy (SALT) were available 9am to 5pm, Monday to Friday. There was no weekend or bank holiday cover. In the absence of SALT, nursing staff could complete advanced screening of a patient's ability to swallow.

Medical staffing

- The trust had a slightly lower percentage of consultants when compared to the England average. The percentage of junior grade staff was slightly higher than the England average.
- The medical handover of emergency medical admissions occurred twice daily, seven days a week, on the acute medical unit (AMU). An acute medical consultant led this. We observed a medical handover where all overnight admissions were reviewed first, followed by the remainder of patients. All clinical and social aspects of the patients were considered. A comprehensive medical review of each patient took place and included appropriate escalation of those patients who were at risk of clinically deteriorating, sepsis and a review of diagnostic tests.
- Medical cover on the AMU consisted of a consultant, a registrar and four junior doctors during the day. At night there was a registrar who also covered ward 16 and three junior doctors. This was the same for weekends and bank holidays. Consultants were available on-call and worked a rota of four consecutive on-call shifts. If a consultant was not in the hospital, they could be contacted and available within 30 minutes if required.
- There were medical vacancies across eight clinical areas at this hospital. Data for March 2016 showed vacancies between 1% in dermatology and 32% in infectious diseases with an average vacancy rate of 15.9% across all eight clinical areas.
- The average medical locum usage for April 2015 to March 2016 across medicine was noted to be between 0% in cardiology and endocrinology and 20% in general medicine.

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

Major incident awareness and training

- Evacuation training was included as part of fire safety training. Compliance in this training across all staff groups was 94%.
- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident.
- We talked to nursing staff in five areas specifically about their understanding of an emergency or major incident that may affect services at this hospital. All the staff we spoke with were aware of the trust major incident and business continuity plans and were able to locate them for us. Some staff gave us examples where they had been involved in a major incident scenario within the emergency department.

Are medical care services effective?

Requires improvement 

We rated the effectiveness of medical care as required improvement because patients were at risk of not always receiving effective care and treatment.

We found:

- Whilst Information about patient's care and treatment, and their outcomes, was routinely collected and monitored, outcomes for patients were sometimes below expectations when compared with similar services at a national level. For example results in the 2014 Heart Failure Audit were below the England and Wales average for all 12 standards and, in the 2015 National Diabetes Inpatient Audit (NaDIA) there were 12 scores worse than, the England average.
- This hospital had a Joint Advisory Group (JAG) status of 'Assessed: Improvements required'. This meant not all aspects of the service had met JAG standards.

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- Consultant presence was not available seven days a week on all wards within medicine. Nor were patients routinely reviewed at a weekend unless their condition deteriorated.
- Assistance at mealtimes was not always carried out in a timely manner and the provision of food outside standard mealtimes was insufficient with staff reporting no or little access to a hot meal.
- Deprivations of Liberty Safeguards (DoLS) were not always applied appropriately. In one instance we saw no regard for the patient's level of mental capacity resulting in an unlawful application for a DoLS.

However, we also found:

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

Evidence-based care and treatment

- Patients had their needs assessed and their care was planned and delivered in line with evidence-based, guidance, standards and best practice. For example, best practice was followed in line with the National Institute for Health and Care Excellence (NICE) quality standard CG68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. The sentinel stroke national audit programme (SSNAP) data submitted by the trust audited stroke services against NICE evidence-based standards.
- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed five sets of patient care records. Four out of

the five patients had received a venous thromboembolism (VTE) risk assessment and had preventative venous thromboembolism (VTE) medication if indicated.

- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection, we saw a number of care bundles in place. Examples included; short stay admissions to Ward R15, neutropenic sepsis, non-invasive ventilation (NIV), peripheral and central lines and urinary catheters. Neutropenic sepsis is caused by a condition known as neutropenia, in which the number of white blood cells in the blood is low.
- In medical oncology a rapid assessment risk assessment tool based on Oncology Nursing Society guidance was used to ensure patients contacting the oncology helpline for advice, received a robust, reliable assessment every time.
- Patient acuity in ward areas was identified using a traffic light system. Coloured circles were displayed behind the patients' bed. Red signified patients who needed full assistance, amber some assistance, and green patients who were independent.
- 'Think Glucose' is a national initiative to improve in-patient diabetes care, including the use of a traffic light system to give guidance to hospital staff as to which patients should be referred to the in-patient diabetes specialist team. To address insulin safety at this hospital senior leads told us this initiative was to be rolled out across the medical wards for a second time.
- Patients on the acute medical unit (AMU) were seen and reviewed by a consultant twice daily. To maximise continuity of care consultants worked multiple day blocks. Once transferred from this area to a general ward, patients were reviewed during a consultant-delivered ward round at least once every 24 hours Monday to Friday. At weekends, a consultant did not routinely review patients unless they were admitted at the weekend, there was concern, or their condition was deteriorating.
- In 2011, this hospital had a Joint Advisory Group (JAG) status of 'Assessed: Improvements required'. JAG accreditation is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. Following our inspection we saw correspondence between this

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hospital and JAG dated 30 June 2016 confirming a 'desk-top' review was to be undertaken of data submitted to JAG by this hospital. A further review by JAG was scheduled for November 2016.

- Local audit activity in endoscopy included an audit of the World Health Organisation (WHO) surgical safety checklist. Audit results at the time of our inspection showed 100% compliance with the 'sign in' moment and 80% compliance with 'sign out'.

Pain relief

- The Faculty of Pain Medicine's Core Standards for Pain Management (2015); Standards 2 and 3 were implemented across the medical wards and relevant clinical areas. For example, nursing care records included care plans for pain, a 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder and, pain was assessed and documented in all 24 patient observation charts we reviewed.
- Of the 13 patients we spoke with, one raised a concern about the management of their pain. The patient told us they had waited two hours for pain relief.
- Patient comfort during a colonoscopy procedure was measured using a five-point scale with zero equalling no discomfort through to five equalling very uncomfortable. Comfort scores for this trust between June 2015 and May 2016 demonstrated across 3,728 procedures, 5.2% of patients indicated a comfort score of greater than four.

Nutrition and hydration

- Fluid balance charts were in use to monitor a patient's fluid intake and output. We reviewed 20 patients requiring fluid balance charts. Of these, four were not up to date and accurately calculated on the acute medical unit (AMU) and ward 26.
- A nationally recognised screening tool was used throughout medicine to identify adults, who were malnourished or at risk of malnutrition. Staff used this tool to inform care planning and identify any specific dietary requirements. In 10 out of 11 nursing records we reviewed the patient had been appropriately assessed using this tool. However, in one set of nursing records we reviewed, a patient had been admitted on 8 June 2016 but had no nutritional assessment documented until 19 June 2016 despite multiple reviews by a dietitian.

- We heard a number of negative comments from patients regarding food access and provision at this hospital. Patients told us they found the food monotonous, they were not offered choices and one patient felt they had not had enough to eat since being an inpatient.
- During our inspection, some patients were fasting for Ramadan. Ward 42 was unable to provide hot meals for patients who wished to fast and eat in the evening because they could only heat food during specified meal times. This meant patients who were fasting were unable to have hot food and had to order a snack box. Another patient on Ward 40 had needed to attend an appointment at 5pm; this meant the patient had missed their meal. When they returned to the ward all that could be offered was toast. We discussed this with nursing staff who told us there was no hot food available outside of set meal times and food could not be heated on the ward including that bought in by patients relatives.
- On the acute medical unit (AMU) suitable cups such as those with two handles were provided to ensure patients could drink independently. However, one patient on the same ward told us they had asked for a beaker to drink out of but had not received one. Another patient on the same ward told us at 7.30am, they had been admitted to the ward at 10pm the previous night and had had nothing to eat or drink since.
- Protected mealtimes were in place across the medical wards. Protected mealtimes encourage hospitals to stop all non-urgent clinical activity on wards during mealtimes. During this time patients can eat their meals without interruptions and nursing staff are available to offer help to those who need it. However, we attended morning handover on Ward 31 at 7.30am. At 7.45am breakfast was being served whilst handover was taking place. This meant there were no available nurses to help those patients requiring assistance with their food. At 8.05am the first patient to be served breakfast had not received assistance with their breakfast.
- Two patients told us they thought the food was good and there was a good selection of food on the menu.
- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.

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- Staff provided jugs of fresh water for all patients who were drinking. On Ward 31, we observed staff pouring drinks of water, which were within the reach of patients.
- On the stroke unit a rapid assessment nurse (RAP) assessed patients who had experienced a stroke and completed a swallowing assessment. Speech and language therapists (SALT) were also available Monday to Friday to complete swallowing assessments. At weekends and out of hours all but three of the registered nurses on the stroke unit had completed swallowing assessment training so could undertake a preliminary assessment to ensure patients were not left without adequate nutrition for any period.

Patient outcomes

- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. From October 2015 to December 2015 SSNAP scored the trust overall at level C, on a scale where level E is the worst possible.
- The trust varied in performance against individual indicators. The trust's SALT indicator had been rated E from January 2015 to December 2015, while performance against the 'standards by discharge' indicator had been graded A for the same reporting period. Following our inspection we reviewed SSNAP data for the reporting period January to March 2016 which showed the trust's speech and language therapy indicator had improved to a D rating with a trust overall rating maintained at level C.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where medicines are given rapidly to dissolve blood clots in the brain). The trust standard was that all patients admitted following a stroke should be thrombolysed within three hours of admission. For the last 300 patients who had experienced a stroke and were admitted to this trust, 27 were thrombolysed (9%). This was lower than the trust target of 12%. All 27 patients (100%) were thrombolysed within 3 hours.
- Leicester Royal Infirmary took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results showed the hospital had five scores better than, and 12 scores worse than, the England average. The indicator regarding 'foot risk assessment within 24 hours' was significantly better than the England average at 75.2% compared to 28.6% nationally.

- Between August 2014 and July 2015 medical patients at this hospital had a lower than expected risk of readmission for non-elective admissions and a higher than expected risk for elective admissions. The elective specialty, medical oncology, had the largest relative risk of readmission. Following our inspection we asked the trust for its readmission rates between August 2015 and May 2016. This was provided but was not broken down into the three hospital sites. Therefore, for the period August 2015 to May 2016 medical patients at this trust had a higher than expected risk of readmission for non-elective and elective admissions.
- Monthly monitoring of dementia screening was undertaken as part of the National Dementia Commissioning for Quality and Innovation (CQUIN). The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this means better experience, involvement and outcomes. Data for the reporting period January to March 2016 showed 95.8% of patients were screened for dementia. This was better than the 90% target set by the commissioners of the service.

Competent staff

- Appraisal rates at Leicester Royal Infirmary between April 2015 and March 2016 averaged 93% across all staff groups within medical services. This was better than previous years with appraisal rates at 90% for April 2014 to March 2015. Senior nurses told us the appraisal process and attendance at mandatory training was now linked to pay progression, they felt this had contributed to the improved appraisal rates for 2015/16.
- Quarterly monitoring of dementia training figures were undertaken as part of the National Dementia CQUIN. Dementia awareness training had been developed using a multi-agency approach and focussed on two categories; Dementia Category A (basic level, required by all employees) and Dementia Category B (enhanced level, required by staff working clinically with adult patients). Between January 2016 and March 2016 category A training had exceeded the trust's target of 90% with 93% of staff having completed this training. For the same reporting period, 89% of staff had completed category B training, which was slightly worse than the trust's target of 90%.
- The trust had employed a number of registered nurses from overseas. There was a comprehensive trust wide

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programme for overseas nurses which included an eight-week induction, followed by a minimum of four weeks supernumerary status within the clinical area. Ward Sisters told us this could be extended if required.

- In Stroke services, dedicated time was allocated to staff, through the electronic roster, to complete their e-learning mandatory and competency packages. Stroke specific training was also available. Some staff had attended stroke specific training on 19 April 2016. Staff were also given the opportunity to attend the UK Stroke Forum (UKSF). Feedback from staff attending the UKSF had led to health care assistants (HCAs) accessing more specialist training.
- Nurses on the stroke ward were competent in undertaking basic swallowing assessments, which meant that patients were assessed quickly and able to eat if it was assessed as being safe for them to do so.
- On ward 31, we were told that all HCAs had completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers follow in their daily working life. The minimum standards should be covered as part of induction training of new care workers.
- Nurses within the chemotherapy suite had completed specialist training appropriate to their role which included for example, cannulation, care of central venous catheters (used for the administration of chemotherapy or other medications), total parenteral nutrition (TPN) (a method of feeding that bypasses the stomach. Nutritional fluids are given into a vein to provide most of the nutrients the body needs) and, advanced communication training.
- On Ward 16 there were two 'acute care bays' and two 'acute side rooms', for those patients deemed as requiring 'level one' and 'level two' care. The ward sister of this area told us newly qualified nurses did not work in this area until they had achieved a number of specific competencies. For example, immediate life support (ILS), administering intravenous medications, cannulation (cannulation is a technique in which a tube is placed inside a vein to provide access) and, male urinary catheterisation (catheterisation is the passing of a plastic tube, through the patient's urethra, into the bladder, to enable the free passage of urine). Staff were also expected to attend an 'acute care' study day which included training in non-invasive ventilation (NIV).

- On the acute medical unit (AMU) and ward 16 dedicated time of one day per year was allocated to staff to allow them to complete relevant e-learning packages.
- Specialist nurses for example, tissue viability nurses (TVNs), discharge liaison nurses and, learning disability nurses were available in the acute medical unit (AMU) and the acute frailty unit (AFU) to provide face-to-face training, guidance and support to staff within these areas.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Within stroke services, MDT meetings took place daily Monday to Friday in addition to a daily conference call with a local trust that provided rehabilitation services.
- Access to specialist support from for example, diabetes, dietetics, SALT and, learning disability were made through the trust's electronic referral system. Ward nursing staff we spoke with all confirmed this was an easy process and had not experienced any delays in patients being seen.
- Within gastroenterology, the alcohol liaison team were involved in the care pathways of patients who had been admitted due to alcohol abuse.
- In medical oncology, morning 'board rounds' took place Monday to Friday. Staff involved included, the responsible oncology consultant, junior and senior doctors, AHPs, the patients nurse and, the discharge co-ordinator. Board rounds were an opportunity for these key professionals to discuss patients' care pathways and discharge plans.
- MDT ward rounds took place twice daily on the acute medical unit (AMU) and included the nurse co-ordinator, AHPs, a discharge liaison nurse and relevant medical staff including the responsible consultant for the week. Where required specialist nurses would attend, for example, the TVN or learning disability nurse.
- Where applicable, the patient's responsible consultant could make a referral to mental health (MH) services at a local MH trust. One ward sister we discussed this with could recall this happening with no more than two patients over the last year and did not recall any issues.

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- Mortality and morbidity meetings took place monthly across all medical specialties. However, we reviewed the minutes from a sample of these meetings and found they did not always reflect a MDT approach to individual mortality reviews.

Seven-day services

- There were eight medical consultants rostered to be on site at the LRI at weekends: five for emergency care (that man all the various acute units such as AMU, EFU, EDU etc) and three that were ward based. This provided coverage for eight out of 15 wards. For the other wards there was a consultant responsible for ward review of patients that fall into the category of those needing discharge, those who deteriorate and those where a consultant review is required at the weekend due to ongoing needs.
- Within all other specialties consultant cover out of hours was through an on-call arrangement. Out of hours care was provided by a 'hospital at night' team which consisted of junior doctors, nurses and clinical support workers, with all patient-related tasks managed by a senior nurse who triaged the tasks and assigned them to a member of the team.
- AHPs including physiotherapists, occupational therapists, dietitians and SALT worked daytime hours Monday to Friday.
- A consultant-led nurse supported system for managing acute gastrointestinal (GI) bleeds was available 24 hours a day, seven days a week at this hospital. Trust wide there was an acute GI bleed 'on-call system'. Monday to Friday (9am–5pm) a GI consultant triaged patients throughout the trust and arranged urgent endoscopy where required. Urgent endoscopies were booked onto an acute GI bleed list every afternoon, Monday to Friday at this hospital. Overnight an acute GI bleed consultant on-call was available to endoscope patients who were acutely unwell. An on-call endoscopy nursing team supported this activity. At weekends, an on-call GI bleed consultant had a dedicated list every Saturday and Sunday morning for emergency cases and was available throughout the weekends to treat patients experiencing an acute bleed.
- Medical staff on AMU told us they had 'open access' to diagnostics. Plain X-rays could easily be arranged with timely access for patients. We were told there was

sometimes a short delay in accessing computerised tomography (CT) or magnetic resonance imaging (MRI) scans but if it was an urgent request, it could be arranged quickly.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included risk assessments, care plans and case notes.
- Information and guidance regarding specific procedures or conditions was available through the trust's intranet.
- On Ward 16 general practitioners (GPs) had direct access to a medical specialist registrar for advice over the telephone.
- Specialist referrals for example, physiotherapy, occupational therapy and dietetics; diagnostic test requests and diagnostic test results were made electronically. Medical and nursing staff we spoke with described this as mostly efficient. However, some medical staff told us that if a request for a routine diagnostic test was rejected they did not always hear about it in a timely way. Where urgent requests were rejected, medical staff said this would be communicated to them immediately through a telephone call.
- Within stroke services access to diagnostics was in accordance with National Institute for Health and Care Excellence (NICE) quality standard CG68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. There was rapid access to head CT. However, senior medical staff described it as a challenge for junior staff when accessing CT at night within stroke services. Consultants told us this was less challenging for the more senior members of the medical team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions.
- Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests. During our inspection we saw two patients receiving care whilst being deprived of their

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liberty. We saw that the deprivation of liberty safeguards and orders by the court of protection authorising the deprivation of a person's liberty were used appropriately in one case. However, we found one person who was being deprived of their liberty but had not had a mental capacity assessment. As there was no mental capacity assessment this meant the patient was restrained unlawfully. The Deprivation of Liberty Safeguards (DoLS) are in place so that only people who lack the mental capacity to make a decision can be deprived of their liberty. We raised this with the ward sister who addressed it immediately. When we returned to the ward later, we found the mental capacity assessment had been completed.

- Human immunodeficiency virus (HIV) testing was mandatory for all patients admitted to the acute medical unit (AMU). Consent for this test was obtained through the trust 'opt-out' policy. We were not assured all patients would have been sufficiently informed to consent to this test. We discussed this with the leads of the service who assured us they would provide us with further detail regarding our concerns. On 22 June 2016, the Clinical Director emailed medical teams to advise that all posters stating that HIV testing was mandatory be removed with immediate effect and that an HIV test should be offered to patients with acute medical problems as such allowing patients to consent.

Are medical care services caring?

Good



We rated medical care as good for caring because:

- We observed staff responding compassionately when patients needed help, and saw a number of examples of good care.
- Patients were supported emotionally and this was reflected in their care and treatment.
- Patients were mostly supported and treated with dignity and respect.
- NHS Friends and Family results were positive with 95% of patients recommending the NHS service they had received to friends and family who may need similar treatment or care.

However, we also found:

- Some patients and their relatives had concerns about the way staff treated them, feedback was mixed with eight patients and three relatives commenting negatively about their experiences.
- Patients privacy and dignity was not always seen as a priority; patient's information was not kept confidential during shift handover and we observed one incident of a male and female patients occupying the same bay.

Compassionate care

- We reviewed the NHS Friends and Family Test (FFT) results in medicine from September 2015 to May 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. In this period on average 95% of patients would recommend medical services at the trust.
- Between September 2015 to May 2016 on average 96% of patients receiving on the medical wards at this hospital said they were treated with care and compassion.
- During our inspection, staff on all the wards were mostly observed to be polite and courteous to patients. We saw staff responding compassionately when patients needed help, and saw a number of examples of good care. For example on ward 31, we observed a nurse expressing concern over whether a patient was warm enough, another nurse enquired as to whether a patient was in pain and, a nurse was observed holding a patient's hand in a reassuring and comforting manner. We also observed a nurse give a good explanation to a patient of why repositioning was important and the use of pressure relieving aids. However, we also observed instances where staff did not always treat patients with kindness and respect. For example, on the acute medical unit (AMU) we saw a nurse ask an elderly patient to put their legs back in the bed in a stern tone of voice, another staff member then went over to this patient and assisted them, putting their legs back up and covering them with a blanket. We saw another patient reaching over the side of their bed to get a mobile phone, which was on the side table out of their reach; staff were at the next bedside but appeared not to notice.
- We spoke with 16 patients and four relatives during our inspection. Feedback from patients was mixed with eight out of 16 patients commenting positively about

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every aspect of their hospital stay. Where negative comments were raised these related to a lack of communication and lack of care. One patient told us they were uncomfortable and had been sat in a urine soaked pad for hours. This patient could not reach their call bell to attract the attention of staff. We raised this immediately with the ward sister who assured us this would be addressed. However, we also heard positive comments from patients. Patients told us nurses were caring and kind, and the care was excellent.

- One out of the four relatives we spoke with were happy about the care at this hospital. The other three relatives cited lack of communication in their concerns.
- During our unannounced visit to this hospital, we visited Ward 23 over the lunchtime period. We observed four members of staff sat around a desk whilst the telephone was ringing, all ignored the phone. A nurse who was trying to help position patients for lunch had to stop what they were doing to answer the telephone. However, we did observe good practice, a member of staff sat assisting a patient with their meal. This was done in a very caring way, asking what part of the meal the patient wanted next, going at a steady speed. The staff member was sat down, not standing over the patient. This was good practice.
- Wards included single-gender accommodation, which promoted privacy and dignity. From February 2015 to January 2016 there were no reported times when male and female patients were treated in the same bay at this hospital. However, during our inspection we visited the acute care bay on Ward 16 where we found level one and level two patients of opposite gender in the same bay. We raised this with the service leads during our interview with them who took immediate action to address this, this had been reported to the local clinical commissioners. During our unannounced visit to this hospital, we went back to the acute care bay on Ward 16 where we found one level two female patient and three level one male patients occupying the same bay.
- We observed the recovery area of the endoscopy unit to be same-gender compliant; a curtained partition separated the recovery area into a male and female area with separate corridor access to each area.

Understanding and involvement of patients and those close to them

- During our inspection, we spoke with five patients specifically about whether they felt involved and understood about their care. Three out of five patients did not feel involved.
- During our inspection, we observed a shift handover taking place by the patient's bedside. Information being shared in the bay could be overheard by other patients. The handover information was of a sensitive nature and included details about continence needs. Another patient was unable to understand or speak English, we observed the nurse to be disrespectful in their tone when discussing this patient's language needs. Patients were not always included in the handover despite being present, nor was an attempt always made to communicate with the patient during the handover. This meant that the patient's information was not kept confidential and they were not always treated with dignity and respect.
- During our inspection, we saw where staff 'signposted' carers to specific support groups and observed multidisciplinary meetings that included patients and their carers.

Emotional support

- Nursing care plans met National Institute for Health and Care Excellence (NICE) quality standard [QS15]: Patient experience in adult NHS services. Patients had their physical and psychological needs regularly assessed and addressed, with care plans including an assessment of nutrition, hydration, pain relief, personal hygiene, rest and sleep, psychological and emotional well-being and promoting health and safe care.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, cancer services, and diabetic medicine and for care of the older person.
- During our inspection, we observed a member of staff comforting a patient through the use of pictorial and signing methods. The patient, although unable to communicate, looked upset. The nurse took time to ensure the patient was given appropriate and timely support and information to alleviate their anxieties.
- On Ward 23, we met the ward 'meaningful activities co-ordinator'. During our visit a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient, they told us by making it a social event they hoped the patient would eat.

Medical care (including older people's care)

Are medical care services responsive?

Requires improvement 

We rated the responsiveness of medical care services as requires improvement because the service did not always meet patient's needs.

We found:

- The numbers of patients being moved between wards out of hours was high with a significant number of patients being transferred between the hours of midnight and 6am.
- The process of referral to the acute medical unit (AMU) resulted in at least one patient per day being inappropriately admitted.
- The capacity of patients using chemotherapy suite was exceeding the planned capacity level for the unit, resulting in delays for patients.

However, we also found:

- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.
- Stroke medicine provided timely access to initial assessment, diagnosis or urgent treatment of those patients who may be experiencing a stroke.
- It was easy for patients to complain or raise a concern. Posters and leaflets were available in the wards and clinical areas and these allowed members of the public to identify how they could raise a concern or make a formal complaint.

Service planning and delivery to meet the needs of local people

- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital. For example, an ambulatory diabetes clinic was available Monday to Friday from 9am to 5pm and; an acute ambulatory deep vein thrombosis (DVT) service was available Monday to Friday, from 8am to 8pm and Saturday, from 8am to 12pm. A DVT is a blood clot in a vein.
- Haematology patients had 24-hour access to specialist medical and nursing support through the bone marrow

transplant unit (BMTU) and the Osborne assessment unit. Haematology is a branch of medicine concerned with the study, diagnosis, treatment, and prevention of diseases and conditions related to the blood.

- Within oncology / chemotherapy, a 24-hour telephone service was available for direct patient advice and admission in addition to providing a follow up telephone service at 48hours, one week and two weeks to patients who were post chemotherapy treatment.
- A transient ischaemic attack (TIA) rapid access clinic was available seven days a week for patients who may have experienced a TIA or mini stroke. Referrals to the clinic were by the patient's own GP.

Access and flow

- Patient flow between the emergency department (ED) and the acute medical unit (AMU) was arranged by the consultant or senior registrar in ED by telephone to a band six or seven senior nurse on AMU. There was no acute physician review prior to the patient arriving on AMU, medical and nursing staff told us this often resulted in inappropriate admissions arriving in this area. During our inspection we observed an inappropriate admission of a 16 year old with learning difficulties who had been admitted directly to AMU from ED.
- Staff on AMU told us at least one patient per day would be considered an inappropriate admission, or, would be discharged from this area with one hour of a medical review. We were also told about patients who would be admitted to AMU in order to receive a meal because they may have been sat in the ED for up to eight hours and not received food.
- Whilst medical staff told us they favoured this system of referral from ED because it meant their time could be spent seeing patients on AMU, they did acknowledge that discharge and flow could be improved if a medical physician in ED reviewed medical patients.
- A frail older persons assessment unit provided acute general medical care (across all specialties) for complex acute frail elderly under the care of acute geriatricians, from 8am to 6pm, seven days a week. The focus of this unit was on older people who were likely to be discharged home within 24 hours.
- A discharge lounge was available at this hospital. However, at the time of our inspection the discharge lounge was closed.

Medical care (including older people's care)

- Stroke medicine provided timely access to initial assessment, diagnosis or urgent treatment of those patients who may be experiencing a stroke. A 36-bedded unit spread over two wards was available at this hospital. This included eight 'hyper acute' beds. Hyper acute refers to those patients in the early stages of stroke onset. A 'rapid access stroke nurse' (RAN) proactively reviewed those patients throughout the admission areas who may be experiencing a stroke. The RAN was also contactable through a bleep system for those health professionals seeking advice or support for patients suspected of having a stroke. A rapid assessment protocol was followed to ensure patients received prompt treatment on the stroke pathway, including computerised tomography (CT), thrombolysis and swallowing assessment.
- Within stroke services there was a daily stroke conference call for discharge planning and, to assess the availability of rehabilitation services. Additionally an 'early stroke discharge service' was available for patients to be discharged directly into their own home with a package of care. Rehabilitation services were provided by ward 3 at Leicester General Hospital and, through a local partnership trust.
- We visited the chemotherapy suite during our inspection. Nursing staff in the suite told us of increasing numbers of patients that were causing significant delays in patient flow. Staff said 50 patients a day meant the area was busy but acceptable; the suite had recently had 67 patients. We noted an incident that had been raised in September 2015 as a result of a three hour patient wait. Staff told us treatment delays due to medication delays, reactions during treatment and, a busy unit could lead to patient discharges being delayed by several hours. Staff were identified on the staff rota to remain on shift if this happened to ensure there was cover.
- On average elective patients spent more time in medical care services than the national average. The average length of stay for non-elective admissions was below the England average. The average length of stay for elective patients at Leicester Royal Infirmary from March 2015 to February 2016 was 7.6 days, compared to 3.9 days for the England average. For non-elective patients, the average length of stay was 6 days, compared to 6.7 in England.
- The average bed occupancy in medicine between April 2015 and March 2016 was 89.8%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients. We found that patients awaiting a bed were unable to access a bed in a timely way.
- Following our inspection we asked the trust if they monitored delayed transfers of care in medicine. Data provided for December 2015 to May 2016 demonstrated there were 2,836 delayed transfers of care bed days reported.
- During our announced and unannounced visits to this hospital, there was one medical outlier. Medical outliers are where patients are receiving care on a different speciality ward. The trust had robust systems in place to monitor medical outliers throughout the trust. There was evidence of a daily medical review and an 'oversight' of the patients' progress including estimated date of discharge, which was held by the senior site manager.
- Between March 2015 and February 2016, 64% of patients' did not move wards during their admission, and 36% moved once or more.
- Data for the reporting period October 2015 to March 2016, showed across 23 clinical areas 4,649 patient transfers had occurred after 10pm with 51% (2370) of transfers from the acute medical unit (AMU) and the acute care bay on ward 16. Of these, 57% (1352) of patients were transferred between the hours of midnight and 6am. We discussed these figures with senior nurses on AMU who told us transfers from AMU could happen at any time of day or night because there was always a need to maintain the flow of patients out of AMU in order to accommodate patients transferred from ED.
- We discussed patient transfers out of hours with senior leads. They told us they were aware of the high numbers, as such, their focus was on ensuring transfers were as early as possible during the day. Where it was necessary to move patients the priority was to ensure the patient was in the right speciality, or those patients with a lower acuity were moved first. We were told there were plans to increase medical capacity in September 2016 with the opening of an additional two medical wards. On a day-to-day basis, senior staff within Wards 15 and 16 did not monitor numbers and times of patient transfers.

Meeting people's individual needs

Medical care (including older people's care)

- A mental health triage team was available at the trust. Between the hours of 8am and 10pm, the team would see any patients on the wards who had been admitted as a result of self-harm. The response time for ward referrals was four hours. An on-call duty psychiatrist provided overnight support to the wards. In addition to this service there was a liaison psychiatry service Monday-Friday from 9am to 5pm. Outside these hours any patients who required a review by liaison psychiatry were assessed by the on-call duty psychiatrist.
- There was a system in place for identifying people in the hospital who had diabetes. An automated daily report that included patient level detail and location of their inpatient stay was sent to key members of the diabetes team.
- A diabetes specialist nurse (DSN) service was available at this hospital for the care of patients with diabetes. A specialist registrar (SpR) who was on call for the speciality supported the service. The team were contacted through an electronic referral system and/or bleep. The DSNs were proactive in attending the acute assessment areas every day to identify new admissions to the hospital. There was an 'inpatient diabetes safety committee', which included a lead consultant, lead specialist nurse and a nurse consultant.
- Staff had access to an external interpreting service, 24 hours a day, seven days a week. The service included the provision of British Sign Language (BSL). There was an interpreting and translation policy in the trust.
- There were 2.5 whole time equivalent (WTE) acute liaison nurses (ALN) that provided advice and support to patients who had a learning disability. In addition, there was a flagging system linked to the Leicestershire learning disability register, which alerted the team, through the trust's patient administration system, of any patient admission who had a learning disability.
- Patients living with a learning disability were assessed using standardised nursing and medical documentation. Where patients had their own hospital profiles they were asked to bring them into hospital with them. On receipt of notification of an admission the ALN would contact the ward and telephone assess the level of priority in terms of their visit, for example, patients with more complex needs may be seen more quickly. However all inpatients with a learning disability should be seen or the ward within 24 hours of admission. On attendance the ALN assessed what reasonable adjustments were required in addition to speaking to carers about the care needs of the patient.
- Between 15 February 2016 and 16 June 2016 trust wide, 230 patients with a learning disability were admitted into hospital. Of these, 19 were not seen by the ALN because the patient came in either as a day patient or over the weekend or bank holiday. The ALN service operated Monday to Friday, from 8am to 5pm. Of the 211 patients seen 190 had a confirmed learning disability. Of the 190 patients seen 54% were seen by a member of the ALN team within 24 hours of admission. The reasons for not being seen within 24 hours were; the admission was at the weekend or bank holiday; the patient had not been identified to the ALN at the point of admission and; the patient was admitted and discharged out of hours.
- In 2015 'Patient-Led Assessments of the Care Environment' (PLACE) were extended to include criteria on how well healthcare providers' premises were equipped to meet the needs of caring for patients with dementia. The assessment of the premises for people with dementia for this hospital demonstrated a compliance level of 62.2%, which was significantly worse than the England average of 74.5%.
- The trust was committed to the implementation and delivery of service improvements for people with dementia in Leicester's hospitals. Care was person centred and individualised to meet the specific needs of each patient using the 'Know me Better' patient profile. The patient profile form allowed the patient to provide information to the health care team that detailed their psychosocial needs, concerns, and what was important to them during their hospital admission. The form was completed by the patient, with or without the assistance of their family. Open visiting was available to carers of patient's living with dementia. A bespoke 'meaningful activity service' had been created and included reminiscence tea parties to encourage patients with dementia to eat and drink. . There was ongoing work to upgrade the environments to make them dementia friendly with quiet rooms and retreat rooms available on Wards 31, 33, 36 and 38. Policies were in place to reduce the number of ward transfers for patients with dementia.

Medical care (including older people's care)

- Patients and carers were signposted and had access to charitable organisations for additional support and information. Whilst in the trust, a dementia 'champion network' of staff with a particular interest in dementia supported patients.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Clinical and cognitive assessments were undertaken as part of the dementia care pathway. Care pathways are multidisciplinary plans of anticipated care.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015. The carers charter described to carers what they could expect from staff in the trust. This included; identifying carers on the wards, assessing carers needs, ensuring open channels of communication and providing essential information.
- We observed posters and leaflets in the wards and clinical areas we visited. These allowed members of the public to identify how the carers charter could help them. Staff we spoke with told us of 'open visiting' for carers.
- Pastoral, spiritual and religious support was available to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Islamic and Sikh chaplains, as well as the country's first paid non-religious carer who focussed on meeting the needs of people who did not identify with a religious belief. Volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives, also supported the team. An on-call service was provided 24 hours a day, seven days a week and where possible a representative of the patient's own faith would attend. The service was widely publicised through posters, leaflets and the trust website.
- A Chapel and Prayer Room (with washing facilities) was available at this hospital and was designed to meet the diverse religious and spiritual needs of patients and staff. Rooms provided a quiet place for private prayer, meditation and contemplation and were open to everyone. The newly opened facilities at this hospital were designed in close co-operation with the different faith chaplains.
- During our inspection, some patients were fasting for Ramadan. Whilst snack boxes were available for the end of the fasting day, there were no adjustments made to make hot food available to patients.

Learning from complaints and concerns

- Posters and leaflets were available in the wards and clinical areas we visited. These allowed members of the public to identify how they could raise a concern or make a formal complaint. We also saw 'message to matron' cards and boxes to allow patients and relatives to make comments or raise concerns which where possible could be dealt with locally.
- A Patient Information and Liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- Between March 2015 and March 2016 a total of 212 complaints were received in medicine. The top three themes for complaints within this services were; integrated care/discharge (40), medical care (36) and, nursing care (35).
- Senior nurses and ward sisters were aware of concerns and complaints raised within their areas. Information around concerns and complaints were discussed at team meetings, handovers and during morning 'board huddles'. Nursing staff told us of changes that had been made as a result of concerns or complaints. Examples included, purchasing televisions and introducing a music therapy session on Wards 25 and 26 and, hourly updates to patients regarding delays or waiting times in the chemotherapy suite.

Are medical care services well-led?

Requires improvement 

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

We found:

- Departmental governance and risk management arrangements were not robust and as such were not suitable to protect patients from harm. Processes for

Medical care (including older people's care)

deteriorating patients; the use of blinds with loop cords and; infection prevention control issues had not been identified on the medical services risk register and key risks had not been addressed.

- We could not see where actions had been agreed and implemented to address poor audit outcomes in infection prevention and control or for national audits where standards were below the England or national average.
- Where the service was not responsive to patient need, for example, movement of patients between the hours of midnight and 6am, we could not be assured actions were being taken to reduce these numbers and as such reduce the likelihood of a poor experience for the patient.
- Staff were able to articulate the trust's vision and the values. However, not all staff were able to articulate the vision and strategy for medical care services.
- Staff did not always deliver care and demonstrate behaviours in line with the trust vision and values.

However, we also found:

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

Vision and strategy for this service

- Medical care (including older people's care) was provided at this hospital as part of two Clinical Management Groups (CMG): CHUGGS (Cancer, Haematology, Urology, Gastroenterology and Surgery), Acute Medicine / ED and Specialist Medicine.
- Most staff we spoke with were able to articulate the trust's vision and the values, which was to deliver 'caring at its best' for everyone who visited the trust. Underpinning this was the trust's values which were; 'We treat people how we would like to be treated'; 'We do what we say we are going to do'; 'We focus on what matters most'; 'We are one team and we are best when we work together' and; 'We are passionate and creative in our work'.
- University Hospitals of Leicester NHS Trust had a detailed five year integrated business plan which

covered 2014 to 2019. A two-year 'Operational Plan' was in place within Emergency and Specialist Medicine with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy.

Governance, risk management and quality measurement

- A comprehensive risk register was held within the CMGS with 32 risks identified for this core service. Risks included a description, controls in place to mitigate the risk and, a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register and cited capacity, nurse staffing and medical outliers as their top three risks.
- Concerns we identified during our inspection however, had not been included on the risk register. These concerns included; not following processes for deteriorating patients; the use of blinds with loop cords on Ward 43, the numbers of patients being moved between wards out of hours and; infection prevention control risks with side room doors remaining open. We were therefore not assured that departmental governance arrangements were fully effective.
- There was a lack of awareness from the leads regarding the concerns we had identified as part of this and previous inspections. Infection prevention and control had been identified as a regulatory breach in January 2014 with insufficient measures in place to ensure patients were protected from the spread of infections.
- Prior to our inspection we reviewed infection prevention control audit results including results of a quarterly walk round audit by the infection control matron. We asked the trust for details of action taken following these audits including any actions taken.
- Senior leads had a good knowledge of complaints themes within the service with their top three complaints aligned to our review of complaints.
- Staff received regular updates through email, on staff notice boards, during morning board rounds and, at ward and department meetings. Updates included information such as incident and complaint themes, serious incidents, safety thermometer information at ward level, medical device information and any relevant trust wide information. Staff we spoke with demonstrated a good awareness of incidents that had occurred within medicine in addition to changes that had been made as a result of incidents across other CMGs.

Medical care (including older people's care)

Leadership of service

- Leadership of the acute medicine / ED and specialist medicine clinical management group (CMG) was a Head of Nursing, Clinical Director and Director of Emergency Care, supported by two Deputy Clinical Directors, a Deputy Head of Nursing and a Head of Operations. Leadership for cancer, haematology, urology, gastroenterology and general surgery (CHUGGS) was provided by a head of service and a general manager.
- Locally, staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support. However, four members of staff could not recall meeting the chief nurse or seeing them in their clinical area. One matron told us they had circulated a photograph of the chief nurse in order that staff would recognise them.
- All staff, both medical and nursing, were aware of the trust whistleblowing policy. Staff told us they felt listened to and felt empowered to raise concerns.
- Leaders of the service told us they were proud of the developments and progress made in medicine and cited examples such as, an improvement in patient safety, a reduction in pressure ulcers and falls with harm, improved patient satisfaction, a reduction in the use of hospital security staff for the one to one supervision of confused patients and, the introduction of 'meaningful activity coordinators'.
- The clinical director talked of a decreasing length of patient stay and readmission rates, a mortality ratio of less than 100, patients being cared for on condition specific care pathways and, the increase in specialist nurses throughout medicine.

Culture within the service

- Staff mostly felt respected and valued, happy to work at the trust and felt part of their immediate team. However, on occasion unregistered nursing staff did not always feel supported during their day-to-day work activities by the registered nurses within their teams. These staff told us they accessed additional support through their immediate line managers.
- Agency staff told us they felt supported and felt able to ask for feedback from staff. They also reported feedback was given through the nurse agency.

- Duty of candour briefing sessions had been held in medicine for all levels and types of staff groups. Roadshows had been undertaken at each hospital site to raise awareness of duty of candour. A duty of candour slide had been added to the complaints e-learning module that all staff were able to access through the electronic trust training portal. A duty of candour slide was also included on the trust induction programme for all new starters and on the medical director's induction slides for new trainee doctors to the trust.
- Whilst we saw some staff delivering care and demonstrating behaviours in line with the trust vision and values this was not consistent across all ward areas.

Public engagement

- The NHS Inpatient survey looked at the experiences of 83,116 people who received care at NHS hospitals in July 2015. Between August 2015 and January 2016, a questionnaire had been sent to 1250 recent inpatients at each trust. Responses were received from 547 patients at this trust. With the exception of 'cleanliness of rooms or wards' the trust received a rating of 'about the same' as most other trusts. Cleanliness of rooms or wards received a rating 'worse than' most other trusts.
- 'Message to matron' cards and boxes and, 'You said, we did' posters were visible in all ward and clinical areas to encourage the public to comment on services provided.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement

- We spoke with 37 staff from a variety of roles. Most staff felt engaged and able to raise concerns and felt empowered to suggest new ways of working within their areas. All staff were invited to attend a monthly chief executive officer (CEO) briefing. Staff told us this was an effective way to learn about current issues within the trust.







Medical care (including older people's care)

Innovation, improvement and sustainability

- Innovative initiatives for specialist medicine included an acute stroke care pathway. This allowed minor stroke patients with set clinical criteria to go home and be seen in the transient ischaemic attack (TIA) clinic. A neurology on call rota included daily ward rounds, seven days a week, ensuring all patients transferred to the neurology service as inpatients were seen and assessed within 24 hours by a consultant, and then daily there-after.
- The Quality Mark for Elder Friendly Hospital Wards had been achieved on Wards 31, 37, 39 and 40. The Quality

Mark for Elder-Friendly Hospital Wards is a subscription-based quality-improvement programme for individual hospital wards. Participation in this process ensures a continuous focus on the care provided for people over the age of 65, and demonstrates the commitment made by a hospital, the ward and the staff to identify and carry out improvements, and to achieve a consistent quality of care for older people.

Surgery

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

Information about the service

University Hospitals of Leicester NHS Trust provide a range of surgery and associated services at the Leicester Royal Infirmary (LRI) as part of four clinical management groups (CMGs). These are cancer, haematology, urology, gastroenterology and general surgery (CHUGGS), critical care, theatres, anaesthesia, pain and sleep (ITAPS), musculoskeletal and specialist surgery (MSS) and renal, respiratory and cardiovascular (RRCV).

At this hospital, there are 209 inpatient beds across 12 surgical wards and 33 day case beds. Inpatient services included general surgical specialties including upper gastrointestinal, colorectal, ear nose and throat, plastic surgery, maxillofacial and trauma/orthopaedics. Services for surgical patients were provided in outpatient consultation sessions, the pre-operative assessment unit, day surgery and inpatient wards.

The surgical division has 22 theatres at the Leicester Royal Infirmary (LRI), three of these are dedicated ophthalmic theatres and two are for day case surgery. None of these theatres had laminar airflow (laminar airflow is a type of air conditioning that reduces the risk of air borne infections). One theatre is available for emergencies 24 hours a day and a second emergency theatre could be made available if required.

Between April 2015 and March 2016, there were 26,123 episodes of care, (admissions for treatment). Emergency

episodes accounted for 41%, day case 44%, and the remaining 15% were elective. General Surgery (26%) and Ophthalmology (25%) were the specialties with the largest percentage of care episodes.

During our inspection, we visited the pre-operative assessment clinics, theatre admissions area (TAA), day surgery unit including ophthalmology, operating theatres, theatre recovery, eight surgical wards and the equipment library.

Before our inspection, we reviewed performance information from and about the trust. During our inspection, we spoke with 33 patients and four visiting relatives. We spoke with 42 staff members from a range of various surgical related roles including doctors, nurses, physiotherapists, occupational therapists, health care assistants, trainee doctors and senior managers. We received comments from people who contacted us to tell us about their experiences.

We reviewed the treatment and care records for 15 patients and observed staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources.

Surgery

Summary of findings

We rated surgical care services as good overall.

We found:

- Nursing staff consistently followed trust guidelines for the completion and escalation of deteriorating physiological observations and early warning scores (EWS)
- On all the wards and departments we visited, we saw staff acting in a kind and caring way towards patients and the public. Relatives and carers told us they felt involved and informed.
- Patients had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. For example enhanced recovery programmes.
- The trust was meeting the majority of 18 week referral to treatment times.
- Staff were positive about the leadership of the surgical services and felt able to raise concerns.

However, we also found:

- Staff did not always recognise, concerns, incidents or near misses for example not reporting missing medical notes, or the lack of computers in theatre.
- Venous thromboembolism (VTE) assessments were not completed in a timely manner or reviewed after 24 hours for patients preparing for surgery.
- Whilst we witnessed the World Health Organisation (WHO) five steps to safer surgery checklist being completed, the trust did not have a robust system in place for monitoring its effectiveness.
- Staff were unaware of the correct use of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) when caring for patients in vulnerable circumstances.
- Consent was not always obtained or recorded in line with relevant guidance or legislation. There was a lack of consistency in how people's mental capacity was assessed in relation to consent.
- The pathway for pre-operative and high-risk anaesthesia patients was not consistently followed

causing potentially avoidable delays and cancellations. Some patients were not having pre-operative assessment despite being identified as high risk for anaesthetic.

- Departmental governance and risk management arrangements were not robust and as such did not always protect patients from avoidable harm.

Surgery

Are surgery services safe?

Requires improvement



We rated the safety of surgical services as inadequate because patients were not always protected from avoidable harm.

We found:

- Systems and processes were not always reliable or appropriate to keep people safe. Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments reviewed after 24 hours.
- Clinical management groups (CMG) did not always share learning across other CMG's from mortality and morbidity meetings.
- Monitoring and audit of safety systems was not robust. There was no effective audit for the World Health Organisation, (WHO), five steps to safer surgery checklists.
- Monitoring of safety systems relating to safe storage of medicines was not robust. Correct recording and monitoring of medicine refrigerator temperatures did not take place. There was no staff consistency in understanding the correct checking method.
- The majority of staff knew how to report an incident. There were not effective and consistent systems for learning from incidents within their areas as not all incidents had been reported appropriately.
- Control of Substances Hazardous to Health (COSHH) was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. Cleaning fluids were not always stored in locked cabinets.

However, we also found:

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

- Staff knew how to protect patients from abuse; they could describe what safeguarding was and knew the process for referring concerns.

Incidents

- Surgical services at the Leicester Royal Infirmary (LRI) reported no never events between May 2015 to April 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been put in place by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Between May 2015 and April 2016, there were five serious incidents reported at the Leicester Royal Infirmary (LRI). Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response (NHS England, March 2015). The five incidents had been investigated and action plans were in place. For example, an incident relating to incorrectly administered pain control resulted in changes to the positioning of intravenous and epidural ports, (thin tubes inserted into a vein or the spinal cavity to administer medication), on opposite sides of a patients' chest.
- Because of another serious incident within the trust, hourly checks of all patients in side rooms had been introduced. We saw documentation outside of all occupied side rooms confirming these hourly checks were taking place.
- The trust had an incident policy, which clearly outlined the process for reporting and managing incidents.
- Incidents were reported through the trust's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents.
- Some staff were not always reporting incidents. Five out of eight staff told us they had received no training in incident reporting and often did not report low staffing levels, bed shortages and missing medical notes. We could not be assured therefore; incidents were appropriately reported on all occasions in order for future planning and learning.

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- Between March 2015 and March 2016, there were 1879 incidents reported in surgical areas at the LRI. Low or no harm incidents accounted for 81% of reported incidents. There were 18 moderate incidents and 46 near misses. A near miss is an unplanned event, which did not result in injury, illness, or damage, but had the potential to do so. The majority of recorded incidents included falls, pressure ulcers and medication errors or omissions.
- Ward and theatre staff were unable to give specific examples of learning from incidents and most staff told us they received no feedback after reporting an incident. However, all ward sisters and managers told us they provided feedback via email and newsletters. The electronic reporting system had a section for staff to request feedback. We found staff understanding of the reporting system to be variable across surgery.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had an understanding about duty of candour. Staff on the surgical wards could describe incidents where duty of candour had been applied. An example provided was following a patient fall, an apology had been given to the patient and family and they were invited to discuss the event and the actions the trust had taken to prevent a recurrence.
- Duty of candour briefing sessions were held in all clinical management groups (CMGs) for all staff groups. Roadshows had been undertaken at each hospital site to raise awareness of duty of candour. A slide was added to the complaints e-learning module that all staff were able to access via the Electronic University Hospital Leicester (E-UHL) training portal. This was also included in the university hospitals of Leicester (UHL) induction programme for new staff at the trust.
- Staff within the different surgical CMGs held monthly morbidity and mortality meetings. These meetings reviewed patient deaths and treatment complications in order to develop improvements to patient safety and aid professional learning. Minutes from these meetings demonstrated all unexpected deaths were reviewed and trends identified. Learning was shared through the clinical audit leads forum which met 4 times a year, individual cases were shared through LEG, RCA reports were circulated to all CMGs.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and harm free care. Data was collected on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers (PU), falls, urinary tract infections in patients with a catheter (CAUTI) and blood clots or venous thromboembolism (VTE). VTE is the formation of blood clots in a vein.
- Information provided by the trust between September 2015 and March 2016 showed Surgery as a whole provided 81-100% harm free care. Maxilla-facial surgery reported 100% 'harm free care', however, trauma and orthopaedic wards reported 81-100% 'harm free care' with 13 PUs, eight falls, seven CAUTIs and three VTEs.
- Safety thermometer data was not publicly displayed on any of the wards or clinical areas we visited. This meant staff, patients and the public could not see how the ward was performing in relation to patient safety.
- The ward sisters and service leads attended a monthly forum meeting and peer review to discuss performance and plan actions for their areas in relation to safety thermometer results.
- Where an increase in patient harm had been identified in a ward area, for example orthopaedics, ward sisters told us they would raise this with staff through email, newsletters and ward meetings.
- An example of this was on ward R32 where patients were cared for following a fractured neck of femur (broken hip). Because these patients have reduced mobility, they are at increased risk of developing pressure ulcers. This ward had recently achieved two years with no patients developing hospital acquired pressure ulcers. The surgical teams were very proud of their achievement in reducing patient harm.
- All areas reported monthly to the trust's pressure ulcer group and undertook a root cause analysis for all patients who developed pressure ulcers. .
- The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) three, statement one states all patients, on admission, should receive an assessment of VTE and bleeding risk. The trust's performance report for March 2016 showed 96% of VTE

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assessments were completed on admission. Within surgery, completion was 95%. This met the trust's target of 95%. However our findings at inspection found VTEs were not always completed or reviewed.

- Ward and theatre staff told us if VTE assessments had not been completed before surgery anti embolic stockings, (AES) were not applied. These stockings are designed to increase the blood flow in the leg veins by compression. Staff reported that in these instances AES were sent with the patient to theatre to be put on the patient in the anaesthetic room. Staff told us that occasionally a prescription had not been written prior to theatre. However all 12 admission VTE risk assessments we reviewed had been completed.
- The NICE QS3 statement four states that patients should be reassessed within 24 hours of admission for the risk of VTE and bleeding. In the 12 patient records we looked at we could not see where a reassessment had taken place. This meant there was a risk of harm to patients.
- Documentation we reviewed during our inspection did not provide evidence that VTE prescriptions were reviewed after 24 hours of admission. This meant some patients were receiving anticoagulant (blood thinning) therapy for longer than necessary and could put patients at a higher risk of complications from this therapy.

Cleanliness, infection control and hygiene

- Leicester Royal Infirmary (LRI) participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 93%, which was worse than the England average of 98%.
- Trust wide there had been 67 cases of clostridium difficile (c. difficile) infections between March 2015 and April 2016 with 10 cases occurring at this hospital in the surgical areas. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.

- Meticillin resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between April 2015 and April 2016 there were 15 reported cases of MRSA with two cases in the surgical areas.
- Patients were screened pre-operatively for MRSA and as soon as possible when admitted as an emergency. This was in line with local policy and national guidance.
- The trust had reported one surgical site infection for the year 2015. A full investigation was carried out which concluded a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts although not all categories of surgery are required to be included. The trust reported on surgical site infections for hip and knee replacement surgery.
- In order to measure compliance with trust policies, the infection prevention team (IPT) carried out regular audits. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy. Following our inspection, we asked the trust for any actions taken because of these audits. The trust told us there was no evidence of actions taken in result of audits.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for December 2015 for two elements of the audit; before patient contact and, after patient contact demonstrated 51% and 63% compliance respectively across the trust. (Not specifically broken down for Surgery) This was better than the trust's overall compliance figures but worse than the trust target of 90%.
- We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw staff followed best practice for hand washing and remaining bare below the elbow to allow for effective hand washing.
- There was access to hand washing and drying facilities on wards and a good supply of PPE, which included gloves and aprons. PPE was used appropriately by staff and disposed of correctly afterwards.

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- We saw patients with infections were nursed in side rooms and appropriate signage was in place to alert staff and visitors of action they needed to take. PPE was provided and appropriately used by staff. Visitors were advised about hand washing and wearing gloves and aprons as required.
- Within the operating theatres, sanitising hand foam was available on entry to anaesthetic rooms. Staff working in the operating theatre areas were observed to adhere to best practice principles for 'scrubbing up', (rigorous hand and arm washing), prior to surgery and for the management of surgical equipment in the operating environment.
- On Surgical ward areas, pre-assessment rooms, operating theatres and recovery areas, were visibly clean. The trust had produced a bed space cleaning checklist, which was filed in each patient's notes as evidence that a pre admission clean had been undertaken. Whilst we saw this chart during our inspection, it had not been consistently completed by staff or filed in notes. Therefore, we could not always be assured a pre admission clean had taken place.
- We saw a range of equipment for use by patients was visibly clean and appropriate for use. The trust used 'I am clean' stickers for staff to sign indicating where equipment had been cleaned. We reviewed ten items of equipment; we did not see the use of 'I am clean' stickers on these items of equipment. We could not be assured therefore that equipment had been cleaned before patient use.
- Throughout the hospital, privacy curtains were a mixture of disposable and non-disposable. Nursing and housekeeping staff told us they were unsure what the schedule was for changing them but changed them if they became visibly soiled or following patient isolation. The disposable curtains had dates on them indicating when they were put up but staff suggested various time spans for routine changes between two and four months. This is contrary to Health Building Note 00-09: Infection Control in the Built Environment Regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.
- The trust had a local policy, which they provided following our inspection. The policy indicated the curtains should be replaced every six months. However, not all staff we spoke with were aware of this. We were therefore not assured that staff were consistently following the trust's policy to ensure privacy curtains were changed every six months.
- The trust's policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow.
- We observed staff in all surgical areas at the LRI disposing of clinical, domestic and recyclable waste. However, not all wards and theatres reported having access to domestic and recyclable waste bags. In these areas, all waste was incinerated as clinical waste. Ward and theatre staff reported no training in relation to waste management.
- Senior nursing staff were aware of the trust's policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium which causes legionnaires disease. Where taps and showers were used infrequently these were flushed three times a week and recorded on a computer system called 'hydrostops' to monitor compliance.
- Staff told us water used to wash patients was generally disposed of in hand wash sinks. This was not in line with Health Building Note 00-09: Infection Control in the Built Environment Regulation 3.63 and 3.64 which states that contaminated fluids such as patients' wash-water should not be emptied down clinical hand wash basins in ward areas. Disposal facilities should be provided in areas where dirty wastewater is disposed (for example, dirty utility rooms and cleaners' rooms/areas for cleaning equipment). Dirty utility rooms were available. However, staff were unsure what the correct procedure was for the disposal of wastewater and there were no signs above hand wash sinks advising staff not to dispose of patient wastewater in this way. This meant there was an increased risk of hand and environmental contamination.

Environment and equipment

- Resuscitation equipment, including emergency medicines, was readily available in all surgical areas, including operating theatres. A difficult airway trolley, providing additional equipment for emergency use, was

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also available in the operating theatre suite. Records showed staff signed that daily checks of emergency equipment were completed in line with trust policy. We reviewed the records for previous months and were assured this was a consistent practice.

- Equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made. We checked 20 pieces of equipment, for example; blood pressure monitors and hoists; all had been appropriately tested and were within their service date. Electrical equipment had been checked annually as per safety test recommendations.
- Bariatric wheelchairs for heavier patients were available and staff spoke with the manual handling team if they required any further equipment for example specialist beds or hoists.
- Most operating theatre staff reported having sufficient equipment to undertake their roles. However, staff in ophthalmology received theatre instrument trays from an external provider. They told us delays in receiving trays resulted in cancellation of procedures. We requested data from the trust, which identified one cancellation from December 2015-June 2016 due to a problem obtaining equipment.
- The trust provided data that equipment had been safety checked in line with trust standards. During our inspection, equipment was visibly well maintained in the wards and operating theatre areas. Equipment was appropriately checked and repaired when requested.
- Clinical areas had limited storage for equipment; however, an equipment library was available. This stocked and repaired regularly used items of equipment, such as infusion pumps. The trust carried out preventative planned maintenance on all equipment in the equipment library.
- All staff reported good access to equipment from the equipment library. However, some elective surgery patients attended the pre-operative assessment clinic where a number of investigations could take place, in an adjacent area. For example, an electrocardiogram (ECG); this is a recording of the heart and assists in the assessment of a patient's general health and suitability to undergo surgery. However, staff reported occasional difficulties in accessing the ECG equipment required to complete a full pre-operative assessment.
- On all wards, we saw oxygen cylinders stored unsecured on the floor in storerooms. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored

in a purpose-built trolley in a well-ventilated storage area and cylinders should be chained or clamped to prevent them from falling over. There was no signage on the doors to indicate the storage of oxygen in these areas. Medical gases Health Technical Memorandum 02-01 (HTM02) guidance states warning notices should be posted prohibiting smoking and naked lights within the vicinity of the store.

- Patients were not always protected from avoidable harm because hazardous substances such as cleaning fluids were not always stored in line with the Control of Substances Hazardous to Health (COSHH) Regulations 2002. On six out of eight wards we found cleaning fluids were not always stored in locked cabinets. Ward sisters told us COSHH information was available on the intranet. However they had no knowledge of any data sheets or information relating to what substances were on their wards.
- The trust provided audit information from October 2015 stating that 92% of staff had been provided with the necessary information, instruction and training to ensure that they were able to use, transport, store and dispose of substances safely

Medicines

- Some surgical areas at the LRI used an electronic prescribing and medication administration (EPMA) system, which was used for the administration of medicines. Staff told us this system reduced the likelihood of medication incidents and gave examples of where prompts in the system would prevent staff from giving a medication at the wrong time or would prompt for a recorded reason for the omission of medication.
- Ward managers told us the EPMA system had enabled them to access clear information when investigating medication related incidents. For example, there was a clear record to indicate which member of staff had administered medication.
- Doctors and nurses told us it was often difficult when patients were transferred to areas that did not use EPMA. This resulted in nurses having to contact doctors to re-prescribe medications on a paper medication chart. This increased risks to patient safety as prescribing errors could be made in transcribing. Additionally, doctors told us they were potentially being

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taken away from acutely ill patients to perform this task. The trust strategy was to have a single EPMA system across the whole of UHL. A time scale for this had not been set.

- Medicine errors were reported as part of the trust's incident reporting process. Between March 2015 and March 2016 there was 192 incidents related to medicines.
- All thirteen surgical wards had reported incidents related to medicines. Trauma, orthopaedics and general surgery reporting the highest numbers. Reasons for raising incidents were prescribing omissions, medication reviews and omission or delays in administration.
- Staff were able to discuss incidents where errors had occurred and described the actions taken to help prevent similar errors. For example, medication charts were checked at all staff handovers to ensure missed doses or signatures could be identified.
- A pharmacist visited all wards each weekday. Pharmacy staff undertook reconciliation checks. This meant they checked that the medicines patients were taking when they were admitted were correct and that records were up to date. They raised any queries with doctors. They also checked antibiotic prescribing complied within agreed protocols. These measures helped to ensure safe medication practice. Nursing staff confirmed they had access to regular pharmacy advice.
- Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines. Patients told us they were told about any new medicines prescribed, what they were for and what side effects to look out for, in a way that they understood.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- We looked at the prescription and medicine administration records for 20 patients across three wards. Appropriate arrangements were in place for clearly recording the administration of medicines although we identified some omitted doses and one patient told us this had resulted in them suffering more pain than normal. With very few exceptions records showed people were getting their medicines when they needed them.
- If patients were allergic to any medicines, this was recorded on their EPMA record.
- Delays in writing tablets to take out (TTO) prescriptions had been identified as delaying discharges and the number of non-medical prescribers, in the surgical assessment unit (SAU) had been increased to address this. An advanced nurse practitioner (ANP) was training to be a non medical prescriber at the time of our inspection. Non-medical prescribers are health professionals who are not doctors but who have undergone specialist training to prescribe certain medicines within their area of expertise.
- There were suitable arrangements in place for the storage and management of medicines in surgical areas, including operating theatres and recovery. Disposal arrangements were in place for expired medicines and medicines, which were no longer required.
- Medicines, including intravenous (IV) fluids were stored securely and controlled drugs were stored and managed appropriately. Controlled drugs are medicines that are controlled under the Misuse of Drugs legislation and have additional requirements relating to their prescribing, storage, recording and administration.
- Staff undertook medication fridge temperatures; they were not recording minimum and maximum temperatures. We were therefore not assured that refrigerated medicines were being stored safely. All of the staff we spoke with said they had never received any training concerning the monitoring and recording of medication fridge temperatures. During our inspection, the trust sent out a memorandum to all areas with a new medicines refrigerator-checking sheet to be started immediately. At our unannounced inspection, a new fridge temperature-recording sheet was available and staff had been shown how to correctly monitor the medication fridges in their areas. In addition, they were taught how to report out of range problems.
- Medicines in the anaesthetic rooms at the LRI were not stored in a consistent way in each room. This meant if an anaesthetic team worked in another theatre, medication might be stored in a different place, increasing the potential risk of medication errors.

Records

- We reviewed 15 sets of medical and nursing records. All nursing risk assessments were completed appropriately. For example, falls, bed rails, malnutrition scoring and a pressure ulcer assessment. However, care plans were not individualised for each patient. This meant care may not be tailored specifically to each patient's needs.

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- Pre-operative checklists were completed which included a record of consent. Staff on the surgical wards completed risk assessments, which included risks of patient falls, pressure ulcers and the need for bed rails.
- All staff we spoke with were aware of their responsibilities for the safekeeping of records and confidentiality of patient information.
- Throughout the wards and theatres, patient identifiable information was stored securely. The wards were in the process of being provided with digitally lockable trolleys, this had improved the timeliness of completing medical records, as doctors did not have to spend time locating a key to open locked trollies.
- Whiteboards on each ward were behind the nurses' station. Patient names were not displayed; this meant patient confidentiality was maintained.
- Comprehensive risk assessments were completed in the inpatient care and risk document. This meant all the information to deliver effective care and treatment was readily available to staff.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. All staff we spoke with were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads.
- All staff we spoke with were clear about how to identify a safeguarding concern and how to escalate appropriately.
- Information received following our inspection showed as of June 2016 94% of staff working within the areas of cancer, haematology, urology, gastroenterology and general surgery (CHUGGS), critical care, theatres, anaesthesia, pain and sleep (ITAPS), musculoskeletal and specialist surgery (MSS) and renal respiratory and cardiovascular (RRCV) had completed level two safeguarding children and, 96% had completed safeguarding adults training. None of the staff we spoke with were able to tell us the level of training they had received. All staff told us the level of safeguarding training was pre-determined dependent on their role.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection

prevention, equality and diversity, information governance, safeguarding children (level one and two), conflict resolution, safeguarding adults (level one), health and safety and basic life support.

- Information received following our inspection showed as at June 2016, training compliance in the surgical clinical management groups (CMG's) was greater than 90% across all subject areas. We were not told the trust target for mandatory training nor was data split into specific staff groups.
- A formal system was used to monitor uptake of mandatory training and senior staff were proactive in prompting staff that needed to attend. Ward sisters and individual staff received an email approximately three months before training was required in order to allow time for booking it onto staff rotas.
- Staff told us they were given time to attend training sessions or complete on line training and we saw this in practice. Ward sisters at the LRI told us they allocated four hours per off duty for staff to maintain their mandatory training.
- Staff we spoke with confirmed they were up-to-date with mandatory training, which included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- Clinical staff followed the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety checklist to ensure each stage of the patient journey, from ward through to anaesthetic procedures, operating room and recovery was managed safely. However, the use of this document was not effectively audited. Fifteen sets of patient notes were audited per month from an average of 2000. This small sample did not provide robust evidence for the trust to demonstrate compliance with the checklist completion.
- An Early Warning System (EWS) was used for patients across the hospital to assist staff in the early recognition of deteriorating patients. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating. EWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.

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- Some wards were using an electronic hand held system (e-obs) whilst others used paper-based documentation to record patient observations. The trust had a plan to roll out e-obs throughout all wards by the end of October 2016.
- Senior nurses told us that e-obs assisted staff in detecting and managing deteriorating patients. However, they were not aware of any audit data to confirm this. They thought it was captured but were unsure how to access it.
- Information from the trust indicated the data was automatically transferred to a data system and would be available for analysis. The trust told us the data would be used to drive improvements in the recognition and response to the deteriorating patient. However the trust had not started using this data.
- During our inspection of this hospital, we reviewed six patient observation charts across two clinical areas. Staff adhered to trust guidelines for the completion and escalation of EWS. Patients scoring one or more on their EWS were required to have further sets of observations recorded within a set timescale for example from half hourly to four hourly. Of the six charts we reviewed, all had observations performed in line with the trust's escalation of EWS monitoring in adult patients policy.
- Patients with a suspected infection or an EWS of three or more, or those for whom staff or relatives had expressed concern were screened for sepsis, a severe infection which spreads in the bloodstream, using an 'adult sepsis screening and immediate action tool'.
- Patients being treated for sepsis were treated in line with the trust's 'sepsis six bundle', key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the sepsis six bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- We saw two patients who scored an EWS of three or above were appropriately screened for sepsis in line with the trust's sepsis pathway. One patient met the criteria for red flag sepsis and had all the appropriate interventions completed and recorded in the appropriate timescales for example, antibiotics were administered within one hour and urine output monitoring had been started.
- Nursing staff used the Situation, Background, Assessment, Recommendation (SBAR) tool to frame conversations requiring a doctor's immediate attention and action. The tool consisted of standardised prompt questions within four sections, which were situation, background, assessment and recommendation. This ensured staff shared concise and focused information and allowed staff to communicate assertively and effectively and reduced the need for repetition.
- Staff took time to identify and respond to the changing risks of patients. Handovers were held each day on the wards to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most attention and allowed them to gain an oversight of the ward. On Ward R7, the charge nurse was introducing 'safety huddles' into daily briefings. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical, opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.
- The majority of patients with multiple medical conditions or increased complications of anaesthesia were seen in a 'high risk anaesthesia' clinic. This ensured patients who were at high risk of complications were fully prepared for their procedure and that an appropriate anaesthetic was selected prior to surgery. For example, some surgical procedures were carried out under a spinal block eliminating the risk of general anaesthesia.
- We saw documentation and spoke with two patients who had attended this clinic. They told us they were reassured that all their medical conditions were being considered before making decisions about anaesthetic.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. From September 2014 UHL, all clinical areas collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for England. . Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically. The data was considered alongside

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staffing information from the electronic rostering system and patient information including admissions and discharges and additional tasks undertaken in different clinical areas.

- Following a trust wide acuity assessment undertaken in June 2015 and January 2016, formal establishment reviews had been undertaken in each CMG. The reviews were led by the chief nurse and had full input from the deputy chief nurse, heads of nursing, , matrons, ward sisters and charge nurses. The overall aim was to ensure there was one nurse to every eight patients on all of the surgical wards.
- Each ward at the LRI had a 'hot board'(safe staffing board), at its entrance displaying planned and actual nurse staffing. During our visit, the majority of wards met the requirement of 1:8 nurse to patient ratio.
- A staffing 'bleep' was carried overnight by the team on ward R08 (surgical admissions).The ward sisters or shift co-ordinators carried the bleep during the day. This ensured there was a point of contact for teams should they encounter any immediate staffing issues and identified staffing shortages for the following day in a proactive manner.
- Information supplied to us by the trust from June 2016 showed surgical whole time equivalent (WTE) vacancies of 58 for registered nursing staff and 26 for healthcare assistants and other support staff. Senior nurses in main theatres told us there were 13 WTE vacancies at the LRI.
- The trust had a rolling programme of recruitment which included recruitment from overseas.
- All staff reported the use of hospital bank staff rather than agency staff in order that gaps in staffing levels were filled by staff that were familiar with the hospital. .
- The average use of bank nurses in surgical areas at the LRI was 6% between April 2015 and March 2016. The highest use was in general surgery with 16% in the same reporting period. Ward sisters and charge nurses told us this was because of increased vacancies and sickness rates over the winter period.
- Information supplied to us by the trust from June 2016, reported an average staff turnover in surgery at LRI of 5.5 %. The trust's recommended average was 10 %.
- Surgical ward band four assistant practitioners (APs) were employed as part of the ward establishments. Staff reported this role as having a positive effect on the registered nurses' workload. APs had been trained to insert intravenous cannulas,(a thin tube inserted into a

vein to administer medication), obtain and record physiological observations and, in some areas, collect patients from theatre recovery. One staff nurse told us, "They do everything except give out medicines".

- . The senior co-ordinating nurses discussed all patients in relation to acuity and safety whilst the day team reviewed patients at the bedside handover. The medical ward round started immediately after this with the co-ordinating nurse taking charge and ensuring patients were informed of any changes to their plans of care. Following the medical ward round a safety and post ward-round update was handed over to staff teams allocated to patients. This ensured effective communication in order to provide patients with care.

Surgical staffing

- Within surgery, consultant, registrar and junior doctor medical staffing levels were similar to the England average. Consultant staffing at the trust was 43% compared to an England average of 41%, registrar grade medical staffing at the hospital was 40%, against the England average of 37%. There was a lower number of middle grade staff at 7% against the England average of 11%. Junior medical staffing at the hospital was 10% with an England average of 12%. This provided a stable team of medical staff in surgery.
- Surgical doctors, registrars and consultants from all specialities were on call to provide advice and treatment 24 hours a day, seven days a week. Doctors and registrars were available on site during the day, including weekends. Consultants were on site during weekdays and were available to attend the hospital out of hours when necessary. Staff told us that on call doctors were available within 20 minutes if they were offsite.
- Handover took place daily, seven days a week for all general surgical and orthopaedic patients. A separate trauma handover took place between the outgoing doctors with the incoming team and the theatre co-ordinator prior to the consultant Multi-Disciplinary Team (MDT) ward round. The on call doctors had a 30-minute overlap in their shifts, which allowed for a handover of all admissions and any concerns regarding particularly unstable patients. However, a doctor told us formal general surgical handovers at night did not routinely take place. This meant there was an increased risk that important patient information may not be passed on.

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- A theatre meeting took place each morning and was attended by the anaesthetic team, theatre team, consultant and surgeon on call for the day to decide if any changes were required to the theatre lists. Medical handover for anaesthetics took place twice a day for theatres.
- Between April 2015 and March 2016 the average locum usage was 5.7% throughout surgical services at the LRI. The highest use of locums was in maxilla-facial surgery with 22% for the same reporting period. Health Education England data indicated there were only five training posts available within this surgical speciality for 2015 throughout England. This contributed to the difficulty in staff recruitment into this specialist area.
- Information supplied to us by the trust showed from June 2016 there were 17 medical staffing vacancies at a rate of 4.8%.

Major incident awareness and training

- All staff we spoke with were aware of the trust's major incident and continuity plan. Staff knew where to find the major incident plan and could describe their responsibilities as part of it.
- The trust provided information in relation to major incident training within surgery. Fifteen members of staff had attended the LRI evacuation workshop as part of emergency planning including nurses and administration staff. In January 2016 five members of staff had attended Exercise Opus Resilience, a multi-agency table top exercise simulating a mass casualty incident. This training and preparation was key to being able to respond in an emergency. The staff we spoke with were unaware of any major incident exercises.
- Teams of senior officers from the police, ambulance service, fire and rescue, NHS hospitals, environment agency, military and search and rescue trained together to rapidly process information reports and decide response plans.
- The LRI had a major incident room in the theatre suite where contact lists (including staff distance from the hospital site), incident cards and continuity plans were stored.

Are surgery services effective?

Good



Overall, we judged the effectiveness of surgical services as good.

We found:

- Patient's care and treatment was mostly planned and delivered in line with current evidence based guidance, best practice and relevant legislation. There was good use of patient pathways aligned to the National Institute for Health and Care Excellence (NICE) quality standards. For example enhanced recovery programmes.
- The outcomes for patients were mostly in line with, or better than the England average.
- We saw evidence of effective multidisciplinary working. Staff were qualified and had the skills they needed to carry out their roles effectively and, staff were supported to maintain and further develop their professional skills and experience.
- Patients pain was assessed and managed. Patient's nutritional risk was assessed in a timely manner and specialist advice sought where appropriate.

However, we also found:

- Staff did not have a full understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and how to use them appropriately.
- Consent was not always obtained or recorded in line with relevant guidance or legislation. There was a lack of consistency in how people's mental capacity was assessed. For example, for patients requiring a consent form four (a form for adults who were unable to consent to investigation or treatment) there was no documented evidence a mental capacity assessment (MCA) had been carried out prior to the consent.

Evidence-based care and treatment

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

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- Policies were up-to-date and followed guidance from NICE and other professional associations for example, the Association for Perioperative Practice (AfPP). Local policies, such as infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- We saw examples of policies and procedures, which were based on nationally recognised guidance. The inpatient care and risk document, completed for every patient, contained the malnutrition universal screening tool (MUST); this identified adults who were underweight or at risk of malnutrition. A nationally recognised screening tool was used to identify patients at risk of developing pressure ulcers and the 'diabetes foot screening assessment' was used to detect the development of foot problems in patients with diabetes.
- Patients' care needs were reassessed throughout their care pathway. Care and treatment was delivered in line with 'NICE quality standards and the Royal College of Nursing guidelines.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend patients with certain co-morbidities (multiple medical conditions) are reviewed pre operatively by an anaesthetist. Examples of co-morbidities include age, heart disease (myocardial infarction and angina), heart failure, ischaemic brain disease (stroke and transient ischaemic attacks). The majority of patients with multiple medical conditions or increased complications of anaesthesia were seen in a 'high risk anaesthesia' clinic. This ensured patients at high risk of complications were fully prepared for the procedure and an appropriate anaesthetic selected prior to surgery. For example some surgical procedures were carried out under a spinal block eliminating the risk of general anaesthesia. We saw documentation and spoke with two patients who had attended this clinic.
- Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists guidance. Theatre managers told us the trust had applied for Anaesthesia Clinical Services Accreditation (ACSA). This is a voluntary scheme for NHS and independent sector organisations offering quality improvement through peer review.
- Day surgery patients mostly received care in line with the best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011. This guidance states it is best practice to have a dedicated telephone helpline for patients during the first 24 hours post day surgery. The day surgery unit did not have this in place. Patients were advised to contact a ward (depending on the surgical procedure) or their own GP if they had any concerns following discharge. A telephone advice sheet was available on wards to record calls received. However, these were not consistently stored in patient records. This presented a risk to safety and continuity of care as all patient contact should be documented for each episode of care.
- During admission, comprehensive care pathways were in place for patients undergoing anaesthesia for surgery, including localised and general anaesthesia. Care pathways are multidisciplinary plans of anticipated care and timeframes. This meant there was a standard system in place for each patient admitted.
- An enhanced recovery procedure was in place for patients having hip, knee, spinal, or colorectal surgery. Enhanced recovery is an evidence-based approach that helps people recover quickly following major surgery. We saw a copy of the enhanced recovery checklist for patients undergoing colorectal surgery, which included information for the patient on what they could expect before and after surgery and discharge information. This was also supported by an evidence based Colorectal Enhanced Recovery Guideline dated July 2013.
- Surgical staff followed NICE guidelines for the prevention and treatment of surgical site infections. The surgical site infection surveillance team (SSIS) monitored surgical site infection in patients who had undergone a total knee replacement or revision and total hip replacement or revision.
- Across surgery, we saw there were arrangements in place aligned to the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. Examples included a dedicated surgical assessment unit (SAU), a consultant-led service with consultant availability at all times for telephone advice, a dedicated surgical team free of elective commitments to cover emergencies and emergency theatre availability at all times.
- The trust followed NCEPOD, (National Confidential Enquiry into Patient Outcome and Death) guidelines for patients requiring emergency operations after 10pm.

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This meant patients, operated on after 10pm, were recovered in theatre and then returned to a surgical ward. There were no reported occurrences of patients staying in recovery over night following their operation.

- The burns team were in the process of putting in place an electronic referral system: Network On-call Referral System (NORSe). This was a secure electronic form based referral solution, which allowed the trust to refer patients with specialised (often emergency conditions) to specialist trusts or 'centres of excellence'. The receiver could advise on, accept or reject the referral. This system was to be used in conjunction with the Midlands Burn Operational Delivery Network (MBODN) to ensure accurate assessment of burn injuries within the Midlands.

Pain relief

- The trust fully complied with all of the standards set out by the Faculty of Pain Medicines Core Standards for Pain Management (2015). For example standardised assessment tools and clear protocols for the management of acute pain by ward staff. The trust were working towards implementation of all recommendations, particularly those in relation to managing pain in the community. They also regularly liaised with other local pain services through the midlands pain forum.
- A dedicated pain management team could be contacted by 'bleep' or pager. The team comprised of nursing and medical staff covering all three Leicester hospitals. They were available from 8am to 5pm Monday to Friday. Over the weekends this service was covered by anaesthetists. All patients who required major elective surgery were referred to the pain nurse pre-operatively and were visited post operatively.
- The pain management team used a variety of pumps to administer analgesia (pain relief) to specific localised areas. These pumps were reviewed daily and adjusted if the patient was experiencing pain. We spoke with three patients using these devices; they all reported an improvement in pain control and increased mobility because of the portable pump.
- Following surgery, appropriate pain relief was administered in theatre recovery. Patients undergoing orthopaedic surgery had pre-planned pain relief plans. Pain control was discussed with patients pre-operatively and documented in the 'admission for adult surgery' documentation.

- National Institute for Health and Care Excellence (NICE) guidance 'Patient Group Directions (PGD)' (2013) was followed. This allowed registered nurses to supply some prescription-only medicines to patients, without individual prescriptions. However, the trust currently used only one PGD for pain relief trust wide. This was for paracetamol. This allowed timely responses to some patients' pain without having to wait for a doctor's prescription. The trust was considering using further PGDs to respond to those patients requiring stronger analgesia.
- A pain aid tool was available for patients with cognitive impairment; we saw these on all wards. This pain behaviour tool is used to assess pain in older adults who have dementia or other cognitive impairment and are unable to reliably communicate their pain.
- In five out of six medication records we reviewed, pain relief medication had been prescribed and given appropriately. However, a patient on ward 8 told us they had been prescribed intravenous paracetamol by the pain team however their intravenous cannula was not working and they had missed three doses of intravenous pain relief. The patient had requested a new cannula. This did not indicate a timely response to this patient's pain. Other patients told us nurses responded quickly to requests for pain relief.

Nutrition and hydration

- Fluid balance charts were in place to monitor patients' hydration. We reviewed 15 fluid balance charts and found all 15 were completed accurately.
- All patients had their nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). The MUST tool calculates the patient's risk of malnutrition. Patients were assessed as low, medium or high risk. Nutrition care plans were in place for each patient where risks were identified.
- Dietitians were available Monday to Friday to assess patients who required nutritional support, including those with a high risk MUST score. Staff told us dietitians were accessible and responded promptly to referrals from nursing staff.
- An inpatient care and risk document was completed for all patient admissions. This included a section on nutrition and hydration. This was mostly completed in all of the 15 care plans we reviewed and stated dietary

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requirements for example 'diabetic' or 'vegetarian', whether any special utensils were required and whether the patient had any difficulties swallowing. However, patient food preferences were not always documented.

- Protected meal times were in place on some surgical wards, which ensured staff had dedicated time to help patients with their meals. However, the system was not established on all wards.
- We observed staff serving lunch on one ward. Food temperatures were checked before serving and patients were asked if they required any help with their meals.
- Housekeeping staff handling food told us they had received food hygiene awareness training. However, nursing staff and ward sisters were also serving and preparing food (e.g. soup, toast); they told us they had not done any food hygiene training. The hospital policy Food Hygiene and Ward/Department Kitchens Policy 2016 and The Food Safety and Hygiene (England) Regulations 2013 require that all "food handlers" are trained and/or supervised and instructed in food hygiene. This meant staff were not adhering to regulations or trust policy.
- Food was available on the wards throughout the 24-hour period. Snack boxes were available for patients who missed a meal.
- During our inspection, we saw patients requiring assistance with eating and drinking were identified using magnetic pictures on the ward patient white boards, and assisted accordingly.
- The trust wide Friends and Family Test (FFT) scored satisfaction for catering at 77% (against the England average of 88%). The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care.
- Patients told us they were generally satisfied with the food provided at the hospital. Three patients, who had been in hospital for longer than four weeks, felt there was not enough choice and they had not been offered different menu choices.
- Depending on their surgical procedure, patients could drink up to two hours before surgery and eat up to four hours before surgery. Patients were given information about when they must stop eating and drinking before their operation. However, some patients reported not eating for two or three days when surgery had been cancelled. This meant a lack of nutrition could potentially reduce healing rates postoperatively.

- We saw medications prescribed for post-operative sickness. This meant patients were provided with medication if required after an anaesthetic.

Patient outcomes

- The NICE clinical guideline on hip fracture management (NICE clinical guideline 124) recommends surgery is performed on the day of or day after admission. The guideline states this will have a positive impact on outcomes for patients. The Leicester Royal Infirmary (LRI) performed worse than the England average for six of the eight measures in the Hip Fracture Audit, 2015. For example, patients admitted to orthopaedic care within four hours was 23.6% compared to the England average of 46.1%. Patients having surgery on the day or day after admission was 60.3% compared to the England average of 72.1%. Following our inspection, we requested the trust's action plan for addressing performance in the hip fracture audit 2015. The plan identified a need for an improvement in the whole hip fracture pathway from admission to discharge. For example to improve patients time to surgery outcomes, (how quickly the patient has their operation), work will concentrate on ensuring patients are optimised (fully prepared and fit) for theatre as soon as possible in the emergency department. Extra theatre lists were planned and a specialist frailty consultant of the day to ensure continuity and access for patients in a timely manner.
- The trust planned to submit details of the implementation plan and the timescale for achieving sustained performance to the local clinical commissioning group (CCG) by October 2016. During April/May 2016, the time to theatre target of 72% had been met however, the trust was aware this did not guarantee sustained performance.
- The trust demonstrated good performance in the national bowel cancer audit 2015 and performed better than the England average for three of the six measures. For example, post-operative length of stay 74% compared to the England average of 69% and case ascertainment, (discovery of the disease) 102% against an England average of 94%.
- On average elective and non-elective patients spent a similar time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from April 2015 to March 2016

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was 3.4 days, compared to 3.3 days for England. For non-elective (emergency) patients the average length of stay was 5.1 days, which was equal to the England average.

- The trust was an outlier nationally for the rate of readmissions within 30 days of discharge. This means the trust had more re-admissions within 30 days than the national average. In response, the trust had made a commitment for 2016/17 to reduce readmissions within 30 days to below 8.5%. The trust plans to reduce readmissions included; monitoring readmissions through their governance structure, focussing discharge resources on those patients at a higher risk of readmission and addressing clinical variations in consultant re-admission rates. The new project had been implemented throughout June 2016.
- Results from the patient reported outcome measures (PROMs) between April 2015 and March 2016 for groin hernia, hip replacement, knee replacement and varicose veins were similar to the England average. PROMs are data collected to give a national-level overview of patient improvement after specific operations.
- The LRI demonstrated a mixed performance in the national emergency laparotomy audit (2015). The audit rates performance on a red, amber, green (RAG) scale, where green is best. A green rating was applied to five out of the eleven indicators. These were for final case ascertainment, documenting risk, arrival to theatre in appropriate timescale, consultant surgeon present in theatre and direct post-operative admission to critical care. The trust scored red against two measures: consultant review within 12 hours of emergency admission and assessment by MCOP (Medicine for Care of the Older Person) specialist.
- At the LRI one surgical site infection had been reported for 2015. A full investigation was carried out however; a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts however, not all categories of surgery are required to be included. The trust reported on surgical site infections where hip and knee replacement surgery had been undertaken.
- Staff told us they attended corporate induction and local induction when they started working for the trust. The trust target for attendance at the corporate induction was 95%. Ninety-two per cent of relevant staff, within the clinical management groups (CMGs) had attended the trust corporate induction in the last year, which was slightly below the trust target.
- The trust recruited nurses from the Europe Union (EU) including Spain, Portugal, Italy and Greece. These nurses were given a comprehensive 12-week induction including lessons to develop their English language; they were supernumerary on the wards to enable them to become familiar with nursing practice in England. During induction these staff wore green name badges in order that patients and visitors could see they were on induction. At the end of the induction, they had to complete and pass a medicines management assessment before being allowed to work independently.
- A specific induction folder was used on the wards for bank and agency staff; 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures; ward orientation and electronic medicine administration. The logbook on the two wards we looked at was completed sufficiently to indicate bank and agency staff had been orientated to the ward or clinical area.
- Within surgery at the LRI from April 2015-March 2016, 88% of staff had received an appraisal. This did not meet the trust target of 95%.
- All staff we spoke with described their appraisal as a positive experience and a process, which enabled them to identify their learning needs for the following year. For example, some staff had identified a goal to undertake mentor training and assistant practitioner training.
- Staff told us that whenever possible, they were given time to attend training sessions or complete on line training and we saw this in practice. However, some staff at the LRI understood they were expected to undertake training and development in their own time.
- Where possible work based learning took place. For example, we observed good interactive learning taking place between a consultant and a junior doctor during an operation.
- Most junior doctors working in surgery told us they attended teaching sessions and participated in clinical audits.

Competent staff

- The trust had systems in place to monitor the registration status of qualified doctors and nurses on an annual basis. There was a nominated responsible officer for medical revalidation. Nurses told us there were learning events to help them with revalidation.

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- Junior doctors told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The majority of patients we spoke with reported a high level of confidence in medical and nursing staff with regard to their knowledge and skills. However, some patients told us they felt the communication between doctors and nurses was not always effective. For example, one patient told us the doctor and nurse had not communicated about a change of wound dressing they needed.
- Staff working in burns and plastics had secured funding for places on a degree programme at a nearby university to ensure the team was working with the most up to date knowledge and skills.
- The burns and plastics nurse specialist was involved in daily ward rounds with consultants and medical teams throughout the hospital to ensure burns patients were reviewed in a timely manner.
- The trauma co-ordinator was responsible for ensuring communication between the ward team and theatres to ensure safe patient flow. During our inspection, we joined the Trauma MDT ward round and witnessed effective communication between the MDT members and theatres when the operating list had to be adjusted.
- An increasing number of advanced nurse practitioners were able to request an ultrasound. This was to the benefit of patients. "It has changed the way care is delivered" a staff member quoted.
- We saw evidence of geriatrician attendance on orthopaedic and other surgical wards and clear management plans in patient records. Ward 32 had MDTs led by an orthogeriatrician Monday to Friday. All aspects of elderly patient care and management was discussed. Attendees included doctors, nurses, occupational therapists, physiotherapists, activities coordinators and voluntary staff. Ward 18 also had an MDT meeting with the orthogeriatrician on a Tuesday afternoon to ensure patients transferred to this ward were reviewed appropriately.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to delivering patient care and treatment. We saw involvement from nurses, medical staff, allied health professionals (AHPs) and specialist nurses. Most staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Medical records demonstrated a MDT approach to the delivery of patient care. Throughout the care records we reviewed, we saw input from physiotherapists, consultants, dieticians, nurses, speech and language therapists (SALT) and specialist nurses.
- As University Hospital Leicester (UHL) is split between three hospital sites, MDT working with surgical specialists involved linking between the sites. All staff we spoke with felt the services on other sites were available in a timely way.
- We observed therapy staff assisting with patient therapy sessions encouraging mobilisation and self-care activities. Therapy staff contributed to the daily MDT meetings on ward R32, which included the nurse in charge, a doctor and the bed co-ordinator. The MDT meeting addressed each patient's condition and progress.
- Therapy staff told us there was effective communication and partnership working between the surgical and orthopaedic MDT. Teams met regularly to identify patients who required a review and to discuss any changes to their care.

Seven-day services

- Operating theatres were available seven days a week. The hospital emergency theatre was available 24 hours a day, seven days a week. A second emergency theatre could be opened and used if required.
- Access to emergency theatre was available seven days a week. A dedicated trauma team was on call 24 hours a day, seven days a week. If required, the trauma team could be in theatre within 30 minutes of being called. This was in line with the trust's policy.
- Lithotripsy (a treatment, using ultrasound shock waves, by which a kidney stone or other calculus can be broken into small particles which can be passed out by the body) was provided 24 hours a day seven days a week as opposed to the previous availability of every three weeks. This was because of the addition of a new machine.
- Surgical consultants worked an emergency on call rota, seven days per week. A consultant was on call 24 hours

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a day from Monday 8am to Friday 5pm then another one Friday 5pm to Monday 8am. This maintained continuity for patients within the clinical management groups (CMG's) and on the ward.

- Seven day access to an orthogeriatrician is a key priority in NICE guidance CG124 (hip fracture management). Senior Staff told us that orthogeriatrician cover at the weekends was extremely difficult, due to national shortages.
- The medical doctors we spoke with told us there was good access 24 hours a day, seven days a week to all diagnostic services to support clinical decision making. For example interventional radiology had an on call system for covering trust sites including nurses and a vascular and non-vascular radiologist.
- Dietetics, physiotherapy, speech and language therapy (SALT) and occupational therapy were available from 9am to 5pm Monday to Friday. Where support was required from physiotherapy out of hours, an on-call system was in place.

Access to information

- Information needed to deliver effective care and treatment was not always available to relevant staff in a timely and accessible way; medical notes were often missing when patients were added to theatre lists at short notice. However, staff did not accurately record this or report it as an incident via the electronic reporting system.
- Information we received after our inspection identified four incident reports in relation to missing patient notes at the LRI. However, because staff were not always reporting missing notes as an incident we were not assured the trust were fully aware of the number of times notes were not available. .
- Where patients surgery had been arranged on a different hospital site, staff told us the medical notes did not always follow the patient causing delays or cancellation of their operation. Information provided by the trust identified four cancelled operations from 6 June to 26 June 2016 because of missing medical notes.
- Information and guidance regarding specific procedures or conditions was available through the trust's intranet. For example diabetes management pre and post operatively. We saw information had been printed and included in the nursing notes to use as a guide.

- There were computers throughout the ward areas to access patient information including test results, diagnostics and records. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- We received mixed feedback from therapy services. Most staff reported good access to the trust intranet for relevant policies and procedures. However, some student therapists did not have access and relied on other team members for access.
- We saw an electronic theatre data system in use; this was an operating theatre management system to assist with the tasks needed to provide safe and efficient care to patients. However, staff in theatres told us patients added late onto theatre lists were not always entered onto the system in real time due to a lack of computers in the anaesthetic room. This meant we could not be assured theatre lists were accurate and up to date. Staff told us they did not report this through the electronic reporting system, as they had not considered it an incident.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- GPs had direct access to the medical staff and could speak to a surgical consultant or other senior doctor for advice on the telephone.
- Discharge summaries were sent to each patient's general practitioner (GP) on discharge to ensure continuity of care within the community. Summaries were sent on the day of discharge by e-mail, post or given to the patient for them to hand in to their GP. The discharge letter detailed the reason for admission, any investigation results and treatment undertaken.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was sought from patients who had capacity to understand in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options about their care and treatment.
- We observed staff asking for consent both verbally and in writing. On checking patient records, we saw copies of signed consent forms, which had been completed appropriately. However, consent form four (used for

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patients who lack capacity to consent to treatment) was inconsistently completed in all of the documentation we saw. For example, the mental capacity assessment had not been completed.

- Staff told us they were aware of, and had access to, the trust policy and procedures for consent.
- Patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and verbally consented to blood tests and scans.
- Mental Capacity act (MCA) 2005) and Deprivation of Liberty Safeguards (DoLS) training and updates were included as part of safeguarding training. However, most of the staff we spoke with had limited knowledge concerning MCA assessments. None of the nursing staff we spoke with felt they received sufficient training on undertaking MCA assessments. When questioned they did not understand who would carry out the assessment or when.
- During our inspection of this hospital, we saw no patients receiving surgical care who required a DoLS.
- Staff we spoke with told us that if they had concerns they would liaise with the hospital's safeguarding team if they felt a patient required a DoLS to be put in place.

Are surgery services caring?

Good



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

We found:

- Staff responded compassionately when patients needed help and staff supported patients emotionally. This was reflected in their care and treatment.
- We observed Staff positively interacted with patients and treated them with kindness, dignity, respect and compassion throughout the delivery of care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.
- Patients were involved and encouraged to be active partners in their care and in making decisions. Relatives and carers told us they felt involved and informed about their care and treatment.
- Multi-denominational spiritual and emotional support was available to all who attended the hospital.

Compassionate care

- The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The overall FFT response rate for Surgery at Leicester Royal Infirmary (LRI) was 35% for the period July 2015 to June 2016. The England average response rate for the same period was 30%. Ward 21 consistently scored very well: 96-100% of monthly respondents would recommend the ward, scoring 100% in ten of the twelve previous months.
- Outcomes of the FFT feedback were used to improve patient experiences. An example of this was staff offered patients earplugs at night to reduce noise and improve their sleep.
- The trust had good results for the Care Quality Commission (CQC) inpatient survey 2015. This survey looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust.
- Responses were received from 547 patients at University Hospitals of Leicester NHS Trust. In all 11 questions, the trust was rated about the same as other trusts. There were three areas where the trust was considered worse, these were cleanliness of rooms or wards, acknowledgment of patients and some respondents felt doctors and nurses talked in front of them, as if they were not there.
- We spoke with 33 patients. The majority of patients spoke positively about the care they received in hospital. They told us staff were kind and considerate and “nothing was too much trouble”. Patients said they felt “well” treated and told us staff were “very attentive”. Patients considered staff were friendly and helpful and no matter how rushed they were, always had a smile. Three patients felt when staff were busy they were sometimes a bit “rough”.

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- In all wards and departments we visited, we observed good interactions between members of staff and patients. We saw written compliments and thank you letters displayed on ward notice boards, which had been received during the past two months.
- Patients told us they were treated with dignity and respect and we observed this in the wards and departments we visited. We observed staff speaking quietly to patients and taking time to explain procedures to them at the patient's own pace. For example, we observed a nurse speaking to a patient about to go to theatre in a calm and compassionate manner. The patient was very complimentary about the care they had received .
- Ward R32 had involved patients in creating a reminiscence board. This was a photo board that helped patients to talk with staff about their past lives and experiences.
- During lunchtimes, we observed patients being provided with support. We saw staff being kind and respectful when supporting patients to eat and drink, taking time to enable patients to eat their meals.
- The ophthalmology day case unit was noted to be cramped and poorly ventilated during our visit. The admission area was mixed gender and due to limited space, privacy and dignity could not be maintained. There were two areas with curtains for male and female patients. However, the curtains remained open as closing them restricted staff view and made the areas feel cramped. Ladies in the female area were dressed in gowns awaiting procedures, opposite them were male patients being monitored and admitted. The nurse in charge said it was a problem they had discussed with managers but nothing had changed.
- Care and treatment was explained by all members of the multidisciplinary team in a way that could be understood by the patient. We observed a member of staff speaking with a patient to explain about their spouse's care. We observed ward receptionists helping relatives with information requests and taking phone messages to patients from relatives.
- We observed good interactions between staff and patients in the theatre assessment area (TAA) and the recovery suite of main theatres. Staff spoke in a quiet calm manner to patients explaining what was happening to them and what was going to happen next.
- There was a team of meaningful activities coordinators at the LRI. These coordinators were well respected by staff and patients. Patients and relatives told us they were grateful for the support they offered. They were able to provide help for relatives in relation to completing attendance allowance documents. Attendance allowance is available for people aged over 65 years who need help with personal care (washing, dressing or eating) due to an illness or disability. They supported patients living with dementia by talking with them and reminiscing about the things that made them happy. They were also able to paint patients' fingernails, wash, and style their hair to make patients feel more at home.

Understanding and involvement of patients and those close to them

- The spouse of a patient on ward R32 was admitted to this hospital, and the team on the ward organised for them both to be cared for in the same ward to ensure they could see each other and be kept informed of each other's progress.
- We spoke with six relatives who told us they had been kept informed of progress and staff were approachable if they needed to ask any questions. Staff were aware of patient confidentiality and told us they always checked with the patient if they were unsure of who was making the request.
- **Emotional support**
 - Chaplaincy services provided spiritual and religious support for patients and relatives and were accessible to staff if required. The chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains.
 - A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss. The bereavement services team produced an information leaflet to assist relatives/carers during the early days of bereavement.
 - Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
 - Patients and staff had access to clinical nurse specialists across the surgical areas. For example, we saw that there were specialist nurses for colorectal, stoma, thoracic, breast care and the acute pain team. Clinical nurse specialists supported patients to manage their own health, care and wellbeing and to maximise their independence.

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- We saw patients treated with care, compassion and respect as we followed them through the peri-operative pathway. For example, nurses reassuring patients before going to theatre and ensuring they were received back from theatre by the same nurse wherever possible.

Are surgery services responsive?

Good



We rated responsive as good.

We found:

- Patient had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. For example enhanced recovery programmes.
- The surgical areas had clear processes in place for the management of patients living with dementia and learning difficulties. Staff could describe their responsibilities to these patients and we were told of examples where these patients had their specific needs met.
- The majority of surgical specialties met or exceeded the 90% target of patients being seen within the 18 week referral to treatment target. The exception to this was ear, nose and throat services where 75% of patients were seen within 18 weeks.

However, we also found:

- The referral to treatment times (RTT) for the surgical speciality standards were not being achieved by the trust. Six of the eight surgical specialties did not meet the 90% standard of the proportion of patients waiting less than 18 weeks from referral to treatment time. This included; ear, nose and throat (ENT), general surgery, oral surgery, trauma and orthopaedics and urology.
- Some patients were not able to access services for assessment. For example, the pathway for pre-operative and high-risk anaesthesia patients was not consistently followed, causing potentially avoidable delays and cancellations.
- Complaints were not always used as an opportunity to learn. Ward staff told us that some complaints raised by patients were dealt with by the ward, but were not always documented.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the people it served and acted on these to plan, design and deliver services. There was a range of appropriate provision to meet needs and support people to access and receive care as close to their home as possible. For example, the trust provided an outpatient intravenous antibiotic facility for patients receiving long-term antibiotic therapies.
- The trust engaged with internal and external stakeholders including patients, governors, members, partners and staff to plan services. For example 'Better care Together' the Leicester, Leicestershire & Rutland (LLR) health and social care teams discussed plans for an integrated, high quality service, delivered in local community settings where appropriate.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally. For example, Leicester Royal Infirmary (LRI) was the centre for surgery of cancers of the stomach and oesophagus for Leicester, Leicestershire, Northamptonshire and Rutland. It was also one of the two designated NHS centres in the East Midlands providing weight loss surgery.
- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was limited.
- Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities to reduce anxiety and disorientation.
- Patients needing sarcoma surgery (a type of cancer found in the tissue of the skin) were referred to a nearby NHS trust for the surgical procedure. A joint sarcoma MDT meeting was held at the receiving trust and involved an oncology and orthopaedic surgeon from Leicester and the oncology-plastic surgeons from the nearby trust. These meeting ensured patients, initially seen in Leicester, were surgically managed at the nearby trust and then safely transferred back to Leicester for further out patient and postoperative follow up.

Access and flow

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- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care.
- The trust wide data for June 2016 showed that the majority of specialties met or exceeded the 90% standard of 90% of patients meeting their RTT. However the ear, nose and throat speciality had seen only 75% of patients within the 18 week target.
- Arrangements were in place to provide protected theatre time for those patients admitted as an emergency following a fractured neck of femur (the neck of the femur is the region just below the hip joint). However, staff told us this protected theatre time was often used for patients requiring emergency spinal surgery. This meant some patients had to be transferred to the Leicester General Hospital (LGH) site to receive emergency orthopaedic procedures due to lack of operating theatre availability at this hospital.
- Sixteen theatres at LRI provided emergency and elective surgery. Theatre utilisation (how often the theatre was used) averaged at 55% for January to March 2016. Ophthalmic theatres reported an average of 73% utilisation. Senior staff in theatres could not explain the low utilisation of theatres.
- The matron in theatre was responsible for scheduling operations. A team leader worked across all theatres each day to identify and solve problems such as capacity, theatre overruns and staffing issues.
- During times of high patient demand, planned elective patients were reviewed according to priority to prevent those patients requiring urgent surgery or those requiring surgery for a cancer diagnosis being cancelled. However, during our announced and unannounced inspections staff told us due to a lack of high dependency beds patients requiring surgery for a cancer diagnosis had been cancelled.
- We requested cancellation information from the trust in relation to the number of cancelled operations during June 2016. Information provided by the trust showed between 6 and 26 June 2016 there had been 76 cancellations for non-clinical reasons. Lack of theatre time accounted for 27 cancellations and 35 were because of lack of post-operative high dependency unit (HDU) or intensive treatment unit beds (ITU). Nurses we spoke with thought there were plans to address these issues but were not informed of any implementation progress.
- Information from NHS England showed that between January and June 2016, the total number of elective operations at the trust, which were cancelled on the day was 854. All but 92 of these were rescheduled within 28 days.
- Cancelled operations as a percentage of elective admissions performance was in line with the England average at this trust (0.8%-1.4%) for the reporting period April 2015 to June 2016.
- Bed occupancy at the LRI was 85% for April 2015 to March 2016. However, in July 2015, it rose to 95%. It is generally accepted when occupancy rates rise above 85%; it can start to affect the quality of care provided to patients.
- Bed capacity meetings were held three times daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability.
- Patients were admitted as emergencies through the surgical admissions unit (SAU), via their GP, or directly from the emergency department (ED). Patients attending the SAU were seen in the triage (initial assessment) area by a specialist nurse practitioner and specialist registrar where a decision to admit or discharge patients was made. This ensured patients were appropriately placed and reduced unnecessary admissions. Staff told us 50% of patients were admitted following surgical triage and 50% would be discharged. Admitted patients progressed to the SAU or a surgical speciality area. To improve flow, patients seen in the ED were triaged to either the LRI surgical unit or the Leicester General Hospital (LGH) surgical unit. For example, patients with hepatobiliary (liver) disease were sent to the LGH for triage, as this was where this speciality was managed.
- Elective surgery patients were admitted through the theatre assessment area (TAA). The TAA provided a facility for patients to be admitted on the day of their surgery, assessed by nursing staff and to meet their anaesthetist and surgeon. The operating theatres were adjacent to the TAA.
- During our inspection, not all patients had been seen in the pre-operative assessment clinic. This meant patients were not always fully prepared prior to arrival at the TAA,

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leading to delays and last minute theatre list changes. Staff told us this was a problem on a daily basis particularly when patient notes were not available in the department. This could present a risk to patient safety and disrupted the flow through the department.

- Pre-operative assessment at the LRI was carried out in different departments and areas of the hospital depending on which clinical management group (CMG) the surgical team belonged to. Staff in the TAA told us if all patients were pre-operatively assessed in a consistent way this would improve patient flow, patient experience and safety.
- Senior staff told us they made decisions about whether to cancel operations the day before the operation wherever possible. Surgical operations were graded one to three; those graded three were of lower priority and were more likely to be cancelled. Cancer patients were grade one and complex operations requiring surgeons from two specialities were grade two.
- The trust had procedures in place for surgical outliers. Outliers are patients cared for in an area outside of their speciality (such as surgical patients on a medical ward). During our inspection, there were no surgical outliers. Staff on surgical wards told us during the winter the surgical wards were often full with medical outliers. During our inspection, there were no medical outliers on any of the surgical wards. Senior staff we spoke with, were starting to plan for winter 2016/17. For example developing the triage systems and teams in order to reduce overnight hospital stays.
- Wards and departments included single-gender accommodation, which promoted privacy and dignity. The trust performance report from April 2016 showed there had been no reported times when male and female patients had been treated in a mixed area at this hospital between March 2015 and April 2016. However, the ophthalmology day case unit was cramped and poorly ventilated during our visit. The admission area was mixed gender and due to limited space, privacy and dignity could not be maintained. There were two areas with curtains for male and female patients. However, the curtains remained open as closing them restricted staff view and made the areas feel cramped. Ladies in the female area were dressed in gowns awaiting procedures, opposite them were male patients being monitored and admitted. The nurse in charge said it was a problem they had discussed with managers but nothing had changed.

Meeting people's individual needs

- All ward areas had clear bathroom and toilet signage to assist patients living with dementia to access toilet where appropriate. Ward areas were also being painted in bright colours to assist patients in recognising where they were.
- The trust provided a comprehensive interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Information could be translated into different languages on request. Large print and easy read material was available on request. The three most commonly requested languages for both written and spoken translation were Gujarati, Punjabi and Polish. The trust had an interpreting and translation policy. Staff we spoke with were aware of this service and the policy.
- During our inspection, we noted very limited signage in different languages to enable non-English speaking patients and visitors to find their way around the hospital site.
- The trust offered a pastoral, spiritual and religious support to patients, relatives and staff. The chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains, as well as the country's first paid non-religious carer. Volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives, also supported the team. A 24-hour on-call service was provided seven days a week and where possible a representative of the patient's own faith attended.
- The LRI, had a chapel and prayer room with washing facilities. Patients we spoke with were aware of the prayer rooms available to them.
- The trust told us they liaised with local faith representatives through the chaplaincy and by representation on the trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- For example a range of diet choices was available including vegetarian, gluten free, kosher and Halal. We saw housekeeping and nursing staff assisting patients with menu choices.
- All patients were asked about their religious and spiritual preferences on admission and we saw evidence of completed nursing care documents to support this.

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- Nursing care documents contained a 'this is me' section. This section captured general information about the patient such as sleep and rest patterns, communication and personal hygiene and enabled patients to express any personal preferences. This document was especially useful when caring for patients living with dementia. On Ward R32, this document assisted the activities coordinator to provide specific care for individual patients, such as having their hair styled or their finger nails painted.
- The patient medical and nursing record identified patients with diabetes. The trust had a team of diabetic nurse specialists who received daily reports of diabetic patients admitted to the hospital. The inpatient care and risk document included a diabetes foot screening assessment. We reviewed four sets of notes belonging to diabetic patients where all appropriate assessments were completed and documented.
- There was no system within the trust for identifying patients who were visually or hearing impaired and the trust did not monitor the numbers of visually or hearing impaired patients treated at the hospital. This meant these patients might not receive care tailored to their individual needs.
- The trust identified patients with learning disabilities through an electronic flag on the patient record system. This enabled the trust to monitor the numbers of patients attending the hospital with a learning disability. This information enabled the trust to tailor services according to the needs of these patients. On receipt of notification of an admission, the learning disability specialist nurse contacted the ward to discuss the patient's individual requirements.
- Staff on all wards were aware of the learning disability liaison team and contacted them if they had any questions or concerns. We did not observe any episodes of care in relation to this service during our inspection.
- Ward and theatre staff described adjustments, which could be made for patients with learning disabilities. These included single rooms with facilities for relatives or carers to stay overnight, being first on the theatre list, relatives staying with patients until they had received their anaesthetic, being given greater time and aiming for consistent nursing staff. One housekeeper told us how they had spent extra time explaining the menu choices to a patient with a learning disability.
- Information provided by the trust reported between April 2015 and March 2016 showed 550 patients with a learning disability had used hospital services. The average number referred to the learning disability specialist (LDS) nurse per month was between 15 and 25. This meant on average 43% of patients with a learning disability were referred to the learning disability specialist nurse. The trust did not provide any evidence of audit of this service in order to identify how many patients within surgery services had been referred to the learning disability specialist nurse.
- All patients with a learning disability were initially assessed using standardised nursing and medical documentation. Some patients had their own hospital profiles, (information booklets about their daily lives and their likes and dislikes), and were asked to bring them into hospital with them.
- The Trust was committed to the implementation and delivery of service improvements for people living with dementia in Leicester's Hospitals. Person centred care was individualised to meet the specific needs of each patient using the 'Know me Better' patient profile. Open visiting was available to carers of patient's living with dementia. Policies were in place to reduce the number of ward transfers for patients living with dementia.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Clinical and cognitive assessments were undertaken as part of the dementia care pathway. Care pathways are multidisciplinary plans of anticipated care. The trust had no dementia specialist nurses. However, there were dementia nursing sisters who worked within the corporate team leading on practice development and improvements and a dementia 'Champion Network' of staff with a particular interest supported patients with dementia.
- Throughout the wards, staff were able to show us changes that had been made in relation to helping patients living with dementia and their relatives. Almost all wards had a retreat room for patients and relatives to use away from the ward area. Retreat rooms were decorated for patients living with dementia and included vintage style 'gramophones', décor and 'china tea services'.
- Patients and carers were signposted and had access to charitable organisations for additional support and information.
- The LRI participated in Patient-Led Assessments of the Care Environment (PLACE). PLACE are a self-assessment of non-clinical services, which contribute to healthcare,

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delivered in both the NHS and independent or private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The 2015 PLACE scores for LRI showed the hospital scored lower than the England average in all five areas. However, facilities for patients living with dementia were the same as the England average at 62%.

- We saw all patients had a board on the wall above their bed, which displayed key information about their care needs and included symbols indicating whether a patient had significant communication difficulties. The symbols were discreet to ensure privacy.
- We saw the meaningful activities co-ordinator on ward 32 organising tea parties and during our visit a local musical ensemble were on the ward playing for the patients.
- When attending the preoperative clinics all patients were given an information pack to take home with them which included pre-surgery high calorie drinks, information on stopping smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving. This was to ensure patients were as fit as possible prior to the surgery.
- The trust provided a bus service (at a small fee) for patients and relatives. The service linked the three hospital sites. There were facilities and arrangements in place at all three sites for relatives to stay if they lived out of area.
- At University Hospitals of Leicester (UHL) staff used the national NHS e-referral service system (previously known as Choose and Book) to assist patients in making, changing and cancelling appointments.
- Departments at the LRI were accessible, however on occasions patients might be expected to travel to the LGH I for treatment, scans or consultations.
- Trauma patients with fractures, not requiring immediate surgery, were sometimes sent home to return to the LGH for surgery the following day. This ensured surgery took place in a timely manner, as surgical teams on both sites were able to work simultaneously clearing any backlog of patients. This reduced the risk of recurrent theatre cancellations.

Learning from complaints and concerns

- We spoke with ward sisters about the management of complaints on the wards. We were told ward staff would speak to anyone raising a complaint at the time they raised it. The aim was to try to resolve the problem or complaint at the time it was raised.
- We were given examples where staff had managed complaints locally and telephoned patients and their carers to discuss their complaint and the learning taken from them.
- However, ward staff also told us some complaints were dealt with by the ward which were not documented. This meant themes and trends could not be identified and evaluated.
- 'Message to matron' cards and boxes allowed patients and relatives to make comments or raise concerns. Where possible these were dealt with locally. Patients and staff told us they felt this was a good idea and often the matron would visit patients prior to discharge in order to address concerns raised.
- Posters explaining how patients could complain were clearly visible around the hospital. The Patient information and Liaison Service (PILS) was located in the Glenfield Hospital and leaflets were available for patients explaining how PILS could assist in managing complaints.
- We saw leaflets throughout the surgical wards for PILS. They were easily accessible by all patients and visitors. Pre-operative information packs also contained information about how to make a complaint.
- The LRI surgical departments, between March 2015 and April 2016, received 87 complaints. Themes included attitudes of staff and poor medical or nursing care or treatment.
- Patients and visitors told us they felt comfortable making a complaint, as nursing staff were approachable and understanding.
- Staff told us they received feedback from complaints and concerns at staff meetings or through the monthly ward newsletter. We were shown staff newsletters that confirmed this.

Are surgery services well-led?

Good



We rated the leadership of surgical care services as good.

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We found:

- Staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support.
- Staff were consistent in delivering care and demonstrating behaviours in line with the trust's vision and values. Staff told us they felt senior staff and managers were visible and they would feel able to report concerns.

However, we also found:

- Departmental governance and risk management arrangements were not robust and as such were not suitable to protect patients from harm. The risks and issues described by staff did not correspond to those reported to and understood by leaders. For example, missing medical notes and computer access in theatres.

Vision and strategy for this service

- Surgical care was provided at Leicester Royal Infirmary (LRI) as part of four clinical management groups (CMGs): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS), critical care, theatres anaesthesia, pain and sleep (ITAPS), renal, respiratory and cardiovascular (RRCV) and musculoskeletal and specialist Surgery (MSKSS)
- University Hospitals of Leicester NHS Trust (UHL) had a detailed five-year integrated business plan, which covered 2014 to 2019. A two-year 'Integrated Annual Plan' was in place within CHUGGS with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy. However, the plan, whilst ambitious, focused largely on the strategic direction of the service. For example to provide services seven days a week and to continue surgical emergency ambulatory care service, to support a reduction in length of stay, better outcomes for patients and supporting the emergency process.
- The CMGs has had individual five-year strategies linked to the trust's strategy, aims and objectives. The strategies had taken into consideration other clinical departments they worked with to deliver high quality care and recognised the assistance required from corporate directorates and other partners.

- The trust's vision was to deliver "caring at its best" for everyone who visits Leicester's Hospitals. Staff were involved in developing the five values. For example, 'we treat people how we would like to be treated', 'we are one team', and 'we are best when we work together'.
- We found the majority of staff were able to articulate the values of the trust and CMGs. Staff displayed them in their daily work and we observed them putting patients first by working as a team, leading and listening, striving for the best and trying to make a difference.

Governance, risk management and quality measurement

- A risk register was held within surgery with 27 risks identified. Risk records included a description, controls in place to mitigate the risk and a summary of actions to be taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register and identified areas such as referral to treatment time (RTT), staff skill mix and ventilation in theatres at the LRI. However, nursing and medical staff told us of potential risks that were not included in the register. For example, lack of computers in theatres, non-reporting of incidents relating to missing medical notes and lack of privacy for patients in the ophthalmology department.
- Clinical management groups (CMGs) held monthly quality and safety board meetings. We reviewed nine sets of meeting minutes and noted good levels of attendance. There was evidence of key themes around incidents and lessons learnt, complaints and a review of risks. However, there was limited evidence of lessons learnt being shared between the CMGs at this forum.
- Where incidents had been identified, they had been investigated. This included undertaking external reviews. Recommendations were made and changes implemented however, training relating to the changes did not always follow in a timely manner. For example a delirium tool was developed following a never event but staff had no training on how to use it so were unable to explain it to us during our inspection and were not using it effectively to assess patients. Delirium is often caused by physical or mental illness, and is usually temporary and reversible.
- However, staff reported not consistently raising incident reports in relation to missing medical notes, staffing levels and skill mix and lack of computers in theatre.
- Individual CMGs identified different risks, incidents, and complaints within their areas but we did not see

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evidence to suggest that the CMGs worked together to share information and learning. This meant that opportunities for learning across surgery services within this trust were limited.

- Information was shared through a network of meetings. Ward sisters attended monthly professional forum meetings. Main points from the meetings were cascaded to staff through ward meetings or ward bulletins. We saw copies of ward bulletins and staff described to us the type of information they received.
- The trust provided minutes of the professional forum meetings for each CMG. These all included topics relating to patient safety, recruitment, and changes to local guidelines and policies.

Leadership of service

- A head of nursing, a medical director and, a head of operations provided overall leadership of the CMGs responsible for surgery.
- Staff told us they felt senior staff and managers were visible, approachable and supportive and they received appropriate support to allow them to complete their jobs effectively.
- All staff explained they would be happy to approach senior staff to raise concerns and the issues would be dealt with in a timely manner. However, some staff felt they would like more information on the plans for changing the activity at the three University Hospital Leicester (UHL), hospital sites. (The trust had plans to change the services offered at the three hospitals locally). Staff said 'the dates for implementation kept changing so they never knew where they were'.
- Matrons and managers of individual CMG's were also covering cross-site. Staff we spoke with did not feel this was a problem as matrons informed them of which sites they would be at and were available by telephone.
- Junior doctors told us they felt supported and there was always a senior member of staff to ask for support.
- We met with clinical managers who felt supported and engaged with the executive team. The majority expressing how proud they were of the changes the executive team were implementing.
- The majority of staff on wards knew the Chief Executive and the Chief Nurse either from meeting them or from information shared through e-mails.

Culture within the service

- The NHS Staff Survey 2015 saw the percentage of staff recommending the trust as a place to work or receive treatment was higher than the 2014 survey. This was in line with the national average of 4%. In five out of eight questions relating to job satisfaction, the trust scored better than the national average for similar NHS trusts. Staff who felt their role made a difference to patients was 91% compared to the 90% national average.
- All members of staff we spoke with were proud to work as part of the trust and they spoke positively about teamwork and the care they provided to patients.
- Staff communicated a strong open and honest culture in all areas visited during our inspection.
- Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers. However, some staff were unsure of exactly what was reportable.
- Staff felt supported to develop their skills and progress their careers. Many staff we spoke with had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.
- The senior managers within the surgical division had high praise for their staff and recognised the challenges staff within the surgical division faced especially with the increasing demand on surgery.
- Duty of candour briefing sessions were held in surgery for all levels and types of staff groups. Roadshows were undertaken at each hospital site to raise awareness of duty of candour. A duty of candour slide had been added to the complaints e-learning module that all staff were able to access via the electronic trust-training portal. A duty of candour slide was also included on the trust induction programme for new starters and on the medical director's induction slides for new trainee doctors to the trust.

Public engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at professional forums and meetings within wards and teams. Patient experience, including compliments and complaints and results of the FFT were displayed within the wards on 'how are we doing' notice boards.

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- 'Message to matron' cards and boxes were visible in all ward and clinical areas to encourage the public to comment on services provided. 'You said, we did' posters were visible however; completion of them was not consistent.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the Trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- To encourage the public to comment on services provided and allow staff to identify changes made as a result 'you said we did' boards were displayed in ward areas.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations

Staff engagement

- Almost all staff responded positively to the trust's 'Listening into Action' (LiA) initiative. LiA allowed staff to share ownership and responsibility for improving care for patients. The burns and plastic specialist nurses used listening into action to develop a change in the availability of the service from five to seven days.
- In the University Hospital Leicester (UHL) pulse check survey, (short engagement surveys sent out several times a year to help trusts to measure staff engagement more frequently), there had been an increase in positive findings in eight out of 16 measures including quality and safety of patient care and recommending the trust to family and friends. There were three measures, which showed a reduction in satisfaction. For example, effectiveness of communication with senior managers was worse than the 2014 results (52%) at 35% in 2015. Staff feeling organisational structures and processes help them to do their jobs was worse than the 2014 results (48.7%) at 34.7% in 2015.





Innovation, improvement and sustainability

- The overall aim for UHL was to make surgery safer at every step of the patient pathway. We were told this would include the World Health Organisation (WHO) safety checklist audit to achieve a 98% completion rate and identification of clinical champions (staff with a particular interest) to lead the 'safer surgery' message. Information provided from the trust after our inspection stated that the UHL safer surgery policy was currently being revised. The policy was in the planning stage with a timeline for implementation set for December 2016.
- The trust was committed to the development of advanced nurse practitioners (ANPs) to ensure patient care was enhanced and to mitigate the potential recruitment difficulties into junior doctor posts. Additional nurse training and education has enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate.
- The trust had remained committed to the band four assistant practitioner role, which offered development opportunities for healthcare assistants to expand their practice and work more independently with qualified nurses on the wards.
- Staff recruitment from Europe including Spain, Portugal and Italy, had significantly improved staffing levels.
- The trust was very proud of the surgical triage area on ward R8 at the LRI and dedicated triage nurse practitioners. As a result, they were actively recruiting additional advanced nurse practitioners.
- A pancreatic cancer, (the pancreas produces digestive juices and hormones that regulate blood sugar), mobile telephone application had been developed and was in early stages of testing for patients to use when at home. It was to be an educational guide for patients, family members and friends facing a diagnosis of pancreatic cancer. A liver application was also in development.
- By August 2016, all partnership hospitals would be able to share real time imaging of patients rather than the current 2-3 day waiting period. This meant that surgical teams in different hospitals and departments could review scans almost immediately.

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- Ophthalmic regional blocks (this is an injection of local anaesthetic prior to ophthalmic surgery), for analgesia were being performed by advanced nurse practitioners. This meant the nurse was preparing the patient ready for the procedure saving the surgeon time and speeding up the process for the patients.
- The retreat rooms (patient quiet areas) on wards were being refurbished in order to provide a quieter calmer space for patients and families whilst visiting or receiving bad news.
- The burns and plastics specialist nursing team had moved to seven day working after gaining evidence from other wider team members, using LiA. “As a nursing team we wanted our patients to have the same level of high quality specialist care regardless of what day of the week it was on”. LiA was used throughout UHL, to engage teams of staff to help develop new ways of working for the benefit of the patients.

Critical care

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

Information about the service

The critical care service at Leicester Royal Infirmary is delivered in a 22 bedded critical care unit that is divided into several distinct areas. There is a four bedded ‘annexe’ situated on the left as you enter the critical care unit. There are two side rooms on the corridor before entering the A and B sides of the main unit, which have six beds plus two side rooms each. The critical care unit uses its capacity flexibly to care for both level three and level two patients. The four-bedded annexe being used predominantly for longer stay level three patients. Level two patients are those requiring observation that is more detailed or intervention including support for a single failing organ system, or post-operative care and those ‘stepping down’ from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all patients requiring support for multi-organ failure.

The critical care service at Leicester Royal Infirmary admits around 1300 to 1400 patients a year and is an active member of the Central England Critical Care Network. For the purposes of management and governance, the critical care service sits in the ITAPS clinical management group. ITAPS also includes theatres, anaesthesia, pain and sleep.

During our inspection, we spoke with four relatives and 15 staff of all grades including nurses, doctors, consultants and allied healthcare professionals.

As part of our inspection, we observed interactions between staff, patients and their relatives, considered the

environment and looked at two medical and nursing care records and two medication prescription charts. We also looked at policies, procedures and we reviewed performance information from and about the hospital.

A review of critical care would normally encompass any level 2 patient areas that lie outside the intensive care unit. Throughout the trust there are a number of ‘high dependency’ or ‘high care’ areas that manage patients with a higher acuity than those normally found on a ward. The acuity of the patients within these areas was determined using the critical care minimum data set criteria and the staffing allocated accordingly. Intensivists did not lead the care in these areas and they were not subject to the management and governance processes of critical care. They were managed by their respective speciality and consequently have not been included in the critical care core service report.

Critical care

Summary of findings

We rated critical care services at Leicester Royal Infirmary as good because:

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

However, we also found:

- There were some issues with access and flow. In 2015, 47 patients had their elective surgery cancelled because there was no critical care bed available.
- Occupancy levels were consistently higher than 90% for 2015 thus making it difficult to respond to individual needs. The trust target was 85%.
- There were higher levels of non-clinical transfers when compared with similar units.
- Pharmacy provision for the critical care service did not fully meet the D16 service specification.
- The trust was not compliant with all aspects of NICE guidance 83 'Rehabilitation after Critical Illness'.

Are critical care services safe?

Good



We have rated critical care services at Leicester Royal Infirmary as good because patients were protected from avoidable harm and abuse.

We found:

- Staffing levels and skill mix was planned, implemented and reviewed to keep patient's safe at all times and there were sufficient numbers of suitably qualified and skilled staff to care for patients.
- There were systems in place for reporting and learning from incidents, accidents and near misses.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and we saw good opportunities for learning from adverse events.
- There was a robust approach to hand hygiene. Antiseptic hand gels were available for all staff and visitors. Staff routinely used antiseptic hand gels and personal protective equipment (PPE) when delivering personal and clinical care.
- There was a high incidence of harm free care.
- There was a low incidence of hospital acquired infections when compared to similar critical care units nationally.
- There was an internal system for raising safeguarding concerns.

However, we also found:

- Ongoing audits of infection control practices showed variable levels of compliance with the use of personal protective equipment (PPE) and source isolation policies.
- Pharmacy provision for the critical care service did not fully meet the D16 national service specification for adult critical care.
- There had been a recent near event involving medicines management and administration.
- The temperature of the clinic room where medicines were stored was regularly in excess of 25°C.

Critical care

- Several items of equipment were in use and had not been serviced according to their displayed maintenance due date.

Incidents

- The trust had an incident reporting policy, which included an incident grading system and requirements for reporting internally and externally. In line with the trust's incident and accident, reporting policy incidents, accidents and near misses were reported through the trust's centralised electronic reporting system.
- Staff knew how to report incidents and were able to give examples of when they had used the incident reporting system. Staff also described how they learnt about incidents that had occurred within the trust. Incidents were discussed at shift handover as well as staff meetings.
- There had been one serious incident between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. We reviewed the full investigation report for this serious incidents. The investigation report was thorough and showed that a robust review had taken place. The investigation report highlighted where lessons had been learned and actions had been identified. The patient and their family were informed of what had gone wrong, and given an apology.
- Between March 2015 and March 2016, data provided by the trust showed there had been 248 incidents reported from the critical care unit at Leicester Royal Infirmary, eight of which related to critical care outreach. These incidents included a range of events which included medication errors and transfusion errors.
- Of the total 248 reported incidents, two were reported as leading to moderate harm, 71 leading to minor harm with the remaining 175 reported as causing no harm or injury.
- Mortality and morbidity meetings were held monthly to discuss patient deaths. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed the minutes of recent mortality and morbidity meetings and saw that incidents were also discussed.

- We asked staff about their understanding of the principles of 'duty of candour'. Staff responded by saying that it was their responsibility to be 'open and honest'. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that following the recent never event the trust had immediately contacted the patient's family to both apologise and explain their actions. We were told that the family would be kept informed as to the outcome of the investigation into the never event, which was in accordance with the trust's responsibilities under the duty of candour regulation.

Safety thermometer

- Critical care participated in the NHS safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas. The NHS safety thermometer is a national improvement tool for monitoring, measuring and analysing avoidable harm to patients and 'harm free' care. It focuses on four avoidable harms; falls, pressure ulcers, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism (VTE). The monthly safety thermometer results were displayed clearly at the entrance to the unit alongside a range of performance metrics. This enabled staff and members of the public to see how the critical care unit was performing in terms of patient safety.
- Safety thermometer results across the trust were published in an annual report. The safety thermometer results for April 2015 to March 2016 for all four avoidable harms on the critical care unit at the Leicester Royal Infirmary was very low and for the last four months of the report demonstrated 100% harm free care.

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean and tidy. We saw green 'I am clean' stickers being used on equipment.
- The trust had infection control policies and procedures in place, which were easily accessible for all staff.
- Side rooms were available for patients who were at risk of spreading infection and for those who were at increased risk of getting an infection.

Critical care

- As part of the inspection we observed staff washing their hands appropriately, using antiseptic hand gels and wearing personal protective equipment (PPE) such as aprons and gloves. We saw staff adhering to the 'bare below the elbows' policy when in clinical areas.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. The results of the trust wide hand hygiene audit published in May 2016 showed a variable level of compliance with hand hygiene practice.
- There had been an audit across the trust of standard infection prevention and control measures and adherence to Methicillin resistant Staphylococcus aureus (MRSA) policies. MRSA is a bacterium responsible for several difficult-to-treat infections. The results were reported per clinical management group and broken down by staff group. For the intensive care, theatres, anaesthesia, pain and sleep (ITAPS) clinical management group (CMG) overall there had been an 8% reduction to 79% in compliance with the use of PPE from quarter 2 to quarter 4 (July to December 2015). There had been a 12% reduction to 78% in compliance with the source isolation policy and 26% reduction to 49% with MRSA policy compliance. Sharps safety was reported as being up 7% to 93%. Source isolation is the term used to describe the physical Isolation of patients with infections to reduce the spread of micro-organisms from an infected/colonised patient to susceptible individuals (e.g. other patients).
- More specifically for the critical care service at Leicester Royal Infirmary, the most recently validated intensive care national audit and research centre (ICNARC) data supplied by the trust for July 2015 to September 2015 showed there had been no incidences of patients experiencing hospital acquired infections in their blood.
- There was a dirty utility room for the whole unit. This was situated outside the clinical areas and was clean and tidy.
- The side room did not have gowning lobbies or variable pressure air flow. This meant that they did not meet the latest health building note guidance for isolation rooms in critical care. A gowning lobby and variable air flow both contribute to the ability to effectively prevent the

spread of infection and also protect the patient that may be immunosuppressed (Patients who are immunosuppressed are at increased risk of infection because their immune system is lowered).

Environment and equipment

- The critical care unit was divided into a number of distinct areas. On entering the unit there was a four bedded 'annexe' quite separate and isolated from the main part of the unit. There were two side rooms on the corridor leading to the main area, which was divided into two sides, 'A and B' each containing six bed spaces and two side rooms.
- The trust's critical care service was subject to ongoing development alongside a reconfiguration of services across the three trust sites. For the Leicester Royal Infirmary site this meant expanding the critical care service into an additional six bedded area adjacent to the new theatre build. Owing to financial pressures, these development plans were currently on hold as there were no nursing staff available to safely open these additional beds.
- All bed spaces were equipped with the equipment required to care for a critically ill patient. However, we did see a number of pieces of equipment being used even though according to their stickers, their respective maintenance due dates had passed. These included the defibrillator in Bay A, and several syringe drivers which were just outside their maintenance date. We also found a ventilator in bed space 22 which had a sticker which indicated it was last checked in 2012 We brought this to the attention of the nurse in charge of the unit who took immediate action and reassured us the ventilator had been serviced more recently but a new sticker had not been applied to the machine.
- The bed spaces in the main unit, areas A and B, were cramped and it wasn't possible to completely walk around the bed space. On the day of our visit the unit was also noisy and hot. Staff told us that this was normally the case. There were only high level windows giving restricted natural light.
- Resuscitation equipment; including defibrillators, airway management trolleys and emergency medications were available. According to the records all were generally checked daily although we did find the occasional missing signature. The equipment items on the trolleys were single use and in date.

Critical care

- We saw a purpose built transfer trolley and associated equipment which was checked on a daily basis.
- Adjoining the critical care unit was a medical electronics area where a technician was based and equipment was serviced and maintained. All the equipment in use in critical care was logged in a database which held details of each piece of equipment's service history. We saw that the unit's only blood gas analyser was situated in the equipment area. On the day of our inspection the unit's blood gas analyser had stopped working. This was soon rectified by the technician on duty. Staff told us that the Leicester Royal Infirmary's critical care unit was not yet going to receive the new blood gas analysers that were being introduced at Glenfield Hospital and Leicester General Hospital.

Medicines

- The trust had a medicines policy which was readily accessible to all staff including locum and agency staff through the trust's intranet.
- All medication cupboards were appropriately locked and the keys were kept securely in a nearby locked cupboard. The controlled drug keys were kept on the person of the nurse in charge of the shift.
- Controlled drugs were checked once a shift and following a recent dispensing issue, the stock check included checking all controlled drug boxes, even those that had not yet previously been opened. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Examples include: morphine and pethidine.
- Medical gases were supplied by a pipeline system directly to the bed areas.
- Staff and patients had access to a critical care pharmacist although the pharmacy service to the unit did not fully meet with the D16 service specification. D16 is the NHS standard service specification for adult critical care. The March 2016 critical care risk register cites the pharmacy service to all three critical care units across the trust as a risk. The issues included; delays in supply and pharmacy advice and a reduced attendance on the daily consultant unit rounds.
- There had been a recent near event involving the management and administration of medicines, though not on the Leicester Royal Infirmary site. As a consequence red trays had been introduced for the

reconstitution and administration of controlled drugs. Staff on the unit knew about the incident and had been instructed in the changes to practice which had been subsequently introduced.

- There were 62 reported incidents relating to medicines in critical care at the Leicester Royal Infirmary between March 2015 and March 2016. These predominantly related to storage of medicines and administration related issues. For example, the frequency of a medicine being given incorrectly.
- There was a clinic room used for the storage of medicines. The temperature of this room was being monitored and recorded daily. All the recordings for July 2016 were above 25°C. All drugs and intra venous fluids were stored safely and securely but were stored in an area where the temperature exceeded the recommended room temperature of 15 – 25°C. We raised this matter with the nurse in charge who told us the unit was awaiting the arrival of replacement parts for the clinic room fan. It was not clear how the efficacy of the drugs was being guaranteed in the meantime.
- Records indicated that drug fridge temperatures were monitored and recorded daily, though we did note the occasional missed record. The records showed maximum and minimum temperatures.
- As part of our record checks we looked at two prescription sheets. They were accurately completed and included details of any allergies.
- Antimicrobial protocols were in place for the appropriate use of antibiotics.

Records

- We looked at two sets of multi-disciplinary patient medical records on the unit at Leicester Royal Infirmary.
- The critical care records were paper based and held at each patient's bedside. These included range of clinical assessments, records and care plans. For example; nutritional risk, skin pressure damage risk, falls assessments, mental capacity assessments, pain scores and various evidence based care bundles. A care bundle is a structured way of improving patient care and outcomes based on a number of evidence based steps.
- Although entries in the records were usually signed and dated, the author's name was not always printed alongside their signature.

Critical care

- The notes we examined included the time and decision to admit to critical care, in accordance with NICE clinical guidance 50, 'Acutely Ill Adults in Hospital: Recognition and response to acute illness in adults in hospital.'
- The nurse caring for each patient recorded physiological parameters on a large chart located by the patient's bed space. This brought together all the patient monitoring and observations onto one chart so that ventilator settings, fluid balance and physiological monitoring could all be reviewed in one place.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding.
- There were trust wide safeguarding policies and procedures in place, which were readily available on the trust's intranet site. Staff had an understanding of how to protect patients from abuse.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse and neglect.
- Safeguarding training formed part of the trust's mandatory training programme. A safeguarding assurance paper from May 2016 reported that compliance with safeguarding training across the ITAPS clinical management group was 96.4% for adult safeguarding and 91.7% for children's safeguarding.

Mandatory training

- A mandatory training record was held for all staff working on the critical care unit. Nursing staff were divided into teams and their team leader encouraged them to keep up-to-date with their mandatory training programme. Individual nurses were contacted by email to remind them of mandatory training due dates.
- Mandatory training included moving and handling, infection prevention, fire safety, equality and diversity, information governance, conflict resolution and safeguarding adults and children. Compliance figures for September 2016 showed that 92% of staff were in date with mandatory training.
- There was a unit based clinical nurse educator who also had some responsibilities for teaching within the wider trust. The Intensive Care Society standards suggest that there should be one full time equivalent clinical nurse educator for every 75 members of staff, responsible for

coordinating the education, training and continuing professional development framework for critical care staff and pre-registration students. So the unit at Leicester Royal Infirmary was not meeting this standard.

- All the clinical staff we spoke with stated that they felt well supported and that there was 'lots' of bedside teaching available.

Assessing and responding to patient risk

- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- Daily consultant led ward rounds were taking place seven days a week.
- We were told that all patients admitted to critical care as emergencies were reviewed to ensure that they had been appropriately escalated.
- We looked at two patient's observation charts, which were completed correctly and included ventilator observations. Staff told us that deteriorating patients were escalated quickly. There were always senior nursing and medical staff present for advice and support.
- The hospital had introduced a range of initiatives to improve patient safety. These had been developed following a review of incidents and focused on five key areas of practice. These were known as the 'five critical safety actions'. They were improving clinical handovers; acting upon results; attention to early warning systems (EWS) and triggers; senior clinical review and the implementation and embedding of mortality and morbidity reviews. The early warning system or EWS is a system that scores vital signs and is used as a tool for identifying patients who are clinically deteriorating.
- There was a critical care outreach team (CCOT) available 24 hours a day, seven days a week. The team worked closely with the nursing and medical teams in the intensive care unit and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.

Critical care

- The critical care outreach nurses attended the daily handovers at each end of each day to keep up-to-date about the patients on the critical care unit who may be ready to step down to a ward bed. They were also able to contribute information about any deteriorating patients on the wards who may require critical care input or admission.
- The CCOT also worked closely with the hospital's acute care bay (ACB), where they undertook a daily ward round.
- The CCOT also formed part of the cardiac arrest response team and responded to cardiac arrests throughout the hospital.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Nursing staffing

- The unit used electronic nurse rostering and also used a 'closed' social media group for staff where they could negotiate shift changes or swaps. All staff we spoke with told us this worked well.
- The critical care matron kept an overview of the nursing establishment for critical care. On the day of our inspection there was an acting matron in place for the Leicester Royal Infirmary critical care unit. We were told that the substantive matron also covered the Leicester General critical care unit but was currently on leave.
- Alongside the performance metrics there was an up-to-date display of planned staffing numbers versus actual staffing numbers on duty. During the inspection the number of nurses planned to be on duty matched the actual numbers though this included staff being 'borrowed' from the other critical care units within the trust.
- Nursing staffing levels and skill mix were planned and reviewed to ensure patients received safe care and treatment. The staffing establishment was calculated using the intensive care society guidance 'Levels of Critical care for Adult patients'. This meant that one trained nurse would care for one or two level two patients with level 3 patients being cared for on a one-to-one basis
- At the time of inspection, there were adequate and appropriate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment. There were 17 registered

nurses on the day shift supported by a supernumerary shift leader at band six or seven plus an additional circulating nurse. There was also a band seven nurse on a management shift. The trained nurses were supported by healthcare assistants (HCA's), administrative and housekeeping staff.

- There were 8.9 full time equivalent registered nurse vacancies and 0.7 full time equivalent health care assistant vacancies at the time of our inspection.
- It was a common occurrence for nurses to move across all three of the trust's critical care units to cover staff shortages. During our inspection nurses from Leicester General Hospital were working at the Leicester Royal Infirmary critical care unit to help out.
- Recruitment and retention was an issue and the trust was currently revising and reviewing its recruitment processes. There had in the past been a recruitment drive for international nurses for critical care, which staff told us had been successful.
- Agency nurses were used and when required. These were staff who had worked on the critical care unit before and who were competent in caring for patients in a critical care environment. Between April 2015 and March 2016, the critical care unit at the Leicester Royal Infirmary used approximately 140 hours of agency nursing shifts per month. Agency staff were given an induction to the unit which included an assessment of their competencies.
- There was a structured nurse handover at the end of each shift. This was communicated as a large team followed by a specific handover at the patient's bedside. This ensured all aspects of the patient's care and treatment were communicated effectively. Handover was also used as a time to share important messages such as incidents and changes to practice.
- Staff sickness and absence rates were closely monitored alongside the management of competency and capability. The sickness rate was 7.65%, for July 2016, against the trust's target of 3%.

Medical staffing

- ITAPS had a designated clinical director and the critical care unit at Leicester Royal Infirmary also had a designated clinical lead who was a consultant in intensive care.
- Following a recent internal appointment, the number of intensivists /consultants had gone up to 11, with two vacancies remaining.

Critical care

- There was consultant cover 24 hours a day, seven days a week.
- The consultant rota saw four different consultants crossing over during the week ensuring that there were always two on duty during the day with three during the week day mornings.
- At the weekends there were two consultants on duty until 2pm and one after 2pm. This meant that at times the consultant to patient ratio of between 1:8 – 1:15 as set out in the Intensive Care Society core standards was not being met.
- Out of hours there was always a doctor with advanced airway management skills on duty.
- When assigned to critical care, consultants had no other clinical responsibilities within the hospital.
- The consultants were supported by a range of middle grade trainees.
- A structured medical handover took place at the beginning of each shift, this usually included attendance by a member of the critical care outreach team (CCOT).
- The trainees we spoke with said there was a good balance between work and teaching.

Major incident awareness and training

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

Are critical care services effective?

Good 

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

We found:

- Care and treatment was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patient's pain was being managed in accordance with UK pain management core standards.
- The use of band 6 nurses as clinical skills supervisors was working well to support staff in the clinical setting.
- ICNARC data reported that patient outcomes were comparable with similar critical care units.
- We saw evidence of both multi-disciplinary and seven day working.
- The assessment of mental capacity and associated deprivation of liberty was being managed in accordance with trust policy.

However we also found:

- The trust was not compliant with all aspects of NICE guidance 83 'Rehabilitation after Critical Illness'.
- Less than 30% of registered nurses had completed a post registration course in critical care.
- Not all policies, protocols and guidance had been reviewed as per their documented review dates.

Evidence-based care and treatment

- The critical care service used a combination of national and best practice guidance to determine the care and treatment they delivered. This included guidance from the Intensive Care Society, the National Institute for Health and Care Excellence (NICE) and the Intensive Care National Audit and Research Centre (ICNARC).
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust-wide intranet. For example, the completion and escalation of the early warning system monitoring system in adults guidance. This guidance had been approved but had passed its June 2015 review date.
- There was a delirium policy and guidance for staff on the impact of delirium on patients in a critical care setting. There were evidence based care bundles in use for the prevention of ventilator associated pneumonia, the management of central venous catheters, venous thromboembolism (VTE) and sepsis. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes.

Critical care

Multidisciplinary teams work to deliver the best possible care supported by evidence-based research and practices, with the ultimate outcome of improving patient care.

- The unit was not compliant with all aspects of NICE guidance 83, 'Rehabilitation after Critical Illness'. The trust's own audit against D16 service specifications for adult critical care reported in 2014 that none of the trust's three critical care units were compliant with this standard that states 'each patient must have an assessment of their rehabilitation needs within 24 hours of admission to critical care and all NICE 83 eligible patients must have a rehabilitation prescription on discharge from critical care.' The actions stated in the review document were to establish a service level agreement for allied health professionals. It is not known if the required service level agreement has yet been implemented.
- Critical care services participated in local audit and benchmarking. Results were collated in a scorecard format and presented and discussed at monthly meetings. Examples of the audits being undertaken were hand hygiene audits, showing compliance between 50% and 90% since April 2016, malnutrition universal screening tool (MUST) assessment audits and audit of high impact interventions. We also saw examples of action plans developed to address poor areas on non-compliance. For example, actions to improve the hand hygiene audit compliance included training and re-education of staff on the importance of adhering to the five moments model for hand hygiene as well as trust policy.

Pain relief

- In accordance with the Core Standards for Pain Management Services in the UK, developed by the Faculty of Pain Management of the Royal College of Anaesthetists with input from CQC in 2015, acute pain management was supervised by consultants and specialist nurses with the appropriate training and competencies.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff also used a paper based pain scoring tool, which we saw in the two sets of records we looked at. From our observations patient's pain was being adequately and appropriately managed.

- The pain management team gave support and advice to staff and patients in the critical care unit in relation to the management of complex pain as well as the management of epidurals and patient controlled analgesia (PCA). Patient-controlled analgesia (PCA) is a method of pain control that gives patients the power to control their pain. In PCA, a computerized pump called the patient-controlled analgesia pump, which contains a syringe of pain medication as prescribed by a doctor, is connected directly to a patient's intravenous (IV) line
- A member of the pain management team attended the critical care team meetings.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure patients received adequate nutrition and hydration. Total parenteral nutrition (TPN) was available seven days per week. TPN review was available Monday to Friday. The risk register stated that the dieticians and anaesthetists were undertaking an audit to establish the numbers of patients admitted to critical care who did not receive dietetic input at the beginning of their care pathway.
- Patient's requiring Total Parenteral Nutrition (TPN) and referred to the Leicester Intestinal Failure and Feeding Team (LIFFT) for assessment to ensure the Trust met NICE guidance (2006). This service operated Monday – Friday. Bespoke, individually tailored TPN bags were ordered 3-5 times a week. Outside of this order schedule and out of normal working hours standard Parenteral Nutrition bags were stocked in pharmacy. Guidelines were available for commencing TPN out of hours, prior to a full LIFFT (Leicestershire intestinal failure and feeding team) assessment, if critical to the patient's clinical condition
- Dietetic input and advice was available although the dieticians did not always attend the multi-disciplinary ward round.
- Nutritional risk scores were updated and recorded appropriately in the patient notes we reviewed. Staff used a MUST to assess nutritional risk.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output. For the two patient records we looked at these were appropriately completed.
- Standardised feeding regimes were available for naso-gastric feeding.

Critical care

Patient outcomes

- The critical care unit provided patient data to the intensive care national audit and research centre (ICNARC). This meant that the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
 - ICNARC data, for the reporting period April to December 2015, showed a risk adjusted acute hospital mortality of 0.99, which was comparable with similar units.
 - Between July 2015 and December 2015, ICNARC data for the critical care unit at Leicester Royal Infirmary showed the case mix comprised 53% of admissions were from planned and emergency surgery with the majority being level three patients, at least for the first 24 hours of their stay. For ventilated admissions, the mean length of stay was just over 4 days and the incidence of hospital acquired infections in patients' blood was zero. For patients admitted with severe sepsis the length of stay was less than similar units at around five days. For admissions with pneumonia, the mean length of stay was less than comparable units at just under five days. Elective surgical admissions had a mean length of stay of just longer than two days with emergency surgical admissions staying on average four days. There was no incidence of unit acquired infections in blood for any surgical admissions. The mean length of stay for admissions with trauma, perforation or rupture was again five days.
 - The latest ICNARC data also showed that the unit had lower numbers of early, late readmissions and post-unit discharge deaths than similar units. Early readmissions are classified as unit survivors that are subsequently readmitted to the critical care unit within 48 hours of their discharge. Post critical care unit deaths are classified as unit survivors that die before ultimate hospital discharge.
 - Sedation breaks were undertaken where appropriate. A sedation break is where the patient's sedation is stopped to allow them to wake up and this has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, is in pain or in respiratory distress.
- Band 6 nurses had additional responsibilities as clinical skills supervisors. This gave them a formal educational role within the team for seven hours each week, where they each led on a specific area.
 - The percentage of trained nurses who had undertaken a post registration qualification in critical care was around 30%. This did not meet guidelines for the Provision of Intensive Care Services (GPICS) standard which states a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing. There were plans for additional staff to undertake this specific training during the next intake. The department had doubled the number of staff supported in undertaking the critical care modules this year in order to meet the standard outlined. Going forward this number of nurses needed to support will be reviewed each intake to sustain the 50%. This needed to be balanced against funding and ability to support study leave. Critical care delivered an in house training program for staff to ensure staff are developed and competent.
 - The unit was also offering a band three/four development pathway in critical care. Two band three and two band four staff were undertaking a foundation degree in health and social care alongside working through clinical competencies. They were well supported by two mentors. Once deemed competent they would be able to look after a level two or a straightforward ventilated patient, though they would not be allowed to administer medication.
 - Staff new to the unit undertook a supernumerary period before they were counted in the staffing numbers. The length of this period varied according to prior experience of critical care. New staff also started to work through their competencies, again the length of time taken to progress this varied according to experience.
 - One of the band 6 nurses was a resuscitation trainer and was able to run in-house immediate life support (ILS) courses for staff.
 - Staff were appropriately trained, competent and familiar with the use of critical care equipment. Support was given to staff on site by the medical equipment technical team as required.
 - When agency nurses were used, the unit tried to obtain nurses who had regularly worked on the unit to provide some consistency. Agency staff had their competencies assessed before they worked unsupervised.

Competent staff

- The critical care unit at the Leicester Royal Infirmary had a full time practice based educator.

Critical care

- Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC).
- At the time of the inspection, 98% of nursing staff had received their annual appraisal whilst the figure for medical staff in critical care was not provided by the trust.

Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place every day in critical care. Although not all members of the multi-disciplinary team were able to be there for the formal round, they did attend the unit at some point. The GPICS standard for ward rounds is that they must have daily input from nursing, microbiology, pharmacy and physiotherapy. So on the unit at Leicester Royal there was daily input but not always at the time of the consultant intensivists ward round.
- The trust had undertaken an audit of compliance with the Intensive Care Society standards for critical care in May 2014. At that point they reported compliance with 40 out of 64 core standards on the unit at the Leicester Royal Infirmary (62.5%). The main areas of shortfall in compliance were with therapy support for rehabilitation and pharmacy services. Consequently, patients were often not getting a rehabilitation assessment within 24 hours of their admission to critical care as stated in NICE clinical guidance 83 'Rehabilitation after Critical Illness in Adults'.
- We saw evidence of multi-disciplinary recording in the two sets of patients records that we saw.
- The care and treatment of patients on the critical care unit was intensivist led but a multi-disciplinary approach to care was used. There was effective communication between the nursing staff, parent teams and the intensivists. The parent team is the speciality team under which the patient was admitted to hospital. For example, surgical or medical.
- There was an admission and discharge/transfer protocol. All patients discharged from critical care to the wards were followed up by the CCOT to support their on-going recovery.
- Medical and nursing staff worked together as a team for the benefit of patients. We saw minutes of multi-disciplinary meetings which were held monthly.

- There was an critical care outreach team (CCOT) available 24 hours a day, seven days a week. . They liaised closely with the critical care team in respect of patients due for potential step down as well as deteriorating patients on the wards. The CCOT then visited the patients once they were on the ward.

Seven-day services

- A consultant intensivist was available seven days a week, 24 hours a day. The physiotherapy team provided a seven day service to the critical care unit during the day with an on call service out of hours.
- The unit was meeting the NHS clinical standards for seven day working. For example, access to diagnostics and key services.
- Dietetic support, pain management, speech and language therapy (SALT), and pharmacy services were available Monday to Friday, 9am to 5pm. Pharmacy was also open Saturday and Sunday mornings. Pain management and pharmacy services provided an on-call system out of opening hours. Imaging and diagnostic services were provided during the working week with specialists on call for specific services out of hours and at the weekend.

Access to information

- Critical care notes were kept in a file by the patient's bedside.
- All the patient's physiological parameters, assessments, fluid balance and ventilator settings were recorded on a large critical care observation chart situated by the bedside.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information.
- The unit had a white board display which gave an overview of the current activity in the critical care unit. It showed the individual bed spaces and the acuity of the patients therein as well as the overall unit acuity or dependency. It also displayed staffing numbers per shift along with anticipated admissions and discharges or step downs.

Consent and Mental Capacity Act

Critical care

- Staff demonstrated an understanding of the issues around consent and patients in critical care having the capacity to make their own decisions.
- There was a delirium policy and there were posters displayed on the corridor noticeboard which highlighted the factors associated with delirium in a critical care setting.
- Staff demonstrated an understanding of the Mental Capacity Act (2007) including best interest decision making.
- There was an assessment of mental capacity/delirium recorded in each patient's record. This was called the confusion assessment method for intensive care unit (CAM-ICU) patients and was used in conjunction with the Richmond Agitation Scale, which was used to measure the agitation or sedation level of a patient. Care plans stated that the CAM-ICU should be completed twice every shift. Examination of two patient records showed that this was carried out twice daily. The rationale being that delirium prolongs critical care and can have long term consequences for the patient. Early detection means earlier treatment. The CAM-ICU is used by non-psychiatric nurses and doctors for diagnosing delirium. The CAM-ICU uses yes/no questions for use with non-speaking mechanically ventilated patients.
- There was a sedation policy which included the use of sedation breaks. Daily breaks in the continuous infusions of sedation have been shown to reduce drug acquired delirium and incidence of ventilator acquired pneumonia.

Are critical care services caring?

Good



We rated critical care services as good for caring. Because patients were treated with dignity and respect, and were involved as partners in their care.

We found:

- Critical care staff were caring, compassionate and committed.
 - Patients, their relatives and friends were consistently treated with dignity and respect.
 - Care was person-centred and patients were treated as individuals.
 - Staff understood the social and emotional impact of critical care on patients and their families.
- ### Compassionate care
- Staff took the time to speak with patients and those who accompanied them, in a respectful and considerate manner.
 - Staff were encouraging, sensitive and supportive in their attitudes. They demonstrated an understanding of patient's personal, cultural, social and religious needs.
 - Patient's privacy and dignity was maintained during episodes of physical or personal care. Privacy curtains were drawn around people with relevant explanations given prior to care being delivered.
 - Without exception, the relatives we spoke with were positive and praising about the nursing and medical staff on the unit. They told us they had been kept informed of everything that was going on with their relative.
 - Friends and family test results were displayed on the noticeboard at the entrance to the unit and reported 100% satisfaction.
- ### Understanding and involvement of patients and those close to them
- Staff communicated with patients and those who accompanied them so that, where possible, they understood their care and treatment.
 - Initial and on-going face to face meetings were undertaken by nursing and medical staff to keep people informed about their relative's care and treatment plans.
 - Staff told us about the trial of patient diaries undertaken at the Glenfield hospital. There was interest in implementing them at the Leicester Royal Infirmary. Patient diaries were usually started after three days in critical care and consent was obtained for their use. Critical care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, friends and family and can include photographs. Research has shown that patient diaries often help the individual better understand and make sense of their time in critical care and help to prevent anxiety, depression and post-traumatic stress.
 - There had been follow up clinic trails held at this hospital and staff enthusiastically told us about these.

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- The unit used a butterfly symbol to highlight discreetly to staff that a patient was near the end of life.

Emotional support

- Staff understood the impact of critical care interventions on people and their families.
- There was a senior nurse for organ donation who worked closely with the critical care staff in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- Bereavement services were offered to families and they were invited back to the hospital for a 'day to remember' event. This provided bereaved families an opportunity to talk to other bereaved families and relatives. They released memorial balloons, looked at photographs and also had an opportunity to revisit the critical care unit should they wish to. This event was usually held in conjunction with the unit at Leicester general hospital and had been positively received.
- There were multiple thank you cards displayed on the unit, which demonstrated the high regard patients and their families had for the staff who worked on the critical care unit.

Are critical care services responsive?

Good 

We rated the responsiveness of critical care services as good.

We found:

- There were low numbers of delayed discharges and out of hours discharges when compared with similar units. The latest, validated intensive care national audit and research centre (ICNARC) data showed that one patient had experienced a discharge out of hours.
- There was a nurse led critical care outreach team (CCOT). This was provided 24 hours a day, seven days a week at the Leicester Royal Infirmary.
- There were plans to develop the service to reflect the needs of the local population.
- The unit had facilities to accommodate patients' relatives and friends.
- Patients were admitted to critical within 4 hours of the decision being made to admit.

However, we also found:

- Bed occupancy levels were consistently higher than 90%, against the trust's target of 85% for 2015. This made it difficult for the service to respond to individual needs.
- There were higher levels of non-clinical transfers when compared with similar units.
- There was a daily 'firefight' to manage the number of planned surgical admissions. During 2015 there were 47 cancelled elective surgical cases as a consequence of there being no critical care bed.
- Patients were not always receiving rehabilitation in accordance with NICE clinical guidance 83, 'Rehabilitation after Critical Illness'.

Service planning and delivery to meet the needs of local people

- The critical care unit provided a 24 hour emergency service for patients. Patients could be admitted from other hospitals, the emergency department, theatres or from any ward.
- The future plans for critical care services at Leicester Royal Infirmary were set out in detailed business plans, which were tied into the reconfiguration of services across the trust. This ultimately would lead to an increase in critical care capacity on the Leicester Royal Infirmary site. However, there was no capital currently available to take the plans forward.
- Bed occupancy levels were consistently higher than 90%, against the trust's target of 85% for 2015. This made it difficult for the service to respond to individual needs. The bed occupancy levels for 2015 only fell below 94% once, in August when they were 90%.
- Trust wide bed management meetings were held throughout the day to monitor and review the availability of beds and flow of patients throughout the three hospital sites and this included the availability of critical care beds.
- There were facilities for relatives to wait or stay on the unit if they wanted to. The facilities included a 'quiet room' where private discussions took place between critical care staff, and patients' friends and family.
- The critical care unit had access to overnight facilities should it be necessary for a patient's family to stay close by. Relatives also had access to food and drinks.
- There was a nurse led critical care outreach team (CCOT). This was provided 24 hours a day, seven days a week at the Leicester Royal Infirmary. The CCOT was

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made up of experienced senior and was led by a critical care nurse manager. The team worked closely with the nursing and medical teams in the intensive care unit and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.

Meeting people's individual needs

- Care plans demonstrated that patient's individual needs were taken into consideration when planning and delivering care and treatment. However, owing to a shortfall in the numbers of therapy staff, patients were not always receiving rehabilitation in accordance with NICE clinical guidance 83, 'Rehabilitation after Critical Illness'.
- Staff had access to external interpreting service which was available 24 hours a day, seven days a week. The service provided a combination of face-to-face and telephone support, which included the provision of British Sign Language (BSL). There was a translation policy in the trust.
- There was a range of patient information leaflets explaining aspects of critical care. Staff knew how to access copies in an accessible format for patients living with dementia or a learning disability and in braille for patients and relatives who had a visual impairment. The leaflets were also available in a range of languages.
- There were 2.5 whole time equivalent (WTE) acute liaison nurses (ALN) that provided advice and support to patients who had a learning disability. In addition, there was a flagging system linked to the Leicestershire learning disability register which alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- Pastoral, spiritual and religious support was available to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Islamic and Sikh chaplains, as well as the country's first paid non-religious carer who focussed on meeting the needs of people who did not identify with a religious belief. The team was also supported by volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives. An on-call service was provided 24 hours a day, seven days a week and where possible a representative of the patient's own faith would attend.
- Whilst the unit did display information about visiting times, we heard from both staff and relatives that visiting was at the discretion of the nurse in charge and exceptions were often made to allow relatives to visit their loved ones.

Access and flow

- Between April 2015 and March 2016 there had been 10,805 admissions to critical care. This showed an increase from the previous year's reporting figures where between 9487 patients had been admitted to critical care between April 2014 and March 2015.
- Patients should be admitted to Critical care within four hours of the decision to admit. In 2014, the critical care service undertook a benchmarking audit against the key standards in the D16 national service specification for adult critical care. The D16 is the NHS service specification which defines the standards of care expected by organisations funded by NHS England to provide specialised critical care. This showed that 100% of patients were admitted to the critical care unit at the Leicester Royal Infirmary within 4 hours of the decision being made to admit. The audit also showed that 100% of patients received a medical review within 12 hours of admission by a consultant qualified in intensive care medicine.
- Discharges from critical care to a general ward must occur within four hours of the decision to transfer. Between April 2015 and March 2016 there had been 1,542 delayed discharges, of four hours or more, from critical care.
- Critical care services at the Leicester Royal Infirmary collected data locally about bed occupancy and patient flow through the service. In addition, they also contributed data to the intensive care national audit and research centre (ICNARC). ICNARC then published a validated quarterly report where the unit at Leicester Royal Infirmary was compared with similar units nationally.
- Between January 2015 and December 2015, the critical care unit at the Leicester Royal Infirmary had 1442 admissions with occupancy varying between a high of 118% in January 2015 through to a low of 90% occupancy in August 2015. We were told that 85% of admissions were emergencies with just 15% of the admissions being for elective cases. The reported figures indicate high levels of bed occupancy, which may have a bearing on the relatively high numbers of

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transfers out of the unit, including non-clinical transfers. The ICNARC figures for April to December 2015 report that there were 29 non-clinical transfers, which represented 2.6% of all admissions, this is higher than for similar units.

- Trust data for 2015 also shows that there were 47 cancelled electives for the period. On the day of our inspection there were a number of cancelled elective surgery cases. On patient having been cancelled for the third time as there was no guaranteed critical care bed available for them. It was clear from talking to staff that the pressure for beds and the cancellation of planned surgical cases was a daily firefight, which as a constant stressor was taking its toll on people.
- Of the 1442 admissions, local data shows that 72 (5.3%) experienced a delay in their discharge greater than 24 hours.
- ICNARC data from April 2015 to December 2015 showed the number of delayed discharges greater than eight hours from critical care was 2.7%. This showed improvement from the ICNARC 2014 results for delayed discharges.
- ICNARC data for the reporting period April 2015 to December 2015 showed that one patient (0.1%) experienced a discharge out of hours. This was better than the national average of similar units (0.6%) and all units (2.2%).

Learning from complaints and concerns

- The hospital had clear policies and procedures to follow in the event of a complaint being made.
- The trust's website detailed information about how to raise a complaint. Help and support was available via the trust's patient information and liaison service (PILS).
- The trust held an independent complaints review panel in conjunction with local Healthwatch and POhWER. The panel was established to review a sample of patient complaints and review them from the patient perspective. POhWER is a charity and membership organisation that provides information, advice, support and advocacy services for people who have a disability or who are vulnerable.
- Senior staff told us that the unit received very few complaints. Between March 2015 and March 2016 one formal complaint had been received regarding the critical care unit at Leicester Royal Infirmary. This related to staff attitude.

Are critical care services well-led?

Good



We rated the leadership of critical care services as good because the leadership, governance and culture promoted the delivery of high quality person-centred care.

We found:

- There was a detailed business plan for developing critical care services at Leicester Royal Infirmary, which included details of the strategic direction of the service.
- There was an effective governance framework in place which supported the delivery of patient care and ensured risks were captured, shared and managed.
- There was strong clinical and managerial leadership at both unit and senior management levels.
- Staff and patients were engaged with to inform the improvement and development and delivery of the critical care service.

However, we also found:

- Plans for the reconfiguration and developing the capacity of the critical care service were on hold as a consequence of financial pressures being felt across the service.

Vision and strategy for this service

- Critical care services was provided at this hospital as part of the intensive care, theatres, anaesthesia, pain and sleep (ITAPS) clinical management group (CMG).
- There was a detailed business plan for the development and reconfiguration of critical care services across the trust. This document included the strategic case for changes to the service. These included the expansion of critical care beds on the Leicester Royal Infirmary site; the trust's five year plan included developing two 'super' critical care units at both the Leicester Royal Infirmary and Glenfield Hospital sites. These would care for level two, three and four patients and would be staffed and delivered to national core service standards to ensure the local population and referrals for tertiary care received the highest standard of care possible in the most appropriate environment. In the interim there has been a need to increase the existing critical care bed capacity at Leicester Royal Infirmary by opening a six

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bedded bay adjoining theatre recovery. This was not built to critical care specification but was a modern build and provided an improved environment when compared to the existing unit. At the time of our inspection the six bedded area was not being used as there was not enough nursing staff to support it. .

Governance, risk management and quality measurement

- There was an effective governance structure in place to support the delivery of patient care which ensured that risks to the service were captured and discussed. The governance framework also enabled the distribution of shared learning and service improvements and a pathway for reporting and raising concerns to the trust board.
- Critical care had six identified risks recorded on their risk register. The trust shared with us a risk register report dated 31 March 2016. Four of the risks related to the critical care units at all three sites and related to bed capacity, lack of clinical support services, recruitment to consultant vacancies and access and flow. Each risk included a description, controls in place to mitigate the risk, and a summary of actions taken. Each risk had a date for review. The clinical leads had a good grasp of the risks on the register.
- The bed spaces in the main unit, areas A and B, were cramped and it wasn't possible to completely walk around the bed space. However, this had not been included on the service's risk register.
- A range of meetings were held regularly, including mortality and morbidity meetings, staff meetings for all grades and ITAPS quality and safety board meetings. We looked at copies of the mortality and morbidity meetings and saw that each death was reviewed and learning points were noted and shared with relevant teams. .
- Senior staff worked daily in collaboration with peers across the hospital and the wider trust to monitor, anticipate and try to alleviate the associated patient flow pressures through the critical care units.
- The critical care unit was a member of the Central England Critical Care Network. We did not see a copy of any network review of the critical care service but we did see the results of a benchmarking exercise, where the unit was measured against the D16 Service Specification for Adult Critical care. The copy of the review we saw was not dated.

Leadership of service

- There was a clear management structure with strong leadership at unit and senior management group level with staff who had the skills, integrity, capacity and capability to lead the service effectively.
- Leadership of critical care services was provided by a clinical director, a head of nursing and a head of operations. In addition there was a deputy clinical director, deputy head of nursing and a deputy head of operations.
- The critical care unit at the Leicester Royal Infirmary was led and staffed by a team of experienced nurses. There was a designated consultant lead and one lead matron.
- Staff told us that senior staff were visible in the critical care unit, and were leading and supporting their teams. We also saw evidence of this throughout our inspection.
- Each shift was led by a supernumerary nurse co-ordinator.

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care.
- Staff were encouraged to report incidents and raise concerns.
- Staff told us how supported they felt by the team approach to managing the critical care unit.
- There was evidence of collaborative working and positive relationships with other departments within the hospital. This could be seen from looking at the minutes of ITAPS quality board.
- There was an understanding amongst staff of the implications of duty of candour and we were given examples of where shortfalls in patient experience or care had been shared with relatives in accordance with duty of candour principles.

Public engagement

- The trust's website included details about the critical care service at Leicester Royal Infirmary.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.

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- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations.
- The critical care service had adopted the use of 'patient partners'. Patient partners are members of the public who could provide a patients' or 'lay' perspective on the experience of being cared for at the trust. Patient partners are encouraged to get involved in a wide range of issues; for example, in relation to changes in services through to advising on new developments and reviewing patient information.

Staff engagement







- Staff reported they were well supported and had access to training opportunities.

- The trust produced a regular newsletter called 'Together', in which the chief executive officer (CEO) introduced a range of news and interest stories from across the organisation. This was used to keep staff engaged and informed about service developments.
- Staff meetings held within critical care gave staff an opportunity to share important messages and also update staff groups about critical care developments. We saw evidence of these discussions in the minutes from these meetings.

Innovation, improvement and sustainability

- The trust recognised that in order to meet the needs of its population and to develop its critical care services in line with strategic objectives, the service needed to be reconfigured. This would include increasing critical care bed capacity at the Leicester Royal Infirmary. However, at the time of our inspection, development and business plans were on hold because of financial constraints across the service.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology services provided by University Hospitals Leicester NHS Trust (UHL) are located on two hospital sites, the Leicester Royal Infirmary (LRI) and the Leicester General Hospital (LGH). However, services on both hospital sites are run by one maternity and gynaecology clinical management team. They are regarded within and reported upon by the trust as one service, with some of the staff working across the two sites. For this reason there is some duplication of information within the two reports. The trust also provides maternity services at St Mary's Birthing Centre in Melton Mowbray however; this service was not inspected and is not included in this report.

There were 5774 babies born at the LRI between June 2015 and May 2016.

The services available to women include home birth, a midwifery led unit (MLU), a consultant-led delivery suite, antenatal clinics including ultrasound scanning and fetal medicine, a midwifery assessment unit and triage (MAU), an antenatal ward (Ward 1) and two mixed antenatal and postnatal inpatient wards (wards five and six). Specialist midwives are available to support the women and midwives.

Community midwives (CMW) are employed by UHL maternity services. They provide a home birth service for women who are assessed to be at low risk. There are ten CMW teams working in partnership with general practitioners (GPs), health visitors (HVs) and children's centres to promote healthy lifestyle choices during the woman's pregnancy and following the baby's birth.

The gynaecology service at the LRI offers emergency assessment facilities on the gynaecology assessment unit (GAU) which includes inpatient beds. A theatre shared with the maternity service is used for emergency surgical gynaecology. There is a gynaecology outpatient clinic and an early pregnancy assessment unit (EPAU). The service also undertakes termination of pregnancy at the LRI which includes medical abortion and a small number of surgical abortions.

We used a variety of methods to help us gather evidence in order to assess and judge the provision of maternity and gynaecology services at the LRI. Prior to our inspection we held focus group meetings for all staff groups and we gave women and visitors an opportunity to comment on services. During our inspection we visited all the wards and departments relevant to the service and interviewed the service leads. We spoke with 14 women, and 39 members of staff including midwives, nurses, health care assistants, junior and senior doctors and housekeepers. We observed interactions between women, their relatives and staff, considered the environment and looked at 10 sets of medical and nursing records. Before our inspection we reviewed performance information from and about the hospital and the service.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology at Leicester Royal Infirmary as requires improvement overall.

We rated the safety and effectiveness of maternity and gynaecology as requires improvement with caring and responsiveness as good because:

- Midwifery staffing levels did not always meet the minimum acceptable numbers for the unit and one-to-one care in labour was not always achieved. There was a lack of junior doctors to cover the service out of hours. Whilst the service mitigated these risks wherever possible, lack of staff, on occasion, posed a risk to patient safety.
- Infection prevention and control was not given sufficient priority. Whilst most of the environment looked visibly clean, there were some areas which did not meet acceptable standards of infection control and compliance with hand hygiene standards was not always achieved.
- Women were at risk of not receiving effective care and treatment as some midwifery staff did not have the competencies required when caring for women who were critically ill or following anaesthesia.
- Staff did not always follow the trust policy on the disposal of fetal remains.
- The leadership and governance of maternity and gynaecology did not always support the delivery of high quality person-centred care. Departmental governance and risk management arrangements were not robust and led to poor oversight of some outcomes for example rates of sepsis and mode of delivery. Some of the women's outcomes were worse than trust targets, for example rates of caesarean section, and post-partum haemorrhage, (bleeding after birth). Action plans from audit did not address all of the issues highlighted by the audit.
- The physical arrangement of services was not always responsive to women's individual needs. Women experiencing pregnancy loss were treated in close proximity to an antenatal ward and some women were taken through the basement from surgery to the gynaecology ward.

However, we also found:

- The majority of women, their partners and relatives were positive about the care they had received. Most of the women we spoke with told us staff were kind and caring and that they had been treated with dignity and respect and were happy with the emotional support they received. Staff involved women in their care and treatment.
- Women were protected from abuse. Staff had an understanding of how to protect women from abuse.
- Systems were in place to ensure that equipment was regularly checked and available for use.
- The number of babies born in the midwifery-led birth centres was one of the highest nationally and the rates of normal birth and instrumental delivery were better than the national average.
- There was effective multi-disciplinary working across maternity and gynaecology.
- Staff effectively supported women with complex needs and in vulnerable circumstances and provided an extensive range of specialist maternity and gynaecology services, including a specialist bereavement service.
- There was a robust system for monitoring, processing and learning from complaints.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



We rated the safety of maternity and gynaecology services at the Leicester Royal Infirmary (LRI) as requires improvement because women were not always protected from avoidable harm.

We found:

- We were not assured that the grading of incidents was always appropriate.
- The service had been an outlier for puerperal sepsis since 2013 and had recorded increasing rates of puerperal sepsis, wound infection and pyrexia of unknown origin. Whilst some of the rates had been attributed to coding errors, we were not assured that sufficient steps had been taken to rectify these errors or that all the infections had been thoroughly audited.
- Whilst most of the environment looked visibly clean, there were some areas which did not meet acceptable standards of infection control and compliance with hand hygiene standards was not always achieved.
- Midwifery staffing levels did not always meet the trust minimum acceptable numbers for the unit, and one-to-one care in labour was not always achieved. Midwives told us that staffing levels overnight on the antenatal ward did not always feel safe. Therefore we were not assured that there were sufficient numbers of midwives to provide safe care for women.
- Consultant obstetric cover in the delivery suite was 82 hours a week.
- There was a lack of junior doctors to cover the service, especially out of hours. The service had tried to mitigate the risks and were actively recruiting, but this led to long delays for women waiting to be reviewed in all areas. This posed a risk to patient safety.
- Four of the five staff we asked were unaware of their responsibilities in relation to the trust's missing baby and major incident policy.

However we also found:

- There was a robust incident reporting procedure. Staff knew how and what to report as an incident and there was evidence of learning from incidents.

- Gynaecology and maternity staff checked and maintained equipment regularly.
- Staff in both gynaecology and maternity knew about trust safeguarding policies and procedures and staff were able to give examples of when they had used these procedures.
- There was good consultant anaesthetist cover for the service as a whole.

Incidents

- Staff understood and fulfilled their responsibilities to raise concerns and report accidents, incidents and near misses. However, some staff we spoke with did not feel that they had time during their shift to complete incident reports.
- Leicester Royal Infirmary (LRI) reported three serious incidents in 2015 to the NHS strategic executive information system (STEIS) for the maternity service. There were no incidents reported for the gynaecology service. None of the serious incidents were classified as never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Following these serious incidents we saw that root cause analysis investigations had taken place. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We requested the serious investigation reports for one of these maternity incidents and saw there had been a full investigation with input from a multi-disciplinary team including a consultant anaesthetist, consultant obstetrician, midwifery matron, clinical risk and quality co-coordinator, supervisor of midwives and maternity clinical educator. Learning from the incident had been recorded along with agreed actions, which included formulating clinical guidance for the management of retained products of conception during the first six postnatal weeks. Learning also included ensuring that staff escalated about women displaying disproportionate amounts of pain for the nature of the procedure. This learning had been shared trust wide.

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- Data provided by the trust showed from March 2015 to March 2016 1015 maternity incidents had been reported through the trust's electronic reporting system that related to the LRI and a further 10 incidents related to both the LRI and Leicester General Hospital (LGH). In the same reporting period there were 348 gynaecology incidents that related to the LRI and two incidents which related to both the LRI and LGH. For maternity, there were 815 incidents (79%) that resulted in no harm, 161 in minor harm (16%), 37 in moderate harm (3%) and 2 incidents resulted in major harm (less than 1%). For gynaecology there were 310 no harm incidents (88%), 36 minor (10%), and four moderate (less than 1%). At the time of our inspection across both sites there were 106 maternity and 37 gynaecology open incidents, the oldest from April 2016. This gave assurance that staff recognised the importance of incident reporting, and incidents were dealt with in a timely manner.
- Data from reported incidents were co-ordinated by the patient safety team for maternity and gynaecology. We reviewed copies of emails from the clinical risk manager to the head of midwifery to ensure actions were taken in a timely manner.
- Specific incidents were discussed at the gynaecology or perinatal risk management meetings. We reviewed three sets of minutes from the perinatal risk management group where there was multidisciplinary staff in attendance. Cases were discussed and learning actions agreed. However following the discussions some incidents were re-graded, we were not assured that the downgrading of some incidents was appropriate. For example a woman had a significant obstetric haemorrhage which was classified as a poor outcome and suboptimal management; this had been downgraded to a minor incident. Another example was an incident where a woman had a serious, life impacting complication post procedure, it was classified as a poor outcome managed appropriately, this also was downgraded to a minor incident.
- Maternity mortality and morbidity meetings were held monthly. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed the presentations from three of these meetings in November and December 2015 and saw that staff reviewed cases in detail, with areas of good practice highlighted, together with learning outcomes.
- Staff told us of learning and actions following a maternity investigation part of which included fetal heart rate monitoring using a cardio tocography (CTG) monitor (which records babies heart rates). The investigation concluded that additional CTG training was required for midwives and obstetricians and the service was in the process of starting a three-month trial of an e-learning package that would enhance the training already provided on the mandatory study days.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good understanding of the regulation and their responsibilities under the duty of candour. We reviewed the minutes of the trust wide gynaecology risk group meeting of April 2016 where it was documented that a duty of candour letter had been sent following an incident investigation.

Safety thermometer

- Maternity and gynaecology services at the LRI took part in the national safety thermometer scheme. Data for this was collected on an identified day each month to indicate performance in key safety issues. This included four key areas, pressure ulcers, falls, urinary catheter related infections and blood clots. We looked at safety thermometer results from April 2015 to March 2016. This included data for the maternity inpatient wards five and six and the gynaecology assessment unit (GAU). During this reporting period, wards five and six provided 99% harm free care and GAU provided 100% harm free care.
- Safety thermometer information was not displayed in all of the areas we inspected. Some staff we spoke with were not aware of the safety thermometer and others stated they did not receive feedback on the data. However, the trust displayed its own nursing metrics data on the wards, which included pressure ulcers, falls, protected meal times, privacy and dignity, infection prevention and documentation.
- The service did not take part in the national maternity safety thermometer scheme. The maternity safety thermometer was launched by the Royal College of

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Obstetricians and Gynaecologists (RCOG) in October 2014. Data was collected on a single day each month to indicate performance in key safety areas. The maternity safety thermometer measures harm from Perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological Safety.

Cleanliness, infection control and hygiene

- Most areas we visited were visibly clean and staff demonstrated a good understanding of infection prevention and control.
- There were supplies of personal protective equipment (PPE) such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms and observed the trust's policy of being bare below the elbows.
- However, the antenatal inpatient ward (Ward 1) was untidy and cluttered. There was dirty crockery on the meal trolley on the ward in the late afternoon and the sluice was not visibly clean. The checklists in the patient bathrooms had not been completed for two weeks so we could not be assured they were regularly cleaned. Midwives told us there were no health care assistants (HCAs) assigned to this area during the day to assist with general tasks and they had to borrow staff from other areas if available.
- At our unannounced inspection we saw that two of the patient bathrooms on the GAU were below standard infection control standards; one had floor seals that were not intact where dirt was accumulating and in the other the plastic seals were not properly fixed to the walls. There were areas where dirt or mould was visible. We highlighted these concerns to the staff in charge of these areas.
- Equipment had 'I am clean' stickers on them. These were visible and documented the last date and time they had been cleaned. This meant staff knew the equipment was clean and ready for use.
- All ward and clinical areas had antibacterial hand gel dispensers at their entrances and by each patient bed space. Appropriate signage regarding hand washing for staff and visitors was on display and we observed most staff using the gel appropriately.
- Compliance with hand hygiene was audited, audit results showed mixed compliance. We looked at the audit of the maternity inpatient wards five and six. The audit looked at the five moments for hand hygiene. The

five moments for hand hygiene focuses on five moments when hand hygiene should take place, these are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings. An audit took place in November 2015 and the trust's target compliance rate was above 90%. A total of 16 staff were observed on Ward 5 and 14 staff on Ward 6. The audit showed staff were not always compliant with hand hygiene requirements. For moment one, 14% of staff on Ward 5 and 60% of staff on Ward 6 were compliant prior to undertaking a patient contact. For moment two, 100% of staff on Ward 5 and 0% of staff on Ward 6 were compliant prior to undertaking a clean or an aseptic procedure. For moment three 50% of staff on Ward 6 were compliant after body fluid exposure risk (Ward 5 staff were not observed for this category). For moment four, 0% of staff on Ward 5 and 50% on Ward 6 were compliant after patient contact. For moment five, following contact with a patient's surroundings, 20% of staff on Ward 5 and 100% of the staff on Ward 6 were compliant. These results meant that staff were not following the trust's own infection control policy and patients were at risk of acquiring a healthcare associated infection.

- We saw copies of action plans as a result of the non-compliance for hand hygiene audits. Actions included posters for the staff notice boards, emails to all staff advising of the audit results and the infection control link nurse shadowing ward staff. However, further audit data from June 2016 showed that hand hygiene was still low for example Ward 5 compliance was 25%.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.
- The latest CQC intelligent Monitoring report (May 2015) found one maternity outlier for this trust: puerperal (infection following childbirth or miscarriage) sepsis and other puerperal infections. Maternity outliers are where the trust performs worse than the national average. The trust provided us with a copy of their action plan which commenced in October 2013 and a copy of the trust wide directorate quality dashboard from June 2015 to May 2016 which included data on puerperal sepsis.
- During this reporting period there were 49 cases of puerperal sepsis (a 12% increase from the previous year), 216 cases of wound infection (about the same as

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the previous year) and 597 cases of pyrexia of unknown origin (an increase of 5% from the previous year).

Pyrexia of unknown origin was defined as a persistent temperature of more than 38°C for more than 24 hours. The trust had not set targets rates for these outcomes and they were not RAG (red, amber, green) rated which is considered good practice (RCOG, 2008). This meant the trust would not be alerted to an increase in cases.

- We discussed these results with the service leads. Service leads acknowledged there had been no investigation into wound infection rates. We were told that incorrect coding was the reason for the puerperal sepsis cases, although high numbers of cases were still being recorded on the dashboard. The trust performed an audit presented on 3 June 2016 of 54 cases, which had been coded as pyrexia of unknown origin for cases in July 2015 and found 14 of the 54 cases would meet the criteria for this coding. We could not be assured that the service were auditing and responding to women's outcomes appropriately.
- The trust reported no cases of Meticillin Resistant Staphylococcus Aureus (MRSA) for maternity and gynaecology services for the reporting period March 2015 to April 2016. MRSA is a bacterium responsible for several difficult-to-treat infections.
- For the same reporting period the trust had reported one case of Meticillin-Sensitive Staphylococcus Aureus (MSSA) on the delivery suite, and one case of Clostridium Difficile (C. Difficile) infection on one of the maternity wards. MSSA differs from MRSA due to the degree of antibiotic resistance. C. difficile is an infective bacteria that causes diarrhoea, and can make people very ill.
- Staff accessed mandatory infection prevention training through an e-learning package. The average compliance for staff across the trust was 93% against a trust target of 95%. The compliance rate for obstetrics and gynaecology medical staff was 84% for consultants and 79% for junior doctors. Data for all staff groups showed staff on the inpatient maternity Ward 5 were 88% compliant, Ward 6 was 96% compliant, delivery suite was 97% compliant and the gynaecology assessment unit (GAU) achieved 100%.
- Staff displayed cleaning audit data on the wards we visited and the trust's target was to achieve 90% or above. The maternity assessment unit (MAU) displayed data from January 2016 to June 2016 and was consistently above 95%. Ward 5 displayed data from

September 2015 to June 2016 and had met the target for eight out of 10 months. Ward 6 displayed data from May 2015 to June 2016 and achieved 90% and above for eight out of 10 months. Ward 1 was above the 90% target for the previous six months.

- The trust collated "share your experience" patient surveys from September 2015 to February 2016. The average score for cleanliness on the delivery suite across both sites was 95 against a total possible score of 100. On the postnatal wards, this figure was 85.
- We spoke to a member of staff from the domestic team who was able to show us a colour coded cleaning schedule for the ward they were allocated to, and was able to demonstrate that there was a system to escalate infection control and cleaning concerns to the ward manager as necessary.

Environment and equipment

- In order to maintain the security of women and babies, doors to maternity inpatient wards and delivery suite areas were locked and visitors were required to use a closed-circuit television (CCTV) buzzer system to gain entry. Staff had swipe cards which enabled them to enter areas they were authorised to enter.
- Most staff told us that adequate equipment was available to run the service safely. All equipment within the maternity and gynaecology service had been serviced and safety tested. However, we were told that staff had asked for specialist CTG monitors for women with a high body mass index and these had not been provided. Following our inspection the trust told us capital bids and charitable funds had approved money to purchase this equipment and they were awaiting money to purchase this. (Women with a high body mass index are at greater risk of a range of complications in pregnancy and during birth and it may prove difficult to monitor baby's heart beats because of the woman's size.)
- We looked at cardiotocography (CTG) equipment on the delivery suite. CTG equipment is used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked at was clean and had been checked and labelled when the date of the next maintenance check was due.
- We saw that pinard stethoscopes were readily available and midwives told us they used them. A pinard stethoscope is a cone shaped tool that midwives use to manually listen to the heartbeat of a baby during

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pregnancy. There was a pinard stethoscope on each of the CTG machines we looked at in accordance with National Institute for Health and Care Excellence (NICE) guidance.

- Staff checked the adult resuscitation trolleys and baby resuscitaires daily (a resuscitaire is a warming platform used to assist in the resuscitation of newborn babies). We observed that the checklists were completed, dated and signed daily and the majority of equipment and consumables stored on them were sterile and within their expiry date. This meant safety equipment was readily available in the event of an emergency. However, we found the laryngoscope blades were attached and unwrapped. Laryngoscopes are used for checking whether a baby's airway is clear. This meant there was no assurance the laryngoscopes were clean and might pose an infection risk to babies.
- There were pool evacuation nets for water birth evacuation in each pool room in the birthing centre. Training for pool evacuation had been given to staff supporting women having a pool birth during the mandatory skills drills day.
- Equipment was stored in the corridor of antenatal Ward 1 and could present a hazard for the transfer of women along the route. Staff we spoke with acknowledged the problem and told us there was insufficient storage space for equipment.
- We found the fridge used to store breast milk was not locked. We escalated this to the ward manager.

Medicines

- Medicines were mostly managed, stored and administered appropriately. We checked medication cupboards and ward trolleys. Intravenous fluids were stored in locked rooms in all areas and fridges used to store medicines were locked, which meant they were protected from the risk of being tampered with. A medicines storage audit was undertaken by the trust's pharmacy staff in June 2016 and the maternity and gynaecology areas were found to be compliant.
- However, in some areas we found that medicines were stored in rooms that felt warm and where the ambient room temperature was not routinely monitored. Fridge temperatures were checked and recorded on a daily basis. However, there was no recording of minimum or maximum temperatures. We found that staff on the maternity inpatient Ward 6 were recording temperatures but not taking action when temperatures were outside

of the recommended range. This meant staff could not be assured that medicines were being stored at the correct temperature which might affect their effectiveness. When we returned on our unannounced inspection we saw room thermometers had been placed into areas where medicines were stored and a new system of recording temperatures had been introduced. This included appropriate actions to take in the event of temperatures outside of the normal range.

- Controlled drugs (CDs) were stored appropriately in all of the clinical areas we inspected. (CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register). A CD audit was undertaken by the trust's pharmacy staff in May 2016 and whilst the maternity inpatient wards five and six and gynaecology recovery area was compliant, delivery suite and theatre, gynaecology theatres and GAU were non-compliant due to administration errors in the registers. We saw a copy of the trust CD action plan. A further audit was planned for July 2016.
- We saw appropriate arrangements were in place for recording the administration of medicines.
- The hospital used paper prescription and medication administration record charts. We looked at 15 prescription charts. The records were clear and fully completed. Records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. These meant women were receiving their medicines as prescribed.
- If women were allergic to any medicines this was recorded on their prescription chart.
- Staff were able to refer to their medicines policy, the up to date British National Formulary (BNF) or ask for pharmacy support if necessary.

Records

- Patient care records were in paper format. Staff stored medical records securely in restricted areas or in lockable trolleys in clinical areas in line with data protection policies.
- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. The hospital also held medical records relating to each woman.

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- Child health records known as 'red books' were given to mothers for each new born baby following the completion of newborn and infant physical examinations.
- The trust undertook a comprehensive trust wide documentation audit of 212 maternity records from April 2014 against 67 standards. There were mixed results and areas for improvement included; completion of choice and domestic violence section, filing of test results, legible writing in notes, medication charts and surgery details, completion of the patient's record of labour and perineal repair page, use of abbreviations and alterations and use of the SBAR (situation, background, assessment, recommendation) to handover information. Following the findings of this audit, the service changed the format of the intrapartum notes and was in the process of repeating the audit. (Intrapartum is the period from the start of labour until just after the baby is born.) All of the records we reviewed were completed accurately.
- A review of the minutes of the directorate specialist areas nursing and midwifery board minutes highlighted that a common theme for incidents with documentation was the unavailability of notes for theatre lists. We saw the monthly reports produced by the trust to show notes that were produced late (after the required date and time), however the data was not split specifically for obstetrics and gynaecology.
- The combined antenatal and intrapartum hand held records included a page for the recording of antenatal screening tests offered, accepted or declined, the date of the screening test and any results. The records we reviewed were completely in full. Records were dated, timed, and had a signature and identifiable name.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated, full-time band seven specialist midwife responsible for safeguarding children and vulnerable adults who liaised with multi-agency safeguarding teams across the catchment areas. The specialist midwives worked Monday to Friday from 9am to 5pm. The trust's annual safeguarding report for 2014-2015 stated that the number of safeguarding alerts or referrals had increased from 825 in 2014, to 951 in 2015. Service leads had recognised maternity specialist safeguarding midwife capacity was not sufficient to provide the frequency of supervision required for clinical staff and level 3 training hours. The trust had recruited an additional band seven specialist safeguarding midwife who was due to start in July 2016.
- There were named leads for maternity safeguarding and adult safeguarding for gynaecology. Staff told us the named safeguarding leads for the trust met to discuss cases and share learning on a monthly basis. Safeguarding leads received one-to-one supervision through the commissioners of the service.
- Staff followed safeguarding legislation and local policy for reporting concerns to safeguard adults and babies from abuse. Staff on the GAU told us of a very recent safeguarding referral made in connection with a patient they were concerned was a victim of people trafficking.
- Community midwives made referrals into a specialist clinic for women who had experienced female genital mutilation (FGM). The World Health Organisation defines FGM as "procedures that include the partial removal of the external female genital organs for cultural or other non-therapeutic reasons". Safeguarding referrals were made for all women with FGM. The trust's annual safeguarding report for 2014-2015 stated that there were approximately 10-15 new cases of FGM seen in the trust per month which were reported under the statutory duties introduced in September 2014 for all organisations. Mandatory safeguarding training for both midwives and doctors included FGM, and also covered child sexual exploitation, modern day slavery and honour based violence.
- Clinical nurse specialists were able to describe the trust's protocol for when children under the age of 14 presented to the termination of pregnancy service. These women were referred to the GAU, and staff involved in their care worked closely with safeguarding leads.
- Midwives, nurses within gynaecology and health care assistants (HCA) received safeguarding training to level three as part of the mandatory study day. Data provided by the trust for maternity showed that 97% of midwives and 89% of HCAs had completed the training session against a trust target of 95%. The level three training had been included for gynaecology staff since April 2016 and, since then 55% of nurses and 6% of HCAs had completed the training.
- The trust had a 'missing baby' guideline, which explained the process to follow in the event of baby abduction or missing baby within the maternity service.

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Junior staff we spoke with were unaware of the guidelines and their responsibilities in the event of a baby going missing from the ward. More senior staff were aware of the policy but were unclear about their role within it. We spoke with ward managers who confirmed the unit did not undertake drills to test the policy.

Mandatory training

- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution, basic life support and safeguarding vulnerable adults and children. Safeguarding training was provided at an appropriate level depending on the requirements of the staff group.
- The majority of mandatory training for staff was done as e-learning. Staff were able to log-in to an on-line system to access any learning that was due. All staff that we spoke with confirmed that they had completed all of their mandatory training.
- Data provided by the trust showed that most of the nursing and midwifery qualified and support staff and consultants had completed the basic life support training. However, 80% of the junior medical staff had completed it, which was lower than the trust target of 95%. Other mandatory training data was reported at a directorate level and could not be separated further into maternity or gynaecology for the staff groups.
- Newly appointed staff completed the trust induction programme. Newly qualified midwives completed a preceptorship programme before progressing to a higher grade.
- There was a mandatory, annual maternity emergency drills day which included midwives, obstetricians and anaesthetists which was organised by the clinical educators.
- There were two mandatory study days for nursing and midwifery staff. The first was for maternity and gynaecology nursing staff, health care assistants and housekeepers and covered breastfeeding, adult basic life support and fire. The second was specifically for midwives and included infant mortality, smoking cessation, diabetes, ante-natal and newborn screening and perinatal mental health.

Assessing and responding to patient risk

- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which

- included an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond to a patient whose health was deteriorating with additional medical support if required. The risk assessment booklet included an SBAR tool, a sepsis screening tool, a venous thromboembolism (VTE) assessment tool which also had a body mass index chart. Venous thromboembolisms are blood clots in the deep veins of the legs. There was also a peripheral intravenous cannula care bundle, a urinary catheter care pathway and assessment tools for nutrition, manual handling and a pressure ulcer risk score.
- Most of the observations on the MEOWS charts were undertaken by HCAs. Data provided by the trust showed that 67% of HCAs had been assessed as competent to undertake, record and calculate MEOWS observations against a trust target of 100%. Staff told us that it was not clear whether staff that had not been assessed as competent were undertaking the MEOWS task and therefore we could not be assured that these assessments were always accurate. However, the records we reviewed contained appropriately completed MEOWS tools for all inpatients.
 - Nursing staff in the gynaecology areas used a paper based early warning score (EWS) tool to identify and respond to women who required additional medical support. Data provided by the trust showed that 100% of HCAs within gynaecology had been assessed as competent to complete the EWS. All of the records we reviewed for gynaecology contained appropriately completed and calculated EWS tools.
 - A paper based newborn early warning score (NEWS) was used for some newborn babies with a clinical reason for observation to enable staff to identify babies requiring additional review and support.
 - Staff on the maternity unit participated in a midwifery safety 'huddle' before the start of every shift. The midwives in charge of every area met on delivery suite with the bleep holder and the delivery suite co-ordinator to discuss issues of concern including staffing and women with complex care needs. We observed the delivery suite co-ordinator briefing the multi-disciplinary team at handover. This ensured that care and staffing was prioritised and staff were used where needed.

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- There were arrangements to ensure that checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion in obstetric theatres of the Patient Safety First's Five Steps to Safer Surgery – an adaptation of the World Health Organization (WHO) surgical safety checklist. We observed the theatre team completing the five steps to safer surgery throughout the sign in before induction of anaesthesia, to the sign-out as the patient left theatre. All stages were completed correctly. There had not been any recent audit of compliance with the surgical safety checklist at the LRI. A review of the trust wide safer surgery policy was underway with the aim of making surgery safer at every step of the patient pathway. This included reviewing best practice from other organisations, paperwork and process design and staff training and was due for implementation in December 2016.
- During the initial booking appointment, pregnant women were given hand held maternity notes which included both antenatal and intrapartum care. Midwives took a full medical, obstetric, social and family history, which included an assessment of emotional well-being. This assessment was used to classify whether the woman was at low or high risk. Low risk women continued with midwifery-led care, whilst high risk women were received consultant-led care. This assessment was repeated at 36 weeks gestation to enable discussions of intended place of birth, and again when being admitted to delivery suite, at a home birth or if there were any changes in pregnancy.
- The trust provided monthly audit data of patient observations and assessments from September 2015 to February 2016. Wards 5, 6 and delivery suite provided data for five out of the six months and were 100% compliant. The GAU provided data for four of the six months and the average compliance was 86%. Data was also provided for correct completion of fluid balance charts for which Ward 5,6 and delivery suite and were 100% compliant. However GAU provided data for four out of the six months and had an average compliance of 86%. The trust expectation for correct completion of both observations and fluid balance was 100%.
- Service leads told us there was a pathway for women with a body mass index (BMI) of 40 and above. Women with a raised BMI have additional pregnancy related risks. The pathway included ultrasound scanning and monitoring of diet and weight at a joint consultant and

midwife clinic. Risk assessment for manual handling and VTE were carried out and the women were reviewed by a consultant anaesthetist in clinic. In addition, women with a BMI of 50 or above were offered a six week postnatal clinic appointment.

- We observed an incident where staff did not respond appropriately to a patient's risk. A planned caesarean section had to be delayed for a woman who had diabetes because there had been a delay in starting the necessary insulin regime. A senior midwife told us that the patient should have been prioritised because of her additional medical complications and an incident report had been submitted and a case review was to be held.

Midwifery staffing

- The maternity department used the National BirthRate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National Institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a patient)
- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. The UHL maternity service ratio of 1:29.5 births was lower (worse) than this recommendation. The staffing ratio included specialist midwives that held a caseload, of which there were 3.2 WTE trust-wide. Birth Rate Plus 2014 suggests ratios of midwives is nearer 1:29.5 although it is individual to each service.
- There were 4.4 WTE midwife vacancies at the LRI and 4.5 WTE midwife vacancies in the community. Interviews were held during our unannounced period and we were told that one band five and three band six midwives, in addition to one bank midwife had been recruited. Bank staff are usually the trust's own staff who work for the trust on a casual basis and supplement the permanent staff as and when required.
- The trust had a midwifery and support staffing policy, which had been reviewed in May 2016. This policy made provision for the use of a midwifery staffing 'red flag' system (which was a warning sign that something may be wrong with the level of midwifery staffing) as

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recommended by NICE. However, senior staff told us the service was not currently using the 'red flag' system and the introduction of a new information technology (IT) system in the coming weeks would allow this data to be collected. Data provided by the trust from the incident reporting system showed there were 77 incidents reported relating to a lack of maternity staff at the LRI for the period March 2015 to March 2016.

- Service leads told us women received one-to-one care when in labour. They also told us this was not audited because it was fully embedded into practice. Staff in the birthing centre told us that one-to-one care was not always provided; planned staffing levels were four midwives to cover six rooms but often three midwives provided care for up to six women either in labour or postnatally. A delivery suite co-ordinator told us they always tried to prioritise women in labour, but this sometimes meant women who had given birth had to wait for less essential care. The service also moved staff from other areas to delivery suite or transferred women between the two sites when possible to support safe care in labour.
- The trust collected 'share your experience' patient surveys from September 2015 to February 2016. The number of women completing the questionnaires was variable; for labour and birth the range was 31 to 79. The ideal satisfaction score from these patient surveys was 100; for one-to-one care in labour the average score was just below the ideal score at 98.
- Staffing levels were displayed in all the clinical areas we visited and we saw information displayed indicated actual staffing levels mostly met planned staffing levels. However, on the day of our inspection the staffing levels displayed for the unit as a whole showed the planned number of midwives on the early, late and night shifts was 16. The actual number of staff as displayed on the board was 18 for the early shift, 20 for the late shift and 12 for the night shift. We reviewed the trust's midwifery staffing policy which stated the preferred staffing level for the night shift was 18 midwives and the minimum acceptable number was 15. We reviewed a copy of the e-roster for the week commencing 20 June 2016 and saw that none of the nights shifts that week met the preferred staffing level and one night (21 June 2016) was under the minimum acceptable number with 14 qualified staff on the rota.
- Community midwives (CMWs) were used as part of the escalation process with four CMWs rostered onto the

late shift and night shift. A system had been introduced two weeks before our inspection whereby the CMWs reported to the delivery suite in order to assist staff on delivery suite and the birthing centre. Community staff told us it had been made clear to them that they were not to be allocated labouring women so that they could be instantly released for home births if required. The trust midwifery and support staffing policy stated that "home birth to take precedence over all other work". On our unannounced inspection, we saw the maternity unit was short-staffed for the night shift; the planned number of midwives was 16 but there were 13 on shift, which was less than the minimum acceptable number. Of the three midwives originally allocated to the birthing centre, two were transferred to work on delivery suite, replaced by two community midwives. However, as there were three women in labour in the birthing centre, the CMWs were obliged to look after them and staff told us that it would be extremely difficult to release them to attend any home births.

- The antenatal inpatient ward cared for up to 13 antenatal women who may be high risk and up to five women having labour induced. Planned staffing levels for this area were two midwives for day shifts and one midwife with one support worker for the night shifts. Midwives we spoke with told us that this level of staffing did not always feel safe and that they had voiced their concerns to service leads. A maternity matron explained that the antenatal ward was jointly staffed with the midwifery assessment unit (MAU) and staff could be moved from there onto the antenatal ward as required. However staff from the MAU told us they were often transferred onto delivery suite during times of peak demand and so were not always available to assist on the antenatal ward.
- Gaps in the staffing rota were filled with bank staff or staff doing extra hours. Bank staff are those who are employed by the hospital and who can be asked to fill gaps in the staffing rota which meant they were familiar with the unit. Agency staff were not used throughout maternity services.

Medical staffing

- In February 2015 the hours of consultant cover on the delivery suite, had increased from 60 hours a week to 82 hours a week. However, this was not in line with the Royal College of Obstetricians and Gynaecologists

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(RCOG) 2007 guidelines, which recommends that a unit which has more than 5000 births a year requires 98 hours of consultant presence by 2007, rising to 168 hours in 2010.

- Consultant obstetricians were resident on the delivery suite from 8am to 10pm Monday to Friday and from 8am to 2pm at weekends. Outside of these hours the consultant obstetricians worked a non-resident on-call system.
- Consultant gynaecologists covered the gynaecology assessment unit (GAU) from 9am to 5pm, Monday to Friday and from 9am to 12pm at weekends. Outside of these hours consultant gynaecologists worked a non-resident on-call system covering emergency gynaecology.
- Junior doctors worked a full shift pattern and covered both maternity and gynaecology services on a rota.
- Out of hours and at weekends trainee doctors covered both obstetrics and gynaecology. The lack of middle grade doctors to provide adequate cover had been added to the maternity and gynaecology service risk register. Service leads told us this was a national problem and they were in the process of recruiting from overseas. They told us they were mitigating the risks by paying their own medical staff locum rates for extra hours worked and by consultants 'stepping down' as necessary to cover the gaps in the rotas. The trust also employed nurse practitioners on the GAU who were able to cover some of the workload of the junior doctors. However, staff we spoke with from all areas including the GAU, maternity assessment unit (MAU) and inpatient wards told us that it was often difficult to get medical reviews for women out of hours and weekends, which meant long delays for women and which could be a risk to patient safety. A consultant told us of their concerns that sometimes junior medical staff had training sessions cancelled to cover the clinical rota. Junior doctors we spoke with confirmed that this had been the case.
- Data provided by the trust from the incident reporting system showed that there were 26 maternity and 15 gynaecology incidents reported relating to a lack of medical staff at the Leicester Royal Infirmary (LRI) for the reporting period March 2015 to March 2016. The majority of the incidents resulted in no harm.
- Consultant anaesthetists provided 27 sessions and three clinic sessions per week for obstetrics and six sessions for gynaecology per week. Consultant obstetric

- anaesthetists were resident on the delivery suite from 8am to 6pm, Monday to Friday. There were two specialist registrar anaesthetists resident from 8am to 10pm seven days a week. There was one specialist registrar anaesthetist dedicated to the delivery suite from 10pm to 8am who was supported by a second on-call registrar resident in the main hospital, and a non-resident on-call consultant anaesthetist.
- Appropriate, dedicated anaesthetic cover was available 24 hours a day for elective and emergency care.

Major incident awareness and training

- There were arrangements to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding quickly and effectively to any major incident. However, we specifically asked five of the nursing and midwifery staff about the major incident plan and their responsibilities. Three of the staff were unaware of the plan.

Are maternity and gynaecology services effective?

Requires improvement 

We rated the effectiveness of maternity and gynaecology services at the Leicester Royal Infirmary (LRI) as requires improvement because women were at risk of not receiving effective care or treatment.

We found;

- The service used a quality dashboard in line with Royal College of Obstetricians and Gynaecologists RCOG guidance, however most outcomes were reported at service level meaning site variance could not be identified and some outcomes on the dashboard were not benchmarked for example rates of sepsis and mode of delivery.
- The rates of caesarean section, and post-partum haemorrhage, (bleeding after birth) were worse than trust targets. Action plans from audit of post-partum haemorrhage did not address all of the issues highlighted by the audit.

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- Midwifery staff had not had anaesthetic recovery training and competency assessment. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia.

However we also found:

- Care and treatment was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Women said that they were able to access pain relief in a timely manner.
- The normal birth rate was above the national average and the number of babies born in the midwife-led birthing centre was one of the highest nationally. The number of babies born by instrumental delivery (where instruments are used to help the baby to be born) was lower (better than) the trust target.
- There was effective multi-disciplinary working across maternity and gynaecology.
- The majority of staff within both maternity and gynaecology had received a meaningful appraisal within the past 12 months.

Evidence-based care and treatment

- Local policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, termination of pregnancy for fetal abnormality guidance was also followed.
- We reviewed five clinical guidelines. These were all in date, were easily accessible on the trust's intranet and were referenced to NICE or RCOG guidance. The guidelines we reviewed included induction of labour, group b streptococcus, intrapartum care, fetal monitoring and perineal care. We also reviewed trust policies that were based on national guidelines including safeguarding and the disposal of fetal remains.
- Whilst the trust policy for disposal of fetal remains was in line with Human Tissue Authority guidance (2015), staff were not always following the policy in relation to the storage and disposal of fetal remains. Staff told us that following termination of pregnancy procedures

remains were sent to the trust laboratory but would be returned to the ward if the paperwork was not completed correctly. Staff on the GAU would then make contact with the patient to arrange completion of the paperwork and the fetal remains would stay on the ward until the paperwork was completed. We raised this with the service leads and when we returned on our unannounced inspection it had been rectified.

- Midwives used a 'fresh eyes' approach for cardio-tocography (CTG) hourly observations. 'Fresh eyes' is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed. A trust wide audit of fetal heart rate monitoring had last taken place in May 2014. The audit looked at various aspects of CTG monitoring from documenting the name of the woman to the outcome being documented on the CTG trace. There were elements of the audit that showed compliance and areas where improvements were required. For example, 44% of the CTGs did not have the indication for monitoring either on the CTG or in the notes. It was found that 13% of CTGs did not have the time and mode of delivery documented on the CTG and 21% of CTGs that had been categorised as suspicious did not have an obstetrician review documented in the notes. The absence of this data meant we could not be assured that care had always been appropriate. However, the audit showed all CTGs that were classified as pathological were appropriately reviewed and action taken. A further audit was planned at the time of our inspection, incorporating new NICE guidance issued in December 2015. We looked at six CTG recordings and found that five were documented according to the trust's policy. The remaining CTG recording did not meet trust policy, as it did not have the signature of the member of staff starting the recording; there was no regular signing of the trace to show that staff had regularly reviewed the recording. In addition, the time and mode of delivery had not been documented on the recording.
- In April 2014 the trust conducted an audit of women requiring elective or emergency caesarean section who were at risk of requiring a general anaesthetic. However, the clinical audit summary form did not specify whether this audit had been conducted at the LRI, LGH or both. These women should follow the starvation and antacid (medicines that control the level of acid in the stomach) guidelines, to reduce the likelihood of potentially fatal

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gastric aspiration during the procedure. (Gastric aspiration is when stomach contents enter the windpipe and get into the lungs) The audit found the trust was compliant in three out of the four outcomes audited in line with the Royal College of Anaesthetist guidelines, and made a recommendation for additional training and for an acid prophylaxis guideline to be introduced. This was subsequently incorporated as part of the intrapartum care guideline.

- We reviewed antenatal hand held records and saw that fetal growth was routinely measured using the symphysis fundal height and recorded on a fundal height chart. (Fundal height is a measure of the size of the mother's uterus to assess how well the baby is growing and is measured from the top of the uterus to the top of the mother's pubic bone) which was in line with MBBRACE-UK (2015) and NICE guidance. There was a clear pathway for abnormal findings.
- The service performed audit in line with the women's/maternity clinical audit and quality improvement programme 2015-2016 and produced action plans for each audit. However, it had been acknowledged that some audit projects had been delayed due to capacity of the junior medical staff. For example, the audit of post-partum haemorrhage (bleeding after birth) had been delayed because the junior doctor allocated to undertake the audit had left the trust.
- The trust reported on its compliance with NICE guidance, and service leads were able to give provide evidence they were reviewing new guidance as and when published to check they were incorporated in their own guidelines.
- Staff we spoke with were able to demonstrate their practice was evidence based. Midwives were able to discuss NICE guidelines, how the guidelines were embedded in their practice and how they kept themselves up to date. However, some staff we spoke with in our focus groups felt that midwives did not always have time during working hours to read new trust guidance.

Pain relief

- Women were able to access pain relief during birth and post operatively in a timely manner for both maternity and gynaecology. Staff regularly offered pain medicines and women told us their pain was well managed.

- Pain was assessed and recorded on women's maternity modified early warning score (MEWS) chart or on the nursing early warning score for gynaecology (EWS).
- There were two birthing pools in the midwifery-led birthing centre that women could use as pain relief in labour. No birth pools were available on the obstetric-led delivery suite.
- Entonox (a pain relieving gas) was available in all labour rooms in both the birthing centre and the delivery suite. Stronger pain control by injection was also available for women who required stronger pain relief in both areas.
- Epidurals were available for women on the delivery suite 24 hours a day, seven days a week. The average waiting time from women requesting an epidural to receiving one should be within 30 minutes; however the service did not audit this data. We could therefore not be assured that epidurals were provided in a timely manner. Data provided by the trust showed that 96% of elective caesarean sections and 87% of emergency caesarean sections were performed under regional anaesthesia, which is in line with the RCOG Safer Childbirth Guidelines 2007.
- Two nurses on the gynaecology assessment unit (GAU) were non-medical prescribers. (Non-medical prescribing is undertaken by a health professional who is not a doctor and has received additional training.) This meant that women did not have to wait for a doctor to come to the ward to prescribe pain relief.

Nutrition and hydration

- The maternity service had achieved level two UNICEF Baby Friendly assessment in November 2013 and was due to undergo reaccreditation later in 2016. (The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding). The service had failed to achieve level three accreditation in Jun 2015 and reassessment was planned for October 2016. The trust had produced an action plan to assist with achieving level three accreditation. (The UNICEF UK Baby Friendly Accreditation has four levels which starts with a certificate of commitment. Stage one assessment is building a firm foundation, stage two is an educated workforce and stage three is full accreditation.
- The average monthly breastfeeding initiation statistics across the trust for April 2015 to March 2016 were 75.4%,

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which was similar to the trust target of 75%. The trust employed two specialist infant feeding midwives who were able to refer women to a specialist-feeding clinic held at the Leicester General Hospital.

- The Malnutrition Universal Screening Tool (MUST) was used to screen women for their risk of malnutrition throughout gynaecology. We looked at nursing records and found the majority had been completed. Fluid balance charts were used appropriately to record fluid intake and urine output. Maternity staff used the nutritional assessment in the maternity risk assessment booklet to record dietary needs and assess their risk relative to their body mass index (BMI).
- All women had access to drinking water beside their bed unless they were nil by mouth.
- A choice of meals was available and women completed menu choices for the day.
- Woman told us the meals were served on time and were acceptable. The trust collated 'share your experience' patient surveys from September 2015 to February 2016. The number of women completing the questionnaires was variable; for the postnatal wards, the average was around 360 per month. Against an ideal score of 100, the patient scores for rating of the food on the postnatal wards averaged 63, which was much worse than the ideal score.
- Health care assistants told us that women could have snacks at any time of the day and women we spoke with confirmed this.

Patient outcomes

- The RCOG guidance states 'Individual maternity units should set local goals for each of the parameters monitored, as well as upper and lower thresholds' The dashboard had been red, amber, green (RAG) rated for some items on the dashboard. This allowed staff to assess the outcomes against the trust's targets. From April 2016, the service had removed the RAG rating for some outcomes including mode of birth. This meant there were no targets set for vaginal birth, caesarean section rates and instrumental deliveries, which might lead to less oversight of outcomes or trends. Service leads told us that outcomes would continue to be monitored and scrutinised by the labour ward forum and the quality and safety board.
- At the time of our inspection, the maternity service was identified as a maternity outlier for maternal infections diagnosed within six weeks of birth. (A maternity outlier is where the trust performs worse than the national average).
- There were no maternal deaths reported for the service from June 2015 to May 2016.
- Between June 2015 and May 2016 there had been 5774 births at the LRI excluding home births and babies born before getting to hospital. The normal birth rate for the trust within this reporting period was 61.2%. This was better than the England average of 60%.
- Between June 2015 and May 2016, 11.2% of babies had been delivered by medically assisted instrumental delivery (forceps and ventouse extraction) trust wide. This was better than the trust's target of 13.4%.
- The trust's average home birth rate was 1.2% of the total deliveries recorded for the trust between June 2015 and May 2016. This was worse than the national average of 2%, however the most recent figure for May 2016 was 1.9%. The trust had not set a target on their dashboard.
- Between June 2015 and May 2016, 22.9% of all babies born at the LRI were delivered in the midwifery-led birth centre. This is one of the highest rates nationally.
- The average caesarean section rate between June 2015 and May 2016 was 28%, this was slightly worse than the trust's target of 26.3% for 2015-2016. No target was set for 2016-2017. Of these caesarean sections, 10.5% were planned and 17.5% were unscheduled. Whilst the planned caesarean section rate was slightly better than the England average of 11%, the rate for unscheduled caesarean sections was worse than the England average of 15%.
- Between June 2015 and May 2016, the average percentage of women trust wide who had a vaginal birth after a previous caesarean section was 23.7%, which was lower than the trust target of 33% for 2015 -2016. No target had been set for 2016 -2017.
- Between June 2015 and May 2016, the average percentage of women who experienced a major obstetric haemorrhage (bleeding following birth) of 1500mls or more was 3.7% trust wide. This was worse than the trust's target of below 2.7%.
- Trust wide, between June 2015 and May 2016, nine women who had a normal delivery experienced serious perineal trauma (fourth degree). This was below the trust's target of less than three per month apart from February 2016 when the number of women was four.

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- Between April 2014 and March 2015, 372 medical and 14 surgical terminations of pregnancies were carried out at the LRI.
- Between June 2015 and May 2016, maternity services across the trust had experienced 51 stillbirths (8.8 per 1,000 births). The trust had not set a target; however, there had been no increase from the previous year. The England average for stillborn rates for 2015 was 4.4 births per 1,000 births so the trust rate was significantly higher.
- The NHS screening programme sets key performance indicators (KPIs) for antenatal and newborn screening programmes. The trust was achieving an acceptable level within four of the six KPIs for which data was submitted for January 2016 to March 2016. The trust had an action plan which indicated steps had been taken to improve performance, for example, community midwives had set up postnatal clinics in the community to reduce the number of avoidable repeat new born blood spot tests.

Competent staff

- There were 25 supervisors of midwives (SoM) within the maternity service at University Hospitals Leicester NHS Trust. SoMs help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for caseloads for SoMs was 1:15. The service was not compliant with national expectations with a current ratio of 1:18. Whilst the trust had identified midwives who wished to receive training to become a SoM, there were no training places available because of the national uncertainty about the future of supervision.
- The local supervising authority (LSA) had audited the SoM service and had produced a report with a number of recommendations for improvements. The recommendations related to the processes for reviewing midwifery practice concerns, the SoM ratio, the use of supervisory investigation toolkits, the recording of annual reviews and evidence on their database, and working with the trust and the head of midwifery to have more contact with the executive board and women using the service. It was also suggested that there should be a part or full time SoM. There was an action plan in response to this report, with appropriate actions against each recommendation, none of which were overdue.
- Midwives received updates in caring for women with epidurals and those whose condition was deteriorating, but had not had anaesthetic recovery training and competency based assessments. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) or the Obstetric Anaesthesia Guidelines 2015, which states that 'a midwife with no additional training is not adequately trained for recovery duties'.
- The midwifery clinical educator told us that recovery training was being included in the preceptorship package for newly qualified midwives and the service was working towards a further programme for recovery and high dependency care training for other midwifery staff. However, although senior staff were supporting the process, the issue had not been identified as a risk, or added to the risk register.
- Midwives told us there were three mandatory study days a year. Day one was also mandatory for nurses within gynaecology and included adult basic life support, fire and safeguarding. On day two staff received updates about the latest research and innovations from specialist midwives. The third was a multi-disciplinary learning skills and drills day, which covered a CTG presentation and test, updates on epidurals, sepsis and the deteriorating woman and bereavement. The day was also attended by junior and consultant obstetricians and anaesthetists and concluded with emergency drill scenarios in both home and hospital settings. This included neonatal resuscitation.
- All of the nurses on the GAU that we spoke with confirmed they had received gynaecology specific training by completing the women's health module.
- A consultant gynaecologist we spoke with told us sometimes trainees found it difficult to access emergency gynaecology surgical training. As gynaecology shared a theatre with the obstetrics elective lists, there was not always theatre time available during the day, which meant completing some emergency cases at night when the availability of registrars was more limited. Heads of service and RCOG tutor were aware of the issue and were looking at ways to resolve it.
- There was no formal training for equipment used within the service. Staff were shown how to use new equipment but there were no arrangements for updates

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or competency checks to ensure staff remained competent to operate the different types of equipment. We were therefore not assured staff had been appropriately trained or were using equipment safely.

- Nurses and midwives were required to pass a medicines maths test every three years to ensure they remained competent in the administration of medicines and completion of documentation. For gynaecology, 83% of nurses on GAU and 79% of specialist nurses had completed the assessment. For maternity, 100% of staff in the birth centre and on antenatal Ward 1/maternity assessment unit (MAU) and 85% of midwives on the delivery suite had completed the assessment.
- Data provided by the trust showed that, within gynaecology, 100% of medical staff and 83% of nursing staff had received an appraisal within the financial year 2015 – 2016. Within maternity for the same reporting period, 95% of midwives and 85% of medical staff had received an appraisal. These rates showed an improvement for nursing and midwifery staff from the same period 2014 – 2015. All staff we spoke with confirmed they had received an appraisal within the past 12 months.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working trust wide. Staff from the Leicester Royal Infirmary (LRI) worked together with those at the Leicester General Hospital (LGH) to co-ordinate the gynaecology service across the trust. The multi-disciplinary team included specialist nurses, gynaecologists, anaesthetists, neonatologists, theatre and recovery staff in both the gynaecology and surgical day case operating theatres, GPs, health visitors, community and specialist midwives, physiotherapists, dietitians and an independent provider of terminations of pregnancy.
- The LRI had a level three neonatal unit based within the same building as the maternity unit and we observed continuous communication with the neonatal team as some maternity care had to be co-ordinated with cot availability on the neonatal unit. We also observed effective three-way co-ordination with delivery suite co-ordinators, the neonatal unit and the Glenfield hospital paediatric intensive care unit in order to schedule a caesarean section for a patient whose baby was thought to require both services.

- Multidisciplinary clinics were held for pregnant women with mental health problems, where a consultant obstetrician and specialist midwife saw them. There was a dedicated pathway for staff to access psychiatry services for maternity women. The teenage specialist midwife told us of strong links with the local children and adolescent mental health service (CAMHS).
- We were told of a recent maternity case where a multi-disciplinary team had been assembled that included obstetricians, interventional radiologist, anaesthetist, haematologist, paediatrician and vascular surgeon working within the main operating theatres. We were told that good planning and multi-disciplinary working had led to a positive result for both mum and baby.

Seven-day services

- The early pregnancy assessment unit (EPAU) provided early scans and consultations for women experiencing problems in pregnancy between six and 16 weeks gestation and was located in a building between the emergency department and the maternity unit. The first appointment was at 8.20am and the last was at 4.15pm, Monday to Friday. The service also offered appointments on Saturday and Sunday mornings from 08.20am until 11.45am if a sonographer was available for scanning, but this was not a guaranteed service.
- The gynaecology assessment unit (GAU) was open 24 hours a day, seven days a week and there was a consultant gynaecologist resident on the unit from 9am to 5pm, Monday to Friday and from 9am to 12pm at weekends.
- The maternity assessment unit was open 24 hours a day, seven days a week.
- Community midwives were available 24 hours a day, seven days a week to facilitate home births.
- A supervisor of midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided support to midwives at all times and was available to women. The front page of the hand held antenatal records included details of how to contact the on-call SoM.
- Consultant obstetricians, gynaecologists and anaesthetists were either resident on the unit or on-call 24 hours a day, seven days a week.

Access to information

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- There were white boards on the walls of the delivery suite and inpatient areas, which included patient surnames. However, no other identifiable information was recorded on the whiteboards. Staff used magnetic stickers so other staff members could identify different aspects of a patient's care and certain risk factors but which maintained patient confidentiality.
- Patient care records were in paper format. In both gynaecology and maternity areas, we saw medical records were kept in filing trolleys that were protected by a security code. This meant only authorised staff had access to the records. On the maternity wards, the inpatient risk assessment booklet, which included the MEOWS, was kept either by the patient bedside, or centrally at the midwives station.
- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. These records included patient individual risk assessments, ultrasound and blood test results. This meant all the information needed to deliver care and treatment was readily available to staff.
- Records were readily available to staff to refer to during the time of a woman's admission.
- GPs were able to make direct referrals to the gynaecology service.
- Hospital staff could access policies and procedures through the trust's intranet system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy, together with consent to examination or treatment policy.
- Consent, MCA and DoLS was part of mandatory training for all staff, provided through e-learning. Data provided by the trust for June 2016 showed, within the Women's and Children's directorate, 45% of doctors, 74% of non-qualified clinical staff and 71% of nurses and midwives had completed the training. This was worse than the trust target of 95%.
- The trust's consent to examination or treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 18 years of age and wished to consent to their own treatment, for example if they wished to undergo a termination of pregnancy, staff followed Gillick Competency assessments and Fraser guidelines to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options. (Gillick competency and Fraser guidelines are used to help assess whether a child under the age of 18 has the maturity to make their own decisions and to understand the implications of those decisions). We looked at the assessment tool used by staff in the early pregnancy assessment unit (EPAU) and saw there was a compulsory section relating to Gillick competence that that nurses were required to complete.
- Nursing staff on the gynaecology assessment unit (GAU) told us they understood the MCA requirements and had recently made a DoLS referral for an inpatient. There were no women within the unit during the inspection who were deemed not to have capacity.
- We looked at the records of women experiencing pregnancy loss and saw that appropriate consent had been obtain to dispose of fetal remains.
- Women gave informal consent for their care and treatment, and this was clearly documented in women's records. We observed staff asking for consent prior to undertaking care such as physiological observations.
- We saw a trust wide consent audit for elective procedures for both obstetrics and gynaecology from July 2015. The audit included 52 sets of notes, a survey of 74 women and which covered 15 outcomes expecting 100% compliance. The results showed that 100% of women and health professionals had signed the consent form. However, 12% of women had been given written information, 38% of women had received a copy of their consent form, 59% of women were consented at the outpatients clinic and 82% of women felt that risk/benefits and alternatives had been discussed. An action plan was developed and the trust planned to repeat the audit in 2016 -2017.
- We saw an audit of consent forms for labour epidurals undertaken in June 2015 at the LRI. The audit included 50 sets of notes and compliance against eight standards. The audit results were that the service was generally compliant against both the trust and the Obstetric Anaesthetists Association guidelines and the audit would be repeated later in 2016.
- Staff members within the termination of pregnancy clinic were aware of the complications that could arise from using family members to interpret for women who

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did not speak English and were considering a termination of pregnancy. Where possible women were seen on their own, interpreters were booked, or a translation service was used.

Are maternity and gynaecology services caring?

Good



We rated caring within maternity and gynaecology services at the at the Leicester Royal Infirmary (LRI) as good because women were supported, treated with dignity and respect and were involved as partners in their care.

We found:

- The majority of women, their partners and relatives were positive about the care they had received and told us staff were kind and caring and that they had been treated with dignity and respect.
- Staff involved women in their care and treatment. The majority of women and relatives we spoke with told us staff gave them enough information about their care and treatment
- A high percentage of women recommended the maternity services in patient surveys. The trust scored better or about the same as other trusts in the 2015 Care Quality Commission (CQC) Survey of Maternity Services.
- Women and relatives were given emotional support whilst using both the maternity and gynaecology service.

However, we also found:

- The privacy and dignity of women being monitored in the maternity assessment unit was not always respected.

Compassionate care

- The majority of women, their partners and relatives were positive about the care they had received. Most of the women we spoke with told us staff were kind and caring and that they had been treated with dignity and respect, however one patient on the antenatal ward told us of a negative experience relating to a midwife's attitude and the care she had received.
- We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited

in to the room, or behind the curtains around the woman's bed space. However, in the maternity assessment unit (MAU), trust policy indicated that when a need was identified to monitor babies heart rates using a CTG machine, the equipment must be visible to the midwives in the unit at all times. As midwives were caring for several women at one time this meant that women were monitored with the curtains open in full view of other people in the waiting area, covered by a sheet. This practice was introduced because of an incident but did not promote privacy and dignity.

- Staff we spoke with demonstrated an understanding of the importance of respect for women's personal, cultural, social and religious needs.
- Between January 2015 and February 2016, a high percentage of women recommended the antenatal services, postnatal ward and birth services. The scores were similar to the England average. More than 90% of women recommended each of the services in every month.
- The trust's scores in the 2015 CQC survey of women's experiences of maternity services were good. The trust scored 'better than other trusts' in the question 'looking back, do you feel that the length of your stay after the birth was appropriate', and 'about the same as other trusts' in the remaining 16.
- The trust collated 'share your experience' patient surveys from September 2015 to February 2016. The number of women completing the questionnaires was variable. For antenatal services the number of completed surveys had increased from around 12 in September 2015 to around 100 in February 2016; for labour and birth, the range was 31 to 79 for labour and birth the range was 391 to 354; for the postnatal wards, the average was 360 and the postnatal community response was from one to four. From this survey, scores for being treated with privacy and dignity averaged at 96 during the antenatal period, 97 for labour and birth and 94 for the postnatal wards against an ideal score of 100.
- Leicester Royal Infirmary (LRI) scored worse than the England average in all five categories of the patient led assessments of the care environment (PLACE) survey in 2015. Categories included cleanliness, food, privacy and dignity and facilities. PLACE are a self-assessment of non-clinical services that contribute to healthcare delivered in both the NHS and independent/ private

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healthcare sector in England. The programme encourages the involvement of women, the public and bodies, both national and local, with an interest in healthcare in assessing providers.

Understanding and involvement of patients and those close to them

- We observed a receptionist talking to an elderly relative of a maternity inpatient. The receptionist was attentive to the visitor and spoke to them in a friendly and informal manner, asking about the new baby to the family and made sure she had a chair while she was waiting for information.
- Staff involved women in their care and treatment. We observed staff discussing care plans with women and ensuring they understood their treatment and condition. Women and those important to them told us staff gave them enough information about their care and treatment; however one patient we spoke with was unhappy with the consistency of information given to her by medical staff.
- We spoke with a woman on the gynaecology assessment unit (GAU), who told us she also had other health issues. She praised the staff and told us she appreciated the extra care they gave her, and although she understood how busy they were, she had never felt they did not have time for her, especially at night times.

Emotional support

- Partners we spoke to were very happy with the care and their involvement.
- Women and relatives were given emotional support whilst on the units. We observed friendly and open conversations between staff and visitors.
- We overheard a telephone conversation between a midwife and a woman in early labour. The midwife was calm and supportive to the woman, taking time to listen and offering advice and encouragement.
- Staff screened women for conditions such as anxiety and depression as part of the maternity booking process. Women whose babies were delivered before 34 weeks of pregnancy due to pre-eclampsia were offered a 'de-brief' appointment in a postnatal consultant clinic. (Pre-eclampsia is a condition that affects some pregnant women, usually during the second half of pregnancy or soon after their baby is delivered.)
- Women considering termination of pregnancy should have access to pre-termination counselling. All of the

women undergoing termination of pregnancy at the LRI were offered pre-termination counselling by a trained counsellor employed by the trust. Women who were anxious or unsure about their decision were provided with extra support.

- Staff dealt with bereavements compassionately. They provided support to parents, relatives and each other. Staff offered the multi-faith chaplaincy service to women to provide extra support.

Are maternity and gynaecology services responsive?

Good



We rated the responsiveness of maternity and gynaecology services at the Leicester Royal Infirmary (LRI) as good because women's needs were met through the way services were organised and delivered.

We found:

- The service employed a range of specialist midwives for women with complex care needs or for those in vulnerable circumstances.
- There was a wide range of specialist antenatal and gynaecology clinics, which included a 'one-stop' post-menopausal, bleed clinic and a hypertension service.
- The 'consultant direct' clinic held every week day on the gynaecology assessment unit allowed general practitioners (GP) to discuss and refer women directly to a consultant gynaecologist.
- The service provided a cohesive and sensitive bereavement service for women experiencing pregnancy loss, including the employment of a specialist midwife, dedicated bereavement rooms and postnatal records.
- The service had a robust system for monitoring, processing and learning from complaints which ensured that responses were sent in a timely manner, themes and trends identified and learning disseminated to staff.

However, we also found:

- The gynaecology assessment unit (GAU) shared an entrance with the antenatal ward which could be

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distressing for women experiencing pregnancy loss. We were also told that women in GAU could sometimes hear babies heart beats being monitored from the antenatal ward.

- Some gynaecology procedures were carried out in the main part of the hospital, and the patient journey to the GAU was inappropriate.

Service planning and delivery to meet the needs of local people

- The trust employed specialist midwives for women with complex needs and in vulnerable circumstances. There were 1.6 whole time equivalent (WTE) teenage pregnancy specialists who provided care to a high-risk population of teenagers up to the age of 20 years. There were also full time specialist midwives for both substance misuse and women in vulnerable circumstances including asylum seekers, immigrants and the homeless. There was a consultant midwife specialising in public health, a diabetic specialist midwife, a bereavement specialist midwife and a midwife who was a specialist in renal and hypertensive disease.
- Consultants and specialist midwives held a joint antenatal clinic on a weekly basis for women with hypertension (high blood pressure) and had developed a home blood pressure monitoring service. This enabled them to access more accurate blood pressure readings on which they could base clinical decisions. The monitoring equipment had been purchased from charitable funds and had been validated by the British Hypertension Society.
- There was a range of other joint consultant/specialist midwife clinics offered at the Leicester Royal Infirmary (LRI) in addition to the hypertension service including diabetes/endocrine, blood born infection and substance misuse. Consultants led clinics for multiple pregnancies, prevention of prematurity, haematology, female genital mutilation (FGM), fetal medicine and an anaesthetic clinic.
- The service had close links with GPs and ran a bi-weekly postnatal clinic to monitor and reduce patient's medication as required. Women with severe pre-eclampsia whose babies were delivered before 34 weeks gestation, or who had needed significant intervention were also seen at this postnatal clinic for a debrief. Pre-eclampsia is a serious condition characterised by high blood pressure and signs of other organ damage, which can lead to a woman having seizures and which is potentially life threatening to the mother and baby.
- There were midwife-led antenatal clinics for teenage pregnancy and administration of Anti-D immunoglobulin. Anti-D is a medicine used to prevent antibody formation in women who have a rhesus negative blood group and who have a rhesus positive baby. Anti-D is given to the mother to reduce the chances of antibodies being formed and any subsequent complications. This can lead to complications that may affect the baby after birth, or complications with a different pregnancy at a later stage should the woman become pregnant again. The consultant midwife led a health and wellbeing clinic for women with a BMI of 40 and over, and there was a multi-disciplinary fetal anomaly meeting. The midwife-led 'birth choices' clinic was for women who were making choices for the birthing of their baby for example women considering a vaginal birth after a previous caesarean section.
- There was a range of specialist gynaecology services offered at the LRI in addition to the general gynaecology clinics, which included endometriosis, infertility and menopause. There were daily early pregnancy and hysteroscopy clinics and weekly colposcopy clinics. Specialist nurse-led termination of pregnancy clinics were held on Tuesday and Wednesday afternoons. There was also a weekly 'one stop' post-menopausal bleed service on a Thursday evening and a menstrual disorder clinic monthly which included an ultrasound scan, clinic consultation and hysteroscopy if appropriate.
- Service leads had introduced and were developing an ambulatory gynaecology service, which enabled women to receive treatment for minor procedures in the gynaecology outpatient clinic. The service was offered for such procedures as removal of polyps (small growths), and treatment for post-menopausal bleeding.
- The gynaecology service operated a 'consultant direct' clinic every afternoon from 2pm until 5pm on the gynaecology assessment unit (GAU) which included an ultrasound scan and a consultant consultation. A gynaecology consultant told us that this service met the needs of those women who were not acutely unwell and therefore did not need to be seen urgently, but for whom it might be inappropriate to wait for a clinic

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appointment. GPs were able to telephone the GAU and discuss their patient, who could be referred to the routine clinic or seen quickly in the 'consultant direct' clinic. Once seen, women would then be admitted, discharged or referred back to the GP. Service leads told us positive feedback had been received about this service.

- Women attending for pregnancy assessment did not have to pass through a postnatal ward. However, the antenatal inpatient ward shared an entrance with the GAU in the maternity block, which meant that women experiencing early pregnancy loss might encounter women who were obviously pregnant. We were also told that these women could also occasionally hear the cardio tocography (CTG) monitors from the antenatal area, which might be distressing for some gynaecology women. A member of the public had also raised this issue as a concern as part of our pre-inspection intelligence gathering process. Service leads agreed it was not ideal but had tried to mitigate distress by making the ward antenatal only rather than mixed with postnatal women. The early pregnancy assessment unit (EPAU) was in a separate building which staff told us women preferred and where women experiencing pregnancy loss did not have contact with antenatal women, unless the EPAU had to refer women to the GAU for further management.
- Induction of labour for both low and high risk women was offered at the LRI. Women who were assessed as low risk attended antenatal Ward 1 for assessment and remained there until labour was established and they could be transferred to the delivery suite. Women who were high risk were admitted into a dedicated bay on the delivery suite where they stayed until they were discharged to the postnatal ward.
- Women assessed as low risk at the onset of labour were automatically directed to the birthing centre for midwifery-led care. However if their level of risk increased during labour, or if they required an epidural for pain relief they would be transferred to the main delivery suite. This 'default' pathway for low-risk women contributed to the high proportion of births in the birthing centre and, as a result, had attracted research interest from a leading university.

Access and flow

- Medical terminations of pregnancy were offered to women under nine weeks gestation. Most surgical

terminations were performed at the Leicester General Hospital (LGH) however women less than 13 weeks gestation with co-morbidities were referred to the LRI for a surgical termination. All other women were referred to another independent termination of pregnancy service.

- Termination of pregnancy clinics were run by the infertility control specialist nurses who ran clinics at the LRI on Tuesday and Wednesday afternoons.
- The maternity unit at the LRI closed 50 times between April 2015 and March 2016. Closure times ranged from two to 15 hours. There was an escalation policy for unit closures. Women would be diverted to the LGH or to other neighbouring units where possible. Staff we spoke with told us that, even if the maternity unit was closed to new admissions, the MAU would remain open to allow women to be assessed. Service leads told us that it was rare for both the LRI and LGH to be closed at the same time and women were booked into the University Hospitals of Leicester (UHL) maternity service, rather than a specific hospital and were advised early on in pregnancy that if one hospital was closed they would be sent to the other. From June 2015 to May 2016 there had been no occasions when both maternity sites were closed.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of women's' legal right to start treatment within 18 weeks of referral to consultant-led care. As of 14 June 2016 the operational standard of 90% for admitted pathways was met for gynaecology and gynaecology oncology with 95.4% of women being seen within 18 weeks.
- The gynaecology service shared the first floor operating theatres with the maternity service. There were two full day elective caesarean section lists on Tuesdays and Thursdays with capacity for up to five procedures per day, and three half-day lists on Monday, Wednesday and Friday afternoons with capacity for two procedures. The elective caesarean lists were staffed separately from the delivery suite, which meant that emergency procedures were not delayed and were carried out in the operating theatre adjoining the delivery suite. There was also a further operating theatre on delivery suite, which could be used for emergency procedures if the main obstetric theatre was already in use. However, this room was smaller and less ideal for obstetric procedures, it had

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been added to the risk register and service leads were currently assessing their theatre requirements. The gynaecology service used the operating theatre on Monday, Wednesday and Friday mornings for emergency and urgent day case procedures.

- Staff carried out all elective gynaecology surgery at the LGH. Occasionally additional operating theatre time was required and some procedures were undertaken in the hospitals' main surgical theatres in another building. Staff expressed concern that this was an unpleasant and potentially frightening experience for the women. We walked the patient journey from the main surgical operating department to the GAU and found it was inappropriate for a patient as it involved travelling through narrow hospital basement corridors, past ventilation and heating pipes and where large waste bins were stored.
- Between April 2015 and March 2016 there were 25,728 gynaecology outpatient attendances and 1,336 gynaecology oncology attendances. For the same reporting period, there were 31,047 attendances at obstetric outpatient clinics.
- Information provided by the trust showed there were 1206 gynaecology women on the waiting list for a new clinic appointment as of 31 March 2016. No women had been waiting longer than nine weeks.
- The newborn and infant physical examination screenings (NIPE) were performed on the maternity postnatal ward by the paediatricians. This could lead to delays in discharges if there were a number of checks to do. Therefore a cohort of midwives were undertaking a NIPE training course with a local university, due to qualify in September 2016 and it was anticipated that more staff would complete the training in the future. This meant more staff would be competent to complete the checks and would help with discharge flow from the wards.
- The trust had been piloting a project to measure the oxygen levels in newborn babies (pulse oximetry). Local clinical commissioning groups had not commissioned this service but the project was continuing as service leads recognised its value for identifying 'at-risk' babies. The trust had purchased mobile electronic devices to input data onto the national NIPE database.

Meeting people's individual needs

- Staff used private rooms to deliver bad news to women and their families. On the early pregnancy assessment

unit (EPAU), there was a private sitting room that women who had received distressing news could use. On the maternity assessment unit (MAU), staff told us they would use one of the lesser-used treatment rooms to break bad news and staff told us of an occasion when staff had cleared the waiting area in order for a distressed patient to be able to leave the unit unobserved.

- Leaflets were readily available in English; however, they were available in other languages on request. In addition to English, menus were printed in five other commonly spoken languages. Information leaflets could also be downloaded from the trust's website. Of the 22 maternity leaflets available, three were also provided in a different language. None of the gynaecology leaflets were available in another language on the website. We spoke with some women that did not speak English as their first language and most were happy with the language services provided however, we spoke with one woman and her partner who were of Chinese origin and who had a basic understanding of English. They told us they did not understand all that was said to them, had not been provided with leaflets in their own language and had asked a friend to translate the English leaflets for them on their return home. On the day we spoke with them they had waited for several hours for a blood test as no one had explained the 'take a number and wait' system to them.
- Staff told us there was a diverse range of languages spoken by staff within the service, who would be asked to translate for women where possible, which is not good practice. Staff told us they would book interpreters when needed or make use of a translation phone service.
- The delivery suite had two bereavement suites. Bracken suite was located on delivery suite, which included facilities for partners to stay and cots for women who wished to keep their baby with them. Clover suite was a room near to delivery suite, where women who were medically fit for discharge but not ready to go home could use for as long as they wanted.
- The service provided 'Dandelion' postnatal records for women who had experienced pregnancy loss which were sensitive records specifically designed for these women.

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- Women who were experiencing pregnancy loss and who were expected to arrive at the unit were identified to reception staff so they were not kept waiting or asked to specify the nature of their appointment.
 - A full time specialist bereavement midwife worked across the trust to provide support for women and staff. Staff felt well supported to care for women and families.
 - Families could use the patient day room on Ward 5 for family gatherings and religious ceremonies; this had a selection of children's toys.
 - The birthing centre was available to women identified as carriers for the Group B Streptococcus (GBS) bacteria providing there were no other risk factors. (GBS bacteria may pass to newborn babies and cause a serious infection). Telemetry was available and used in cases where vaginal birth after caesarean (VBAC) women wished to use the birth pools within the birthing centre provided an antenatal plan had been made and agreed with the patient.
 - Staff told us of a recent case where a woman with learning difficulties needed to be admitted to the gynaecology assessment unit (GAU). Whilst relatives were not usually allowed to stay on the ward, staff arranged for a relative to stay overnight with her. A similar case involved a woman with disabilities related to multiple sclerosis whose sister stayed overnight to assist her.
 - A health care assistant (HCA) on the GAU told us of a time an elderly woman was an inpatient on the ward. She only had one set of clothes with her which were dirty and she did not have any visitors during her stay. The HCA subsequently took the clothes home to wash them and returned them to the woman.
 - Data from the 2015 maternity experience survey found that women reported the response time to the call button was in line with England average, scoring 7.6 out of 10. We observed that patient call bells were answered promptly on GAU and on the maternity inpatient wards.
- complaint. We also saw 'message to matron' cards and boxes which allowed women and relatives to make comments or raise concerns which where possible could be resolved locally.
- The trust complaints policy stipulated that complaints should be acknowledged within three days and a comprehensive response sent within 25 days. The response time could be extended to 45 days for cases that were more complex but only with the agreement of the complainant. The clinical risk and quality manager told us they were currently 100% compliant with the trust standard for responding to complaints.
 - Between March 2015 and March 2016 there were 119 formal complaints about the service provided at the LRI; 55 complaints for maternity and 64 for gynaecology. During our inspection, we were told that the service also monitored verbal complaints and concerns raised by staff and other agencies for example clinical commissioning groups (CCGs), GPs, adult and social care and the NHS Ombudsman. We reviewed a copy of the quality and safety report to the directorate quality board for activity during May 2016 and saw that 13 verbal complaints had been recorded for that month; five for maternity and eight for gynaecology across the trust.
 - The quality and safety report highlighted the themes that emerged from the formal complaints. The five most common themes in May 2016 related to; complications of treatment, professionalism of staff, nursing care, waiting times and medical care. A training digital versatile disk (DVD) relating to communication skills and behaviour was being shown to all staff in response to a number of complaints that included communication and attitude as a factor.
 - Service leads told us that learning from complaints was cascaded as part of a weekly newsletter and was sent to all staff. We reviewed the programme for the mandatory study day that maternity and gynaecology staff attended and saw that time had been allocated to the quality and safety team to cascade learning from investigations and complaints. Staff who were expected to attend these sessions included registered nurses and midwives, medical staff, housekeepers and nursing and midwifery support staff.

Learning from complaints and concerns

- A Patient Information and Liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- Posters and leaflets were available in the wards and clinical areas we visited. These identified how members of the public could raise a concern or make a formal

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Requires improvement



We rated the leadership of maternity and gynaecology services at the Leicester Royal Infirmary (LRI) as requires improvement because the leadership, governance and culture did not always support the delivery of high quality person-centred care.

We found:

- There was a clear vision and strategy for the service, however there was a degree of doubt amongst staff that the vision would ever be achieved.
- Whilst there was a clear governance structure and use of a quality dashboard, junior staff were not involved in the process and had a poor understanding of the dashboard. Some of the dashboard outcomes were reported trust-wide and some were not red, amber, green (RAG) rated against the trust's targets, which meant we could not be assured that service leads had good oversight of the outcomes for women and may not be able to appropriately identify trends in poor performance.
- Incidents and concerns were discussed at a variety of meetings and forums; however, we were not assured that incidents were correctly graded following these discussions.
- Lines of communication between the clinical director of this service and other service leads were not always robust.
- The risk register was reviewed and regularly updated, however not all risks were recognised or added to the register, for example lack of recovery and care of the critically ill woman training for midwives.

However, we also found:

- Heads of service were visible and respected and there was generally good local leadership.

Vision and strategy for this service

- Maternity and gynaecology services were provided at this hospital as part of the Women's and Children's Clinical Management Group (CMG).
- The maternity and gynaecology service leads had a clear vision for the development of the service, demonstrated by the 'Project Initiation Document – Women's services December 2015'. The objectives were

clear with actions driven by both national and local directives. This was aligned to the trust's five-year strategy and the 'Better Care Together' programme. However, this vision was dependant on trust wide rationalisation and movement of services. The aim of the project was to consolidate all of the women's and neonatal services onto a single site, possibly the LRI site, subject to public consultation. The size of the project meant external funding would be required and had been a long-term goal.

- All of the staff we spoke with understood the vision and strategy, although some staff expressed a degree of cynicism that it was achievable.

Governance, risk management and quality measurement

- There was a clear governance structure in place for the CMG. Quality and safety issues including incidents, complaints, risks and patient outcomes were discussed at separate monthly maternity and gynaecology clinical governance meetings. Serious concerns were fed into the trust board through the executive quality board and the CMG quality and safety meetings. In addition, there were regular meetings of the delivery suite forum and the nursing and midwifery board. We reviewed a selection of minutes from these meetings, and saw that these were multi-disciplinary and attended by senior staff from both sites. There were no junior medical or nursing/midwifery staff included in these meetings. Staff we spoke with were either not aware they could attend, or did not have time to attend. The agenda included discussions around the service's risk register and incidents together with complaints and the quality dashboard.
- Data from reported incidents were co-ordinated by the trust-wide patient safety team for maternity and gynaecology. It included a band eight clinical risk quality manager, a band seven clinical risk quality co-ordinator, a band seven quality and safety midwife, a band five complaints coordinator and administration staff. Members of this team sat on the monthly clinical governance meetings for maternity and gynaecology, the specialist nursing and midwifery board meeting for their directorate, and the clinical risk meetings for both maternity and gynaecology where incidents were discussed and reviewed. The team were part of the East Midlands Risk Management Network and were therefore able to share concerns and learning from across the

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region. Staff in the team had direct access to the head of nursing and the head of midwifery and reported to the quality and safety board. The team tracked overdue incident investigations or actions.

- Staff discussed specific cases and incidents at the gynaecology or perinatal risk management meetings. We reviewed minutes of a perinatal risk management group meeting from May 2016, which was multi-disciplinary, and we were not assured that incidents were not being inappropriately downgraded. We also reviewed minutes of the maternity governance meeting for November 2015 where grading of incidents related to post-partum haemorrhage was discussed and which suggested that staff were uncomfortable with incident downgrading.
- The service maintained a women's services quality dashboard, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. However, we did not see this document on display for staff and members of the public. The data provided was trust wide. Following our inspection, we asked the trust for the data at location (hospital site) level. The trust was unable to provide this.
- The service used a quality dashboard that was reviewed on a monthly basis, which used a red, amber, green (RAG) flagging system to highlight areas of concern. However, apart from the number of births, the data on the dashboard was for the service as a whole. Junior nursing and midwifery staff we spoke with had a poor understanding of the quality dashboard.
- We were not confident that actions were taken if trends were identified. For example when the caesarean section rates had increased unexpectedly the service performed an urgent review of all emergency cases during that period, with all of the consultants looking at a proportion of medical records, however no themes emerged from the review and the rate had returned to an expected level at the next review.
- We reviewed a trust audit from June 2015, which stated the incidence of all post birth bleeding of 500mls or more was 19.3%. This was higher than the rate of 13.2% in the Midlands area. The audit suggested that national standards were not being met however; we were not assured the action plan addressed the issues raised within the audit. In addition, we reviewed an audit of post birth bleeding data from a six-month period in

2013. The action plan had not been completed until March 2016. We discussed these findings with one of the deputy heads of service who had limited awareness of the audit findings and actions.

- The maternity risk register was reviewed and updated regularly. Actions taken were visible and when processes were completed, risks were removed from the register. Some issues identified during our inspection had already been highlighted on the service risk register although the lack of appropriately trained staff in maternity for anaesthetic recovery and care of the critically ill woman had not been recorded as a risk despite being discussed during clinical governance meetings.
- The service performed an audit for compliance with the legal documentation for abortion services at University Hospitals of Leicester (UHL) in September 2014 and found 100% compliance with completion of consent forms, HSA1 and HSA4 forms (a requirement of the department of health) and fetal tissue disposal forms. However, we found that fetal remains were returned to the GAU because of discrepancies in the completion of fetal tissue disposal consent forms therefore we could not be assured that all such forms were completed correctly.
- The government had commissioned an independent investigation into maternity and neonatal services at Morecambe Bay (the Kirkup report, 2015), to examine concerns raised by the occurrence of serious incidents. Good practice would be to benchmark against these recommendations. Data provided by the trust demonstrated the service monitored compliance with some of the key elements of the Kirkup report such as staffing, multi-disciplinary working and the maintenance of good working relationships between all groups of staff. Staff we spoke with told us there was a supportive culture between midwifery and medical staff.

Leadership of service

- The chief nurse for the trust was the executive board lead for obstetrics and gynaecology.
- The Women's and Children's Clinical Management Group (CMG) was led by a clinical director (CD). Two clinical service leads, one each for maternity and gynaecology, supported the CD. The deputy clinical director had recently moved to a different service and had not yet been replaced. There was a directorate head of operations and deputy, general managers and service

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managers. The head of midwifery (HOM) was also the head of nursing (HON) for the directorate and was responsible for four midwifery matrons and one gynaecology matron who organised the day to day running of the obstetrics and gynaecology service.

- There was strong local leadership on the wards. Staff told us the HOM/HON was visible and approachable and they felt supported by ward managers and managers. However, staff within gynaecology, told us the gynaecology matron was not as visible.
- Nursing staff of all grades felt the gynaecology service had a lower profile than that of the maternity service. Nurses on the GAU did not have access to information as quickly as nursing staff in other areas. Staff we spoke with on the EPAU told us they did not feel part of the service as they were located “away from everything”.
- Consultants spoke highly of the clinical service leads. Junior doctors told us they felt well supported by consultants throughout the maternity and gynaecology service.
- Lines of communication from the CD to the other service leads were sometimes poor. The HOM had to obtain copies of executive board meetings from the chief nurse as they were not routinely circulated by the CD and they did not feel well informed about trust board level discussions that affected the maternity and gynaecology service.

Culture within the service

- We saw staff consistently delivering care and demonstrating behaviours in line with the trust vision.
- Midwives, nurses and medical staff spoke positively about the care they provided for women. Staff reported positive working relationships and we observed that staff were respectful towards each other, not only within their area of work but across all disciplines. However, one senior midwife we spoke with acknowledged there was some tension with the consultants. A consultant ‘away-day’ was planned for senior medical staff.

Public engagement

- The maternity lead, head of midwifery, consultant midwives, midwifery matrons and community midwives attended the Leicester, Leicestershire and Rutland Maternity Service Liaison Committee (MSLC) meetings on a quarterly basis. The MSLC is a forum for maternity service users, providers and commissioners of maternity services to come together to design services, that meet

the needs of local women, parents and their families.

We looked at the minutes of the meeting from

September 2015 which indicated discussions took place around strategy, ante-natal pathways, public health, mandatory staff training and outcomes for women.

- We saw ‘message to matron’ cards and boxes in wards and clinical areas to encourage the public to comment on services provided.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust’s progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement

- Both leaders and staff understood the value and importance of raising concerns. Most staff we spoke with said they could approach their ward sister or matron about any issues on the ward. Managers and ward sisters demonstrated a desire and willingness to listen to staff.
- We reviewed minutes of a support staff meeting held in February 2016, which was attended by HCAs and housekeepers. This was one way that support staff could raise issues and concerns. It was here that staff discussed mandatory training and appraisals as well as concerns about workload.
- The majority of staff we spoke with in both maternity and gynaecology services were proud of their hospital and the service they offered, Staff told us they thought the LRI was a very good place to work.







Innovation, improvement and sustainability

- The consultant midwife for public health and a senior research midwife won an award sponsored by a midwifery journal for their work setting up a dedicated midwifery research team and for publishing a study into pregnancy and wellbeing.

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- Although there was a weekly 'birth choices' midwife-led clinic for vaginal birth after caesarean section (VBAC) women, the team planned to set up a specific VBAC clinic and were organising a visit to another similar NHS maternity unit who were willing to share good practice.
- The service had devised a new notification to health visitor form, which had improved communication between midwives and health visitors.
- The 'consultant direct' gynaecology service allowed GPs to discuss women, who did not require emergency admission but whom a wait for a routine clinic appointment was not appropriate. Through a telephone triage service the GP could arrange an immediate appointment with a consultant gynaecologist on the GAU.
- The ambulatory gynaecology service allowed women to receive treatment for minor procedures in the outpatient's clinic.
- The specialist midwife for renal and hypertensive disease had been invited to speak at an internal midwifery conference to discuss the home blood pressure monitoring scheme.

Services for children and young people

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

Information about the service

Children's services at the University Hospitals of Leicester NHS Trust are based at the Leicester Royal Infirmary (LRI), Leicester General (LGH) and Glenfield (GH) Hospitals. The LRI has nine wards with 93 inpatient beds, including six beds offering paediatric intensive care and 18 providing day case facilities.

The LGH had 12 cots to provide care to moderately ill babies.

Between September 2014 and August 2015 the trust recorded 14,906 paediatric episodes of care for children and young people of which 55% were classified as emergency, 17% elective and 28% day case. Of these episodes of care 57% of emergency episodes, 14% elective and 29% day case were at the LRI.

Between July 2014 and June 2015, for patients aged under one year old, the most diagnosed illnesses on emergency admission was 'acute bronchiolitis', acute inflammation of the air tubes in the lungs, and 'other perinatal conditions,' conditions that arise in the 20 to 28 weeks of development and to the first to fourth weeks after birth. For patients aged one to 17, the most common diagnosis recorded on emergency admission was 'viral infection.'

The neonatal service operates as a single service, despite being based on two sites (LRI and LGH) and includes joint clinical governance arrangements, training, joint guidelines, audit and clinical research. The LRI neonatal unit has capacity for 28 cots and provides level two care for moderately ill babies and level three care for complex and severely ill babies. The LGH provides level one care for

normal newborn infants requiring additional nursing and has capacity for 12 cots. The service provides a tertiary service for the Central Newborn Network. Care is provided for all the smallest and sickest babies and for babies with surgical and medical needs. Babies with cardiac problems are stabilised and transferred to the GH that specialises in this field.

The children's service comprised of ten clinical areas, including the neonatal units (LGH and LRI). During our inspection of children's services at the LRI, we visited the neonatal unit, the children's outpatients departments, the paediatric intensive care, high dependency unit, child assessment unit, paediatric theatres and three inpatient children's wards. At the LGH we visited the neonatal unit.

We spoke with 15 medical staff, nine nursing staff including managers, two members of the multi-disciplinary team, 10 parents and four young people. We looked at 13 care and treatment records.

Services for children and young people

Summary of findings

We rated safety in the children's and young people's service as requires improvement.

We found:

- Training levels for Advanced Paediatric life support, mandatory training and level three safeguarding training did not meet the trust target.
- The service could not provide at least one nurse per shift in each clinical area trained in Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training.
- The service had a backlog of children needing to be seen for certain specialities which meant children waiting long periods of time for surgical procedures.
- Staff were not always trained to look after complex patients requiring high dependency care.
- Medical records were not always kept safely and securely.

However we found:

- Learning from incidents was shared with staff through emails and team meetings. There were robust safeguarding policies and procedures in place.
- Equipment was checked and available for staff to be able to carry out their role.
- The service offered a holistic range of services to meet children and young people's needs.
- Medication monitoring practices were effective and medications were administered safely.
- Patients received evidenced based care and there was good multi-disciplinary working between nursing and medical teams.
- Staff were caring, compassionate and respectful to children, young people and their families.

Are services for children and young people safe?

Requires improvement 

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

- Training shortfalls existed in some areas, for example in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the RCN (2013) staffing guidance.
- LRI does not always meet the British Association of Perinatal Medicine (BAPM) standard due to vacancies, sickness and maternity leave.
- The service did not meet the trust target of 95% for all subjects covered under mandatory training for both medical and nursing staff.
- We found shortfalls in staff attendance at level three children's safeguarding training which did not meet the trust target of 95% and did not meet the safeguarding intercollegiate guidance recommendation that qualified staff groups are trained to a level three standard in safeguarding.
- Data provided by the trust for LGH and LRI demonstrated, as of July 2016, four out of 23 (17%) and 11 out of 16 (69%) of nursing staff were up to date with one day Paediatric Life Support training. This did not meet the trust target of 95% compliance.
- Infection prevention audits showed an improvement in compliance; however they remained below the trust target of 95%.
- The trust did not meet Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants.
- The staff knowledge of the Duty of Candour was not robust although it had been applied appropriately in an incident report we reviewed.
- The trust had a back log of 4565 letters for paediatrics starting from 12 March 2016.
- Medical records were not always kept safely and securely.

However, we found:

Services for children and young people

- Equipment was checked and available for staff to be able to carry out their role.
- Staff were encouraged to report incidents and raise concerns.
- Learning from incidents was shared with staff through emails and team meetings. There were robust safeguarding policies and procedures in place.
- Record keeping was good and documentation was in line with professional standards.

Incidents

- An incident reporting policy was available to staff and included the incident grading system and external and internal reporting requirements. Incidents were reported through the trust's electronic reporting system.
- There were no never events in this service between March 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm was not required to have occurred for an incident to be categorised as a never event.
- The trust reported 46 serious incidents between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant require a thorough investigation. Children and young people's service reported two serious incidents at this hospital classified as 'diverse media coverage or public concern about the organisation or the wider NHS' and a 'diagnostic incident.'
- Children and young people's services at this hospital reported 830 incidents from March 2015 to March 2016. Of these one resulted in major harm, two in moderate harm, 142 in minor harm and the majority, 685 in no harm or injury. Staff we spoke with told us they were not able to report all incidents due to staffing levels.
- Of the 830 incidents, 33 were reported as near misses. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so.
- The most frequently reported incident categories were injury to skin and tissue, 54 incidents were reviewed and time delay incidents 45 were reviewed. There was evidence of learning a checklist had been implemented to help prevent the damage to the neonates skin and tissue.
- At the time of our visit we saw 39 incidents had taken place at the Leicester General Hospital (LGH) neonatal unit from March 2015 until March 2016. Each incident was categorised and identified actions taken. Of these, five were in the category of minor harm and the majority (34) in no harm or injury.
- At the time of our visit we saw 319 incidents had taken place at the Leicester Royal Infirmary (LRI) neonatal unit from March 2015 until March 2016. Each incident was categorised and identified actions taken. Of these, two were in the category of moderate harm, 32 in minor harm and the majority, 285 in no harm or injury. Of the 319 incidents, 11 were reported as near misses.
- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incidents, complaints and significant events were discussed at clinical governance meetings, during the quality, safety and governance and at monthly trust board level meetings. Lessons learnt from incidents were shared with staff on notice boards or by email or with on an individual basis.
- Staff we spoke with said they received a weekly nursing update bulletin by email which contained any medical device alerts.
- We reviewed four serious incidents where a root cause analysis approach had been taken. Root cause analysis is an approach for identifying the underlying causes of why an incident occurred. We saw there had been full investigations, action plans and lessons learnt. One of these incidents had taken place from November 2015 to March 2016 within the children's hospital. We saw evidence of learning across the whole directorate following this incident. The outcome resulted in changes to processes, for example, all senior doctors on the paediatric intensive care unit (PICU) covering paediatric cardiology were given access to the computer system where information for cardiology patients was stored.
- Clinical performance data was captured monthly from each clinical area and reported within the 'Children's Services Quality Dashboard.' Minutes of the 'Quality, Safety and Governance group' (October, November 2015

Services for children and young people

and January 2016) confirmed discussion of ongoing performance and actions relating to dashboard data including mandatory training, safety issues and medication errors.

- The children's hospital and neonatal units had monthly mortality and morbidity review meetings. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed four sets of minutes (December 2015, January 2016, March 2016 and April 2016) which included lessons learnt, preventability and duty of candour implication. A presentation from the Perinatal Mortality Review Panel (April 2016) demonstrated shared learning and feedback to neonatology staff.
- Clinical staff we spoke with said they did not receive duty of candour training, although staff demonstrated some knowledge about the duty of candour regulation. However the trust told us that training had been offered through various forums. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We saw examples of where duty of candour had been applied appropriately. These incidents included parents being informed of a surgical complication relating to an error in a surgical technique.
- The trust provided a booklet 'Being open' to parents explaining the process of Duty of Candour in terms that they were able to understand.

Cleanliness, infection control and hygiene

- The Leicester Royal Infirmary participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 97.1% which was better than the England average of 95.5%. We did not have data specifically for the children's and young people's service.
- All areas we visited appeared visibly clean.

- There were 65 cases of Clostridium difficile (C. difficile) infections between April 2015 and April 2016 with 5 cases occurring in the children and young people service. C. difficile is an infective bacteria that causes diarrhoea related to the use of antibiotics, and can make patients very ill.
- MRSA is a bacterium responsible for several difficult-to-treat infections. Between April 2015 and April 2016 there were 11 cases of MRSA bacteraemia reported at this trust with zero cases occurring in the children and young people service.
- Meticillin sensitive Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between April 2015 and June 2016 there was one recoded case of MSSA bacteraemia within the children and young people service.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits against key policies. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
- Results for December 2015 for two out of five of the elements of the audit; before patient contact and, after patient contact demonstrated 60% and 78% compliance respectively across 16 clinical areas within Women and Children's clinical management group. This was better than the trusts overall compliance figures but worse than the trust target of 90%.
- Monthly infection and prevention environmental audits demonstrated 57% (March 2016) and 73% (April 2016) compliance. The auditor clearly documented feedback and actions for the leads to implement.
- We observed staff using hand gel sanitiser prior to and after treating patients; they were placed in locations for staff and visitors to use.

Environment and equipment

Services for children and young people

- The Leicester Royal Infirmary participated in the 2014 Care Quality Commission (CQC) Children and Young People's Survey. This is the first national children's survey conducted by CQC. It represents the experiences of nearly 19,000 children and young people who received inpatient or day case care in 137 acute NHS trusts in 2014. The trust scored nine out of ten from parents and carers of children aged nought to fifteen for the question 'Did the ward where your child stay have appropriate equipment or adaptations for your child?' This was about the same as other trusts.
- Emergency equipment and resuscitation equipment was checked daily and maintained according to manufacturers' instructions which ensured it was safe to use.
- Entrance doors to children's areas were locked and accessed by staff with electronic swipe cards. Visitors had to ask staff to leave the locked areas.
- There were no ligature cutters on the ward areas if they were needed, however no ligature points were identified on the wards and the windows opened to a small gap of 10 centimetres.
- Ceiling tracking on ward 14 enabled easier access to the hoist system to facilitate moving and handling. There was access to a specially adapted bath for patients with physical difficulties.
- A multi-sensory room provided space for children and young people to "escape" from the regular ward environment.
- Side rooms were available to reduce stimulation for youngsters who were prone to an increase in seizures or where greater degree of privacy was required.
- Portable multi-sensory units were available on both of the children's intensive care units and the high dependency unit for children who have varying degrees of cognitive (the mental process of knowing) impairment.

Medicines

- Medicines management was in line with policy, medicines were locked in cupboards the nurse in charge carried the controlled drug keys which were separate from the ward keys. We reviewed 12 drug charts, allergies were recorded if appropriate and no gaps were seen against the entries.
- We saw that staff used local trust protocols when administering medication for babies, children and young people.

- At the Leicester Royal Infirmary (LRI) hospital between June 2015 and May 2016 there were 208 medication errors reported in paediatrics 194 were 'no harm' and 13 were 'minor harm'. In the neonatal unit there were a total of 137 medication errors of this 136 were reported as 'no harm' and the one was 'minor harm'. At the Leicester General hospital (LGH) there was a total of 16 all were classified as 'no harm' for the same period.
- In response to the increase medication incidents the service added this to their risk register. Medical staff completed a medicines learning package and it was added to mandatory training.
- One fridge which contained expressed breast milk also stored food items and was not locked. The rom was locked but could be accessed by mothers and their visitors in an unsupervised capacity as breast pumps were located in the room. This meant it was not protected from tampering and anyone could gain access.
- Daily checks of the temperature of the drug fridges had taken place from Monday to Saturday we saw records of checks confirming this.

Records

- We reviewed 13 care records which were up to date, and reflected the needs of each individual child and young person. We saw examples where clinical staff had updated individual records immediately after each consultation.
- Entries in records were signed and dated, so followed good practice guidelines on record keeping from professional bodies such as the General Medical Council and the Nursing and Midwifery Council.
- Risk assessments were completed for example we observed the proforma to prevent pressure sores paperwork being completed.
- Medical records were not always kept safely and securely, we saw records left unsupervised. Trolley were lockable however we saw the code to the open the trolley on a sticker next to the key pad lock. Which meant the public could get access to the records.

Safeguarding

- The trust had a safeguarding children's policy (review November 2018) with reference to child abduction (Appendix 19) and a current Safeguarding Supervision policy (review April 2019).

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- The trust had a safeguarding lead at executive level in addition there was a named paediatric consultant and local named leads for children and adult safeguarding.
- The number of children's safeguarding referrals or alerts received by the trusts safeguarding teams for 2015 was 7921; this was a significant increase in comparison to 5478 referred in 2014. In response to this there has been further investment to improve access to the specialist safeguarding teams and increased visibility within clinical areas.
- The Intercollegiate safeguarding guidance recommends qualified staff groups are trained to a level three standard in safeguarding. Staff attended level one and two child safeguarding training, initially at trust induction and then during annual mandatory safeguarding training. The safeguarding team provided safeguarding training at level three. All levels of training included female genital mutilation (FGM) and child sexual exploitation (CSE). The trust-training target was 95%; in 2015-2016, the service confirmed as of July 2016 between 55% to 73% paediatric consultants, 87% to 100% of nursing staff, 50% to 100% non-registered nursing staff, 37% Advanced Neonatal Nurse Practitioners (ANNP), 100% specialist nurses had completed level three safeguarding training. As of July 2016 a total of 57 out of 73 doctors had completed level three safeguarding training for children's services within the Women's and perinatal services however, children's hospital site specific data was not provided.
- The trust followed the Local Safeguarding Children's Board (LSCB) core competency framework and the intercollegiate document Protecting Children and Young People: The responsibilities of all doctors, General Medical Council (2012). A joint safeguarding review group was held monthly to discuss cases, experiences and learning.
- All named safeguarding leads received one-to-one safeguarding supervision however; matrons and designated safeguarding link staff provided safeguarding supervision for all other staff as required. The trust acknowledged they planned to extend supervision opportunities and would be offering 12 members of staff places to undertake safeguarding supervision in September 2016.
- Staff guidance notes for the management of women who had undergone FGM, a flow chart and information links were available on the trust website. The trust also undertook mandatory reporting of FGM to the Home Office. Data provided by the trust showed there were 53 cases reported by staff at Leicester Royal Infirmary and 32 cases reported by staff at Leicester General Hospital.
- The trust followed the Local Safeguarding Children's Board (LSCB) policy related to CSE. Staff accessed guidance notes for the management of children suspected of suffering from CSE from the trust website. The trust was in the process of adding a list of children at risk of CSE to the main computer system with alert flags attached.
- FGM and CSE was a standing agenda on the trust's Safeguarding Assurance Committee (SAC) monthly meeting (April 2016).
- The trust had nine serious case reviews (SCR) which were responded to through involvement and engagement with partner agencies. Shared learning and development of procedures included a neglect tool due for launch in July 2016. The trust's SAC monthly meeting between April 2016 and May 2016 demonstrated evidence of learning outcomes and trust board priorities. A SCR action plan devised with other partner agencies demonstrated key learning themes for the trust such as ensuring the central computer system recorded multiple attendances.
- The trust scored 9.4 out of 10 from parents and carers of children aged eight to fifteen for the question 'Did you feel your child was safe on the hospital ward' which was about the same as other trusts and 9.8 out of 10 for the question 'Did you feel safe on the hospital ward?' which was better than other trusts.
- There was a 'traffic light system' within the trust safeguarding children's policy designed to support staff to identify a process to follow to address the safeguarding needs of a child or young person. The system included 'red' for child protection, 'amber' for safeguarding concerns and early help and 'green' for information only. Staff we spoke with were aware of this guidance how to access it.
- The trust confirmed there was no automatic system to identify children subject to a child protection plan and due to the volume of children using the service it was impractical to ring and check with social care for every attendance. The trust had signed a commitment to use the national Child Protection Information Sharing Project (CP-ISP) once this was available in the region.

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day, pain study day and safe care and communication day. An action plan to assist the development of qualified nurses to record their progress and areas of development was in use. Staff we spoke with described an induction and competency pack they completed when new to the trust.

- Mandatory training for all staff groups included fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (level one and two), conflict resolution, safeguarding adults (level one), health and safety, basic life support, consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.
- The trust reported all mandatory training data under the clinical management group 'women's and children's' but information wards could access live data through the 'Team Builder System' to see a breakdown for individual areas.
- We submitted an information request for the percentage of paediatric medical and nursing staff attendance at mandatory training for 2015/16 for the children's and young people's service.
- Training statistics for the 2015 to 2016 training year for the whole directorate demonstrated staff were below trust target of 95% for attendance for completion of mandatory training. Data confirmed six subject areas out of 11 for qualified nursing staff which included information governance (85%), consent, MCA and Deprivation of Liberty Safeguards (63%), fire safety (87%), moving and handling (94%), infection prevention (89%) and basic life support (91%).
- For medical staff all 11 subject areas were below target which ranged from 44% consent, MCA and Deprivation of Liberty Safeguards and 88% for equality and diversity and health and safety. For non-qualified nurses six out of 11 subject areas included consent, MCA and Deprivation of Liberty Safeguards (63%), basic life support (82%) and fire safety (85%). For allied health professionals seven out of 11 included consent, MCA and Deprivation of Liberty Safeguards (39%), basic life support (73%) and information governance (81%).

Assessing and responding to patient risk

- The trust was working in partnership with another acute trust to establish a Paediatric Intensive Care Transport service alongside the well-established Centre Newborn Transport service to ensure children are in the right hospital, at the right time, for the right care.
- Staff told us the service had daily safety huddles where a member of staff from each area attended to discuss activity, staffing, risks and other issues relevant to the service. They did not record the huddles which meant we were unable to confirm they took place daily.
- The paediatric early warning score (PEWS) and the neonatal early warning score (NEWS) were additional tools used to monitor children and babies who may be at risk of deterioration to record routine physiological observations such as blood pressure, temperature, and heart rate. PEWS and NEWS were used to monitor patients and initiated calls to the medical staff when required.
- Patients with a suspected infection or a PEWS or NEWS of three or more, or those for whom staff or relatives had expressed concern were screened for sepsis, a severe infection which spreads in the bloodstream.
- Patients treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions increase survival from sepsis. There is strong evidence the prompt delivery of basic aspects of care detailed in the sepsis six bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- During our inspection of this hospital we reviewed 14 patient observation charts across four clinical areas. All charts we reviewed had full observations and pain scores completed and recorded. Nursing staff completed PEWS scores at each time of recording the patients' observations and calculated correctly. A patient's intake and output was recorded on fluid balance charts. Of the six patients requiring fluid balance charts all were up-to-date and accurately calculated. However, we found nursing staff did not always adhere to trust guidelines; eight out of 14 charts did not have the frequency of observations recorded on the observations charts.
- Patients triggering on their PEWS required specific actions to be carried out, for example, the nurse in charge must be notified to review a patient with a PEWS score of two. We saw two patients had triggered two on

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their PEWS we did not see evidence they had been reviewed by the nurse in charge, there was no entry on the observation chart to indicate a call had been placed to alert the nurse in charge.

- We saw one patient who scored a PEWS of three reviewed appropriately by a doctor and the nurse in charge, a plan of care was made which was documented in the notes.
- We saw one child who had scored a PEWS of three with a raised temperature who was screened for sepsis in line with the trust sepsis pathway, they did not require any intervention, but appropriate escalation took place.
- All children attending the Children's Assessment Unit were screened for sepsis on admission; we reviewed three patient admissions and found this to be the case.
- We noted one of the sepsis screening criteria on the sepsis proformas, stated the proforma should be completed using agreed criteria. One of the agreed criteria on the sepsis proformas was to document if the capillary refill time was above three seconds, this was the time taken for colour to return to an external blood vessel after the application of pressure to cause blanching). However, we could not see any prompting on the PEWS charts to remind staff to perform this. Which meant there was a potential risk some children may not get appropriate screening for sepsis should they meet the criteria.
- Data provided by the trust demonstrated the Leicester Royal Infirmary (LRI) had a back log of 4565 letters for paediatrics starting from 12 March 2016. A statement provided by the trust stated they were working in partnership with an external provider to reduce the backlog over a 12 to 14 week period with priority focusing on the oldest waiting letters first. Weekly monitoring of progress against planned activity was on-going. This was a new addition to the children's risk register as referenced in the Children's Hospital Quality, Safety and Governance meeting minutes (May 2016). We were not assured that clerical backlogs were not affecting children's safety by delays in referral and prompt treatment.

Nursing staffing

- Planned nursing staffing levels across the 12 clinical areas totalled 459.3 whole time equivalents (WTE). Data for March 2016 showed actual staffing levels to be 399.1 WTE giving a combined vacancy rate of 13%. Vacancies varied across clinical areas with vacancy figures of

between 1.4 WTE and 16.3 WTE. The top three areas with the highest vacancy rates were at the Leicester Royal Infirmary (LRI) neonatal unit (16.3 WTE), children's intensive care unit (8.2 WTE) and ward R10 (8 WTE).

- Reduced staffing capacity was recorded as an issue on the trust's Women and Children's clinical management group risk register. All staff we spoke with were aware of how to report and escalate staffing issues to their ward manager.
- LRI did not always meet the British Association of Perinatal Medicine (BAPM) standard because of vacancies, sickness and maternity leave. The service had funding to recruit 11 whole full time staff. There was an active recruitment campaign ongoing. We were told that sickness was actively managed and the service tried to backfill maternity leave.
- The trust identified they did not have one nurse per shift with either the Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training. The trust highlighted none of the ward areas currently have up-to-date APLS competence. In the interim the higher dependency wards have an increased percentage of staff with one day Paediatric Life Support training. This did not comply with the Royal College of Nursing (RCN) 2013 standard Defining safe staffing levels for children and young people's services of at least one nurse per shift in each clinical area to be trained in APLS or EPLS. We could not be confident safe care and treatment would be provided in a safe way for patients.
- Data provided by the trust for LGH and LRI demonstrated, as of July 2016, between four out of 23 (17%) and 11 out of 16 (69%) of nursing staff were currently in date (the last four years) for one day Paediatric Life Support training. This did not meet the trust target of 95% compliance.
- The children's service prioritised the provision of access to courses for intensive care unit staff but recognised high dependency areas and the Children's Admission Unit (CAU) were also high priority areas. Due to limitations of education funding the service were exploring different ways of funding to meet the current need.
- The Paediatric Intensive Care Unit (PICU) had some members of staff previously trained in APLS but required their three yearly update. A total of nine staff were up-to-date with their APLS competencies. Staffing rotas for a four week period between May and June 2016 for

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the PICU at the Leicester Royal Infirmary demonstrated a member of staff trained to APLS competence covered 94% of day and night shifts. This did not comply with the Royal College of Nursing (RCN) 2013 standard.

- The trust confirmed staff receive training on 'recognising the sick child' as part of their basic life support training which was incorporated in the mandatory training.
- The average nursing agency usage for April 2015 to March 2016 across the children and young people's service was noted to be between 0.1% and 5.4%.
- Staff told us there were three nursing handovers a day, the trust told us these were verbal and recorded electronically.
- Outpatients had a communication book to support the verbal handover between staff this ensured that everything was discussed for staff to be fully aware of activity.
- All staff we spoke with said their worry was staffing, although they did not always complete an incident form when they were short staffed.

Neonatal staffing

- Neonatal staffing at the Leicester Royal Infirmary (LRI) neonatal unit did not fully meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM) because they were unable to provide one nurse to one baby care in the intensive care unit for all babies. Information provided by the trust stated this was due to staff vacancies, sickness and maternity leave. Funding was available to recruit a further 11 WTE staff and there was an active recruitment campaign.
- Inadequate neonatal staffing and skill mix levels to meet clinical requirements was highlighted as a current risk on the Women and Children's clinical management group risk register (opened 2006). Information provided by the trust recorded current controls in place and a summary of actions being undertaken. On our visit to the neonatal unit the acuity required 14.9 staffing and on shift actual staffing was 10. Staff told us if they did not get breaks during a shift they were paid overtime for not getting a break.
- The neonatal service had seven full time equivalent advanced neonatal nurse practitioner (ANNP) posts which contribute significantly to medical rotas and provide advanced nursing support and education

across the service. They work at both the LRI and Leicester General Hospital (LGH) neonatal units and rotate between these sites three monthly. There were two trainee ANNP's completing training this year (2016).

- A critical care and critical care transport team was available to transfer ill babies. A neonatal nurse and paediatrician would accompany the baby in an emergency or routine transfer to ensure staff were qualified to assess for any deterioration of condition.
- The trust neonatal service nursing staff escalation policy (June 2016 to June 2019) for short term management of staff shortage and capacity issues was used to identify problems when they occurred during shifts. An incident report was completed for shifts, which were calculated to be below requirements, according to the neonatal risk rating.
- Staffing incidents were discussed and actions planned with the matron on a daily/weekly basis, at monthly ward sister review and shared at the monthly safer staffing meetings. One staffing incident (June 2016) related to the neonatal unit regarding a shortage of nursing staff and over capacity of the unit by three extra cots being opened and saw appropriate escalation and measures were in place.
- Between May 2016 and June 2016 there was one incident recorded (June 2016) for the LRI neonatal unit relating to staff shortages. The neonatal unit had three babies over the recommended staffing capacity with the potential of more births on the delivery suite. Action was taken as stated in the escalation policy and there was evidence of lessons learnt.
- Measurement of the intensity of nursing care required by patients was recorded four times per day. Escalation pathways were in place which worked effectively and nursing staff worked across the units when gaps in staffing had been identified. Seven advanced nurse practitioners worked across the LRI and the LGH sites to ensure the units were safe.
- All staff we spoke with and asked them what was their worry told us it was staffing although they did not always complete an incident form when they were short staffed.

Medical staffing

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- The children's service confirmed they were compliant against the Royal College of Paediatrics and Child Health (RCPCH) and the British Association of Perinatal Medicine (BAPM) consultant staffing standards and guidelines.
- Information provided by the trust showed the service had a total of 112 WTE medical staff, 35 (31%) of the 112 were consultants which was in line with the England average and 17 (15%) of the 112 were junior doctors which was a larger proportion than the England average.
- A consultant paediatrician was available in the hospital during peak activity seven days a week. The escalation plan for the children's assessment unit (updated October 2015) established a confirmed their role during the escalation phase.
- An anaesthetic consultant and intensivists were available out of hours to provide anaesthetic advice and support for children's services.
- We observed a critical care paediatric handover and saw they were thorough, with clear plans and actions identified for each child. The handover included discussions about newly admitted children and those who were unwell or required some input.
- The average medical agency locum usage for April 2015 to March 2016 across the children and young people's service noted to be between 0.7% and 27.4%. However, agency use in paediatric surgery noted to be between 4.0% and 27.4% across the same reporting period.
- Information provided by the trust and staff confirmed the paediatric assessment unit had access to the opinion of a consultant paediatrician at all times.
- The paediatric inpatient units adopted an attending 'consultant of the week' system. This model of care was to improve quality, ensure good handovers and improve communication with patients and their families.
- Information supplied by the trust stated all general paediatric rotas were compliant with the European Working Time Directive and Regulations. Medical staff told us they had 8.4 whole time equivalents and used locums to ensure compliance.
- Specialist paediatricians were available for immediate telephone advice for acute problems twenty four hour per day for diabetes, oncology, haematology, cardiology, extracorporeal membrane oxygenation (ECMO), cardiac surgery, general and ear, nose and

throat surgery. Respiratory, allergy, immunology, neurology and gastroenterology specialist advice was available until 10pm and then covered by the on call paediatrician overnight.

- Only medical staff who were a specialist trainee level (a doctor who has between three and seven years' experience) or above could discharge a child who had been admitted with an acute medical condition. Discharge for children referred for acute medical treatment is covered by a number of protocols and policies. We reviewed six which gave clear guidance of the level of medical staff that should assess and discharge the child.

Major incident awareness and training

- The trust had a Part A major incident plan and Part B for clinical management group service area response plans which ensured critical services were delivered in exceptional circumstances.
- Part B identified specific roles for children's services including measures put in place should a major incident take place. It identified responsibilities including coordinating activity using the Paediatric Network Major Incident Plan, a statement from the trust confirmed this was not currently in place and clarification was being sought from NHS England, however, work was on-going nationally to assess how the network functions due to be tested on June 2016.
- Escalation plans were available for the Children's Hospital, Paediatric Intensive care and the Children's Assessment Unit. We observed that the major incident planning protocol was displayed for staff to refer to when necessary.

Are services for children and young people effective?

Good



We rated the effectiveness in the children's and young people's service as good.

We found:

- Overall the service provided effective services to the local population. Multi-disciplinary team working had resulted in positive outcomes for babies, children and young people.

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- Staff delivered programmes of assessment, care and treatment in line with standards and evidence based guidance.
- There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health professionals.
- Consent was always sought appropriately dependant on the circumstances, from parents, children and young people.
- Staff in children's and young people's services had received an appraisal which met the trust target.

However we found:

- The service had not achieved three of the five standards of the neonatal audit programme (NNAP) 2014

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care.
- We reviewed eight evidenced based guidelines which included acute asthma, acute kidney injury, and urinary tract infection. All of these were within their review by dates and evidenced based.
- Guidelines were available on the trust's intranet homepage for staff to access and refer to.
- The neonatal unit participated in the 'UNICEF Baby Friendly Initiative' which is designed to support breastfeeding and parent-infant relationships by working with public services to improve standards of care.
- A number of evidence based protocols, care bundles and policies including bronchiolitis (review December 2016), asthma management (review June 2019) and croup (review December 2016) were available for reference on discharge for children referred for acute medical treatment.

Pain relief

- A named consultant paediatric anaesthetist led the children's pain management team. In addition there were 1.4 whole time equivalent specialist children's pain nurses with non-medical prescribing skills.

- The team performed daily ward rounds and followed up children receiving morphine (a strong pain medication to relieve pain) and epidural pain relief (an injection of pain-relieving medicines into a space that surrounds your spinal cord).
- The pain management service was available Monday to Friday 9am to 5pm with nursing advice and 24 hour answerphone cover for referrals and advice for the Children's hospital and theatre recovery.
- Out-of-hours an anaesthetist was on call for complex pain issues.
- The service provided different types of pain relief which included morphine infusions, epidurals, patient controlled analgesia (PCA) and regional pain relief.
- The service undertook pre-admission pain consultation with the child and family prior to extensive surgeries requiring epidural or morphine pain relief. Non-pharmacological therapies such as heat/cold packs, diversion and transcutaneous electrical nerve stimulation (TENS) therapy were offered.
- The team provided education and support for the multi-disciplinary team, pre-registration nurses and medical students.
- Nursing staff used a pain assessment scoring flowchart and child pain assessment tools. We reviewed two pain assessment charts and saw the pain scores were recorded as per trust guidance.

Nutrition and hydration

- The Baby Friendly Initiative (BFI) is a worldwide programme. The Organisation and UNICEF established in 1992 to encourage maternity hospitals to implement the ten steps to successful breastfeeding. The neonatal unit achieved BFI Stage Two Baby Friendly Accreditation in 2013. Stage two of the programme involved the assessment of staff knowledge and skills, they continued to work towards stage three full accreditation.
- Nutritional requirements were calculated and recorded in the care plan. Staff supported women with their choice of feeding their baby.
- The service assessed nutrition by completing a malnutrition score proforma. This had a clear pathway for staff to follow depending on the result of the assessment. Staff we spoke with said they were able to gain access to the dietician easily.

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- Dieticians attended the multidisciplinary team on ward rounds to support the child's nutritional needs or staff can refer to a dietician if necessary.
- The teenage and young people oncology ward had a dedicated chef we observed them asking oncology patients what they wanted to eat. There was no time limit of meal times for this group of patients to enable them to eat when they felt able to.

Patient outcomes

- The trust met the recommended national level for two of the five standards and almost met the remaining standards in the national neonatal audit programme (NNAP) 2014. For example, 98% of babies, less than 29 weeks gestation had their temperature taken within the first hour of birth and antenatal steroid use was 86% in 2014.
- One of the three NNAP standard not achieved was, the trust scored 94% compared to a national standard of 100% for screening eligible babies for Retinopathy of Prematurity and 99% against a standard of 100% for consultations with parents within 24 hours of admission.
- An audit conducted May 2016 reviewed the procedure appendectomy (surgery to remove an appendix), it showed the service had not met the service target of above 90%, however there was an improvement from 69% to 82% for decision to surgery within 12 hours. Learning points were identified and share to improve patient's experiences.
- The trust scored about the same as other trusts for six out of the eight questions related to effectiveness in the 2014 Care Quality Commission (CQC) Children and Young People's Survey. The remaining two questions scored worse than other trusts. This was not broken down to ward areas within the service.
- The clinical audit and quality improvement plan for 2015 to 2016 identified 117 audits the service was undertaking and the lead for each audit. Of the 117 audits 92 were in children's services and 25 were in neonatology. It identified the children's service had taken part in a number of national audits, for example, the diabetes and epilepsy 12 audits.
- The service audited compliance with High Impact Intervention Care Bundle for the Management of Peripheral Vascular Devices quarterly. The last audit results from May 2016 showed the overall care bundle compliance had improved from the previous quarter from 79% to 81%. There were actions with a deadline date to improve the visual infusion phlebitis (VIP) score and label the infusion lines.
- The National Paediatric Diabetes Audit completed from April 2013 to March 2014 demonstrated a similar percentage of children have well controlled diabetes compared to the average for England. The indicator regarding diabetes control was the same as the England average.
- The Epilepsy 12 National Audit January 2013 to June 2015 demonstrated significant improvement in care during its first five years.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care was delivered and to achieve transparency and overall improvement in healthcare. For patients this means better experience, involvement and outcomes. The proportion of children who received appendectomy surgery within 12 hours of the decision being made in April 2015 to April 2016 was 82%. This was below the CQUIN standard of 90% for 2015 – 2016; however, the target (less than 15%) was met for diagnostic accuracy (8%) for the same time period.
- For the period December 2014 to November 2015 the trust had lower emergency admissions than the England average for the rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes.
- For the period November 2014 to October 2015, the trust's readmission rate within two days of discharge for non-elective babies less than one year of age in the paediatric specialty was low, indicating fewer individuals were re-admitted to hospital than the England average. The rate was lower than the England average for non-elective one to 17 year olds.
- The multiple admission rates within 12 months for one to 17 year olds with asthma was 14.1%. This was similar to the England rate of 16.5%. However, a comparison cannot be made for babies less than one year old, or for children with diabetes or epilepsy due to the small numbers of multiple admissions. The trust did not have enough re-admissions for elective specialties to make a comparison.
- Surgical Safety Checklist (previously referred to as WHO audits) audits had taken place. The audit was

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completed to show compliance with the World Health Organisation (WHO) surgical safety checklist documentation. Between April 2015 to February 2016 data demonstrated 90% to 100% compliance relating to indicators such as patient dignity, resuscitation equipment, observation and safety. The data provided was for adult and paediatric patients as the information could not be separated.

- The results of the children's survey scored 9.4 for parents who felt their children were safe on the ward this was about the same as other trusts.

Competent staff

- Appraisal rates at Leicester Royal Infirmary for the reporting period April 2015 to March 2016 averaged 94% across all staff groups within children and young people's services this met the trust target of 90%. This was better than previous years with appraisal rates at 87%.
- Appraisal rates at Leicester General Hospital for the reporting period April 2015 to March 2016 averaged 91% across all staff groups within children and young people's services. This was better than previous years with appraisal rates at 90% for April 2014 to March 2015.
- Information provided by the trust demonstrated nursing staff as 100% compliant for medicines management training at the LGH neonatal unit as of July 2016. Neonatal nursing staff demonstrated 85% compliance and neonatal unit specialist nurses were 64% compliant at the LRI as of July 2016. Compliance for the same period for paediatric nursing staff at the LRI paediatric service ranged from 64% for children's management to 100% for clinical areas.
- Staff we spoke with told us they received comprehensive inductions. They had eight weeks induction and completed their induction pack and a following eight weeks with a preceptor.
- Staff working with neonates rotated across hospital sites to enable them to update their clinical skills.
- The five steps to safer surgery training were covered in all preceptorship training for new starters in theatres. This was also included in the safer surgery e-learning module, theatre processes and competency packages for theatre staff which outlined the expectations of their role in the process of safer surgery.

- Ten anaesthetists with children's experience were allocated to the children's surgical team to provide specialist care to children having surgery. This ensured that children were treated by anaesthetists with paediatric knowledge whilst they were anaesthetised.
- Registered children's nurses provided recovery care to children following their operation.
- We spoke with nursing staff who were providing care to high dependency neonatal patients they told us they had not received formal training and had not completed Qualified In Speciality (QIS) Neonatal nurses training or completion of the high dependency unit training module.

Multidisciplinary working

- The children's hospital provided the Leicester Airway and Home Ventilation Service (LeAHVes) in collaboration with another community service providing care and support for children and families requiring special nursing care in a community setting. This team won an award in 2015 recognising the collaborative work undertaken between hospital and the community to improve care for children and young people who require long term ventilation.
- A multi-disciplinary team which included the play team, speech and language specialists, occupational therapy and the Children's Hospital school supported children and young people with communication disorders, physical disabilities, long term conditions, special educational needs and end of life care.
- Within the cardiac services a yearly bereavement day was organised by the specialist cardiac liaison nurses for families.
- A community nursing service (who specialise in oncology), managed by another provider supports the Children's hospital. The service provided nursing and supportive family care to children aged nought to 18 years and their families who were under the care of a paediatric oncology or haematology consultant, from diagnosis and throughout the disease process. Hospital staff were aware how to refer to this service.
- Senior medical staff attended a regional general paediatric network, minutes from the meeting (March 2016) recorded discussions of topics which included patient information leaflets, regional radiology services and proposed regional website for Children's Specialised Health Services.

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- We were given good examples of MDT working to improve patient experiences. For example the pathway for Antenatal Renal Pelvic Dilatation (ARPD) held a MDT clinic which included the urologist surgeon, paediatrician, neonatologist and the renal team.
- Staff explained the importance of cross service working to ensure the family, continuing care and outreach team within the neonatal service assists families during their baby's stay, discharge preparation and liaises with allied services in the community to ensure ongoing care and support was provided.

Seven-day services

- Twenty-four hour paediatric and neonatal consultant support was in place. The consultant rota provided details of which paediatricians to contact each week.
- Seven day scheduled services for in-patients included x-ray, ultrasound scanning, computed tomography (CT) and magnetic resonance imaging (MRI).
- Out of hours a pharmacist was on call to answer any questions staff may have.
- Staff told us the Children's Adolescence Mental Health Service (CAMHS) was available 24 hours a day seven days a week. The number for contacting them was displayed on the wall.

Access to information

- Parent and child information leaflets on pain relief after surgery were sent out pre-operatively for planned surgery and available on the wards for unplanned surgery.
- The trust audited and recorded all information sharing agreements yearly which were reported to the information governance steering group for Caldecott Guardian information. Caldecott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The sharing agreements included guidance related to what and how data would be shared, how consent would be obtained, how dissent would be managed, what security would be in place to secure the information and which parties the information would be shared with.
- In one area the names of the patients were on a board in reception which was visible to the general public which meant patients could be identified.

Consent

- Staff were informed of the consent process and understood the Gillick competency and the Fraser guidelines, (used to decide if a child is mature enough to make decisions about their care and treatment). Staff we asked about consent were aware of the pathways and could explain the two processes.
- The trust had an up-to-date consent to examination or treatment policy (October 2018) which included the Deprivation of Liberty Safeguards, Mental Capacity Act guidance and Gillick competence.
- Staff received education on Deprivation of Liberty Safeguards and the Mental Capacity Act as part of mandatory training. The most recent directorate training figures provided by the trust demonstrated completion rates within children's services for allied health professionals as 39%, doctors were 44%, non-qualified nurses and qualified nurses as 63%. This was below the trust target of 95%.
- The trust had a safeguarding children's policy (review November 2018) which provided guidance for staff, a check list to confirm parental responsibility. This was also confirmed and documented as part of the admission process. We observed evidence of parents being asked the check list and saw staff document in the medical records.

Are services for children and young people caring?

Good



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

We found:

- Children, young people and their parents said they had received compassionate care with good emotional support.
- Parents and young people said they were fully informed and had been involved in decisions relating to their treatment and care.
- Facilities for both parents and children were satisfactory and support had been provided by the multi-disciplinary team during the child's admission, stay and in preparation for their discharge home.

Compassionate care

Services for children and young people

- Throughout our inspection, we observed members of medical and nursing staff provided compassionate and sensitive care met the needs of babies, children, young people and their parents and carers.
- Feedback cards and comment boxes for parents to use were available throughout the service. The friend and family score for May 2016 was between 92% and 100% for all areas of children's and young people's services.
- Staff had a positive and friendly approach and explained the care they were giving, for example when completing their clinical observations.
- In the 2014 Care Quality Commission (CQC) Children and Young People's Survey, for the question are staff caring, the trust scored 'about the same as other trusts' for 26 out of the 27 (96%) and 'better than other trusts' for 1 out of 27 (4%).
- The teenage and young adult integrated cancer service undertook a patient experience survey in September 2015. General comments included, 'excellent service, felt informed about the treatment, rooms were well equipped and we always felt looked after.'
- We reviewed the NHS Friends and Family Test results in the children and young people's service for the period March 2015 to March 2016. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The FFT information received from all children's wards was 97%.
- We observed nurses being sensitive and caring with children remaining calm and assuring with them and their parents, especially during stressful procedures for example anaesthesia for surgery.
- The service used red dignity pegs to indicate that staff could not access certain consulting rooms in clinic.
- The young people we spoke with told us when they needed a nurse it did not take them long to respond and were approachable and helpful.
- One mother told us she had been given several different explanations of what was wrong with her baby. She felt some staff were patronising towards her because of her young age although they were certain members of staff they were caring.
- Sensory equipment was available for children and young people to access if they wanted time out or a quieter experience. The emphasis of this equipment is to encourage interaction, learning and to offer children control over their surroundings.
- Two parents told us their babies on the neonatal unit always had good care from the staff.
- Visiting times were flexible and there were facilities for parents to stay with their children. This meant they were involved with all of their child's care and could ask questions if they did not understand treatments.
- All parents we spoke with felt involved with the decision making of their child's care and felt that everything had been explained to them.
- The view of a parent of a child with a learning disability was they had really motivated play staff but there was no real understanding of complex learning disabilities and how to support parents of those children.

Emotional support

- A community child and family support service nursing team managed by another provider supports the Children's hospital. The service helped children, young people and their families to understand their thoughts and feelings about how they are being affected by illness by offering emotional support, using counselling techniques, and encouraging special therapeutic play to help children and young people express themselves.
- A mother on the neonatal unit told us they were pleased with the care and had good emotional support. If required the bereavement midwife would support parents for bereavement or bad news.
- There were 2.5 whole time equivalent (WTE) Acute Liaison Nurses (ALN) who provided advice and support to patients admitted to the trust who had a learning disability. In addition to this a flagging system linked to the Leicestershire Learning disability register alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- Staff were confident to refer children to Children's Adolescence Mental Health Service (CAMHS) if they required a review of their emotional or psychological well-being.

Understanding and involvement of patients and those close to them

- We spoke with 10 parents and four young people about their experiences. Nine parents told us they had been involved in and were happy with the care and treatment their children had received.

Services for children and young people

Are services for children and young people responsive?

Requires improvement

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

We found:

- The service was not always able to take neonatal admissions due to 100% cot occupancy. At the time of our inspection the unit was over capacity in the number of babies being cared for.
- The service did not meet several targets regarding medical reviews in defined timeframes.
- There was backlog for patients waiting for ear, nose and throat treatment.

However we found:

- Children and young people had a choice of services at various locations and times to access health care and or support.
- The service offered a holistic range of services to meet children and young people's needs.
- Parents and staff we spoke with told us that the care delivered within the neonatal unit, children's ward and paediatric clinics had met their needs.
- Parents were aware how to complain and the service used feedback constructively to improve care.

Service planning and delivery to meet the needs of local people

- The teenage and young adult integrated cancer service had a coordinating parent and carer representation group since 2010. The group met every three months with the cancer management team and specialised commissioning.
- The Children's Hospital project board have parent and carer representation. As part of the engagement the service use social media to communicate with trust members.
- Out of 41,434 imaging tests 2,942 (7.1%) were conducted in a predominantly adult setting.
- Listening into Action (LiA) was a comprehensive, outcome-oriented approach to engage all the right people behind quality outcomes. The Cystic Fibrosis

home care team ran a LiA event in June 2014 for children and young people to allow them the opportunity to contribute to service planning and delivery.

- The trust engaged with local faith representatives through the chaplaincy and through representation on the Trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- The service provided a drop in coffee morning group for parents to access which provided additional support for them.
- Areas in outpatients had suitable waiting areas for children with activities to occupy them while they waited for their appointment.
- Patients aged 17 to 18 years old were offered the choice to see a paediatric or adult consultant. Managers we spoke with were aware that the transition from child to adult services needed developing.

Access and flow

- Information provided by the trust demonstrated the Leicester Royal Infirmary (LRI) hospital neonatal unit was closed to admissions for a total of 57 days between January 2016 to 20 June 2016, due to 100% cot occupancy.
- The neonatal unit the LRI was frequently full and at the time of our inspection was over capacity by three babies, having 31 babies when usual capacity was 28 cots. Staff and parents told us of examples where babies were receiving care at other hospitals, often some distance away. This caused added stress and practical difficulties for families, particularly where they had other children to care for.
- Data from the trust demonstrated clear admission pathways for the Children's Hospital which included walk in and ambulance presentation via the emergency department or referral to the Children's Assessment Unit (CAU) by a health care professional. The service could not provide data on the length of time children spend in the CAU as this was not audited.
- We reviewed the children's hospital 18 week referral to treatment performance data (June 2015 to May 2016) for admitted and non-admitted performance against each speciality. During the 12 month period the monthly

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range for admitted performance was between 72.7% (December 2015) to 88.6% (July 2015). Non-admitted performance monthly totals confirmed 97.5% to 98.7% compliance against 18-week targets.

- The referral to waiting target between June 2015 and May 2016 for admitted and non-admitted was 92%.
- The trust had a higher length of stay for non-elective patients aged less than one year compared to the England average. The length of stay for non-elective patients aged one to 17 years was the same as the England average. Non-elective patients stay at short notice because of clinical need or because alternative care was not available.
- We reviewed data from the Women's and Children's Quality Dashboard between June 2015 to May 2016 against Facing the Future: Standards for Acute General Paediatric Services (2015) Standard Two states every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional (middle grade doctor) within four hours of admission. Statistics showed 80% to 100% for patients with a clinical management plan less than four hours after arrival. A Red, Amber, Green (RAG) status of reporting was used by the trust. Red was below 80% indicating problems, amber 80–90% was satisfactory and green above 90% indicated performance was going well. This meant the trust was not always meeting the national standard.
- A link consultant paediatrician for each local GP practice or group of GP practices was not in place within the children's and young people's service. A statement from the trust confirmed this was not currently in place within the service. This meant the trust was not meeting the national standard. However, the paediatric department has provided education sessions at learning events for GP's covering topics for acute and speciality care needs. There was a named doctor working on improving links and education with primary care givers.
- We saw evidence of a clinical assessment tool for babies and children under two years with suspected bronchiolitis (a common lower respiratory tract infection that affects babies and young children under two years old) for use out of the hospital setting. Review of this document was due in 2015 post publication of the most recent National Institute for Health and Care Excellence guidance.
- A community nursing team managed by another provider supported the Children's hospital. The service

provided short term and continuing nursing care to children and young people up to the age of 18 years. The services offered included wound care, passing feeding tubes and intravenous antibiotic therapy (the infusion of liquid substances directly into a vein). Hospital staff told us they had good links with other organisations in order to meet the patient's needs.

- Podcasts (a digital audio file made available on the internet) on recognition of the sick child have been produced by a senior member of the medical staff for GPs to use in the community. These were accessible from the university hospitals website and included recognising the sick child, fits, faints and strange turns.
- Trust figures demonstrated between December 2015 and May 2016 142 (5.5%) out of 2581 outpatient clinics were cancelled. Reasons for cancellation included 'consultant other reason' (42), 'clinician annual leave' (27), strike action (16) and clinic cancelled (9).
- Between June 2015 and May 2016 752 patients were offered an appointment to the ear, nose and throat outpatients department 73 (10%) of the 752 did not attend. Staff told us there was a backlog of 300 patients requiring surgery.
- The 'Did Not Attend' (DNA) outcome form was managed by the medical staff. The service did not monitor DNAs and some staff were unclear where the policy was. Staff searched for it and found the DNA guidance within the safeguarding policy. One member of staff could describe the process and follow up by the health visitor or school nurse if the child missed three appointments in a row.
- Staff told us the general ward often had surgical outliers. However there was good support from the surgeons and they reviewed their patients daily to make a plan of care.

Meeting people's individual needs

- Staff could access a 24 hours a day seven days a week interpreting service provided externally which included the provision of British Sign Language. There was an interpreting and translation policy in the Trust
- Patients living with a learning disability were assessed using standardised nursing and medical documentation. Where patients had their own hospital profiles they were asked to bring them into hospital with them. On receipt of notification of an admission the acute liaison nurse (ALN) would contact the ward and telephone assess the level of priority in terms of their visit i.e. patients with more complex needs may be seen more quickly. However all inpatients were to be seen or

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the ward contacted within 24 hours of admission. On attendance the ALN would assess what reasonable adjustments were required in addition to speaking to carers about the care needs of the patient.

- Pastoral, spiritual and religious support was available to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains, as well as the country's first paid non-religious carer who, focussed on meeting the needs of people who did not identify with a religious belief. Volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives, also supported the team. A 24 hours a day seven days a week on-call service was provided and where possible a representative of the patient's own faith would attend. The service was widely publicised through posters, leaflets and the trust website.
- A Chapel and Prayer Room (with washing facilities) was available at this hospital and was designed to meet the diverse religious and spiritual needs of patients and staff. Rooms provided a quiet place for private prayer, meditation and contemplation and were open to everyone.
- Between June 2015 and May 2016 a total of 645 young people aged between nine and 18 years presented in the emergency department with a mental health condition. Out of the 645 patients 14 were admitted and 631 were not.
- The Children's Hospital had access to a senior Child and Adolescent Mental Health Service (CAMHS) doctor between 8am and 9pm, out-of-hours on-call care was provided by a Psychiatric junior doctor accessed through the emergency department. The CAMHS service was provided by a neighbouring NHS trust. There was a weekly CAMHS Liaison psychiatry meeting led by a consultant psychiatrist where any concerns were discussed.
- The trust scored about the same as other trusts in the four responsive questions from the 2014 Care Quality Commission (CQC) Children and Young People's Survey. The questions four were:
 - Did you have access to hot drinks facilities in the hospital?
 - How would you rate the facilities for parents or carers staying overnight?
 - Did the hospital give you a choice of admission dates?
 - Did the hospital change your child's admission date at all?
- A community end of life nursing team managed by another provider supports the children's hospital. The service was involved in setting up packages of care specific to the child's individual needs within the home or community setting. It provided planned visits when the child's symptoms changed and support when a child died.
- Staff told us they arranged electronic face time for parents to see their babies when they were not able to visit. An example was given of a dad who was overseas serving in the armed forces; he was able to be involved in his babies care and treatment by using face time access.
- The bereavement midwife provided support to families experiencing poor prognosis and outcomes. Parents were able to stay and use the cool cot to keep their child with them for a number a days if they chose to.
- Choice of place of care and involvement of care planning was offered to all families with long-term conditions when entering the end of life phase of care which included partnership working between community teams and a local children and young people's hospice.
- Parents we spoke with told us the play therapist was involved with their child and toys were changed regularly. Medical staff requested the play therapist to divert the child's attention through play whilst performing invasive procedures.
- Parents and cares were able to stay with the children and young people which enabled them to be involved with planning their care and they were supported by staff.
- Specialist provision at the LRI (ward 14) which included specialist neurological rehabilitation care and environmental adaptations was provided for children with special educational needs and physical disabilities.

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Patient Information and Liaison service (PILS).
- The trust had a complaints procedure to enable complaints to be made. Leaflets were available for families within the Children's Hospital and the outpatient area. Parents told us they knew how to make a complaint if they wanted to.

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- Data provided by the trust demonstrated the directorate had 24 complaints made to the children's service between December 2015 and May 2016. There was clear evidence of review, actions taken, lessons learnt, time scales and outcomes documented.
- One example of learning from complaints was shared with us. A family complained about waiting times in outpatients which resulted in a display for patients explaining waiting times and the reason for waiting.

Are services for children and young people well-led?

Good



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

We found:

- A leadership structure was in place and there was a clear vision and strategy within the service.
- Individual management of the different areas providing acute children's services were well led. Staff told us the senior team were visible and the executive team did walk rounds.
- There was a governance framework and a clear reporting structure from local team meetings to monthly management meeting which fed into the clinical governance meetings public and staff engagement processes captured feedback and used in service improvements.
- Evidence of ongoing innovation and improvement had taken place within the service which meant that service provision had been focused towards improving children's and young people's experiences.
- The service had strong public engagement which contributed to developing and improving services and patient experiences.

However we found:

- The service does not have a non-executive director lead representing the service at board level.
- Staffing had been an issue and had been on the risk register since 2006

Vision and strategy for this service

- A separate 'Clinical Vision and Strategy for Children's services 2016' was in place, which identified four strategic goals to provide an age-appropriate service for children and young people with a focus on outstanding, compassionate clinical care.
- Staff were aware of the trust's five step vision and values, which was to deliver 'Caring at its best' for everyone who visited the trust. Staff could also describe the local vision of developing a new children's hospital.
- University Hospitals of Leicester NHS Trust had a detailed five year integrated business plan which covered 2014 to 2019.

Governance, risk management and quality measurement

- The trust divided the services into seven Clinical Management Groups. Children's service was in the Women's and Children's group. Quality governance structures were identified within this structure. The organisational diagrams for governance showed a comprehensive governance system in place which identified the lead persons for each area.
- There was an executive lead for the Children's Hospital Configuration Board however; the service does not have a non-executive director lead representing the service at board level.
- Quality and governance information updates had been communicated in team meetings we saw evidence of this in three minutes of meetings we reviewed, emails and observed this on notice boards.
- The service performance dashboard was monitored monthly and actions were delegated to individuals to feedback to the next meeting.
- The service had a risk register we looked at the March 2016 report and all reviews at that time were in date. The risks identified were allocated to a lead and actions documented to mitigate the risk were observed. However low staffing had been on the risk register since 2006 without resolution.

Leadership of service

- Staff generally felt supported by the executive team and told us they were visible.
- Ward managers were very proud of their teams and that staff appointed stayed in the service for long periods.

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- Staff told us managers and matrons were visible and approachable. Managers were honest and gave clear feedback to their teams. Sisters worked clinically to support their teams when necessary.
- The service supported staff to seconded roles to enhance their professional development. A senior member of staff was seconded into a regional role and returned to share her experiences with her team and the service.

Culture within the service

- There was a culture of openness, flexibility and willingness among all the teams and staff we met. Staff morale was generally good and staff told us they enjoyed working within the service.
- Throughout the service we were informed that communication was open and transparent.
- Staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of children's health services.
- Staff told us if they needed to raise a concern they felt confident and supported to do so.

Public engagement

- The NHS Inpatient survey looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust. Responses were received from 547 patients at this trust.
- With the exception of cleanliness of rooms or wards the trust received a rating of about the same on how performance compared with most other trusts. Cleanliness of rooms or wards received a rating 'worse than' most other trusts.
- The National Children's in patient survey action plan for the Children's Hospital (September 2014 to March 2015) identified the areas for improvement, actions, measures, timescales and responsibilities. Some of the areas for improvement included having enough age appropriate things for a child on the ward and parents being told different things by different people.
- The NHS England Neonatal Survey 2014 survey results for Leicester neonatal service compared to national

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

- An ex-patient of the teenager's oncology ward had donated an ice cream cooler which was refilled by the teenage cancer charity.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement

- The trust had a 'UHL Way Implementation Plan' 2016 to 2017 setting out how they were going to manage change, engage and empower staff which also offered a framework for patient and public involvement in the improvement of care. It consisted of three components including better engagement, better teams and better change.
- Listening into Action (LiA) was a comprehensive, outcome-oriented approach to engage all the right people behind quality outcomes. Ward 27 ran a LiA event in 2014 to improve and contribute to service planning and delivery making a positive difference to young people receiving chemotherapy from the day care service.

Innovation, improvement and sustainability

- The leads of the service were passionate about developing a children's hospital. The design processes has begun, but funding was the significant block they are trying to access charitable funds to proceed.
- The service had refurbished the children's wards and designed a children's logo which has improved the directorate's identity.
- A teenage and young adult survey identified that fertility knowledge amongst cancer patients was poor. The survey data was collated and feedback in two regional

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multidisciplinary video link meetings. The outcome was to ensure a fertility conversation took place with teenagers and young people prior to the consent for cancer treatments.

- A mobile phone application for teenagers and young people is to be launched in July and August 2016 to enable those patients to rate their health and wellbeing in-between appointments with their consultants. They also have the choice of handing the device to the consultant to view if they are not confident to discuss their health.
- The Long-Term Ventilation Team won an East Midlands Academic Health Science Network, Innovation in

Healthcare Award (2015). Which was a collaborative hospital- community partnership model to improve health care for children and young people who need long term ventilation.

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

End of life care

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

Information about the service

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

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

The specialist palliative care team who supported ward staff to deliver care to patients at the end of their life are available 7 days a week 9am-5pm. The full team works Monday-Friday 9am-5pm and a clinical nurse specialist works across all 3 sites on Saturday to Sunday 9am-5pm.

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

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

Total number of deaths from April 2014 to March 2015 for the trust was 2940. For the period April 2015 to March 2016 the number of deaths was 2905. The trust is in the top five percent of trusts nationally for deaths that occur in hospitals, which was expected due to the size of the trust.

The specialist palliative care team accepts referrals for patients with progressive life threatening illness when life

expectancy is likely to be less than one year. Referral criteria include difficult pain and symptom control, complex psychosocial problems and/ or specialist needs related to end of life care.

Referrals to the specialist palliative care team at this hospital for the period April 2014 to March 2015, were 1016 cancer and 122 non-cancers.

At this hospital for the period April 2015 to March 2016 the total referrals for cancer patients were 1016 and for non-cancer patients it was 216.

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

We reviewed 22 medical and nursing care records of patients at the end of life and 25 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders. We observed the care provided by medical and nursing staff on the wards. We received comments from the public listening event which was held before our inspection and from people who contacted us separately to tell us about their experiences.

Before our inspection, we reviewed performance information from, and about the trust.

End of life care

Summary of findings

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

- The medical staff levels were not in line with the recommendations from the National Council for Palliative Care who recommend that there is one whole time equivalent (WTE) consultant for every 250 beds. The service had 3.5 WTE and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended.
- The trust had 82 syringe drivers that were in line with best practice guidelines, though many were missing. This meant only ten were ready for use. This meant another syringe driver was being used instead, which did not meet the NHS patient safety guidance.
- We looked at 23 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR) across the trust and found there were inconsistencies in how these were completed. We found that out of 23 DNACPR orders, six were completed correctly (28%). We found staff had not always followed trust policy when they completed DNACPR orders.
- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust scored lower than the England average for all five Clinical KPIs.
- The trust had undertaken an audit in April 2016 in response to the National Care of the Dying Audit 2016, and an action plan had been developed to address the KPI's that had not been achieved.
- The service does not have its own risk register the incidents were not recorded on the trust wide risk register.
- There was no strategic plan for end of life care throughout the trust.
- The service did not have a non-executive director representing end of life care at board level.

However:

- We found care records were mostly maintained in line with trust policy.

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

End of life care

Are end of life care services safe?

Requires improvement 

The safety of end of life care services at Leicester Royal Infirmary requires improvement.

We found:

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

However, we also found:

- Care records were mostly maintained in line with trust policy.
- Staff understood their responsibilities in following safeguarding procedures. The staff within the service understood their responsibilities for making sure patients were protected from the risk of harm and to protect people from abuse.
- The service had systems in place to recognise and minimise patient risk.
- Patient records were kept securely when not in use.

Incidents

- The trust had an up-to-date incident reporting policy for staff to follow.
- The specialist palliative care team were familiar with the process for reporting incidents, near misses and accidents using the trust electronic incident reporting system. Any serious incidents would be investigated through the use of root cause analysis and where necessary further training would be arranged.

- The SPCT told us there were very few reported incidents relating to end of life care.
- Between May 2015 and April 2016, there were no serious incidents or never events reported in the end of life care services at the Leicester Royal Infirmary (LRI). Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although a never event, incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Staff understood their responsibilities to raise concerns and told us they felt well supported and were encouraged to report incidents.
- Mortuary staff told us they were unable to access the trust's electronic incident reporting system, and had to rely on their manager to report any incidents should they occur. Mortuary staff told us, they rarely heard anything further about any incident they reported. The trust told us mortuary staff did have access to this incident reporting system.
- All staff we spoke with were knowledgeable about the duty of candour and were able to give us an example of when this had happened due to a medication error in 2015. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust's electronic incident reporting system had recently been updated to take staff through the duty of candour process when a notifiable patient safety incident occurred at both the reporting and final approval stages.
- The trust had a 'Being Open' Leaflet, which was given to patients and relatives as part of the process for serious incidents, Never Events and those incidents that had undergone a comprehensive internal investigation.

Medicines

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

End of life care

- At the time of our inspection, the trust had a shortage of syringe pumps that met current NHS patient Safety Guidance and the SPCT told us there were only ten of these pumps for patients throughout the trust.
- The shortage of syringe pumps meant staff were using an alternative syringe pump that was not tamperproof and did not have the recommended alarm features. This was not in keeping with the trust policy.
- Whilst all the syringe pumps we checked at the hospital had a sticker on which detailed they had been safety tested, we could not be assured the syringe pumps being used in the community were within their service date.
- Two nurses from the SPCT were non-medical prescribers and one was undertaking training to become a non-medical prescriber. Non-medical prescribers are nurses that are able to prescribe any medicine for a health condition, within their field of expertise.
- The trust had a protocol for the prescribing anticipatory medication. Anticipatory medicines are prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as a patient reaches the end of their life. We reviewed the medicines administration records of two patients who were receiving anticipatory medicines. We found these medicines had been appropriately prescribed and administered.
- There was a palliative care pharmacy protocol on the hospital's intranet system. The pharmacist told us if a palliative care patient is flagged on the system, then a quick list of standard prescriptions is highlighted. The pharmacist said this reduced the likelihood of a medication error as it is all prescribed for the doctors to initiate.
- End of life care services at this hospital followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS61. This quality standard defines clinical best practice about how people are prescribed antibiotics in accordance with local antibiotic formularies. Additionally, nurses followed the standards set out in the nursing and midwifery council (NMC) standards for medicine management.
- The trust had implemented individualised care plans for patients requiring end of life care. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2014.
- We looked at 21 sets of patient records throughout our inspection; all of them were clear, legible and up-to-date.
- Patient records for patients receiving end of life care were kept in secure trolleys at the end of each bay or near the nurses' station.
- The service had a patient register that trust staff could access via the trust's centralised, electronic patient co-ordination system. However, staff working in the community, for example, GPs, district nurses and hospice at home teams could view these but not update them electronically. The GPs could amend them by manually entering the care plan into their electronic system and then making amendments on this new electronic care plan or handwriting amendments onto the plan the hospital produced. The SPCT had created emergency healthcare plans for patients known to them. Staff working in the community could view these but could not update them.
- The SPCT reviewed the records of their patients on a daily basis in order to assess the care needs of each patient. We saw evidence of this when attending a daily huddle on one of the wards.
- The bereavement office issued medical certificates of cause of death (MCCD) which enabled the deceased's family to register the death. We found the death certificates had been issued within 14 days of death or cremation and the forms had been signed in accordance with the Births and Deaths Registration Act 1953.

Safeguarding

- There were up-to-date trust wide safeguarding policies and procedures in place, which were accessible to staff via the trust's intranet site.
- All the staff we spoke with in the SPCT were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding team. None of the staff we spoke with could recall a recent safeguarding incident regarding patients receiving end of life care.

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- Staff who provided end of life care had received mandatory training in safeguarding children and vulnerable adults. One hundred per cent of the SPCT were trained to level two in children's safeguarding and 93.8% were trained to level two adults safeguarding.
- The SPCT did not provide end of life care for patients below age of 18 years.

Mandatory training

- There was variability in the levels of compliance with mandatory training within the SPCT. Up to the end of April 2016 staff had achieved 100% compliance with infection control, equality and diversity and safeguarding children modules. Fire, health and safety, were recorded at 81.5%, moving and handling at 87.5%, information governance, conflict resolution, safeguarding adults and health and safety were all recorded as 93.8% and resuscitation training which was recorded as 81.5% compliance. This was against the trust's target of 95%.
- End of life care training was not mandatory but some staff were mandated to complete end of life training as part of 'essential for role' training. The SPCT had devised an end of life care training schedule for nursing staff, which they carried out on a weekly basis. Each training session was ten minutes long, in order to ensure it did not interfere with workloads of staff.

Assessing and responding to patient risk

- We reviewed the nursing documentation for two patients receiving end of life care. Risks such as falls, malnutrition and pressure damage were assessed. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to assess malnutrition risk and the Waterlow tool was used to assess patients' risk of pressure ulcers. We found the risk assessments were completed appropriately.
- Nursing staff used the Early Warning Score (EWS), to record routine physiological observations such as blood pressure, temperature and heart rate. EWS was used to monitor patients and prompt staff to follow appropriate procedures, should a patient's vital signs fall out of expected parameters. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care.
- Intentional rounding took place for all patients receiving end of life care. Dependent on the individual patient risk, these checks were undertaken between one to four

hourly intervals. Intentional rounding is an organised process where nurses carry out regular checks with individual patients at set times, normally one to four hourly.

- The trust had devised the 'BEST SHOT' assessment. This was an additional pressure area checklist which was completed at the same time as intentional rounding documentation. This could only be completed by a registered nurse.

Nursing staffing

- There were no dedicated 'end of life care' beds at the LRI. General Nurses provided care and treatment for patients requiring end of life care with support from the SPCT throughout the medical and surgical wards.
- There were 15 palliative care nurses in the SPCT, equating to 12.93 whole time equivalent (WTE) nurses. However, due to sickness and absence the SPCT staffing levels were reduced to 10 nurses, or 8.93 WTE nurses.
- The SPCT told us, the reduction in staff meant they had to undertake extra work to compensate and this impacted on the amount of time they could dedicate to teaching on the wards.

Medical staffing

- There were five palliative care consultants in the SPCT equating to 3.5 whole time equivalent (WTE) staff members. This did not meet recommendations by The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care, which states there should be a minimum of one consultant per 250 beds.
- Patients receiving end of life care were reviewed on the wards on a daily basis and sometimes more than once a day as needed.
- Medical staff we spoke with all told us they had good access to and support from, the consultants within the SPCT.

Major incident awareness and training

- The trust had a major incident plan, which was readily available to staff via the trust's intranet. The plan detailed the role of the mortuary in arranging to receive and manage the deceased, liaising with the police and the Coroner in the event of a major incident.
- The mortuary manager was knowledgeable about the role of the mortuary if there was a major incident. They

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told us about the local facilities that they could use if there was an increase in the requirement for extra storage facilities. For example transferring the deceased between hospital sites.

- Staff were not aware of the trust's major incident plan and could not remember undertaking major incident training.
- Porters stated they had not heard of a major incident plan and would not know what procedure to follow in the event of a major incident.

Are end of life care services effective?

Requires improvement



We rated the effectiveness of end of life care services at Leicester Royal Infirmary as requires improvement because people were at risk of not achieving effective care and treatment.

We found:

- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs) and the trust scored lower than the England average for all five Clinical KPIs. The trust did not have a lay member on the trust board with a responsibility for end of life care and there was a lack of formal training in relation to communication skills for staff.
- We looked at 21 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders at Leicester Royal Infirmary and found there were inconsistencies in how these were completed. We found that out of 21 DNACPR decisions that we looked at six were completed correctly (30%).
- Staff said they had not received any training on The Mental Capacity Act 2005.
- Nursing staff we spoke with had a basic awareness and understanding of Deprivation of Liberty Safeguards, but not of The Mental Capacity Act 2005.

However, we also found:

- Data showed that for the period 2014/15 98% of patients were seen within 24 hours of referral to the specialist palliative care team.
- Medical and nursing notes were stored securely on all the wards we inspected.

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.

Evidence-based care and treatment

- Following the withdrawal of the Liverpool Care Pathway in 2014, the trust had introduced individualised care plans for patients on the end of life care plan. The individualised care plans recognised the five priorities for end of life care according to the Leadership Alliance for the Care of Dying People (2014).
- The trust's end of life-individualised care plans were being used consistently where patients were identified as end of life to ensure they received evidence based end of life care. We saw patient's records where staff were using individualised care plans for the dying patient. This gave clear guidance for staff on how to meet the patient's needs in respect of repositioning, food and fluid intake and pain relief.
- The trust had guidance for the care of patients in the last days of life which had been updated following the publication of NICE guidance in December 2015. The guidance incorporated information about the five priorities for care of the dying person. Staff were able to tell us about the current guidance relating to end of life care.
- All of the records we looked at demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. The records also demonstrated the care followed NICE Quality Standard QS66, which refers to patients receiving intravenous fluid therapy and NICE Quality standard five which refers to inpatients being assessed for venous thromboembolism (VTE). This is when there is formation of blood clots in the vein. When a blood clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or (PE).
- During our inspection, staff told us the trust was not contributing data concerning palliative care to the National Minimum Data Set (MDS). The National Council for Palliative Care collects the MDS for specialist palliative care services for palliative care on a yearly basis, with the aim of providing an accurate picture of

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specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England, Wales and Northern Ireland.

- The trust had participated in the National Care of the Dying Audit 2016 and had performed worse than the England average in five of the eight organisational indicators. (KPI's) and in all five clinical key performance indicators. The trust had devised an action plan in response to information in the National Care of the Dying audit.
- The trust participated in the Transforming End of Life Care in the Acute Hospitals programme (Transform programme). The programme aimed to improve the quality of end of life care within acute hospitals across England. It focuses on both the quality of care provided by acute hospitals, as well as the role acute hospitals have that provide care for people who are approaching end of life.
- One of the key elements of the transform programme is the AMBER Care Bundle, this is a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.
- Across the three hospital site, 44 wards were using the AMBER Care Bundle. End of life care facilitators within the SPCT had launched the Amber Care Bundle and had supported staff in its implementation.

Pain relief

- Patient's symptoms were managed and anticipatory medicines were prescribed (medication that patients may need to take to make them more comfortable). We checked two medication administration records and found they demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms.
- We saw evidence of patients regularly being assessed for pain and given medication in a timely fashion.
- Patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief.

- We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- We saw the Core Standards for Pain Management Services were being met in the medical notes we reviewed. The core standards for pain management in the United Kingdom is a comprehensive index of recommendations and standards for pain management. However, we saw documentation that showed the trust had not undertaken any audits on pain relief during 2015 or that any staff had received practical training on the use of syringe drivers for end of life care patients. The trust stated a training video had been produced for staff to view as a refresher and 'how to' when the SPCT were not available to support them in person and that some training had been delivered as part of Champions Day and Matron QELCA.

Nutrition and hydration

- There was an assessment for nutrition and hydration in each patient's individual care plan. We reviewed two sets of nursing records for patients in the last days of life and found patients were screened for their risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify patients who are malnourished, at risk of malnutrition and to ensure those who were nutritionally at risk were identified accordingly.
- Where interventions were required we saw these documented on the patient's daily record. For example we saw where a patient required extra nutritional supplements; this was because there was a reduction in the patient's appetite which was a recognised aspect of their illness.
- Staff told us patient's families were encouraged to assist their relatives at mealtimes when this was appropriate.
- Patients had access to drinks when this was appropriate and safe.
- We spoke with three doctors as part of our inspection, they were all aware of the General Medical Council (GMC) guidance for supporting nutrition and hydration for end of life care patients.

Patient outcomes

- The hospital did not contribute data about palliative and end of life care to the National Minimum Data Set

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(MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark themselves against a national agreed data set.

- The trust had taken part in the End of Life care Audit – Dying in Hospital 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). Where the trust had not achieved the organisational KPIs these were because there was no lay member on the trust board with a responsibility for end of life care and there was a lack of formal training in relation to communication skills for doctors; nurses; health care assistants and allied health professionals.
- The trust scored worse than the England average for all five clinical KPIs. Where the trust had scored worse than the England average this was because the trust did not perform well against documented evidence at the end of a person's life.
- As a response to the results of the National Care of the Dying audit, the lead consultant for the specialist palliative care team had commenced a trust wide audit. The audit made multiple recommendations and specified these should be integrated into clinical practice, education and training for all staff involved in providing care to patients who are dying. In addition, there were eight recommendations identified as fundamental for the trust in improving end of life care. The specialist palliative care team told us they were currently working to improve outcomes for end of life care patients which had been recognised as part of the audit.
- In January 2016, the trust started a review of patients' last place of care and death. This was the first time the review had been undertaken.

Competent staff

- At the time of our inspection, there were 35 end of life care champions on the wards throughout the hospital. End of life care champions were responsible for developing in conjunction with the SPCT standards and

quality of care for palliative and end of life care patients. They promoted good practice for end of life care had undertaken specific training relevant to their roles. Most of the wards had an end of life care champion.

- The SPCT had undertaken the Quality End of Life Care for All (QELCA) training. The training is concerned with end of life care education. It was designed for teams of health and social care practitioners from acute, community or care home settings to lead on the delivery of care to patients and families at the end of life. QELCA training was undertaken in conjunction with a local hospice four times a year for ward sisters and matrons.
- All members of the SPCT received appraisals as well as clinical supervision and these were up to date. Clinical supervision is a formal process of professional support and learning, which helped staff to develop knowledge and competence by reflecting on their practice.
- The SPCT clinical nurse specialists were also able to access clinical supervision from a local hospice. A palliative care consultant led these supervised sessions on a bi-monthly basis.
- The SPCT ran a twice yearly conference on palliative care for other medical and nursing professionals.
- The SPCT undertook regular teaching every week on a number of subjects for trust staff. An example of this was training undertaken recently for palliative and end of life care ward link nurse champions.
- Training was also undertaken on AMBER care bundles, QELCA, communication skills training, included breaking bad news, the five priorities for care and individualised end of life care plans. Quality End of Life Care for All (QELCA) is an education programme, delivered by hospices for nurses working in other healthcare settings.
- The SPCT provided 'shadowing' opportunities for all levels of staff. This allowed more inexperienced staff to work alongside a member of the SPCT to develop their own skills and knowledge.
- Porters who transferred the deceased to the mortuary as part of their job reported they could not remember when they last received an appraisal. The porters said they had not received any end of life care training, only a three hour induction when starting the job and then they were expected to shadow an experienced porter.

Multidisciplinary working

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- Patients requiring end of life care received support from an end of life care multidisciplinary team (MDT). This included the SPCT, consultants, nursing staff, occupational therapists, physiotherapists, oncologists and other relevant professionals. The chaplain and the bereavement team were also part of the MDT for end of life care patients.
- The SPCT told us that members of the team, tried to attend as many multidisciplinary team meetings as possible. These were undertaken to help identify and coordinate care for patients approaching the end of their life or requiring supportive care.
- The SPCT attended the cancer multi-disciplinary meetings and either received or self-referred patients from the meeting.
- The SPCT had a good and effective relationship with the specialist discharge sisters and ensured that patients nearing the end of life, who had expressed a wish to be referred to the hospice were referred in a timely way. However, the trust did not audit these referrals to the hospice. We could therefore not be assured that referrals to the hospice took place in a timely manner. Staff in accident and emergency and in the intensive care unit told us of the good relationship between themselves and the SPCT.
- All patients receiving end of life care were discussed in the daily huddle and at the specialist palliative care multi-disciplinary meetings. The daily huddle is a short gathering of the SPCT to discuss new information and each patient's care.
- We attended a daily 'huddle meeting' with the SPCT, and observed them discussing new patients and patients already known to them.
- The SPCT supported other health professionals to recognise and consider when patients may be approaching the need for palliative or end of life care.
- The trust did not use an electronic palliative care coordination system (EPaCCs). This is an electronic computerised information system regarding patients who are known to be dying that could be accessed by all staff, including staff in the community.
- Rapid discharges could be undertaken seven days a week. The SPCT worked closely with a local hospice and the hospice at home team to facilitate this.
- The bereavement service was open Monday to Friday 9am to 4.30pm as was the mortuary.
- The chaplaincy service provided pastoral and spiritual support, and was contactable out of hours on a 24 hour basis.
- The mortuary provided a 24 hour, seven day a week service to both the trust and the community.
- The trust provided seven day services in line with other core services for patients who were at the end of their life.

Access to information

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- There were advice leaflets for relatives related to the withdrawal of treatment in the intensive care unit. The leaflet included information about the symptoms which might occur during the final stages of life
- GPs were informed through an end of life GP referral form by fax if a patient was being rapidly discharged from hospital.
- Information needed to deliver end of life care was available to staff in a timely and accessible way. There was good access to the specialist palliative care team and relevant guidance was available on palliative care and end of life care through the trust's intranet
- Medical staff told us they would either call the consultants for palliative care to discuss end of life patients care needs or the local hospice advice line out of hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients and relatives told us that staff did not provide any care without first asking their permission.
- Signed consent forms were evident in all the patient records we examined. This demonstrated that staff obtained consent to treatment appropriately.
- Nursing staff we spoke with told us they had not received training on the MCA. They had a basic awareness and understanding of DoLS, but not of the MCA. The trust told us MCA was included in DoLS and consent training. The MCA is a piece of legislation

Seven-day services

- The SPCT worked Monday to Friday 08:30am to 5pm. A specialist palliative care nurse worked between 9am and 1pm at the weekends. Outside of these hours, there was a dedicated advice line at a local hospice for professionals and members of the public to call.

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applying to England and Wales, its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The DoLS is part of the MCA. DoLS aims to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Anybody under a DoLS application must first have had a mental capacity assessment and be found to lack mental capacity to make a decision with regard to the situation they find themselves in.

- The trust did not audit MCAs or DoLS applications. This meant the trust could not tell us if these assessments were being completed correctly.
- The ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) forms were kept at the front of the patients’ medical notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All of the DNACPR orders were easy to read.
- We looked at 21 DNACPR forms at the Leicester Royal Infirmary and found there were inconsistencies in how these forms had been completed.
- Out of 21 DNACPR forms we looked at, six were completed correctly (30%).
- DNACPR orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families, community DNACPR orders dated 2013 and lack of discussion with the patient.
- Of the 15 not completed accurately, none of them had been discussed with the patient, or where the reason was given for not discussing with the patient was confusion or dementia, none of these DNACPR orders had a mental capacity assessment undertaken. This meant the trust’s DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not being followed on all of the DNACPR’s we inspected.
- We spoke with a doctor on ward 31 about a DNACPR order which stated the patient was confused but did not have a mental capacity assessment in. They stated that “If the patient is obviously confused then we don’t do them, but I suppose we should really”.
- We looked at the trusts Do Not Attempt Cardiopulmonary Resuscitation Policy. The policy states

‘The trust had a legal duty to consult with and inform patients if a DNACPR order is placed in their notes (and relevant others if the person lacks capacity to be involved in the process)’.

- This meant the trust’s DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not being followed.
- The trust routinely reviewed 25 sets of DNACPR records 10 of these were from this site.
- We discussed our findings with the safeguarding lead for the trust, who agreed there was a need for staff training on undertaking mental capacity assessments.

Are end of life care services caring?

Good



We rated the caring of end of life care services at Leicester Royal Infirmary as good.

We found:

- Staff cared for patients with dignity and respect. Staff were seen to be compassionate.
- Patients we spoke with told us that staff were caring and looked after them well.
- A bereavement service was offered on site, with staff available to support family members with practical and support issues following bereavement.
- The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital as well as their relatives and aimed to see people within the hour.

Compassionate care

- All staff spoke about the patients they cared for with compassion, dignity and respect.
- We saw examples of care that was compassionate, caring and focused on supporting patients as much as possible during difficult times. We saw staff using the skills of empathy when speaking to patients and using good eye contact.
- During our inspection, we observed patients being treated with compassion, dignity and respect. An

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example of this was a patient's family were allowed to bring the patient's dog in everyday to see them and sit on the bed for a few hours. The patient was in a side room.

- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- The trust had a bereavement service and staff who provided support for relatives, following the death of a patient.
- The trust did not contribute to the National Bereavement Survey. The National Bereavement Survey aims to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country and to different groups of patients. It is conducted by the Office for National Statistics on behalf of the Department of Health.
- Porters told us that deceased patients were treated respectfully by ward staff.
- Services provided in the mortuary demonstrated respect and understanding of a patient's cultural or religious needs an example of this was the trust's urgent release policy, this was when the deceased was released within 24 hours of death and was used regularly with regard to cultural and religious beliefs.

Understanding and involvement of patients and those close to them

- We saw staff discuss care requirements with patients and relatives where possible and these were generally clearly documented in patient's notes. An example of this was we sat in on a meeting between the doctor and the family where the doctor gave bad news about the life expectancy of the patient to the family; this was done in a clear, concise and compassionate manner. We spoke with the family after the doctor had left and they were very complimentary about their loved ones care and said the doctors and nurses had kept them informed and involved in their relatives care since admission to hospital.
- The trust did not have an advanced decision (living will) for patients receiving end of life care.

Emotional support

- The chaplaincy service provided a 24 hour seven days a week on call service for patients in the hospital, as well as their relatives, and aimed to see people within the hour. However, this was not audited by the trust.
- The chaplaincy service held communion at the patient's bedside if patients were too ill to attend the chapel. The chaplain told us they conducted last rites and blessed the deceased in the mortuary if this was requested.
- The chaplain supported patients, their families and staff. There were a number of thank you cards in the multi-faith chapel.
- The chaplaincy service was not licensed to conduct weddings for end of life care patients. They told us they were able to facilitate this with one of the community registrars who would conduct weddings. The service employed 80 volunteers who would sit with end of life care patients as required.
- The trust provided memorial services for relatives of patients who had died at the hospital.

Are end of life care services responsive?

Good



We rated the responsiveness of end of life care services at Leicester Royal Infirmary as good because people's needs were met through the way the service was organised.

We found:

- Patients who were referred to the specialist palliative care team were seen according to their needs. The SPCT were committed to ensuring that patients receiving end of life care services had a positive experience. Patients requiring end of life care could have access to the specialist end of life team.
- For the period April 2015 to March 2016 the total referrals for cancer patients were 1672 and for non-cancer patients it was 600. As a percentage, this equates to 74% and 26%. The combined total referrals were 2172 for this period. The referral data therefore indicated that specialist care was being provided for patients with other life shortening conditions.
- On ward 32, there was a side room called the 'blue butterfly room'. It was decorated with different colours of blue and lilac with blue butterflies on the wall. There was subdued lighting, a bed throw, a wardrobe, facilities to make hot drinks and an on-suite bathroom. Families

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were also able to stay in the room with their loved one. The trust either provided a recliner chair or a temporary bed. Relatives were offered a voucher for a hot meal once a day.

- There was a specialist end of life care pathway for patients living with dementia; this was overseen by the Dementia Implementation Group. The SPCT attended this group.

However, we found :

- The trust did not audit the number of patients who received a successful rapid discharge.

Service planning and delivery to meet the needs of local people

- Patients who were referred to the specialist palliative care team were seen according to their needs. The SPCT were committed to ensuring patients received end of life care services had a positive experience. Patients requiring end of life care could be referred to the SPCT.
- During April 2015 and March 2016, there were 2,940 deaths across the trust. For the same reporting period, the SPCT received 2,272 referrals. Seventy four percent of these were patients with a diagnosis of cancer and 26% of these were patients with a non-cancer diagnosis. This was a slight increase from the previous year, when there had been 2937 deaths across the trust and 2006 patients were referred to the SPCT. Whilst 78% of these patients had a diagnosis of cancer, 22% of all referred to the SPCT did not. This showed that staff were committed to ensuring specialist care was being provided for patients with other life shortening conditions.
- Members of the SPCT visited the medical assessment units across all three hospital sites on a daily basis. This had resulted in an increased referral rate, particularly for non-cancer patients.
- Whilst there were no dedicated beds for end of life care beds at the Leicester Royal Infirmary (LRI), staff delivered end of life care throughout the most of the wards, with the support of the SPCT. Ward staff told us the specialist palliative care team would attend the ward if requested to supply advice and assistance.

- The SPCT did not collect information of the percentage of patients who died in their preferred place of care. Without this information, the service was unable to monitor if they were honouring patient's wishes or if they needed to improve this.
- The SPCT did not collect information of the percentage of patients that had been discharged to their preferred place of death within 24 hours. Without this information, the trust was unable to monitor if they were meeting patient's wishes or if they needed to improve this.
- Where possible, patients who had been recognised as being in the last hours or days of life were nursed in a side room to protect their privacy and dignity. However, this was not always possible and was dependent upon the patient and the capacity on the wards.
- The trust had introduced a 'blue butterfly' initiative. This is where staff placed a blue butterfly on the side room door or to the closed curtains of the bed area of a person who was at the end of their life. This signified to staff that the patient was nearing the end of their life.
- Blue butterfly bereavement cards were sent to families and loved ones; these were hand written by the staff who had taken care of the patient. The bereavement cards had contact details on them if families wanted get in touch with the bereavement follow up service nurse.
- On ward 32, there was a side room called the 'blue butterfly room'. It was decorated with different colours of blue and lilac with blue butterflies on the wall. There was dimmed lighting, a bed throw, a wardrobe, facilities to make hot drinks and an en-suite bathroom. This enabled families to stay in the room with their loved one. The trust provided a recliner chair or a temporary bed. Relatives were offered a voucher for a hot meal once a day. Staff told us that families and loved ones could stay as long as they liked with the patient in the blue butterfly room.
- The trust had an open visiting policy for patients who were in receipt of end of life care. This enabled the patient's family to remain with the patient for as long as they wished, including throughout the night.
- All patients attending palliative care outpatient clinics were given a card with contact details for their consultant. They could contact the consultant if they were experiencing problems. For example, if their condition worsened.
- Following a patient's death, bereaved families were able to make an appointment to meet with the bereavement team the following day. The team would ensure all

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necessary documentation and property belonging to the patient was ready to collect, arrange and support viewing if required, and provided practical information to the family. The bereavement team discussed any queries regarding the patient's care or death with families, or if they were unable to answer questions, would arrange for a member of the medical team to do so.

Meeting people's individual needs

- The mortuary had a viewing suite where families could visit their relatives and loved ones. We visited the area and saw the viewing suite was divided into a waiting room and a viewing room.
- The mortuary waiting room was clean, and provided facilities for relatives such as comfortable seating, tissues and information booklets about bereavement and the trust's bereavement service. The suite was neutral with no religious symbols, which allowed it to accommodate people of all faiths and religions.
- Mortuary staff worked closely with Muslim and Jewish undertakers to ensure deceased patients were cared for following their cultural and religious requirements. However, there were no facilities available for bereaved relatives to wash the deceased. The mortuary manager told us that by agreement, all ablutions of the deceased were carried out in the community.
- The mortuary had an 'urgent release policy', to enable the deceased to be released within 24 hours. This was used regularly with regard to cultural and religious beliefs.
- The mortuary, chaplaincy and ward staff had access to information about different cultural, religious, spiritual needs and beliefs. Staff told us this helped them to respond to the individual needs of patients and their relatives.
- The chaplaincy team, which included 80 volunteers, visited the wards every day and visited all patients who had been placed on the individualised end of life care plan if appropriate.
- Within the chapel, there were separate prayer rooms with prayer mats and washing facilities for Muslim prayer.
- There were separate prayer rooms for other faiths such as Sikhs and Buddhists.
- The chaplain told us about two weddings and a blessing that had been conducted for patients in the last few days of their life.
- In January 2016, the trust had employed the first non-religious chaplain to support patients who did not follow a particular faith.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen. There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life. These were available in languages other than English.
- As part of the individualised care plan there was a booklet called 'Information for relatives and friends'. The booklet explained in plain English what to expect when someone close to you is very ill, such as medication, changes that occur before death and the last days of the care plan.
- We saw advice leaflets for relatives with regards to the withdrawal of treatment in intensive care. There were leaflets in both the bereavement office and the mortuary concerned with help for the bereaved and what actions to take when someone dies.
- Information about the bereavement service was available on the trust's website. This provided guidance on how to arrange a funeral, what to do when a baby has died, information on the chaplaincy service and what to do after the funeral.
- Following a patient's death, bereaved families were able to make an appointment to meet with the bereavement team the following day. The team would ensure all necessary documentation and property belonging to the patient was ready to collect, arrange and support viewing if required, and provided practical information to the family. The bereavement team discussed any queries regarding the patient's care or death with families, or if they were unable to answer questions, would arrange for a member of the medical team to do so.
- Patients at the end of life would be cared for where possible in individual side rooms to give them more privacy. Staff were also able to provide temporary beds or recliner chairs in patient's side rooms.
- There were facilities for relatives to stay in overnight accommodation close to the hospital. Visiting hours were relaxed for visitors of patients who were identified

End of life care

as being at the end of their life on all the wards we visited and throughout the hospital. This ensured family and friends could spend unlimited time with the patient.

- We looked at the menu on each ward we visited. The menu had a main section and one for cultural meals which included kosher, Afro-Caribbean, halal, vegetarian and vegan options. Staff told us that patients in receipt of end of life care could also order from the children's menu.
- The trust used a translation service when required for those patients who could not speak or understand English. This was either undertaken face-to-face or a phone line could be used at the bedside.
- In the intensive care unit, when someone was nearing the end of life, the staff would place them in a side room. There was not a separate overnight room for relatives to stay on the intensive care unit; however, the trust did have accommodation which could be used for relatives.
- The 'Last days of life' booklet had been adapted for patients in intensive care, for example, what to expect if the patient is on a ventilator in the last days and hours of life.
- The trust had recently commenced a new initiative of a bereavement follow up service nurse. This specialist nurse provided a liaison and listening service for the loved ones of the deceased, as well as attend to the families of any deceased in the accident and emergency department.
- Bereavement support was offered to relatives (adult inpatient deaths), aiming for contact six to eight weeks post-bereavement. Between January 2016 and March 2016, 49% of relatives took up the offer of bereavement support. Feedback from 104 relatives in March 2016 rated the quality of care as good to excellent for the majority (82%). Eleven per cent of relatives rated the care as 'ok', with 4% rating the care as 'poor' and 3% of relatives stated they were 'unable to say'.

Access and flow

- The service had a patient register that trust staff could access via the trust's centralised, electronic patient co-ordination system, however, there was no electronic flagging system for end of life care patients on admission. This meant, the specialist palliative care team were reliant on staff to refer end of life care patients to them.

- Referrals to the specialist palliative care team could be made at any time from the patient's diagnosis. This meant the specialist palliative care team could be involved in the patient's care at an early stage. Audit results demonstrated 98% of patients had been seen within 24 hours of a referral being made to the specialist palliative care team.
- There was no electronic flagging system on admission for patients in receipt of end of life care. This meant the SPCT were reliant on staff to refer end of life care patients to them.
- There was an end of life care lead nurse in the emergency department who liaised with the SPCT when patients in receipt of end of life care or palliative care were seen in the department. This helped to facilitate a fast track system for these patients.
- The trust did not have a specialist palliative care ward or any specialist palliative care beds. General nurses throughout the hospital with input from the SPCT delivered end of life care.
- The specialist palliative care team (SPCT) had established links with community palliative care services and the local hospice. Staff told us this promoted shared learning and expertise and facilitated consistent care for patients who transitioned between services. Patients had timely access to the specialist palliative care team. Data showed between April 2015 and March 2016 they had 600 contacts, 983 of these were new referrals.
- The Specialist Palliative Care Team (SPCT) had undertaken a review of 30 patients who were part of their caseload at the time of death or within 30 days of death in January and February 2016. The results showed that 83% of patients, who identified their preferred place of death, were supported to die there. Where this had not been achieved, it was due to the patients being assessed as too unwell to transfer home.
- The review had four recommendations which included recommending that earlier discussion of preferred place of death should be undertaken with patients referred to the Specialist Palliative Care Team, patients should be offered the opportunity to discuss their preferred place of death, staff needed to identify persons important to the patient who they would want involved in discussions about their care if they cannot be involved in this.

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- The SPCT were fully aware of the outcomes of the review and were undertaking the recommended actions.
- The trust had a rapid discharge policy and the specialist discharge sister undertook rapid end of life care discharges for patients who wished to return to the community or a 24 hour care facility. Rapid discharges are normally undertaken for patients who have rapidly deteriorating condition which may be entering a terminal phase.
- Rapid discharges could take place within four hours. The hospice at home service was able to provide short-term care to support this. The trust did not audit their rapid discharges which meant they could not be assured a rapid discharge was achieved for all patients.
- The SPCT gave us a recent example of a rapid discharge home for a patient that was achieved within four hours. The SPCT advised they liaised with the hospice at home team from the local hospice to support the patient on discharge.
- The SPCT worked closely with the specialist discharge team to discharge people to their preferred place of dying.

Learning from complaints and concerns

- Posters and leaflets were available in the wards and clinical areas we visited. These allowed members of the public to identify how they could raise a concern or make a formal complaint. We also saw 'message to matron' cards and boxes to allow patients and relatives to make comments or raise concerns which where possible could be dealt with locally.
- A Patient Information and Liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- The clinical lead would investigate formal complaints relating to end of life care and palliative care patients
- Staff told us if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.
- The SPCT told us complaints about the service would be reviewed and investigated. Where appropriate actions would be taken and lessons learnt for the future. An example of this was a complaint about a patient transfer of care to the local hospice. . The patient was referred to the local hospice by the SPCT, but deteriorated and died

before the transfer. The complaint was discussed at the end of life care board, following which a leaflet was produced in conjunction with the hospice explaining about the process of transfers. Following this complaint a leaflet was developed and is now given to all patients in receipt of end of life care who request a transfer. The leaflet states the reasons for transfers and reasons why it may not be possible, for example if a patient requires oxygen or if there are not sufficient beds at the local hospice.

- All end of life care complaints were reviewed at the end of life care board on a quarterly basis.

Are end of life care services well-led?

Requires improvement 

We rated the well-led of end of life care services at Leicester Royal Infirmary as requires improvement because the leadership, governance and culture did not always support the delivery of high quality person-centred care.

We found:

- The trust did not have a fully developed end of life care strategy that included prioritised, time bound actions with appropriately allocated leads.
- End of life care services were discussed at board level. However, there was no non-executive lead for end-of-life care at board level.
- The leadership team did not always ensure routine local audits were in place to measure the effectiveness and outcomes of the service.
- Departmental governance and risk management arrangements were not robust and as such were not suitable to protect patients from harm. There was no risk register for the service and the leadership team had not identified or taken into account the risks associated with a lack of safe infusion pumps used to deliver anticipatory medication.

However, we also found:

- Staff at ward level felt supported by the SPCT. They told us the SPCT were approachable and worked hard to help ward staff provide the best end of life care for the patients

Vision and strategy for this service

End of life care

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

Governance, risk management and quality measurement

- We were told that end of life care services were discussed at board level. The Specialist palliative care team had recently started presenting end of life care patient stories to the board. Staff told us this was to raise the importance of end of life care with the view that all board members would have responsibility and acknowledge the importance of end of life care.
- The trust did not have a risk register specifically for recording end of life care as an area of concern. Instead the service used the trust's general risk register. The trust had developed a system where all incidents, concerns and complaints relating to end of life care are centrally collated and thematically analysed in addition to the usual process of reviewing and developing actions from these issues. This is to ensure that patterns and learning are accurately collected across the trust. The results were shared and additional actions developed at the End of Life and Palliative Care committee
- There were clear lines of accountability within the service. Staff knew who was responsible for managing communications both up to senior managers and downwards to the front line staff.
- The SPCT had regular team meetings in which issues and general communications were discussed.
- We saw the action notes of the executive quality board for April 2016 which discussed The National report for England 2016 End of Life Care Audit – Dying in Hospital. The results of the audit concluded there was a clear need for improvement in the care of dying patients to better align with the 'five priorities for care'. The results of the audit concluded there was a clear need for improvement in the care of dying patients to better align with the 'five priorities for care'. The audit showed that

when compared to other trusts in England, this trust consistently ranked in the bottom 20, for two of the five clinical indicators and was classified in the bottom ten compared with the national average for England. It was accepted the trust recognised dying later and the interval between the recognition of dying and death was shorter.

- In almost all areas of the case note review undertaken within the trust it was agreed that when determining why discussions did not take place, there was a higher incidence of 'no reason recorded' documented for UHL than nationally, therefore suggesting documentation of end of life issues was poor and required improvement.
- In response to the audit, the trust had an interim at the end of life plan which had since been reviewed to improve usability. However, we could not see an end of life care strategy that included prioritised, time bound actions with appropriately allocated leads.
- SPCT leads had started attending other speciality mortality and morbidity meetings to identify if there were any end of life care issues which still needed to be addressed. The SPCT told us their attendance at these meetings had improved collaborative working between themselves and other specialists in providing end of life care for their patients.

Leadership of service

- The chief nurse for the trust was the executive board lead for end of life care. However, there was no appointment of a non-executive director (NED) specifically for end of life care. Non-executive directors work alongside other executive directors as an equal member of the board. They share responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the local improvement of healthcare services. There was a lay representative from Health watch and a non-executive director who was the Quality Lead non-executive director, however, although they both had an interest in end of life care, there was not a dedicated NED for the service.
- The trust told us, not having a non-executive director did not disadvantage them and they had received no negative feedback from the board about the provision of end of life care.
- There was no intention at the time of our inspection to identify a non-executive director.

End of life care

- End of life care was part of the cancer, haematology, urology, gastroenterology and general surgery (CHUGGS) clinical management group. The end of life care service lead who was a palliative medicine consultant was also the deputy clinical director for CHUGGS.
- Staff we spoke with said they were aware of the leadership structures and received good leadership and support from their immediate line managers.
- The SPCT confirmed there were regular formal information relaying processes including messages from the chief executive and board of directors, such as monthly e-mails.
- Ward staff felt management were approachable and supportive.

Culture within the service

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

Public engagement

- We saw that patients experience stories were discussed at the board of directors meeting.
- There were no specific consultation groups in place for patients and the public to contribute to the development of end of life care services in the trust.
- The chaplaincy service had recruited 80 volunteers of differing faiths who worked with patients and their families throughout the three hospital sites.

- Bereavement support was offered to relatives (adult inpatient deaths), aiming for contact six to eight weeks post-bereavement. Documentation showed that between January and March 2016 49% of relatives took up the offer of bereavement support. Feedback from 104 relatives in March 2016 rated the quality of care as good to excellent for the majority 82%. 11% of relatives rated the care as 'ok', with 4% rating the care as 'poor'. 3% of relatives stated they were 'unable to say'.






Staff engagement

- The chaplain was part of the multi-disciplinary team who worked in end of life care and supported patients, families and staff as required.
- Most wards had a designated end of life 'champion' in place with responsibility for promoting the use of the end of life AMBER care bundle when this was appropriate.
- Ward staff told us they were not invited to formally feedback about the SPCT.
- There was a process in place to feedback information to staff via newsletters, emails and staff meetings. Staff were informed about the outcome of complaints and incidents within their area of practice.

Innovation, improvement and sustainability

- The trust had recruited a bereavement nurse specialist in July 2015 who worked across the three hospital sites and closely with the SPCT. The SPCT told us they felt this new post had improved the service they delivered by providing a specific person for bereaved families to talk with after the death of their loved one.
- The trust participated in the Transforming End of Life Care in the Acute Hospitals programme (Transform programme). The Transform programme aimed to improve the quality of end of life care within acute hospitals across England. It focuses on both the quality of care provided by acute hospitals, as well as the role acute hospitals have that provide care for people who are approaching end of life.
- There were very few audits and quality measures in place to monitor the effectiveness of end of life care in order to benchmark against end of life services nationally.

Outpatients and diagnostic imaging

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

Information about the service

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

The specialities with the most numbers of outpatient attendances at the LRI are: ophthalmology, dermatology, and gynaecology

The trust offers a range of diagnostic imaging services at the LRI. These include; x-ray, computerised tomography (CT) scanning, and magnetic resonance imaging (MRI).

Seven clinical management groups (CMGs) managed outpatient specialities. For example, cancer, palliative care, urology, gastrointestinal, and general surgery were in the cancer, haematology, urology, gastro intestinal and general surgery (CHUGGS) clinical management group; ophthalmology, orthopaedics, plastics, maxillofacial, oral surgery, and ear nose and throat (ENT) reported to the musculoskeletal and specialist surgery (MSK) clinical management group. The clinical support and imaging (CSI) CMG had responsibility for diagnostic imaging, medical records management and the booking centre.

We visited a range of clinics including the Balmoral and Windsor eye clinics, eye casualty, and the rheumatology, gynaecology, dermatology, ear nose and throat (ENT), haematology and fracture clinics. We also saw x-ray, CT scanning and MRI diagnostic facilities at the LRI site.

During our inspection of the LRI we spoke with 24 patients, three consultants, seven managers and senior radiographers, twelve senior level and nine band five nurses, two health care assistants, two clinic coordinators, three administrators and one student.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient services and diagnostic imaging at Leicester Royal Infirmary as requires improvement overall.

- The trust had backlogs of patients waiting for initial and follow up appointments. It did not meet its target for two week cancer waits, although performance was improving. Managing outpatient capacity was complicated by booking multiple appointments at the same time. Clinical schedules did not reflect the time needed to carry out consultations.
- The hospital did not fully recognise, assess or manage the risks associated with outpatient services, for example, the need to schedule timely follow up appointments for eye patients. Ophthalmology and rheumatology specialities had backlogs of follow up patients.
- Clinical outpatient services lacked regular dashboards to show performance against quality, safety activity and financial indicators. Clinical management group (CMG) level plans were not clear about how they would match capacity with demand for outpatient services.
- The approach to assessing and managing day-to-day risks to people who use services did not take a holistic view of patient's needs. Standards of hygiene were not met in some outpatient clinic rooms, waiting areas and toilets. Overcrowding in the eye clinic was unpleasant and unsafe for patients.
- There were periods of understaffing. Nurse staffing levels, at Leicester Royal Infirmary (LRI), based on information given to us by the trust, were 18.5% below the planned level.
- Patient privacy and dignity was not protected in the eye clinic. Overcrowding long waits and cancellations led to a poor quality outpatient experience.

However, we also found:

- Patients told us that nurses and doctors were kind, caring and courteous.

- Outpatient services and diagnostic imaging learned from incidents and there was an open reporting culture
- Patient care and treatment were planned and delivered in line with current evidence-based guidance, standards, and legislation. This was monitored to ensure consistency of practice
- Staff spoke highly about senior leadership and there were effective staff and public engagement initiatives

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safe as requiring improvement because there was limited assurance about safety.

We found:

- The trust did not use any assessment tool to ensure there were sufficient number of outpatient nursing staff available. This resulted in periods of understaffing or inappropriate skill mix, which were not addressed quickly. Nurse staffing levels, at the Leicester Royal Infirmary (LRI), based on information given to us by the trust, were 18.5% below the planned level.
- The risks associated with anticipated events were not fully recognised, assessed or managed. Ophthalmology and rheumatology had backlogs of follow up patients. The services had not fully assessed their clinical priority for appointments, which meant patients were at risk of harm.
- The approach to assessing and managing day-to-day risks to patients who used services did not take a holistic view of patient's needs. Standards of hygiene were not met in some outpatient clinic rooms, waiting areas and toilets. Overcrowding in the eye clinic was unpleasant and unsafe for patients, however this was addressed both during and after our inspection.
- Medicines were not always kept securely. They were in unlocked cabinets or in fridges with unreliable temperature control. We found open cupboards containing hazardous materials, and liquid nitrogen which was not stored safely.
- Patient records were not always stored confidentially.

However, we also found:

- Diagnostic imaging and outpatient services had a positive incident reporting culture and could demonstrate learning from incidents. Staff received regular mandatory training and knew what to do to safeguard vulnerable patients.

- Diagnostic imaging had arrangements in place for patients who were at risk of spreading infection to others. The environment in diagnostics was visibly clean.
- Staff checked resuscitation equipment and imaging equipment in outpatients and diagnostics on a daily basis.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- There were no 'never events' reported in outpatient or diagnostic imaging services at the Leicester Royal Infirmary (LRI) between May 2015 and April 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event.
- Leicester Royal Infirmary (the LRI) reported four serious incidents between May 2015 and April 2016. These included a failure to provide timely care in ophthalmology, wrong site post-operative radiotherapy, failure to act on a diagnostic test result and a scan on the wrong patient. In-depth investigations were completed to ensure learning from these incidents was undertaken. Action plans were developed to address risks and learning was shared through clinical governance processes, for example through mortality and morbidity meetings (meetings between clinicians and management to review learning and processes around safety) and clinical management group (CMG) safety board meetings. For one incident, resulting actions included extra training for staff and a new policy and process on follow up eye appointments.
- Diagnostic imaging reported radiation exposures which were greater than intended and learned from these serious incidents. In February 2016, one patient at the LRI received a computerised tomography (CT) scan (a 3D x-ray) instead of another patient on the same ward. This was because a doctor requested the scan electronically on the wrong patient's record. The imaging service did

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not notice that the patient who attended was significantly physically different to the clinical details on the request form. The trust reported the incident to the Care Quality Commission (CQC) to comply with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) regulations. These regulations aim to protect patients from unintended, excessive or incorrect medical exposures. The trust developed an action plan to mitigate future risks and share the learning trust-wide.

- Staff within diagnostic imaging followed procedures so they were open and transparent when errors occurred. For example, when radiotherapy was administered in error to the wrong part of a patient's body in September 2015, an investigation was undertaken and the error was reported to the Trust Development Authority (TDA) and the CQC. The investigation report explained how the service apologised to the patient and involved relatives in response to their verbal complaint. The service took action to put in place additional checks on patient identity to prevent such an incident from happening again.
- There was a culture of openness in diagnostic imaging, which encouraged the reporting of incidents. Between March 2015 and April 2016 the clinical management group (CMG) responsible for diagnostic imaging, reported 796 incidents trust-wide.
- Staff told us they reported every sort of incident including incidents relating to radiation protection. Managers received an up to date report of incidents. There were lead managers for different types of scans, such as CT and magnetic resonance imaging (MRI). MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Managers at the LRI ensured their teams knew about incidents that had occurred at Leicester General Hospital (LGH) and the Glenfield Hospital (GH), and which incidents had to be reported to the CQC as part of the IR(ME)R regulations. This meant learning from radiation protection incidents was shared across hospital sites and was externally reported.
- On investigating serious incidents, managers in the service were open and honest with patients and their families about what they found, and apologised in writing. We saw examples of this.
- Staff in the dermatology outpatient specialty told us about changes that had happened following a wrong site surgery incident. Following an investigation of the

incident, an adapted version of the World Health Organisation (WHO) five steps to safer surgery checklist was put in place to ensure surgical sites were correctly identified. However, at the time of our inspection, the trust had not audited whether staff were using the tool effectively.

- Nursing staff in outpatient clinics knew how to report incidents. Not all health care assistants were sure how to report incidents on the trust's electronic reporting system, but told us they would know how to escalate concerns to senior nurses. Some staff at various levels expressed frustration about not hearing the outcomes from reporting incidents.
- Outpatient and diagnostic imaging services responded appropriately to safety alerts (external alerts about processes, equipment or medication to keep patients safe). They communicated these through joint clinical governance and mortality and morbidity meetings.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' We saw from incident investigations that incident investigators involved patients and their families through the investigation process.
- Knowledge about duty of candour was not embedded. Outpatient clinic staff were aware of it, but had limited understanding. Staff in outpatient clinics explained to us what they thought the duty of candour was, they had not had any specific training and the trust did not audit the effectiveness of training or understanding of the duty. Staff told us they were open and honest about mistakes, but could not remember a specific time when they used the duty. Outpatients and diagnostic imaging services were not systematic in how it applied the duty, but for example, apologised after a complaint rather than proactively explaining the situation and apologising to the patient or the patient's family.
- However, we observed staff in diagnostic imaging applying the principles of the duty of candour. We witnessed a misunderstanding in CT scanning which meant a patient nearly had the wrong type of scan. There was no harm to the patient but the scan was delayed and staff explained the error to the patient and apologised.

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

- There had been a recent change to cleaning at the hospital with the contract for cleaning returning to the trust. At the time of the inspection, not all of the problems with cleanliness at the hospital had been addressed. We raised all of our findings during the inspection with the senior managers in the trust. They were very responsive and took action to address these problems straight away.
- The hospital did not consistently maintain standards of cleanliness and hygiene in outpatient clinics. The patient's toilets in the eye clinic and eye casualty department were not visibly clean, with dirty lavatory pans. There were no cleaning schedules on display to monitor that cleaning had taken place. We raised this during the inspection and action was taken to address the concerns.
- We visited the rheumatology clinic in clinic four. There was visible dust in the clinic rooms and we could not see any evidence to suggest that equipment was clean and ready for use.
- We found several toilets in various clinics that were not visibly clean. We also found problems with clinical waste bins being full or being used for items that did not require incineration.
- Cleaning schedules were not always displayed. Where outpatient clinics had introduced cleaning records, they were not maintained accurately.
- Cleaning audits did not cover all outpatient clinic areas and consulting rooms at the hospital.
- The trust's infection prevention team carried out environmental audits in imaging to check cleanliness and results showed there were issues with dirty floors and changing rooms and dusty equipment and blinds.
- When we asked nursing staff about cleanliness they knew it was a problem but they had not addressed this. For example, staff confirmed a toilet had not been cleaned for two or three days.
- The cleaning rota facilitated a clean of facilities for two hours on weekday evenings Monday to Friday within the outpatient clinics.
- We checked toilets and waiting areas in the diagnostic imaging areas and saw they were visibly clean. We observed diagnostic imaging staff washing their hands before and after contact with patients.
- Some materials were not locked away safely. We found an open domestic store cupboard in the Balmoral building which was open. It contained sodium hypochlorite tablets and hand sanitiser. This breached the Control of Substances Hazardous to Health (COSHH) regulations which states that such substances should be kept in a locked cupboard. The biopsy room contained COSHH materials such as chemicals for cleaning. These were stored in the same cupboard as equipment such as sutures, needles, sanitiser gel and syringes which would be used for clinical procedures. Liquid nitrogen canisters were stored on top of a cupboard in clinic four for collection at the end of each day. These canisters were not stored securely. This was not good practice in accordance with COSHH guidelines.
- Hand sanitiser was readily available throughout all clinics and in diagnostic imaging.
- The trust carried out hand hygiene audits but reported the results by clinical management group and by ward. There were no results for outpatient clinics per se.
- Staff in outpatient clinics and diagnostic imaging observed the 'bare below the elbow' rule in clinics and treatment rooms. (No sleeves, watches or jewellery below the elbow so that staff could wash their hands and forearms thoroughly to ensure good hand hygiene.)
- Diagnostic imaging had arrangements in place for patients who were at risk of spreading infection to others. Patients were scanned or x-rayed at the end of the day to minimise the risk of cross contamination and spread of infection to others. Diagnostic imaging had their own staff to clean the scanners and to carry out safety checks.

Environment and equipment

- The design and maintenance of facilities sometimes did not keep patients safe. The waiting environment for ophthalmic (eye) patients and eye casualty was overcrowded and felt airless. During our announced inspection we observed 10 patients standing up because all the seats were occupied and a further five patients sitting on the floor. There were also six patients sitting in wheelchairs along the corridor which reduced the corridor access. This represented a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
- During our unannounced inspection of this hospital the eye clinic was less crowded. However, the temperature in the eye clinic waiting areas was 26 degrees centigrade (°C); the external temperature was 20°C, and patients told us they thought it was "hot and stuffy".
- Haematology staff were concerned about overcrowding in the haematology day case area as sometimes as

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many as 70 patients were admitted there. Staff had raised this as a safety concern on the electronic incident reporting system, but the problem had not been resolved.

- We raised these issues to the trust during our inspection and they took immediate action to address some of the immediate concerns we had such as providing extra seating so patients were not having to stand.
- We checked resuscitation equipment in clinics and found that staff checked resuscitation trolleys daily. The contents were all present and in date. Resuscitation safety checks in diagnostic imaging were all up to date. This meant resuscitation equipment was safe and ready to use in an emergency.
- We observed staff using personal protective equipment (PPE) such as lead aprons in diagnostic imaging. A lead apron is a type of protective clothing that acts as a radiation shield.
- Diagnostic imaging had signs outside rooms where radiation took place to show that access was restricted. Staff also locked doors when imaging involving radiation was taking place, which kept staff and patients safe from accidentally walking into the room.

Medicines

- We observed medication (eye drops) in an open unlocked cupboard in eye casualty in the patient waiting area. Staff told us this was left unlocked for access during the clinic and then locked when the clinic was finished. This meant that the eye drops were publicly accessible, could be tampered with and were not kept securely.
- We identified that medication fridge temperatures were recorded on a daily basis. However, staff were not recording maximum and minimum temperature levels. This meant staff could not be assured that a consistent temperature had been maintained and the safety and effectiveness of the medicines had not been compromised. This was addressed with the trust during our inspection.
- The trust had policies and protocols in place to ensure the safety of controlled drugs and chemotherapy given in outpatient clinics. Controlled drugs have stricter legal controls to prevent them from being misused or causing harm. The Leicestershire Medicines Code specified there

should be an official prescription and how medicines should be checked against the prescription. Prescription pads were locked away safely in outpatient clinics, complying with the medicines code.

Records

- Patient's medical notes were not always kept securely. In rheumatology and dermatology clinics for example, we observed patient's medical notes left unattended on top of reception counters with patient details visible, or on publicly accessible shelves outside clinic rooms. This meant there was a risk of access to a patient's medical notes by an unauthorised person.
- There was a trust-wide system for ensuring medical records were available for clinics and for tracking the location of records electronically. However, staff from medical records told us that outpatient clinic staff did not always comply with the system and medical staff sometimes had to search for records.
- Last minute additions to patient lists meant staff could not always find patient records in time for a clinic. When a patient was required to attend more than one clinic appointment, these were sometimes booked within a short time of each other. This meant there was little time for records to be transferred to the next clinic or hospital. In many cases, doctors saw patients even if medical records were missing. For example, in gynaecology staff estimated there were two to three sets of notes missing from every clinic list (clinic lists varied from 12 to 30 patients). However, the gynaecology clinic had its own computer system which held all the patient details. This provided patient details if the medical records were missing.
- The trust generated monthly reports which tracked when notes arrived too late for a patient appointment. This information was shared at clinical management group (CMG) assurance meetings. CMGs did not review this by type of hospital activity or by site so were unaware of how information affected outpatients or specific hospitals. The percentage of late notes trust wide varied between 3.7% and 5.3% for April 2015 to March 2016. Specialties cancelled around 10% of requests for notes.
- The trust had started to put in place an electronic patient record system but then stopped as some clinicians could not find the records easily enough. A task and finish group was working to complete the project.

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Safeguarding

- Data provided by the trust showed all qualified and unqualified nurses in outpatient clinics had up to date adult safeguarding training and either level one or two for safeguarding children.
- Staff in the eye clinic completed safeguarding training and the children's safeguarding nurse knew who to contact if a matter needed clarifying or escalating. Staff told us they would speak to their line manager and could give recent examples of how they had taken action on safeguarding.
- Staff in clinics were aware they might identify people at risk. They told us they would tell the senior nurse on duty and inform the safeguarding team. Staff working in the eye clinic were particularly aware they might identify cases of domestic abuse, and gave us examples of action they had taken.
- Gynaecological outpatient services received training on female genital mutilation (FGM) and how to handle situations sensitively and alert the safeguarding team if necessary. Patients with FGM received help from a specialist counsellor. The service held a specialist FGM clinic once a month. Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- In diagnostics, MRI and CT staff were clear on what to do if they were concerned about safeguarding. They told us they did on-line training and knew what signs to look for concerning children and vulnerable adults.
- There was a procedure in place to ensure patients received the right radiological scan at the right time. This included identity checks (name, address and date of birth) at reception and before scanning. The before scanning check included which side of the patient's body was to be checked, the area to be checked, the patient's scanning history and the pregnancy status for female patients.
- Diagnostic imaging had a radiation safety policy which outlined all safety areas overseen by the radiation protection committee. This specified measures to keep doses to patients as low as reasonably possible and to minimise staff radiation exposures.
- Interventional radiology (non-diagnostic) used an adapted version of the World Health Organisation (WHO) five steps to safer surgery. This kept patients as safe as possible during these procedures.

- Some diagnostic imaging safeguarding policies were not up to date. For example, the guidelines for providing written and verbal statements to the police in safeguarding cases went out of date in 2007 and the policy for children accompanying patients, written in 2006 had not been reviewed. The trust advised us that new policies were available however, the presence of outdated policies being available to staff meant they may refer to them and use them.

Mandatory training

- Mandatory training included basic life support; conflict resolution; consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS); equality and diversity; fire safety; health and safety; infection and prevention; information governance; moving and handling; safeguarding adults; and safeguarding children level one and two.
- Training compliance rates in most CMGs within outpatient clinics was between 90% and 100%. The trust's target was 95% compliance. Exceptions were consent, Mental Capacity Act and Deprivation of Liberty Safeguards where 67% of qualified nurses in specialist medicine complied and non-qualified nurses in cardiac and gynaecology were 83% and 88% compliant respectively. In specialist medicine, 83% of qualified nurses completed basic life support training and conflict resolution training. This meant not all staff were trained on key areas, and there was scope to improve training compliance, particularly for consent, MCA and DoLS training. The trust did not monitor training by hospital site or by overall attendance to all mandatory training topics.
- Almost all diagnostic imaging staff (98%) were up to date with their radiation protection training. The diagnostic imaging service had a staff record training database which stored up to date records of Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000 e-learning, Ionising Radiations Regulations (IRR 99) e-learning and compliance with equipment training. Training records were comprehensive and accessible.

Assessing and responding to patient risk

- CT and MRI scans leading to a clinical incident, lack of outpatient follow up appointments available, insufficient middle grade doctors in women and

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children's services and insufficient staffing in ultrasound. However, it did not identify specific backlog risks in specialities where there was a risk of harm to patients.

- The trust had backlogs of follow up and initial appointment patients. For example, there was an eye clinic follow up backlog of 2670 appointments. The trust was in the process of assessing the clinical priority of these patients. A patient had been harmed because of delays in follow-up treatment. The trust identified this as a serious incident, carried out an in-depth investigation and developed an action plan. A rheumatology follow up backlog of around 190 patients was also awaiting clinical prioritisation.
- The trust had not adequately risk assessed the patient waiting area in the eye clinic and eye casualty which tended to be overcrowded. We saw a risk assessment produced by the trust's contractor which did not identify the evacuation risks. The area was overcrowded and it would be difficult to evacuate people with mobility issues in a safe and timely manner.
- We asked staff what they would do if a patient's health suddenly deteriorated. Staff in the eye clinic and ENT would take observations to score against the early warning system (EWS), alert a junior doctor and take the patient to the emergency department. Other clinic staff responded similarly.
- Diagnostic imaging appointed radiation protection supervisors for each clinical area and they were available to give radiation advice. The service managed risks to patients. They ensured they asked girls/women from the age of 12 to 60 for the date of their last menstrual period during the consent procedure before imaging. This protected pregnant women and their babies.
- The trust's Ionising Radiation (Medical Exposure) Regulations 2000 policy outlined its arrangements to meet IR(ME)R regulations. It detailed roles and responsibilities, the need for clinical audit, correct maintenance of equipment, training and compliance arrangements in order to limit risk. The imaging service developed a range of local policies such as the procedures for identifying patients correctly and minimising unintended doses. The trust also had a system in place, approved in March 2015, for identifying referral practitioners. This allowed nurses, allied health

professionals and health care scientists to request x-rays under delegated arrangements, if they had received the relevant training. The IR(ME)R policies were monitored by the imaging radiation protection group.

- Diagnostic imaging had signs outside rooms where radiation took place to show that access was restricted. Staff also locked doors when any imaging involving radiation took place. This meant the trust had robust processes in place to protect patients and staff when radiation was involved.
- There were protocols for the management of contrast medium in patients with renal failure; this protected patients from an adverse reaction. Diagnostic imaging had a policy for managing the risk to patients with acute kidney injury (AKI) and contrast induced nephropathy (CIN). AKI is sudden damage to the kidneys that causes them to not work properly. CIN is defined as the impairment of renal function within 48-72 hours of intravenous contrast administration.
- The service identified and acted on risks to patients and the public from the nuclear medicine service and other clinical areas where there could be a security threat.

Nursing staffing

- The trust did not use a nursing tool to assess how many nurses should staff an outpatient clinic. There are no standards nationally for staffing levels in outpatient clinics. Services assessed the needs of each individual clinic with the speciality to determine the level of nursing support needed, based on specialty and complexity of case mix. Each outpatient clinic had a trained nurse to deal with any situation that might arise, for example, patient collapse, patient becoming unwell and needing extra-support such as oxygen.
- The clinical support and imaging clinical management group (CSI) provided Registered Nurses, Health Care Assistants, Plaster Technicians and light therapy technicians to the OPD services that they were responsible for. The Clinic Coordinators and Admin Team leaders were all managed and supplied by the other CMG's/ specialties that the OPD provided services for. The clinical support and imaging clinical management group (CSI) supplied administrative and health care assistants but specialities supplied nursing staff clinics themselves
- Nurse staffing levels, at the LRI, based on information given to us by the trust, were 9% below the planned

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level for outpatients. The outpatient staffing level at 107.2 full time equivalent staff was 9 full time equivalent staff below the agreed establishment. The trust did not supply the reason for this.

- Nurses in clinic four (rheumatology) told us they felt overworked. A senior nurse told us she would come in on non-working days to cover staff sickness. The emergency department occasionally requested clinic four phlebotomy staff to help them when they were busy. This resulted in a shortage of staff in clinic four.
- Outpatient services did not use agency staff. They filled gaps with trust bank staff. Bank staff are from the trust's own database of temporary workers, often they are trust nurses doing extra shifts.
- All new staff in outpatient clinics had a local induction that was recorded on the trust's e-learning system. Clinics recorded bank staff training in a local induction record book.

Medical staffing

- The trust did not know how many doctors it needed to meet patient demand for outpatient services. Outpatient administrative staff told us the trust did not review clinic schedules regularly. Along with clinical commissioning group partners and an external consultancy company, the outpatients programme board initiated projects to analyse current and future demand. When we inspected, this work was still in progress.
- Some specialities recognised they had to take action on recruitment to ensure that patients had timely appointments. For example, the ear, nose and throat service advertised for two more doctors to run clinics to manage the workload. The dermatology service was recruiting doctors and addressing skills gaps through collaborative work with other local hospitals and general practitioners with a specialist interest. The musculoskeletal clinical management group had recruited two additional consultants and planned to recruit another. The ophthalmic department needed two more consultants on their rota and planned to attract staff from overseas. It was too early to assess the impact of this recruitment.
- The diagnostic imaging service told us they did not have enough radiologists. In response, they had successfully recruited 11 imaging consultants to start in September 2016. There were 50 diagnostic imaging vacancies though these were mainly for ultrasound and CT

procedures. MRI staff at the LRI were concerned about staffing, especially for the provision of a 24 hour rota. Staff told us that filling ultrasound vacancies was a particular problem. However, a screening sonographer (ultrasound operator) had just joined the trust, which gave the service the extra capacity to carry out audits.

- The imaging service had a local policy approved in March 2015 to allow nurses, allied health professionals and health care scientist to request x-rays under delegated arrangements, if they had relevant training.

Major incident awareness and training

- The trust had a business continuity management policy and the CMG's had procedures and service incident response plans to follow in case of events such as loss of electrical power and flooding. As outpatient clinic staff reported to different CMGs, their understanding of what to do in an emergency varied.
- Staff were sometimes not aware of what to do if there was a major incident. For example, fracture clinic staff told us that if it was busy they would go to the emergency department to help but could not tell us what would happen in their own clinic. Other staff said they would report to the duty manager.
- The service had flowcharts for staff to follow in case of accidental exposure to radiation due to equipment failure, and accidental spillage in nuclear medicine. They had measures in place in case of a radiation or radioactivity incident occurring. The trust's ionising radiation and IR(ME)R policies described arrangements at a high level. The trust had a procedure for reporting adverse incidents on its electronic incident reporting system.
- The nuclear medicine service had a quality management system which included contingency plans for spillages which included prioritising injured people and decontamination arrangements; syringe failure and what to do in the event of a fire, theft or loss. These policies also included action to be taken if the incident occurred outside of normal working hours.

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Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. We found:

- Patient care and treatment were planned and delivered in line with current evidence-based guidance, standards, and legislation. This was monitored to ensure consistency of practice
- Access to imaging services was available seven days a week and up to midnight. Ear, nose and throat (ENT) and eye clinics offered Saturday and Sunday appointments as part of an initiative to reduce waiting lists.
- Staff developed their skills and specialist nurses added a depth of knowledge and assisted clinics to offer a range of services.

However, we also found:

- Patients in some specialties told us staff did not ask them about their level of pain or comfort on arrival or while they were waiting for appointments. Patients often had a long wait and were not always asked about nutrition, which was a risk for patients with diabetes and older patients.
- The use of performance and quality dashboards to monitor and display patient outcomes was limited.
- Patients told us that working specialties did not always work effectively together was not 'joined up'.

Evidence-based care and treatment

- We saw some evidence that local medical policies were based on national best practice. For example, dermatology practices were based on National Institute for Health and Clinical Excellence (NICE) and British Dermatology Society guidance. The dermatology service used the baseline assessment tool for NICE guidelines on psoriasis (CG153) and it met all NICE recommendations. Psoriasis is a skin condition that causes red, flaky, crusty patches of skin covered with silvery scales.
- The hospital completed a variety of clinical audits. It carried out a baseline assessment for gallstones (CG188)

which included diagnostic imaging and upper gastro intestinal specialities. In 2014 it met all of the NICE criteria. It audited its compliance with NICE QS 90 for urinary tract infections (UTIs) in adults in June 2015 and fully met the criteria.

- The rheumatology service audited its compliance with NICE guidance on a specific medication, used to treat osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue), and established a new document to be completed for every patient. The service planned to re-audit in 2017, to ensure it continued to meet the guidance.
- The ophthalmic service evaluated its care of patients with glaucoma (a degenerative eye condition which can lead to blindness) against NICE guidance in 2014 with the results presented in January 2015. Improvement actions included expanding the service and widening the criteria from low risk to low and moderate risk. These actions were ongoing when we inspected.
- The gynaecology service was proactive in starting its own audits. In 2015 they started a database of patients who were living with human immunodeficiency virus (HIV) with the aim of creating trust guidelines for these patients.
- In 2016 a specialist nurse started an audit on borderline squamous cancers. They audited vaginal pre-cancers and the 'test of care' to assess care after treatment following smears and viral tests.
- Outpatient services at the trust did not contribute to the NICE shared learning database. The trust submitted a nil return, but did not inform us about the reason.
- Diagnostic imaging services worked with specialities on local audits which provided learning. They reviewed their approach to investigation of unprovoked venous thromboembolism (VTE) also known as a blood clot. This led to the development of local guidelines for clinicians and haematologists. (blood specialists)
- The diagnostic imaging department contributed to national audits. They contributed to the Down's Syndrome Screening Quality Support Service (DQASS) audit of June 2016 which measured the quality of ultrasound image by operator code. They did this in response to an ultrasonography incident. The audit led to supervised training and work protocols for obstetricians, which was continuing when we inspected.
- The diagnostic imaging service could demonstrate learning from audits. For example, following the 'accuracy of renal tract ultrasound in the detection of

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renal scarring compared to DMSA audit', training on how to detect renal scarring had been introduced. A DMSA scan is a radionuclide scan that uses a radioactive tracer in assessing the structure and function of a kidney. The audit programme complied with IR (ME)R guidance and the service reviewed a different audit each month at the radiation protection board.

- Diagnostic imaging had a procedure for the use of local diagnostic reference levels (the dose set at the average of a group of patient doses). This included gathering the data and establishing the level for patients within a weight tolerance, and displaying the data in the imaging control area. The service identified three cases trust wide where there was a difference with regional practice. Its practice was evidence based. It had a knowledge base and used I-refer on the trust's I-drive to refer to good practice.
- The imaging service had a range of policies and protocols. This ensured staff applied the same standards to each patient and helped with the collection of patient outcomes.

Pain relief

- In outpatient clinics the pain of an individual patient was not always assessed and managed appropriately. Staff did not routinely check whether patients were in any pain or review pain using a pain assessment tool. We spoke with a patient who had a fractured elbow and had been waiting in the fracture clinic for five hours 45 minutes. Staff had not explained to them why they were waiting or assessed their need for pain relief. We informed the staff in the clinic about this who responded appropriately.
- Ophthalmic clinic patients told us no-one asked them if they were in any pain. This meant patients could sit and wait for their appointment time in pain if a patient felt unable to ask for pain relief. However, nurses told us the clinic stocked paracetamol for pain relief, and doctors could prescribe a stronger medication for pain if it was required.
- The trust had a specialist multidisciplinary pain management service. It ran clinics for children and adults with facial, pelvic, drug addiction pain and those requiring complex pain management programmes. Their multidisciplinary team consisted of pain consultants, nurses, physiotherapists, occupational therapists and health care assistants. There was a pain management team working at all three hospital sites.

Nutrition

- In outpatient clinics, we spoke with 16 patients, many of whom had waited a long time past their agreed appointment time. They reported that no-one had offered them refreshments. Staff did not proactively tell patients how long they would have to wait, so patients felt they could not leave the clinic to find their own refreshments. This meant patients who needed to eat on a regular basis, such as those with diabetes, may have been at risk.
- Outpatient clinics received donations from private individuals for refreshment rounds for patients who were waiting for their appointments. The eye clinic received a donation for a refreshment round shortly before our inspection. We received no further details.
- Staff told us that patients could go to snack machines, positioned in or near the outpatient and diagnostic imaging areas. In the ophthalmic clinic there was a coffee machine accessible and a water dispenser for patients in the centre of the area.

Patient outcomes

- Patient outcomes were not always monitored regularly or robustly. Nor did the service benchmark itself against similar services. This meant the service was unable to identify what actions needed to be taken to improve the service it provided. We saw no dashboards showing how the clinics were performing against quality or performance measures displayed on noticeboards showing patients clinic outcomes. Most clinics lacked quality standards, targets or evidence of quality or safety monitoring.
- Diagnostic imaging services had not implemented the Imaging Services Accreditation Scheme (ISAS). This is a patient focused assessment and accreditation programme designed to help diagnostic imaging services ensure their patients receive high quality services. The annual plan showed the trust intended to work on this accreditation in 2016/2017.
- The haematology service submitted an outcome dashboard to the British Society of Bone Marrow Transplantation. The department compared favourably nationally and benchmarked with other centres. The Human Tissue Authority (HTA) accredited the haematology service. The HTA is an executive non-departmental public body of the Department of

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Health. It regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training.

- The diagnostic imaging service was proud of its cardiac CT and CT colonography pathways. A colonography is a CT scan which looks specifically at the colon (large intestine).
- The service also had the contract for paediatric x-rays on-call for the East Midlands.

Competent staff

- Staff received appraisals at yearly and six monthly intervals. Data from the trust showed 90% of staff in diagnostic imaging and outpatient clinics had completed appraisals, meeting the trust's target of 90%. Staff told us the appraisals were helpful.
- Outpatient staff were able to develop specialist skills. The fracture clinic had competency assessments for unregistered staff in orthopaedics, which encouraged staff to develop. Nursing staff in gynaecology were colposcopy or hysteroscopy accredited. A colposcopy is a diagnostic procedure to examine an illuminated, magnified view of the cervix and the tissues of the vagina and vulva. A hysteroscopy is a procedure to look inside a woman's womb.
- Assistant radiographers in diagnostics could act as operators, under supervision. They worked within specific guidelines. Diagnostic staff at all levels felt that quality was their responsibility.
- The trust had identified there was a lack of competent staff to arrange outpatient bookings to meet the 18 week waiting list target. To address this, they had developed an e-learning module for the processes for the referral to treatment standard (waiting time of less than 18 weeks). The effectiveness of the e-learning package had not yet been evaluated.
- Managers in diagnostic imaging encouraged staff to develop. Diagnostic imaging operational meeting notes showed they had accessed funding for two radiographers to train in musculoskeletal magnetic resonance imaging (MRI) reporting and for two people to train in a CT head course.
- Radiographers were keen to develop and volunteered to be trained for the mobile lithotripsy unit. Lithotripsy is a procedure using ultrasound shock waves, by which a kidney stone or other calculus (type of stone) is broken into small particles that can be passed out by the body.

- Some imaging staff completed training in specialist areas. A radiographer/nurse service was available when undertaking hystero-salpingograms on female patients. This is an X-ray test that looks at the inside of the womb and fallopian tubes and the area around them. Staff informed us this added to their job satisfaction.
- Diagnostic imaging had a practice learning team. They aimed to develop assistant practitioners in radiography and to give students the best possible training. Student numbers had increased over time and other trusts had copied this practice.
- New radiographers told us there was a good induction process in place with a period of observation/preceptorship, and always a more experienced radiographer available to give guidance, even at night. The departmental manager set learning objectives with target dates, which ensured that radiographers developed their skills.

Multidisciplinary working

- Some patients told us that care between specialities was not coordinated. One patient visited the ear nose and throat (ENT) clinic on multiple occasions for separate routine ear and throat issues which they felt the hospital could have dealt with on the same day. Another patient was transferred repeatedly for seven months between dermatology and ENT until a consultant undertook a specific procedure and treated the patient.
- Specialities held multidisciplinary team meetings to review complex cases. For example, in gynaecology this took place every month and specialist nurses, who had undertaken extra clinical training in their specialism and consultants attended.
- Some clinics had specialist nurses in attendance, for example, the dermatology clinic had a specialist practice nurse, and there were specialist urology nurses. Gynaecology had four specialist nurses who added to the ability of clinics to undertake such procedures as colposcopies and hysteroscopies. They worked at the Leicester General Hospital as well as the Leicester Royal Infirmary (LRI).
- There was an electronic (email) advice and guidance function for GPs so they could access advice from a consultant. The referring GP received a response within two days and this initiative reduced the number of GP referrals by 16%.

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Seven-day services

- Access to scans at the Leicester Royal Infirmary (LRI) was 24 hours a day, seven days a week. The service also opened overnight and all radiographers were trained in CT. Up to 20 patients could receive a CT scan overnight. MRI scans were also available every day of the year, and offered an on-call service out of hours.
- The eye casualty area and fracture clinic opened on a Saturday morning. These were long standing arrangements to meet demand. A small number of outpatient clinics offered Saturday and Sunday appointments to reduce the number of patients waiting for first appointments. For example, the ENT service outsourced Saturday appointments to an external company. The eye clinic opened in the evenings, initially to reduce the number of patients waiting. However it had then established a pattern of evening opening and was continuing the service because of ongoing demand.

Access to information

- The diagnostic imaging service provided electronic access to results in other services in the trust. This meant specialties could take action quickly if it was necessary.
- Consultants told us they expected letters to GP's and patients to be sent out after clinics within a few days for urgent treatment and no more than four weeks for non-urgent matters.
- We checked six sets of patient notes in the dermatology clinic. All had letters sent to patients two days after attending the clinic. A consultant in dermatology told us they would hand-write a letter or facsimile (fax) it if a GP needed notifying of anything quickly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training about the Mental Capacity Act 2005 and Deprivation of Liberty safeguards through an e-learning package. The trust had not evaluated its effectiveness when we inspected.
- Staff in gynaecology told us they had recently experienced a patient who lacked mental capacity and described the action they took, which was appropriate.
- Consultants told us they would ask for consent with carers present or ask for those with lasting power of attorney to sign. A lasting power of attorney (LPA) is a

way of giving someone the legal authority to make decisions on a person's behalf if they lack mental capacity at some time in the future or no longer wish to make decisions for their self.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good.

- Patients were complimentary about the care they had received from medical nursing staff in outpatient clinics and diagnostic imaging.
- Some clinics provided information to patients about their treatment and condition.
- We observed that consultants and nurses took the time to explain diagnostic imaging results to patients and allowed time for questions.

However, we also found:

- Patient privacy and dignity was not always protected in some clinics.
- Availability of chaperones were not publicised outside consulting rooms, so there was a risk that patients did not know that they could ask for one.

Compassionate care

- We saw examples of positive interaction between staff and patients whilst they waited for appointments in clinics. For example some patients had attended clinics for many years and staff knew them well. As a result, a rapport had developed between them. This helped to relieve tensions that patients sometimes felt.
- In some clinics, such as the eye clinic, ENT and dermatology, patients could not speak to clinicians or receptionists without being overheard. The reception areas in eye casualty and eye clinic were very close to where patients were seated. The eye examination area in eye casualty was segregated by curtains which meant patients could overhear each other's conversations with nurses, optometrists or consultants. This compromised patient privacy.
- There were no posters or notices to make patients aware they could request a chaperone. (a nurse of the

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same gender to be present with the patient during a clinical examination). Staff assured us they asked patients whether they would like a friend or family member to be present. However three patients told us staff did not ask them.

- We reviewed 'tell us about your care' trust feedback cards which patients attending outpatients and diagnostic imaging had completed. Five of the sixteen cards returned contained negative comments about waiting times and cancellations. Five of the remaining nine cards contained positive comments about outpatient services at Leicester Royal Infirmary (LRI).
- We reviewed the NHS Friends and Family Test (FFT) results from October 2015 to March 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. In most specialties only a small percentage of respondents had completed the survey. For some specialties, over 90% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care. Specialties with less than 85% satisfaction were gastroenterology (83%), urology (81%), dermatology (80%), endocrinology (81%), rheumatology (78%), maxillofacial (76%), plastic surgery (71%), and allergy (83%).
- The Leicester Royal Infirmary (LRI) analysed patient feedback contained in the January 2016 to March 2016 'message to matron' cards. There were 72 'compliments and thank you' comments to caring staff, and 25 suggestions. The suggestions concerned issues such as car parking, communication, signage, facilities, changing rooms, cleaning standards, in-clinic wait times and incorrect medical records.
- Patients were complimentary about medical staff and nurses in outpatient clinics, describing them as "lovely" and "very kind". In imaging services, such as x-ray, computerised tomography (CT) and magnetic resonance imaging (MRI), patients described the staff as "caring", "courteous" and "helpful". We saw that imaging staff brought patients refreshments if they had been waiting a long time.

Understanding and involvement of patients and those close to them

- Patients were generally kept informed of delays in waiting times although we did speak with two patients who were not happy about the time they had to wait before they had their consultation and said they hadn't been kept informed.
- Patients understood when they would receive their test results or when their follow up appointment should be, following their outpatient or diagnostic appointment.
- Patients told us they also received a copy of the letters sent between the hospital and their GP.
- Clinics gave patients information about their treatment and procedures. For example, dermatology patients were given a sheet to take home explaining their procedure. This showed what would happen and gave details about consent. Patients told us that clinics gave out details of who to contact if they were worried about their condition or treatment after hospital.

Emotional support

- Some outpatient services gave patients timely support and information to cope emotionally with their condition. For example, the gynaecology service had access to a psychology team to support patients who had received a diagnosis of cancer. The urology clinic had an oncologist and a full time counsellor who saw any patients with a diagnosis of cancer. They supported patients with information about their condition and where to access more help.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

We rated responsiveness as requires improvement because services were not planned or delivered in a way that met patient's needs.

We found:

- Service planning was not based on local needs. Patients did not always have timely access to treatment. There were backlogs in some outpatient specialities. Patients complained of multiple cancellations.
- The environment in which patients waited for their consultation was not always comfortable.

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- The trust did not meet its two week cancer wait target in April 2016 and risked not meeting its referral to treatment waiting list target in June 2016 because of ear nose and throat (ENT) and orthopaedic performance challenges.
- The services lacked a comprehensive approach to meeting individual needs.
- Services were not alerted to patients with a learning difficulty or living with dementia, so they could not prepare or make reasonable adjustments for them.

However, we also found:

- The trust met its 18 week target for inpatients and outpatients in the month before our inspection, May 2016. It also met its diagnostic response time target.
- Some services learned from complaints and patient feedback.
- There was some use of virtual clinics.

Service planning and delivery to meet the needs of local people

- Service planning was not based on an analysis of local needs. The trust acknowledged that demand for outpatient treatment and diagnostic processes was in excess of supply. For example, staff in haematology reported a 30% increase in workload in the last five years because of new treatments and an increase in patient demand, with no corresponding increase in consultant numbers.
- The trust was starting to use information to plan and develop services with partners. Commissioners were involved through jointly chairing and managing a clinical problem solving group to develop action on the waiting list and the x-ray reporting backlog.
- The hospital started to review specialties which could not meet demand in order to develop better clinic schedules for the future. It had difficulty in finding appointment times to meet demand in a number of specialties, for example, ear nose and throat (ENT), ophthalmology, gastroenterology and orthopaedics. Some specialties overbooked patients (booked more than one patient for an appointment time), in the hope that some patients did not attend, for example dermatology which had 106% appointment slots booked in. This had a negative effect on patient experience, as some patients turned up for their

appointments at the same time and as a result appointments over ran. The hospital started a programme of different projects to analyse needs and manage clinics better.

- The CCG had issued a Contract Performance Notice in ophthalmology and radiology and the trust was required to set out a remedial action plan to address issues in both those areas.
- Some patient environments were not comfortable. In the eye clinic, the seating was too close together and there was no specific seating for larger people. Patients did not always hear when their names were called and there were no electronic displays used to indicate to patients that it was their turn to see the doctor.
- Patients we spoke with did not have a clear idea of their wait time so did not feel they could leave the area to get for example a drink. Patient pagers were not available. The eye clinic/eye casualty area had consulting rooms. Following the inspection the trust responded to this feedback and purchased pagers so patients could leave the clinic until it was time for their appointment.
- Some clinics tried to inform patients of possible wait times. For example, the fracture clinic informed patients in their appointment letter they may have to wait four hours to see a doctor.
- In ear, nose and throat (ENT), dermatology and ophthalmology we spoke with 16 patients. Patient views varied. Some patients were happy with their appointments and the information they received about their condition. However, other patients were unhappy about cancelled appointments, misleading letters, or long waiting times in clinics
- Some administrative arrangements did not show an understanding of patients. A patient in dermatology explained they received a text about their appointment at 2pm the day before the 9am appointment. When they arrived for the 9am appointment, the receptionist explained the appointment had been cancelled. We spoke with patients (three in ENT, two in the eye clinic and two in dermatology) who had their appointments cancelled up to four times.
- Patients complained about lack of car parking, although a new multi-storey car park had helped to ease the problems this caused. Car parks had a pay and display system which was not user friendly when clinics overran as patients could run the risk of receiving a fine.
- The eye clinic and eye casualty used 'virtual clinics' to try to reduce clinic time for patients.

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- The hospital offered outpatients telephone consultations as an alternative to being seen face-to-face. Clinical nurse specialists in gynaecology carried out patient follow up consultations by telephone. Doctors in gastroenterology and urology also undertook telephone consultations.
- Diagnostic imaging used telemedicine services (the use of technology to facilitate consultations where a patient and consultant cannot be present in the same room) to report computerised tomography (CT) colonographies, (colon scans) which helped to speed up diagnosis and treatment.

Access and flow

- The outpatient service had a backlog of patients who were waiting for follow-up appointments.
- The eye speciality had a backlog of 964 patients needing follow up from 2015/2016 and 1706 patients from 2014/2015. The trust had a plan in place to address this and we could see it was reducing. Following the inspection the trust told us how this back log was being managed so that the risk to patients was being managed.
- There was a backlog of approximately 200 rheumatology follow-up appointments. Following the inspection we received confirmation that patients were being assessed for any risk so the backlog could be prioritised.
- Some outpatient clinics did not treat patients in a timely way. In May 2016, the last reported month before our inspection, four patients across three specialities waited for treatment for more than 52 weeks. We noted from the trust's board performance report that the trust took action to arrange appointments for these patients. (Commissioners usually fine trusts who do not treat patients within 52 weeks).
- Patients did not always have timely access to initial assessment, diagnosis or urgent treatment. The trust provided us with evidence that diagnostic imaging had backlogs of patients waiting for their scans to be authorised. In May 2016, there were 1012 patients waiting for magnetic resonance imaging (MRI) scans, 655 patients waiting for computerised tomography (CT) scans and 139 patients waiting for ultrasound scan. In each of these groups, nine patients should have been seen within two weeks.
- Diagnostic waiting times are a key part of Referral to Treatment (RTT) waiting times. RTT waiting times measure the patients' full waiting time from GP referral to treatment, which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within six weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks. Since June 2015 the trust had performed worse than the England average, with a higher than average percentage of patients waiting six or more weeks for diagnostics.
- Trust wide, diagnostic imaging did not meet its own internal target of carrying out 80% of cancer imaging within seven days. It achieved 62.3% in May 2016, the last month before our inspection. In the same month, MRI scans took longer than the national target of no more than 1% to exceed six weeks. Instead, 2% of MRI scans exceeded six weeks.
- Between April 2014 and December 2015 cancer waiting time standards for the two week wait standard, the 31 day standard and the 62 day standard had not been achieved and was worse than the England average for every month. Cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.
- This meant the service did not consistently prioritise care and treatment for people with the most urgent needs. In April 2016, the most recent recorded month before our inspection, the trust did not achieve the nationally reported target for a two week wait for 93% of suspected cancer patients with an urgent GP referral, achieving 91% instead. This target monitors joint working between diagnostic imaging and outpatient services. The trust missed this target in all but two months from April 2015 to April 2016. This was due to continuing problems with capacity in ear nose and throat (ENT), lower gastrointestinal and dermatology clinics. However, in April 2016, the trust met the target for two week waits for asymptomatic breast patients.
- The trust met its waiting list target of treating 92% of patients within 18 weeks in May 2016. This target covers both the outpatient and inpatient journey. The earlier patients are reviewed in an outpatient clinic, the quicker they receive inpatient treatment if needed, for example, if an operation is required. The trust recognised that significant numbers of patients waited over 13 weeks. The trust indicated that it might not achieve the target in June 2016 because ENT, allergy and orthopaedic

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patients had very long waiting times for appointments. When we inspected, the ENT specialty had arranged for an external company to hold clinics every weekend in June and July 2016 to reduce the waiting list.

- At the end of July 2016, there were 2400 chest and abdomen plain film x-ray images that needed reporting on. We saw evidence that the numbers of x-rays in the backlog had been coming down month by month. There was a plain film backlog recovery plan in place which was a combination of additional clinic sessions, increased reporting radiographers and outsourcing to other providers of care. From the information that was provided to us following the inspection we were satisfied the trust was taking the appropriate actions and progress was being made.
- The trust cancelled outpatient appointments more than the England average. From September 2014 to August 2015 the England average was 7%, but University Hospitals Leicester (UHL) NHS Trust cancelled 15% of patients. Between June 2015 and May 2016, the LRI cancelled 30% of ENT appointments, 30% of rheumatology, 25% of eye clinic and 15% of dermatology and gynaecology appointments. We spoke with six patients who had their appointments cancelled three or four times. Cancelling appointments created patient dissatisfaction, delays and complications with rebooking, and a need to clinically re-assess the urgency and the patient in some cases.
- Clinics did not always run on time. The trust carried out its own analysis of wait times and the causes of delay in October 2015. Patients and clinic co-ordinators completed a questionnaire about delays in patients being seen. At LRI 19% of patients waited over 30 minutes. The trust set a target of triage of within 15 minutes for putting patients in the correct clinical priority order to see the doctor. The data showed that 57% of patients were seen within 15 minutes of their appointment time. The data identified the eye clinic was particularly prone to delays, but did not analyse the findings any further. The trust developed an action plan to improve waiting times, but when we inspected it was too early to assess its impact.
- Patients told us they sometimes had lengthy waits once they arrived in clinic. At 3pm, we spoke with a patient who had been waiting for their fracture clinic appointment since 9.30am. We spoke with three patients in ENT who had waited between one and two hours. We also spoke to two patients with a booked appointment in the eye clinic who told us they regularly waited between two and four hours.
- Depending on the clinic, staff put waiting times on a notice board in the waiting area, or sometimes informed patients of the delay when they came to reception. Staff wrote waiting times on a white board in the eye clinic but patients we spoke to said they could not read it. In addition, these waiting times were not always correct. On one visit, patients told us the notice board showed that consultants were 'on time', when they were running nearly an hour late.
- One of the reasons for delays was 'overbooking'. This meant more than one patient was being booked into the same appointment slot. In outpatient clinics there were sometimes up to four patients waiting for one appointment time for example in the sarcoma (bone tumour) clinic. Staff told us they overbooked because patients did not always attend for their appointments and there were not enough clinic slots available to see every patient separately. However, between September 2014 and August 2015, the percentage of appointments which patients did not attend was between 5% and 6%. (Hospital Episode Statistics). This was slightly better than the England average of approximately 7%.
- The trust's 'outpatient's clinic template management UHL policy' stated, 'All patients will be scheduled to attend at a realistic time to avoid several patients attending simultaneously for an individual appointment time and then having to wait.'
- Clinical need was the only basis for adding patients to a clinic which was already full. Arrangements to book patients varied across specialties. Each speciality had its own booking team and some overbooked but others did not. This showed not all specialties complied with the trust's access policy. Clinical templates (schedules) had not been reviewed to reflect the real time a consultant needed with a patient.
- Administrative processes were sometimes unreliable. Patients told us they received letters inviting them to the wrong clinic, or which stated the wrong appointment time. One patient was sent a follow-up letter before their first treatment. The trust recognised this inefficiency as a risk and was recruiting and training administrative staff.
- The trust was starting to take action to minimise wait times. In the eye clinic, it had introduced telemedicine

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for consultations with patients who had cataracts. This did not have an impact on over-crowding, because patients still needed to attend clinic to have a photo taken of their eye.

- Patients could not always access appointments readily. Staff told us the sarcoma clinic and ENT balance clinic (for people who were losing their balance due to conditions affecting their ears) were in high demand. The sarcoma clinic was usually overbooked and the balance clinic was prone to running late. Patients across seven clinics, for example dermatology and diabetic medicine often had to wait longer than 14 weeks for their first appointment.
- Outpatient capacity did not meet demand. ENT, gastroenterology and orthopaedics did not have enough clinic slots to offer to patients. Some specialties did not have enough doctors to offer more clinics. For example, the eye and dermatology specialties were all trying to recruit doctors.
- Only 65% of the available clinic space was used by clinics. This meant 35% of room space was available for booking. Specialties did not always communicate when they cancelled a room and the trust did not have up to date data on room availability. As a result, it planned to implement an electronic booking system, successfully trialled in haematology, to avoid wasting room space.
- Four clinics had started to work at weekends and in the evenings using locum doctors to reduce backlogs. For example, the orthopaedic speciality, eye clinic and ENT arranged additional locum clinics on Saturday and Sunday mornings and on some weekday evenings in the case of the eye clinic. The gastroenterology service also reduced its backlog by using locums.
- Patients did not usually wait long for a diagnostic scan. They told us it was either on time or a short wait, of up to 20 minutes. At this hospital, the emergency department and inpatient services could access a scan on an urgent basis. For example, there were rapid access to MRI slots reserved for the minor stroke (transient ischaemic attack) patients, recognising their treatment was time-critical.
- Diagnostic services helped improve performance on the cancer two week wait target although they acknowledged there was more to be done. They did this by creating extra slots to meet demand and employing

two people to take bookings before the patient left the hospital. The gynaecology service offered same day colposcopy appointments if needed. This meant the service could identify cancers and pre-cancers quickly.

Meeting people's individual needs

- Clinics did not take into account the needs of different sections of the population. There were no accessible signs to show patients with visual impairments where the eye clinic was. There were no signs to any of the clinics in locally used languages such as Gujarati, Polish or Latvian. However, the staff in the eye casualty and eye clinic showed us they had ordered yellow notice boards with black writing on them, which were easier to read for patients with visual impairments. When we inspected the clinic a week later we saw the boards had been installed on the clinic wall.
- The hearing loop in the ENT clinic did not work as it had a broken amplifier. It had been broken for two weeks. Staff in the service did not know when it would be mended. Staff had not received training to communicate with patients using sign language.
- Clinics for patients who were being treated for excess weight were held on the first floor of the Jarvis building, away from other hospital services. However, we did not observe any specialist seating for larger people in other clinics such as the eye clinic, ENT or dermatology.
- Clinics were not adapted to meet the needs of children who had a learning disability. A parent told us they had to return for separate appointments for their child's ear and throat difficulties and if they had to cancel for any reason they would have to wait another three months. They informed us the hospital had cancelled their child's appointment three times.
- There were some patient-orientated initiatives by individual services. Where possible, the ENT service tried to resolve problems for patients with hearing aids, rather than sending patients for another appointment to the hearing aid service. This meant patients did not have to come back for another appointment.
- Staff told us it was easy to book an interpreter if they knew in advance that a patient did not speak English. We noticed information about interpreters on the notice board in clinic four but it was in English so its usefulness for non-English speakers was limited.

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- Some information for patients was available in clinics. For example, in clinic four rheumatology, there were leaflets on arthritis. Patient Information and Liaison Service (PALS) information was available in languages other than English at the back of the leaflets.
- Leaflets and information to help patients were mainly in English, and displayed in clinics where patients could read them. However, information in other languages and formats was limited.
- Clinics were not routinely alerted to patients with individual needs. In the eye clinic there was a learning disability nurse to advise staff about good practice. Doctors referral letters sometimes alerted staff to whether patients were living with dementia or had a learning disability. There was no system of electronic alerts to allow staff to meet the needs of a new patient with a learning disability. Patients living with dementia were cared for in a quiet area and were prioritised for an appointment.
- Electronic systems did not automatically alert staff about patients who had a learning disability or those who were living with dementia; so staff relied on GP referral letters to identify such patients. This meant there was a risk that services would not be able to plan for all of these patient's individual needs.
- The trust had difficulties meeting the needs of patients who were living with a learning disability. The May 2016 clinical support and imaging safeguarding committee discussed high rates of did not attends (DNAs) for patients who were living with a learning disability. Staff told us they thought this was because care home staff were unable to attend with the patients or because of patient illness. Outpatients' staff did not know if patients had a learning disability unless it was stated in the GP's letter. This limited outpatient clinic's ability to prioritise this patient group.
- Staff in diagnostic imaging and outpatient clinics completed dementia awareness training. There were appointed staff champions for patients with a learning disability and older people. Staff knew how to locate a dementia champion (a staff member with a specific interest in dementia) if they had questions.
- The diagnostic imaging service tried to accommodate patients with individual needs.

- The computerised tomography (CT) imaging service sourced CT friendly PICC (intravenous tube to guide chemotherapy drugs to the right place in the body) lines to make CT easier for cancer patients taking chemotherapy.

Learning from complaints and concerns

- Over half of formal complaints to the trust concerned outpatient clinics. We reviewed formal complaints from March 2015 to March 2016, and 58% concerned outpatient clinics across all three hospital sites (457 complaints out of 787), with 5% (43) of all complaints being about diagnostic imaging services trust-wide.
- Of the outpatient complaints, 56% were about clinics at this hospital. They focused on delays in clinics, cancellations, waiting time and administration of appointments, and communication.
- Of the 43 complaints about diagnostic imaging trust-wide, 23 complaints (53%) concerned diagnostic imaging at the Leicester Royal Infirmary (LRI). Waiting times and communication were common themes.
- The diagnostic imaging service learned from customer complaints. They received complaints about staff attitude and responded by giving the staff concerned customer service training. Other themes were wait times, which were monitored and escalated if excessively long.

Are outpatient and diagnostic imaging services well-led?

Requires improvement 

We rated well led as requiring improvement because governance arrangements did not always support the delivery of high quality patient-centred care.

We found:

- The arrangements for governance did not operate effectively. Improvements to performance monitoring and action plans had not yet resulted in better patient experience. We noted backlogs, inconsistent environmental cleanliness and lack of privacy for patients on our inspection.
- Clinical outpatient services lacked regular dashboards to show performance against quality, safety activity and financial indicators.

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- Directorate level plans were not clear about how they would match capacity with demand for outpatient services.
- There was a high turnover of staff and many staff were under constant pressure.

However, we also found:

- Staff spoke highly of local and board level leadership. They understood the vision for the services.
- The trust had a programme of work to improve outpatient services and had shared their remedial planning arrangements with commissioners. They had started using specialty level performance dashboards.
- Quality and safety governance arrangements to meet radiation protection requirements in diagnostic imaging were effective.

Vision and strategy for this service

- The trust had a five year plan, 'Delivering Care at its Best.' Quality and safety had been identified as a priority. Delivering services which consistently met national access standards was one of the trust's 2016/2017 annual priorities.
- The clinical support and imaging clinical management group (CMG) annual plan outlined how it contributed to this annual priority. Amongst its annual plan priorities it listed actions such as; Imaging Services Accreditation Scheme Accreditation to be achieved for imaging, reducing wait time from six weeks to four weeks for orthopaedic magnetic resonance scans; and centralising clinical room bookings.
- Progress on annual plans was reviewed at directorate board meetings under a standing item entitled 'strategy update'.
- Other CMGs action plans included actions which would benefit patients but did not say how capacity would meet patient demand. For example, the cancer, haematology, urology, gastro-intestinal and general surgery (CHUGGs) CMG planned to take outpatients services out to community settings, and renal, respiratory and cardiovascular CMG (RRCV) intended addressing complaints in cardiology. Plans did not explain how demand would be met or how services would be re-designed in a specific, timed or measurable way.
- Staff knew about the trust's vision and values. They were committed to values such as: 'we treat people how we would like to be treated' and 'we do what we say we are

going to do.' They were aware there was a trust vision to centralise all outpatient clinics and elective services at Glenfield; they were less clear about timescales for the relocation.

- The trust's outpatient strategy was new. Clinic staff we spoke with did not know about it. It included improving clinic customer service, centralising clinic booking and introducing patient quality standards.

Governance, risk management and quality measurement

- The governance arrangements for outpatient clinics were complex. The clinical support and imaging (CSI) directorate included diagnostic imaging, the booking centre and medical records departments for all three sites. Other clinical management groups (CMGs) managed some bookings, the number of appointments per clinic and doctors and specialist nurses. This meant that booking and management arrangements differed between outpatient services across the trust.
- The hospital did not have capacity and demand plans for clinics. The trust, the local clinical commissioning group and an external consultant had started to work together to map demand for the range of outpatient services.
- The trust lacked information to be able to performance manage outpatient services robustly and to meet the standards outlined in its vision. They did not have reliable information about the availability of clinic space, because staff did not always inform managers when clinics were cancelled. The trust planned to use clinic booking software to manage this better. The programme board had started to ask clinic coordinators to complete a clinic utilisation template to monitor waiting times. This was reported back to CMG board level. A programme management board oversaw all of these initiatives. It programme managed outpatients efficiency projects such as centralising outpatients bookings, improving the uptake of the Friends and Family Test and shortening in-clinic wait times. These projects were in the early stages of development.
- Departmental risk management systems were not effective. Service specific risks, issues and poor performance were not always managed appropriately or in a timely way. Specialties did not have transparent reporting arrangements to manage their own quality and performance, for example, dashboards. Most clinics lacked quality standards or targets or evidence of

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quality or safety monitoring. Managers did not set targets at clinic level for wait times, appointment slots or the response levels for completed of patients surveyed for Friends and Family Test feedback. We did not see cleaning audits displayed consistently or 'you say, we did' information.

- Risk management was not effective. It did not identify risks to follow up patients in specialities such as the eye clinic or rheumatology so that managers could take preventive action. However, the trust had a risk register and reviewed risks that had been identified, regularly at CMG boards.
- The trust provided action plans for commissioners which detailed how it would improve waiting list times. We saw action plans for orthopaedic surgery which included weekly reviews of all patients without an appointment date, and training for staff on the 18-week waiting list target. The allergy service action plan included diverting resources from the ward to outpatients, setting up dietician and nurse clinics, and refining the pathway of referrals from the emergency department.
- Ear, nose and throat (ENT) started outsourcing extra clinics in May and June 2016 to be run by locums. They outsourced two week wait scans for cancer patients to catch up their workload and had set up new arrangements for two week wait clinic. They had recruited two more head and neck consultants, which enabled the speciality more able to cope with demand in the future.
- There were monthly CMG board meetings to discuss quality issues, complaints and incidents, and a separate quality and safety meeting. The governance framework to support the delivery of the strategy was developing. Nursing staff also discussed quality in their own teams. Nursing staff at all levels attended a monthly team meeting where the discussed incidents and patient feedback.
- The trust had a weekly access meeting for outpatient and diagnostic imaging services to monitor performance on the 18-week waiting list target. It aimed to find solutions for patients who had waited a long time, and deal with performance constraints, for example staffing shortages.
- The trust had a cancer action board which had representatives from imaging, theatres, oncology, and radiology. This reviewed any delays in individual patient's pathways.

- CMGs reviewed incidents, safety issues and complaints at quality and safety and board meetings. Assurance meetings were run by service rather than site.
- No formal governance meeting where incidents discussed (eyes) fed back to reporter on individual basis.
- Complaints and incidents were discussed at monthly team meetings, which meant staff were up to date with learning from them.
- Diagnostic imaging had a planned programme of quality assurance, for example, in breast imaging and CT colon. They had a programme of audits for x-ray, CT and MRI and were developing audits for ultrasound.
- The IR(ME)R policies were monitored by the imaging radiation protection group. They reviewed quality and safety issues at the clinical support and imaging CMG.
- The trust had governance arrangements for radiation protection. The radiation protection supervisor had dedicated time for the job and oversight of the incident forms, and clarity about which incidents were IR(ME)R reportable. Medical physics dealt with IR(ME)R reportable incidents. There were radiation protection supervisor meetings every two months, which were an opportunity to feed back to the team.
- Arrangements to monitor quality in outpatient services were effective. Clinical management groups reviewed incidents, safety issues and complaints at quality and safety and board meetings. There was a weekly sister's meeting with matron and one to one meetings between the sister and manager every two months. Staff told us that complaints and incidents were discussed at monthly team meetings.
- Working arrangements with partners and third party providers were not fully developed. The services had contractual arrangements with its locum ENT provider. This contract covered weekend working, provided reports to the trust and attended relevant meetings. The trust had contracts with key providers but how it would measure contractor performance was not clear.

Leadership of service

- Staff told us the chief executive officer (CEO) was approachable. They could have 'breakfast with the boss' and make an appointment with the CEO to discuss any issues they might have. Senior nurses had the option of attending a monthly briefing with the CEO.
- Nurses said they met with clinical management group (CMG) heads of nursing but did not know the trust chief nurse.

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- Haematology and clinical support and imaging (CSI) managers and staff told us the CEO and medical director had led a positive culture change in the last two years. They told us the CEO was proactive about finding new bone marrow donors, for example.
- Staff felt valued and well supported by their line managers, heads of nursing and general manager. Teams met regularly, for example eye clinic staff explained they had monthly staff meetings, weekly band six nurses meetings and weekly sister's meeting with matron. Staff had one to one meetings with their line managers every two months in order to discuss issues and review performance.
- Diagnostic imaging staff were complimentary about their new management structure and the general manager's leadership. They said the culture had improved since the new CEO had arrived.
- Some staff had no time to address their managerial responsibilities. In one clinic, a senior nurse with a job description which was 50% management, had no time to manage, and covered the duties of other nurses at different levels who were absent.
- Balmoral computerised tomography (CT) scanning appeared to be disorganised and under pressure. It was busy and all members of staff were changing the patient list as the patients arrived. Errors occurred while we were there, such as nearly giving a patient the wrong scan and almost omitting the pre-contrast questionnaire before performing a contrast enhanced scan. Neither of these errors resulted in any harm or discomfort to the patient and staff apologised to them.
- Certain roles were in place for staff to provide leadership on particular themes, for example, there was a diabetes clinical champion in CSI. A champion is a member of staff with a high level of specialist knowledge who raises awareness about an issue, and who can be relied upon for expertise.
- Staff felt well supported and valued in specialties we inspected. In the eye clinic, staff told us they felt confident to raise concerns and that they were listened to. They were encouraged to take up opportunities for development.
- In diagnostic imaging, staff told us the culture among radiographers was good but they were under pressure. New radiographers felt very well supported by colleagues and their managers and said they were always approachable if they had any queries.
- Outpatient and diagnostic imaging services had administrative and managerial vacancies. Vacancies were highest in the musculoskeletal clinical group which had 12 full time equivalent administrative vacancies and two managerial vacancies.

Public engagement

- Services responded to patient feedback. For example in fracture clinic they arranged for patients to go to x-ray at the start of the clinic, set up more clinic time waiting audits, and took action on transport waiting times by arranging transport through an electronic system, ensuring that the transport service received the message quicker.
- The eye casualty clinic responded to patient feedback by providing a water fountain to make patients more comfortable while waiting in a hot overcrowded area.
- The trust involved patient representatives. It had patient partners to advise on development from the patient's perspective. A patient partner was a member of the outpatient programme board and advised on improving the patient experience.
- The trust surveyed outpatients but did not give them a free choice about what they fed back. It surveyed outpatients with closed questions with yes/no answers about care, treatment and involvement, between September 2015 to May 2016 and feedback was positive. However, there was no space to allow patients free choice to comment on whatever aspect of the service they would like to.
- The trust outpatient feedback was collected electronically, either on a device in the clinic, a touch screen device situated in the reception areas in all three hospitals or via the Trust website. The Friends and Family Test question was followed by a free text box that allows for patients to give the reason for the answer that

Culture within the service

- Outpatient services at Leicester Royal Infirmary (LRI) had a 7% turnover of staff. A turnover level of over 10% can be a sign of a difficult culture to work in. LRI's sickness and vacancy rates were 3% and 8.5%, respectively, which were both lower than the other hospitals.

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they have given. This free text box could be accessed at any time while the patient was completing the survey, for example when completing the questions about their care and treatment.

- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement

- The trust adopted an NHS staff engagement initiative called 'listening into action' (LiA). Each outpatient specialty set up 'link teams'. They created resource folders with reference information, for example how to prepare the clinic, information on patients' needs, and doctor's preferences. This led to rotas for the cleaning of specialist trolleys and equipment for outpatient clinics. This increased staff knowledge and confidence to work in a new clinic, because they could readily access the reference information.
- Some specialties showed examples of improved services resulting from staff engagement. The

September 2015 LiA progress report listed ear nose and throat improvements such as: re-routing of all calls that are not for ENT to free up clinic staff, buying a television, DVD player, water cooler and fans for the patient waiting area; and improved signage and directions for patients.

- LiA in gynaecology resulted in minor improvements such as ordering extra pens. The clinical support and imaging clinical management group's LiA initiative led to inviting chemotherapy patients to attend at different times during the day, more in line with when their drugs were ready. This avoided patients coming in at the start of the day and having to wait until their drugs were prepared.

Innovation, improvement and sustainability

- Diagnostic imaging at Leicester Royal Infirmary had an internationally recognised forensic service which had been involved in a recent project of public interest. The service also had a reputation for high quality cardiac and vascular work.
- The services and individuals within diagnostic imaging were recognised for their achievements. A diagnostics imaging manager received a trust award for their work in reducing wait times for their service.
- There was little sharing of best practice across all outpatients specialties within the trust. The services did not routinely benchmark or network with other trusts to find best practice.

Outstanding practice and areas for improvement

Outstanding practice

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback through greatix and told us how this made them feel proud and valued.
- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.
- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24 hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The risk assessment booklet also included a situation, background, assessment, recommendation (SBAR) tool, a sepsis screening tool, a venous thromboembolism (VTE) assessment tool which also had a body mass index chart, a peripheral intravenous cannula care bundle, a urinary catheter care pathway and assessment tools for nutrition, manual handling and a pressure ulcer risk score. This meant that all assessment records were available together.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

Urgent & emergency services

- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department. **This also applies to medical areas.**
- The trust must take action to ensure standards of cleanliness and hygiene are maintained at all times to prevent and protect people from a healthcare-associated infection. **This also applies to medical areas and outpatient and diagnostic areas.**

- The trust must ensure that patient in the emergency department have venous thromboembolism (VTE) risk assessments completed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

Medicine

- The trust must ensure patient side rooms with balconies have been risk assessed in order to protect vulnerable patients from avoidable harm.

Critical Care

Outstanding practice and areas for improvement

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

Surgery

- The trust must ensure DNACPR decisions are documented fully in accordance with the legal framework of the Mental Capacity Act 2005.

Maternity and gynaecology

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the maternity and gynaecology service.
- The trust must ensure that midwives have the necessary training in the care of the critically ill woman and anaesthetic recovery in line with current recommendations.

Services for children and young people

- The trust must ensure at least one nurse per shift in each clinical area is trained in APLS or EPLS as identified by the RCN (2013) staffing guidance.
- The trust must ensure Neonatal staffing at the Leicester Royal Infirmary (LRI) neonatal unit is compliant with the British Association of Perinatal Medicine Guidelines (BAPM) (2011).

- The trust must ensure children under the age of 18 years are not admitted to ward areas with patients who are 18 years and above unsupervised.
- The trust must ensure nursing staff have the appropriate competence and skills to provide the required care and treatment for children who require high dependency care.

End of life

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

Outpatients & Diagnostic Imaging

- The trust must ensure the waiting environment for ophthalmic patients and eye casualty is fit for purpose.
- The trust must ensure that all equipment, especially safety related equipment is regularly checked and maintained.
- The trust must ensure it has oversight of planning, delivery and monitoring of all care and treatment so it can take timely action on treatment backlogs in the outpatient departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>Regulation 9(2)</p> <p>Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">The trust did not have an audit system in place to ensure 'Do Not Attempt Cardio-Respiratory Resuscitation' decisions were always documented legibly and completed fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005.
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>Regulation 10 (2)(a)</p> <p>Service users must be treated with dignity and respect, ensuring the privacy of the service user.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">The trust did not ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department. There were five red bays in the middle of the majors area on which patients requiring a trolley waited until a bay became available. There were no screens to afford the privacy of patients with male and female patients being located in very

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Requirement notices

close proximity next to each other. In addition, the way the trolleys were positioned meant these patients were facing the bay opposite them and this compromised the privacy of the patient in the corresponding bay.

- **Within the assessment area of the emergency department, we observed overcrowding with patients waiting on marked out red bays whilst they waited for an assessment cubicle to become available. We observed patients being transferred from ambulance trolleys to hospital trolleys. This was done in view of other patients with no screens in place to afford the privacy and dignity of the person being transferred.**

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11(1)

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

How the regulation was not being met:

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

Regulated activity

Regulation

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

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

Regulation 12 (2)(a)

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

Requirement notices

How the regulation was not being met:

- There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients. Nursing staff did not consistently adhere to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always document a clear plan of treatment if a patient's condition had deteriorated.
- Where patients had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance.
- The trust's sepsis protocol was not embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration.
- Patients in the emergency department did not have venous thromboembolism (VTE) risk assessments completed.

Regulation 12 (2)(c)

Care and treatment must be provided in a safe way for service users by ensuring that person providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

How the regulation was not being met:

- Midwives did not have the necessary training in the care of the critically ill woman and anaesthetic recovery in line with current recommendations.
- Nursing staff were providing care to high dependency children and young people without having qualified in speciality (QIS) training or having completed a High Dependency Unit training module.

Regulation 12 (2)(d)

Care and treatment must be provided in a safe way for service users by ensuring the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

How the regulation was not being met:

Requirement notices

- The waiting environment for ophthalmic patients and eye casualty was overcrowded. Patients were standing or sat on the floor because all the seats were occupied. There were six patients sitting in wheelchairs along the corridor which reduced the corridor access.

Regulation 12 (2)(e)

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

How the regulation was not being met:

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

Regulation 12 (2)(g)

Care and treatment must be provided in a safe way for service users by ensuring the proper and safe management of medicines.

How the regulation was not being met:

- Medicines were not always kept securely. They were stored in unlocked cabinets or in fridges with unreliable temperature control.
- Hazardous materials and liquid nitrogen were stored in unlocked cupboards.

Regulation 12 (2)(h)

Care and treatment must be provided in a safe way for service users by assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

How the regulation was not being met:

We found systems and practices did not protect patients from the risk of the spread of infection.

We found:

This section is primarily information for the provider

Requirement notices

- Staff were not consistent in isolating patients at risk of spreading infection to others. On Wards 16, 23, 24, 31, 42 and 43 we saw doors left open to side rooms where it had been identified patients might present an infection control risk to others.
- Hand hygiene audits across 20 clinical areas were worse than the trust's target of 90%.
- Staff were not consistent in adhering to the trust's infection prevention control policy including adhering to the dress code, which was to be 'bare below elbows'.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13(1)(2)

Safeguarding service users from abuse and improper treatment

How the regulation was not being met

There were no effective systems and processes in place to protect children and young people on Ward 27 from abuse and harm. The admission criterion for Ward 27 allowed children and young people age 13 to 24 years old to share the same unsupervised social space.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 15(1)(a)

All premises and equipment used by the service provider must be clean.

How the regulation was not being met

Requirement notices

- Systems and processes to prevent and control the spread of infection were not operated effectively and in line with trust policies, current legislation and best practice guidance.
- There were a number of toilets in the emergency department which were not clean. In the outpatient department clean areas were not always respected and some areas were dusty and not clean. There were no cleaning schedules on display and no evidence to suggest that equipment was clean and ready for use.

Regulation 15 (1) (e)

All premises and equipment used by the service provider must be properly maintained.

How the regulation was not being met:

- The trust must ensure patient side rooms with balconies have been risk assessed in order to protect vulnerable patients from avoidable harm.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1)(a)

Systems or processes must be established and operated effectively to ensure the quality and safety of the services provided are assessed, monitored and improved.

How the regulation was not being met:

- The service had failed to prioritise some patients with urgent needs who were waiting for follow-up appointments. The eye speciality had a backlog of 964 patients needing follow up from 2015/2016 and 1706 patients from 2014/2015.
- Some outpatient clinics did not treat patients in a timely way. In May 2016 four patients across three specialities waited for treatment for more than 52 weeks.

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Requirement notices

- Patients did not always have timely access to initial assessment, diagnosis or urgent treatment. Diagnostic imaging had backlogs of patients waiting for their scan to be authorised. In May 2016, there were 1012 magnetic resonance imaging patients, 655 computerised tomography scan patients and 139 ultrasound scan patients. In each of these groups, nine patients should have been seen within two weeks.
- The service did not consistently prioritise care and treatment for people with the most urgent needs. In April 2016, the trust did not achieve the nationally reported target for a two-week wait for 93% of suspected cancer patients with an urgent GP referral, achieving 91% instead.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)

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

How the regulation was not being met:

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- Midwifery staffing ratios did not meet current recommendations or minimum acceptable levels. One to one care in labour was not always provided.
- Consultant obstetric cover in the delivery suite was 82 hours a week which did not meet the Royal College of Obstetrics and Gynaecology recommendation of 168 hours a week for a unit of this size.
- Lack of junior doctor, especially out of hours, led to delays in patient reviews which could pose a risk to patient safety.

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Requirement notices

- Neonatal staffing on the neonatal unit did not meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved.
- Training shortfalls existed in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Section 31 HSCA Urgent procedure for suspension, variation etc.</p> <p>On 4 December 2015, following an unannounced inspection to the emergency department at the Leicester Royal Infirmary, we exercised our powers under section 31 of the Health and Social Care Act 2008 to impose conditions on the trust's registration because we believed that patients in receipt of care in the emergency department at the Leicester Royal Infirmary were or may be exposed to the risk of harm if we did not impose these conditions urgently.</p> <p>The trust failed to demonstrate that it had an effective system in place so to ensure:</p> <ul style="list-style-type: none">• An appropriate skill mix to provide a safe standard of care to patients who require care and treatment within the emergency department at the Leicester Royal Infirmary.• Patients received an appropriate clinical assessment by appropriately qualified clinical staff within 15 minutes of presentation to the ED at the Leicester Royal Infirmary in line with best practice.• Patients received care and treatment in accordance with the trust's sepsis clinical pathway. <p>Following our inspection of the Leicester Royal Infirmary, the section 31 HSCA Urgent procedure for suspension, variation etc. remains in place.</p>