University Hospitals of Leicester NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the trust's second inspection using our comprehensive inspection methodology. We had previously inspected this trust in January 2014 where we rated it as requiring improvement overall. This inspection was a focused inspection which was designed to look at the improvements the trust had made since the last inspection.

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 we inspected critical care 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 provider was performing at a level which led to the judgement of requires improvement. We inspected 8 core services across three hospital locations. We rated the Leicester Royal Infirmary, Leicester General Hospital and the Glenfield Hospital all as requires improvement. Although the overall rating we gave the trust in this inspection was the same as they were awarded in their 2014 comprehensive inspection, we did find improvements had been made. These were particularly evident in staff engagement and confidence in the leadership team.

Our key findings were as follows:

- We found many staff commented on the positive culture change in this trust under the current Chief Executives leadership. There was recognition there were a lot of things that still needed focus and attention but they were in better position now than a few years ago. These comments reflected the changes to the staff survey results which showed an upward trend over the past three years.
- The trust was led by a respected board. Executive staff were much respected and staff had confidence in their leadership.
- The trusts vision and values were generally embedded into practice.
- The trust had an established governance process in place which was generally working well.
- The main committee responsible for quality was the Quality Assurance Committee (QAC). It was felt that the awareness of quality problems was high but more improvement was required to ensure the QAC was in a position to bring about rapid resolution.
- The non-executive directors were well sighted on the quality governance agenda.
- A series of quality indicators were used to identify wards or departments which required additional monitoring or support. We saw evidence of how these reports were used to identify areas of concern and how these areas were subsequently monitored. However, we found some areas during the inspection such as the concerns in the outpatients department at the Leicester Royal Infirmary which had not been identified by the quality monitoring process.
- Some of the executives and non-executives felt that there wasn't enough pace in the organisation to address some of these areas.
- The trust had a Board Assurance Framework (BAF) which was a standing item on the Board's agenda. The BAF was described to us by several members of the executive team as being in development. For example there were some gaps in controls.
- The challenges that were faced in the A&E department were well known and were often spoken about during our inspection. All of the senior leaders whom we spoke with cited this as one of the trusts highest risks. In addition, we noted clinical staff who did not work in A&E were also aware of the significant challenges in A&E and the knock on effect this had one the rest of the trust. At our focus groups, some staff commented they felt the A&E department received too much attention by senior leaders and external agencies.
- There was no doubt the A&E department was causing significant problems for the trust. We observed how the patient experience was in some cases below the standard we would expect. It required a system wide approach to solving some of the problems being experienced. The trust saw a constant increase in the number of attendances at A&E and they could not always provide the level of care they wanted to. This was a problem that the trust alone could not address

and it required action amongst the whole health and social care system across Leicester, Leicestershire and Rutland. Although there were plans in place and different initiatives to address the problems, we saw little evidence that these were making any impact on the numbers of attendances at A&E. The outpatient service had a backlog of patients who were waiting for follow-up appointments. The trust had a plan in place to address the backlogs and we could see they were reducing. Following the inspection the trust told us how this back log was being managed so that the risk to patients was as safe as possible.

- We found a number of problems with the outpatients clinics, particularly at the Leicester Royal Infirmary and the Leicester General Hospital. Patients told us they were not always satisfied with the outpatient service. This was also reflected in the number of trusts complaints as well as feedback from other organisations such as Healthwatch.
- The trust cancelled outpatient appointments more than the England average. Cancelling appointments created patient dissatisfaction, delays and complications with rebooking as well as 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 and found the eye clinic was particularly prone to delays. The trust developed an action plan to improve waiting times, but when we inspected it was too early to assess its impact.
- 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.
- The trust had already recognised they needed to make improvements to the management of deteriorating patients and the management of sepsis. Although we found poor performance during the inspection, evidence we have received since the inspection shows that the improvement plans are having some impact. Performance in relation to sepsis within the ED has particularly improved. We were confident the trust had effective plans and monitoring in place to make the necessary and important improvements.
- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) had been below 100 for the past 3 years. Hospital standardised mortality ratios (HSMRs) are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.
- The latest published Summary Hospital-level Mortality Indicator (SHMI) for April 2015 to March 2016 was 99. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The trust rate was as expected.
- We saw patients were mostly being care with kindness and dignity and respect.
- The trust used recognised tools to assess the level of nursing staff and skill mix required. The chief nurse was sighted on nursing risks and wards which were flagging as requiring more support. There were some areas where staffing fell below the planned levels. Recruitment to vacancies' was in process and staff were able to use bank or agency staff were available to fill staffing shortfalls.
- Concerns were expressed to us about the trusts IT infrastructure. The Patient Administration System was old and was not supported by the service provider any more. At the time of the inspection the trust was waiting for funding from the Department of Health to implement a new IT system.

We saw several areas of outstanding practice including:

Leicester Royal Infirmary

- 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.
- A range of medicines to manage Parkinson's disease was available on the Clinical Decisions Unit (CDU) at the Glenfield Hospital. These medicines are time

sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.

- 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 bound together.

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- 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.

Leicester General Hospital

- A new computerised individualised dosing system was in operation on the renal wards.
- New Starters in nephrology had a 12-week supernumerary period within the ward area and a bespoke Professional Development Programme. Included within the development programme was; trust behaviours, early warning score (EWS), infection prevention control, planning / evaluating care, managing pain, care of the dying patient and equipment training. Templates were also included to assist registered nurses in their revalidation process.
- An MDT meeting took place weekly on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals (physiotherapy, occupational therapy and speech and language therapy), medical and nursing staff and a neurological psychologist. The patient and relevant family member would also be present at this meeting where a patient's individual rehabilitation goals would be discussed and reviewed.
- 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.
- On ward 1, a flexible appointment service was offered for patients. In order to help patients who had other personal commitments, for example work

Summary of findings

commitments, staff would work flexibly sometimes starting an hour earlier in the day to enable the patient to receive their care at a time and place to meet their needs.

- The development of a pancreatic cancer application to support patients at home with diagnosis and treatment. This will potentially assist patients and family members face the diagnosis and treatment once they have left the hospital.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified obstetric early 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 range of risk assessments. This meant that all assessment records were bound 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.

Glenfield Hospital

- 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.
- A range of medicines to manage Parkinson's disease was available on the clinical decisions unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.
- A 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, and body language and physical changes to help determine level of patient comfort.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Trust wide

- The trust must ensure all Directors and Non-executive Directors have a Disclosure and Barring check undertaken to ensure they are of good character for their role.

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 patients requiring admission who wait in the ED for longer that 8 hours have a VTE risk assessment and appropriate thromboprophlaxis prescribed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

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Medicine

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

Surgery

- The trust must ensure hazardous substances are stored in locked cabinets.
- The trust must ensure staff know what a reportable incident is and ensure that reporting is consistent throughout the trust.
- The trust must ensure patients preparing for surgery have venous thromboembolism (VTE) reviewed after 24 hours.
- The trust must take action to address the shortfalls in staff education in relation to mental capacity (MCA) assessments and deprivation of liberty safeguards (DOLs).

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.
- The trust must ensure staff report incidents in a timely way.

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, anaesthetic recovery and instrument/scrub practitioner line with current recommendations.
- The trust must address the backlog in the gynaecology administration department so that it does not impact patient safety.

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 paediatric medical staffing is compliant with the Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants.
- 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 care

- 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 that all equipment, especially safety related equipment is regularly checked and maintained.
- The trust ensure building maintenance work is carried out in a timely manner to prevent roof leaks.
- The trust ensure patient notes are securely stored in clinics.
- The trust must ensure the privacy and dignity of service users is protected.
- The trust must take action to comply with single sex accommodation law in diagnostic imaging changing areas and provide sufficient gowns to ensure patient dignity.
- 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.
- The trust must ensure that it carries out patient tests in private surroundings which maintain patients privacy.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals of Leicester NHS Trust

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 specialist and acute services to a population of one million patients throughout Leicester, Leicestershire and Rutland. There are three main hospital locations; Leicester Royal Infirmary, Leicester General Hospital and The Glenfield Hospital. Glenfield Hospital has a heart centre which provides specialist heart surgery for patients across the East Midlands. The trust has 1,784 inpatient beds and 175 day-case beds. It is one of the biggest acute NHS trusts in England.

We inspected the trust in 2014 under our new inspection methodology and rated it as "Requiring Improvement". 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 inspection teams visited all three hospital locations.

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 educations 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, Care Quality Commission

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

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

How we carried out this inspection

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

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

Before our inspection, we reviewed a wide range of information about University Hospitals of Leicester NHS

Summary of findings

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. 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.

What people who use the trust's services say

The Friends and Family test scores were about average when compared with other trusts. This test is based on a question asked of patients in all NHS trusts in England, "How likely are you to recommend this ward/clinic to friends and family if they needed similar care or treatment." In August 2016 the trust scored:

o Inpatient services 96% (NHS average (95%)

o Urgent and emergency services 87% (NHS average 87%)

o Outpatient services 94% (NHS average 93%)

The CQC Adult Inpatient Survey 2015 received responses from 547 patients. The survey asks questions under 11 areas. The trust was rated about the same as other trusts for all 11 areas, however, the questions relating to cleanliness of rooms or wards and patients feeling that doctors and nurses were not acknowledging them were worse than other trusts.

We received information from people through emails, our website and through phone calls prior to and during this inspection. Responses were mixed, some patients spoke very highly of the care they had received whilst others raised concerns. The information was used by the inspectors through the inspection process.

Facts and data about this trust

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 1,771 inpatient beds and 176 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 patients throughout Leicester, Leicestershire and Rutland. There were 149,806 inpatient admissions, 993,617 outpatient attendances and 135,111 emergency department attendances between April 2015 and March 2016.

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 income of £866 million and its total expenditure was £900.1million. The 2015/16 deficit was £34.1million.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall, we rated the safety of services requires improvement. For specific information, please refer to the reports for Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital.	**Requires improvement** 

Key findings were:

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The executive team were able to articulate a good understanding about duty of candour.
- We reviewed a report on the duty of candour to the Executive Quality Board dated 7 June 2016. The report set out the current position in the trust. The report provided evidence of reassurance rather than assurance that the duty was being discharged in accordance with the regulation. This was because the trust was not able to provide assurance that the process was being completed in full. However, there were actions underway to enhance compliance with the duty, such as modifications to the incident reporting system, staff briefing sessions and staff training.

Safeguarding

- There were trust wide safeguarding policies and procedures in place. These were readily available on the trust's intranet site.
- Staff had an understanding of how to protect patients from abuse. All staff we spoke with were clear about how to identify a safeguarding concern and how to escalate appropriately.
- The trust had a safeguarding lead at executive level (the deputy Chief Nurse) in addition to local named leads for children and adult safeguarding.
- Safeguarding training formed part of the trust's mandatory training programme and the compliance of this was generally good.
- There was a trust wide safeguarding committee which reported through the governance process to the board. The trust complied with the requirement to provide a safeguarding annual report.

- 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 safeguarding training for both midwives and doctors covered child sexual exploitation, modern day slavery and honour based violence.

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 we found staff knew how to report incidents through the trusts electronic incident reporting system.
- The trust report approximately 27,000 incidents every year. We were told the patient safety team reviewed all cases graded as moderate or above. A decision on whether the incident qualified as a serious incident was made by the Director of Safety and Risk with input from the Medical Director and Chief Nurse.
- We received a mixed picture regarding staff receiving feedback from incidents. Some areas were able to tell us they received feedback and learning through email, staff meetings, board 'huddles' and, during handovers. Whereas in some areas, staff did not feel they received feedback.
- In some areas we inspected we were able to find evidence of changes that had been introduced as a result of learning from incidents.
- The trust had an array of techniques to communicate and embed learning. These included bulletins and the use of the East Midlands Learning Network to spread and absorb lessons, utilising incidents in clinical education and using clinical simulations.

Staffing

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

England. It is important to note that this tool is only applicable to acute adult ward areas. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically and matrons and the senior nursing teams confirmed this data on board rounds as well as unannounced visits to clinical areas

- The Trust used recognised tools to assess the level of nursing staff and skill mix required. The Chief Nurse was sighted on nursing risks and wards which were alerting as requiring more support. There were some areas where the actual staffing fell below the planned staffing levels. Recruitment to vacancies was in process and staff were able to utilise bank and agency staff to fill the staffing.
- We found differences in staffing levels on the three sites. Generally, staffing levels across the trust were sufficient to deliver safe care. There were some wards where there were more vacancies but recruitment was underway.
- 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.
- The maternity department used an 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.
- 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.
- We held a number of focus groups with staff before the inspection, staffing levels were discussed in these groups. Although staff felt there were gaps in staffing in some areas they generally felt the trust were taking steps to recruit staff. Some staff expressed concern that they perceived there might be cuts to staffing due to the financial position of the trust. Nurses generally felt able to raise concerns if they didn't feel they had enough staff to deliver safe care.

Summary of findings

- 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.
- Essential information and guidance was available for all temporary staff including bank, locum and agency staff and there was an induction process in place. We were not always assured that this process had been followed at Leicester Royal Infirmary.

Infection

- There were 68 cases of C difficile at this trust between March 2015 and April 2016. C.difficile is an infective bacterium that causes diarrhoea and can make patients very ill.
- There were 11 cases of Meticillin-resistant Staphylococcus aureus (MRSA) between March 2015 and April 2016. MRSA is a bacterium responsible for several difficult to treat infections.
- There were 27 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) between March 2015 and April 2016.
- In order to measure compliance with trust policies the infection prevention and control team carried out regular audits against key policies. For example, hand hygiene, sharps safety and availability and appropriate use of personal protective equipment (PPE). Performance against these audits varied across the three hospital sites and the different core services that we inspected.
- We found concerns about the isolation of patients at the Leicester Royal Infirmary. We saw numerous occasions when staff did not always isolate patients who were at risk of spreading infection to others.
- There had been a big change to the way cleaning services were provided throughout the trust. Shortly before our inspection the contract for providing hospital cleaning services had returned to the trust. All cleaning staff had been transferred back to being employed by the trust having previously been employed by a private provider.
- It was very clear there had been a lot of challenges for the trust with regards to cleaning. At the time of the inspection not all of these challenges had been addressed. We found there were areas of cleanliness during our inspection, particularly at Leicester Royal Infirmary (LRI) which fell short of the standards we would expect to see. However, without exception, when we raised this with the executive team, they were responsive and immediately addressed the concerns.

- We heard feedback from staff, volunteers, patients and carers that the standards of cleanliness at LRI were a concern. We did not hear the same level of concern about the other two hospitals.

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required.
- Patients with a suspected infection or an EWS of three or more, or those for whom staff or relatives had expressed concern were 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 we reviewed patient observation charts. 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.
- In the emergency department, he 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.
- 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

Summary of findings

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 and their performance was showing improvement.

- 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) 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.

Are services at this trust effective?

Requires improvement

Overall, we rated the effectiveness of the services required improvement. For specific information, please refer to the reports for Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital.

Key findings were:

Evidence based care and treatment

- We found patients had their needs assessed and their care was planned and delivered in line with evidence-based, guidance, standards and best practice.
- 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.
- 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.
- The trust had a clinical audit and quality improvement plan for 2015 to 2016 which identified 117 audits the service was undertaking and the lead for each audit. In additional to local audits, the trust participated in all the national audits it was eligible to participate in.
- Following the withdrawal of the Liverpool Care Pathway, the trust had introduced individualised care plans for patients on the end of life care pathway. The individualised care plans recognised the five priorities for end of life care according to the Leadership Alliance for the Care of Dying People (2014).

Patient outcomes

Summary of findings

- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) had been below 100 for the past 3 years. Hospital standardised mortality ratios (HSMRs) are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.
- The latest published Summary Hospital-level Mortality Indicator (SHMI) for April 2015 to March 2016 was 99. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The trust rate was as expected.
- 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.
- The endoscopy unit at Glenfield Hospital was accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. The endoscopy unit at the Leicester Royal Infirmary was "Improvements required," however a further assessment was due in November 2016.
- The trust participated in the Heart Failure Audit. Glenfield Hospital's results in the 2014 Heart Failure Audit were higher than the England and Wales average for five of the 11 standards.

Summary of findings

- The trust performed well in both the 2012/13 and 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audits. MINAP is a national clinical audit of the management of heart attack. In 2013/14, almost 100% of patients who had sustained a non ST elevation myocardial infarction (NSTEMI), also known as a heart attack, were seen by a cardiologist or a member of their team, compared to 94% nationally and 83% were referred for, or had, an angiography, compared to 78% nationally. Angiography is a type of X-ray used to examine blood vessels. In total, 49% of patients experiencing a NSTEMI were admitted to a cardiac unit or ward compared to 56% nationally, this was the only standard to fall below the England national average.
- From January 2016 to May 2016 patients presenting with a NSTEMI waited on average four days to undergo a coronary angiogram, this was in line with NICE guidance CG94: Unstable angina and NSTEMI: early management, who recommend this should occur within 96 hours. A NSTEMI is a type of heart attack caused by a blood clot partly blocking one of the coronary arteries. A coronary angiogram allows the cardiac team to look inside coronary arteries for narrowing or blockage. Special dye is passed into the coronary arteries through a thin flexible tube (catheter) and shows up narrowed areas on an X-ray.
- From August 2015 to May 2016 medical patients at this trust had a higher than expected risk of readmission for non-elective and elective admissions.
- Within the maternity services, the normal birth rate was 61% which was slightly better than the England average of 60%.
- 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%.
- The 2014 Lung Cancer Audit found the trust discussed a higher percentage of patients at multidisciplinary team meetings than the England average of 95.6% at 99.6%. The trust also had a higher percentage of patients receiving a CT scan before bronchoscopy at 97.3% compared to the England average of 91.2%. Trust performance therefore met the required 95% standard in both areas.
- On average elective and non-elective patients spent a similar time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from April 2015 to March 2016 was 3.4 days, compared to 3.3 days for England. For non-elective (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 Leicester Royal Infirmary (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.

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 weekly 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.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training were not delivered as part of the mandatory training programme across the trust.
- We found variances in how many staff understood the MCA. Nursing staff we spoke with told us they had not received training on the MCA. Some staff had a basic awareness and understanding of DoLS, but not of the MCA. The MCA is a piece of legislation applying to England and Wales, its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The DoLS is part of the MCA. DoLS aim 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.
- We looked at a number of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. 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, and lack of discussion with the patient.
- The trust routinely reviewed 25 sets of DNACPR records from across the three sites (10 each from the LRI and GGH, 5 from the LGH).This monthly DNACPR audit included compliance with policy and specifically the communication with patients and relatives. Face to face feedback was given to individuals who were found not to have correctly followed policy.

Are services at this trust caring?

Good

Overall, we rated caring for the services in the trust as good.

For specific information, please refer to the reports for Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital.

Key findings were:

Compassionate care

- The Friends and Family test scores were about average when compared with other trusts. This test is based on a question asked of patients in all NHS trusts in England, "How likely are you to recommend this ward/clinic to friends and family if they needed similar care or treatment." In August 2016 the trust scored:

o Inpatient services 96% (NHS average (95%)

o Urgent and emergency services 87% (NHS average 87%)

o Outpatient services 94% (NHS average 93%)

- Across the trust, the majority of feedback we received suggested care was compassionate and patients were treated with dignity and respect. We observed examples of care being

provided which was compassionate and staff were kind and caring. However, we did find some examples at the Leicester Royal Infirmary where staff were not always treating patients with the level of compassion we would expect.

- Across the trust patients privacy and dignity was respected, however there were some areas, particularly at LRI where this was more difficult due to the limitations of the environment. For example, the overcrowding in the Emergency Department meant that staff had no alternative but to care for patients in areas that were not suitable. This was also the case in one of the two ophthalmic outpatient clinics.
- In the maternity service, women and their partners reported they were treated with compassion, dignity and respect.
- 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.

Understanding and involvement of patients and those close to them

- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'University Hospitals of Leicester (UHL) carers charter' was developed in 2015. The carers charter described to carers what they could expect from staff in the trust. This included; identifying carers on the wards, assessing carers needs, ensuring open channels of communication and providing essential information.
- 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. However, 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

- 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.

Summary of findings

- 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 and staff had access to clinical nurse specialists across many 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.

Are services at this trust responsive?

Requires improvement

Overall, we rated the responsiveness of the services required improvement. For specific information, please refer to the reports for Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital.

Key findings were:

Service planning and delivery to meet the needs of local people

- Generally, the services we inspected 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.
- 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.
- 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.

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.

- The trust employed 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.
- 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.
- During our inspection, some patients were fasting for Ramadan. Ward 42 at the Leicester Royal Infirmary 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.

Dementia

- The trust had a dementia strategy in place.
- The trust had appointed approximately eight meaningful activity facilitator across the trust. They were able to provide reminisce therapy for patient living with dementia.
- 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.
- 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.

Access and flow

- The outpatient service had a backlog of patients who were waiting for follow-up appointments.
- The trust had a plan in place to address the backlogs and we could see they were reducing.
- Following the inspection the trust told us how this back log was being managed so that the risk to patients was as safe as possible.
- The trust cancelled outpatient appointments more than the England average. Between June 2015 and May 2016, the trust cancelled 30% of ENT appointments, 30% of rheumatology, 25% of eye clinic and 15% of dermatology and gynaecology appointments. Cancelling appointments created patient dissatisfaction, delays and complications with rebooking as well as 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 and found the eye clinic was particularly prone to delays. The trust developed an action plan to improve waiting times, but when we inspected it was too early to assess its impact.
- 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.
- Diagnostic services helped improve performance on the 62 week cancer pathway 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.
- 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.

- The emergency 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 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.
- A new emergency department was being built on the Leicester Royal Infirmary site. This would significantly increase the capacity of the department. Some staff expressed concern to us that even though they would have more space and modern facilities, the numbers of patients coming through the department would continue to be difficult to manage.
- 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. Between March 2015 and February 2016 the operational standard of 90% for admitted pathways was met in all but one of the applicable medical specialties (cardiology, dermatology, neurology, rheumatology and thoracic medicine). Gastroenterology was the only specialty to fall below the 90% standard at 89%.
- 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.
- The trust were experiencing an issue with sustainable performance in the 2 week cancer wait. The trust had mitigating actions in place to sustain performance and had improved. Cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.
- 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

Summary of findings

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.

Learning from complaints and concerns

- Leicester Royal Infirmary (LRI). Waiting times and communication were common themes. There were 19 complaints during 2015/16 that were referred to the Parliamentary and Health Service Ombudsman of the 19, four were partially upheld.
- The trust had an independent complaints review panel who reviewed a sample of complaints from a patient's perspective.The panel was held quarterly and provided important external scrutiny on the quality of complaints responses and the complaints handling process.
- 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).
- Of the outpatient complaints, 56% were about clinics at the Leicester Royal Infirmary. They focused on delays in clinics, cancellations, waiting time and administration of appointments, and communication.

Are services at this trust well-led?

Requires improvement

We rated the trust as requires improvement for well led because:

- The main committee responsible for quality was the Quality Assurance Committee (QAC). Although the awareness of quality problems was high, more improvement was required to ensure the QAC was in a position to bring about rapid resolution.
- A series of quality indicators were used to identify wards or departments which required additional monitoring or support. We saw evidence of how these reports were used to identify areas of concern and how these areas were subsequently monitored. However, we found some areas during the inspection where standards of care fell lower than those we would expect.
- There was no doubt the A&E department was causing significant problems for the trust. We observed how the patient experience was in some cases below the standard we would expect. It required a system wide approach to solving some of

the problems being experienced. The trust saw a constant increase in the number of attendances at A&E. Although there were a number of initiatives in place, there was little evidence that these were having an impact.
- The trust board had been strengthened, but the minutes did not provide assurance that sufficient level of challenge had occurred by the Board.
- There was recognition that although the trust had moved a long way under the new leadership there was still more to achieve.
- The Trust had 10 indicators in the top 20% and 8 in the lowest 20% in the 2015 NHS staff survey. The remaining14 indicators were within expectations and included 6 above average, 4 average and 4 below average. The trust improved on 3 of its scores, which would suggest the changes the trust have implemented were making a difference.
- The overall staff engagement score was 3.77 which was worse than average, however there was a marked increase in this score since the 2014 staff survey.

However:

- The trust had a five year plan, and a vision and strategy and most of the staff we spoke to knew about this.
- The Quality Assurance Committee provided a report of key issues to the trust Board. All of the non-executive directors attended the Quality Assurance Committee and it was chaired by a non-executive director.
- We found many staff commented on the positive culture change in this trust under the current Chief Executives leadership. There was recognition there were a lot of things that still needed focus and attention but they were in better position now than a few years ago. These comments reflected the changes to the staff survey results that showed an upward trend over the past three years.

Vision and strategy

- In 2015 the trust launched a five year plan called stating their purpose which was to, "Deliver Caring at its Best." The five year plan set out the vision for Leicester Hospitals. The vision was, "To become a trust that is renowned for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience".

- The vision was underpinned by five values; "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, we are passionate and creative in our work".
- Most of the staff we spoke with during the inspection knew about the trusts vision and we found information displayed around the hospital sites.
- Many of the staff who we spoke with during the inspection told us they were frustrated that the trust had been held back because of historic plans which were never implemented. These plans related to reconfiguring services and the building of a new hospital. Any improvements to the hospital estate had been on hold for several years. There was now a feeling that the trusts estate had suffered as a result and there was a sense the trust needed to catch up with the modernisation of its estate.

Governance, risk management and quality measurement

- The trust had a governance structure of sub committees and groups who reported through to the trust Board. There were terms of reference for committees.
- The main committee responsible for quality was the Quality Assurance Committee (QAC). The chair of the committee felt confident that concerns or problems were being escalated to the QAC. They told us that although the awareness of quality problems was high, more improvement was required to ensure the QAC was in a position to bring about rapid resolution.
- The QAC provided a report of key issues to the trust Board. All of the non-executive directors attended the Quality Assurance Committee and it was chaired by a non-executive director. This meant the non-executive directors were well sighted on the quality governance agenda.
- A series of quality indicators were used to identify wards or departments which required additional monitoring or support. We saw evidence of how these reports were used to identify areas of concern and how these areas were subsequently monitored. However, we found some areas during the inspection such as the concerns in the outpatients department at the Leicester Royal Infirmary which had not been identified by the quality monitoring process.
- From our interviews with the senior and executive leaders within the organisation, we could see they were aware of many of the key quality and performance issues the trust faced. Some of the executives and non-executives felt that there wasn't enough pace in the organisation to address some of these

areas. For example, the executive team were aware that not all patients were getting treatment in accordance with national guidance in relation to the management of the deteriorating patient and sepsis.

- We looked at a number of the board and subcommittee reports and found some of the performance data and feedback being received provided reassurance rather than assurance.
- The trust had a Board Assurance Framework (BAF) which was a standing item on the Boards agenda. The BAF was also reviewed by the various sub committees of the Board. We saw the Chief executives report references the principle risks in the BAF and significant risks in the risk register which we considered was good practice. The BAF was described to us by several members of the executive team as being in development.
- The executive Board determined the specific inclusion and exclusion of risks on the BAF. Operationally, specific risks such as the ophthalmology pressures, plain film reporting backlog, management of the deteriorating patient and sepsis, and fractured neck of femur intervention performance were reported on the Datix risk register to the Executive Performance Board monthly. These risks were escalated on to the BAF as part of principle risk one, which was “failure to deliver the quality commitments
- We looked at the other risks on the BAF and found some of the controls were not progressing in a timely way.
- We reviewed a number of sets of minutes from the trust Board meetings. The minutes did not provide information about the comments made by individual Board members so it was difficult to ascertain the level of challenge that had been offered. We were told by several members of the leadership team that the non-executive directors were developing their capability to confirm and challenge the assurance or reassurance being received.
- The challenges that were faced in the A&E department were well known and were often spoken about during our inspection. All of the senior leaders whom we spoke with cited this as one of the trusts highest risks. In addition, we noted clinical staff who did not work in A&E were also aware of the significant challenges in A&E and the knock on effect this had one the rest of the trust. At our focus groups, some staff commented they felt the A&E department received too much attention by senior leaders and external agencies.
- There was no doubt the A&E department was causing significant problems for the trust. We observed how the patient experience was in some cases below the standard we would

expect. 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 it 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. Senior leaders told us the problems would be solved once the department moved into its new building where they would have the space and environment to care for the increased numbers of patients they saw. However other staff told us they were concerned that there was too much reliance that this would fix the problems. The challenges faced in the emergency department were not solely because of the numbers of patients and the cramped environment.

- A system wide approach with the whole health and social care community was needed to support the trust to address the increasing attendances in the Emergency Department. Although there were plans in place and different initiatives to address the problems, we saw little evidence that these were making any impact on the numbers of attendances.
- In July 2015, NHS England instructed their regional team to set up A&E Delivery Boards. The board for Leicester, Leicestershire and Rutland was chaired by the trusts Chief Executive. An action plan had been developed and was subject to twice weekly monitoring to ensure the actions were having the desired impact. It was too early to comment what impact this was having on the trusts Emergency Department.
- 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 warned the trust and 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. However, at the time of the inspection, not all patients were getting treatment in accordance with national guidance.

Leadership of the trust

Summary of findings

- The rating we gave the trust in this inspection was the same rating as they were awarded in the 2014 comprehensive inspection. However, we did find improvements had been made, particularly in staff engagement. Confidence in the leadership team had been sustained.
- When we inspected this trust in 2014, the Chief Executive had been in post about a year. At that time, staff were very positive about the changes in leadership and the general direction of the trust. When we inspected in 2016 the same Chief Executive had been in post for three years. Staff continued to speak highly of his leadership and the vision and strategy for the trust. Staff told us they knew who the Chief Executive was and many commented on him being approachable and they knew they could contact him directly either through email or at his "Breakfast with the boss" meetings.
- The Chief Nurse had joined the trust in August 2015. We found nursing staff generally knew who she was. The Chief Nurse worked clinically in different areas of the trust and aimed to be as visible as possible. We found the Chief Nurse was knowledgeable about the areas of risk in the trust and was realistic about the challenges they faced and the improvements that were required. She was very open and honest with the inspection team. We also found the Chief Nurse was very responsive when we raised issues that needed addressing during the inspection.
- The Medical Director had been in post since February 2016 but as the interim medical director since April 2015. We found the medical staff generally knew who the Medical Director was and generally most of the medical staff spoke very positively about the leadership he provided. We also heard comments from medical staff that they felt confident in his leadership. Again, we found the Medical Director to be sighted on areas of risk in the trust and where improvements were needed.
- From our interviews and ongoing conversations with the Chief Nurse and Medical Director we could see they worked exceptionally well together. There were no professional barriers between them and they worked closely together to get the best possible care for patients.
- The trusts chairman joined the trust in October 2014. During our interview with the Chairman it was clear he was focused on patient care and what mattered most to patients.
- The non-executive members of the trust Board had people with different backgrounds from the private and public sector. The Board members we spoke with were able to articulate the top

risks of the trust. We were told by several leaders in the organisation that they felt the non-executive directors were very engaged and were taking steps to ensure they were fully informed by attending the different trust Board committees.
- The executives told us that relationships between the trust executive team and other organisations such as the Clinical Commissioning Group and the local authority were said to have improved under the current leadership. We spoke with commissioners before our inspection and they echoed this.

Culture within the trust

- We found many staff commented on the positive culture change in this trust under the current Chief Executives leadership. There was recognition there were a lot of things that still needed focus and attention but they were in better position now than a few years ago. These comments reflected the changes to the staff survey results which showed an upward trend over the past three years.
- The trust executive and non-executive directors told us they set the culture of the organisation. The chief exertive told us they felt they were still on their journey to excellence.
- The Chief Executive told us that good staff engagement was really important to him and he felt strongly that without it the trust would not succeed.
- There was a ward to Board oversight programme. The Board members did ward visits but it was difficult to find evidence to demonstrate the impact from these visits. Staff did however tell us they thought it was good that the board members visited the wards.
- There were different initiatives in place to encourage staff to speak up and raise concerns or areas that needed improving. One of these initiatives was the Gripe reporting tool which was designed for junior doctors to raise concerns about patient safety or training concerns. We found evidence that a newsletter was produced to feedback the response and action to rectify the gripes they had received.
- The QAC had received a report on the requirements for the trust to have a Freedom to speak up Guardian. A working group was in place to progress the required actions. It was planned that the September trust Board would consider a proposed plan for the implementation of the role.
- Staff told us they felt able to raise concerns and they knew about the trusts policies to do this.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. The regulation intends to make sure senior directors are of good character and have the right qualifications and experience.
- We reviewed the files of three executive directors and three directors. Four had all the required checks in place. One director did not have evidence of a disclosure and barring service check in their file and two directors did not have evidence that two reference checks had been completed. However these directors had previously been in post and the trust had taken the decisions that references and DBS were not required.
- The trust had a policy for FPPR in place which included all the requirements of the regulation.

Public engagement

- 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
- The trust had a patient experience committee and a patient and public involvement strategy. All of the clinical management groups had PPI leads (usually the heads of nursing). They reported monthly to the patient experience committee on patient equity, patient experience and patient engagement.
- The patient engagement team told us they felt the executive leaders in the trust were committed to patient engagement.
- The trust had a patient involvement, patient experience and equality assurance committee (PIPEEAC) and a patient and public involvement (PPI) strategy.
- All of the clinical management groups had PPI leads (usually the heads of nursing). They reported monthly to the PIPEEAC on service equality, patient experience and patient involvement.The patient and public engagement team told us they felt the executive leaders in the trust were committed to patient/ public engagement. The trust had "Patient Partners" who are members of the public that provide a lay perspective. Patient Partners were attached to all of the Trust's CMGS and

are involved in committees and reviewed literature, as well as being involved in new developments or service changes. We saw how they had been involved in the plans for the building of the new Emergency Department

- Prior to the inspection we spoke with a representative from the local Healthwatch. Healthwatch are a consumer champion organisation who represent people who use health and social care services. The Healthwatch representatives told us they had a good relationship with the trust and that they listened and were responsive to concerns that were raised. We also noted the Healthwatch representative was invited to meetings after the inspection where we monitored the trusts performance in relation to the management of sepsis and the deteriorating patient.
- We observed in the board meeting minutes of September 2016 that Healthwatch had raised a question for the trust which was highlighted and responded to in the Chief Executives report.
- The trust had a number of volunteers and we observed them during the inspection carrying out important roles across all of the three hospital sites. The volunteers often provided a way finding service to patients.
- We noted the trust had acknowledged the difficulties many patients faced with finding their way around the hospitals, particularly the Leicester Royal Infirmary. Volunteers were on hand to provide assistance and we saw this happen during our inspection. However, we also observed some patients who were struggling to find their way around the hospital and needed advice.
- We observed members of the public visiting the hospital did not always consider the signs or loud speaker announcements. For example, at the LRI there was a speaker asking patients not to smoke by one of the main entrances alongside the A&E and urgent care centre. This was a very busy entrance with patients being taken in and out of the hospital. We noted throughout the inspection that despite the announcements and signs, people continued to smoke. The entrance to the hospital was untidy and there were lots of cigarette ends littered all over the floor. It did not create a welcoming entrance area to the hospital.
- The Friends and Family test was offered in different languages. The hospital had electronic patients feedback surveys located in different parts of the hospital. The survey was available in an easy read version as well as a version for children.
- The Friends and Family test scores were about average when compared with other trusts. This test is based on a question

asked of patients in all NHS trusts in England, "How likely are you to recommend this ward/clinic to friends and family if they needed similar care or treatment." In August 2016 the trust scored:

o Inpatient services 96% (NHS average (95%)

o Urgent and emergency services 87% (NHS average 87%)

o Outpatient services 94% (NHS average 93%)

- The CQC Adult Inpatient Survey 2015 received responses from 547 patients. The survey asks questions under 11 areas. The trust was rated about the same as other trusts for all 11 areas, however, the questions relating to cleanliness of rooms or wards and patients feeling that doctors and nurses were not acknowledging them were worse than other trusts.

Staff engagement

- The trust had three positive findings and eight negative findings in the 2015 NHS staff survey. The remaining 23 indicators were within expectations. The trust improved on 18 of its scores which would suggest the changes the trust had implemented were making a difference.
- The overall staff engagement score was 3.77 which was worse than average, however there was a marked increase in this score since the 2014 staff survey. This would suggest efforts to improve how engaged staff feel have made had some impact. This also reflected what staff told us during the inspection.
- During 2013 the trust implemented a process called "listening into action," which is a process designed to empower staff to improve the care of patients. This was an area the chief executive was very passionate about. We saw examples of changes that had been made from listening into action during out inspections of the core services.
- The Staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The trusts score was worse than average, but was improving and was better than the 2014 score.
- The trust had a staff awards programme called 'Caring at its Best Awards.' This was designed to reward inspirational staff, those that live the values of the organisation and deserved recognition for their success and commitment to caring at its best.

Innovation, improvement and sustainability

Summary of findings

- The trust operated with a £34.1 million deficit in 2015/16. This meant there was a gap between what it cost to run the trust to what they received by way of payment for the services provided. One of the reasons for the deficit was due to the current configuration of the hospitals. The trust had a financial recovery plan in place. The recovery plan showed an improvement in the trust's financial position in each year through productivity and efficiency gains. The greatest savings were due to be made in 2019/20 as a result of moving from three acute hospital sites to two, thereby reducing the expensive clinical duplication of staff and equipment.
- All cost improvement plans (CIPs) were assessed and reviewed for their impact by the Chief Nurse and Medical Director. We discussed examples where they had either not supported or asked for revisions to CIPs to ensure patient safety and quality were paramount.
- The trust was part of a 5 year programme called Better Care Together which aims to change the way health and social care was delivered across Leicester, Leicestershire and Rutland."
- The trust ran the largest single site A&E department outside London. As part of the NHS five year forward view, Leicester, Leicestershire & Rutland submitted an application to be an urgent and emergency care Vanguard site. Vanguard sites are a term given to areas where new models of care are being developed. The Vanguard has been designed to create an alliance based urgent and emergency care system where all providers work as one network. It brought together ambulance, NHS111, out of hours and single point of access services to ensure that patients get the right care, first time. Despite the Vanguard programme being in place we found the A&E department to be seeing increasing patient numbers year on year and were dealing with over 50% more patients than the department was designed for. The trust executive team shared concern that the pace of improvement was slow and there was a dire need for real integration between health and social care.
- In response to the need to change the nature of healthcare to be in a position to treat an increasing number of older people, the trust was working collaboratively with a local university, trust and charitable organisation as part of the Leicester academy for the study of ageing (LASA). The aim was to improve outcomes for older people, as well as those who care for them with a holistic, multi-disciplinary approach.

Summary of findings

- Concerns were expressed to us about the trusts IT infrastructure. The Patient Administration System was old and was not supported by the service provider any more. At the time of the inspection the trust was waiting for funding from the Department of Health to implement a new IT system.
- The trust had implemented software across the trust so that an electronic tool could be used to record electronic observations, handover, task management and clinical assessments. The implementation of this software would allow the trust to have increased oversight and real time data regarding patient's physical condition. It also provided the trust with data on how well staff were escalating any deterioration in a patient's condition. The Medical Director and Chief Nurse told us the system would support the improvements that were needed in the management of the deteriorating patients. At the time of the inspection the trust were implementing this using a phased approach so staff could receive the appropriate level of training and support. Since the inspection, we noted the trust had implemented this system at pace and it was helping them to improve their performance in the management of deteriorating patients.

Overview of ratings

Our ratings for University Hospitals of Leicester NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

Leicester General Hospital

- A new computerised individualised dosing system was in operation on the renal wards.
- New Starters in nephrology had a 12-week supernumerary period within the ward area and a bespoke Professional Development Programme. Included within the development programme was; trust behaviours, early warning score (EWS), infection prevention control, planning / evaluating care, managing pain, care of the dying patient and equipment training. Templates were also included to assist registered nurses in their revalidation process.
- An MDT meeting took place weekly on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals (physiotherapy, occupational therapy and speech and language therapy), medical and nursing staff and a neurological psychologist. The patient and relevant family member would also be present at this meeting where a patient's individual rehabilitation goals would be discussed and reviewed.
- 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.
- On ward 1, a flexible appointment service was offered for patients. In order to help patients who had other personal commitments, for example work commitments, staff would work flexibly sometimes starting an hour earlier in the day to enable the patient to receive their care at a time and place to meet their needs.
- The development of a pancreatic cancer application to support patients at home with diagnosis and treatment. This will potentially assist patients and family members face the diagnosis and treatment once they have left the hospital.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified obstetric early 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 range of risk assessments. This meant that all assessment records were bound 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.

Glenfield Hospital

- 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.
- A range of medicines to manage Parkinson's disease was available on the clinical decisions unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.
- 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.

Outstanding practice and areas for improvement

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

Areas for improvement

Action the trust MUST take to improve

Trust wide

- The trust must ensure all Directors and Non-executive Directors have a Disclosure and Barring check undertaken to ensure they are of good character for their role.

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 who wait in for longer than 8 hours have a VTE risk assessment and appropriate thromboprophlaxis prescribed.
- 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.

Surgery

- The trust must ensure hazardous substances are stored in locked cabinets.
- The trust must ensure staff know what a reportable incident is and ensure that reporting is consistent throughout the trust.
- The trust must ensure staff learning is embedded after a never event and are trained in the use of the delirium tool.
- The trust must ensure patients preparing for surgery had venous thromboembolism (VTE) assessments completed in a timely manner and reviewed after 24 hours.
- The trust must take action to address the shortfalls in staff education in relation to mental capacity (MCA) assessments and deprivation of liberty safeguards (DOLs).

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.
- The trust must ensure staff report incidents in a timely way.

Maternity and gynaecology

Outstanding practice and areas for improvement

- 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, anaesthetic recovery and instrument/scrub practitioner line with current recommendations.
- The trust must address the backlog in the gynaecology administration department so that it does not impact patient safety.

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 paediatric medical staffing is compliant with the Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants.
- 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 care

- 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 that all equipment, especially safety related equipment is regularly checked and maintained.
- The trust ensure building maintenance work is carried out in a timely manner to prevent roof leaks.
- The trust ensure patient notes are securely stored in clinics.
- The trust must ensure the privacy and dignity of service users is protected.
- The trust must take action to comply with single sex accommodation law in diagnostic imaging changing areas and provide sufficient gowns to ensure patient dignity.
- 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.
- The trust must ensure that it carries out patient tests in private surroundings which maintain patients privacy.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(2)** Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service. **How the regulation was not being met:** • The provider did not have an audit system in place to ensure 'Do Not Attempt Cardio-Respiratory Resuscitation' decisions were always documented legibly and completed fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (2)(a)** Service users must be treated with dignity and respect, ensuring the privacy of the service user. **How the regulation was not being met:** • 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

This section is primarily information for the provider

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.
- The privacy of patients was not ensured in changing area D at Leicester General Hospital in diagnostic imaging, which was shared between male and female patients.
- The lack of patient gowns at Leicester General Hospital in the computerised tomography (CT) waiting/changing room at Leicester General Hospital compromised patients' privacy and dignity. It was difficult for patients to tie up the backs of their gowns. There were insufficient gowns for patients to be routinely offered one to use as a dressing gown to cover gaps at the back.
- Not all patient tests were carried out in private surroundings, this compromised patients privacy.

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.

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Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2)(a)** Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. **How the regulation was not being met:** • There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients. Nursing staff did not consistently adhere to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always document a clear plan of treatment if a patient's condition had deteriorated. • Where patients had met the trust criteria for sepsis screening, they were not all 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 preparing for surgery did not always have venous thromboembolism (VTE) assessments reviewed after 24 hours. patients requiring admission who waited in the ED for longer that 8 hours did not always have a VTE risk assessment and or appropriate thromboprophlaxis prescribed. **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.

Requirement notices

- 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.
- Staff caring for patients after a never event had no formal training in the use of the documentation designed to reduce the risks to patients suffering delirium.
- Staff had a limited understanding of what was a reportable incident and were not consistently reporting patient safety concerns in a timely manner. There had been a delay in the timely reporting of a recent never event.

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:

- 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.
- Control of substances hazardous to health materials were stored in unlocked cupboards.

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)

This section is primarily information for the provider

Requirement notices

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

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:

- 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**

This section is primarily information for the provider

Requirement notices

- 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 social space, unsupervised.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15(1)(a)** Premises and equipment **How the regulation was not being met** • 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 premised and equipment used by the service provider must be properly maintained. **How the regulation was not being met:** • At Leicester General Hospital five items had not been safety tested by the required date. In outpatients three, a defibrillator had not been safety tested on its due date in April 2016. A sphygmomanometer, a thermometer and two urilisers (diagnostic apparatus) had not been safety tested by the required date. • At Leicester General Hospital there was a roof leak by the diagnostic imaging reception area. A container was in place to catch the water and stop the floor getting slippery for both patients and staff.

This section is primarily information for the provider

Requirement notices

- At Leicester General Hospital there were lifted floor tiles in between diagnostic imaging waiting areas C and D which could cause a trip hazard

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1)(a)** Good governance 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. • 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	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

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.
- At Leicester General Hospital in maternity and gynaecology services the lack of junior doctors, especially out of hours, led to delays in patient reviews which could pose a risk to patient safety.
- Medical staffing in the children's and young people's service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants.
- 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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

This section is primarily information for the provider

Requirement notices

Regulation 5 (3) (a)

The individual is of good character,

How the regulation was not being met:

- We reviewed the files of three executive directors and three directors. Four had all the required checks in place. One director did not have evidence of a disclosure and barring service check in their file and two directors did not have evidence that two reference checks had been completed.

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	Section 31 HSCA Urgent procedure for suspension, variation etc. 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. The trust failed to demonstrate that it had an effective system in place so to ensure: • 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. Following our inspection of the Leicester Royal Infirmary, the section 31 HSCA Urgent procedure for suspension, variation etc. remains in place.