

University Hospitals of Leicester NHS Trust

Leicester General Hospital

Quality Report

Gwendolen Road
Leicester
LE5 4PW

Tel: 0300 303 1573

Website: www.leicestershospitals.nhs.uk

Date of inspection visit: 20 – 23 June 2016

Date of publication: 26/01/2017

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

Ratings

Overall rating for this hospital

Requires improvement



Medical care (including older people's care)

Good



Surgery

Requires improvement



Critical care

Good



Maternity and gynaecology

Requires improvement



End of life care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,959 general and acute beds. 147 of these beds are maternity beds and 49 are critical care beds. 394 inpatient beds and 86 day-case beds are located at Leicester General Hospital.

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

Leicester Royal Infirmary is close to Leicester city centre and provides Leicestershire's only emergency department. The hospital has approximately 975 inpatient beds and 66 day-case beds. There were 149,806 inpatient admissions, 993,617 outpatient attendances and 135,111 emergency department attendances between April 2015 and March 2016.

Leicester General Hospital has 394 beds and provides services which include a centre for renal and urology patients. As a teaching hospital it works in partnership with several universities including the University of Leicester, Loughborough University and De Montfort University, to provide teaching, research and innovation programmes for doctors, nurses and other healthcare professionals.

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, taking place between the 20 and 23 June 2016, and critical care being inspected between the 25 and 27 July 2016. We also carried out unannounced inspections to Leicester Royal Infirmary, the Glenfield Hospital and Leicester General Hospital on 27 June, 1 July and 7 July 2016.

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

Our key findings were as follows:

- There were systems in place to report incidents. However, staff did not always recognise concerns, incidents or near misses which meant that opportunities to learn from incidents may be lost. Never events had been reported but a delay in reporting and poor systems to embed learning did not ensure that the event would reoccur.
- We were concerned about the trust's management of deteriorating patients and those who presented with sepsis. This is a severe infection which spreads in the bloodstream and if left untreated can lead to death. Where patients had met the trust's criteria for sepsis screening, they were not all screened in accordance with national guidance. This put patients at risk of not receiving the correct treatment in a timely manner.
- Infection control was not always given sufficient priority. Standards of cleanliness and hygiene were not consistently maintained across all areas of the trust. Audits showed variable performance.
- Staffing were mostly being met, supplemented by the use of bank and agency staff.
- Care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment. Where outcomes for patients were below expectations when compared with similar services action plans had been put in place.
- Staff were mostly aware of the correct use of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) when caring for patients in vulnerable circumstances. However, in surgical services staff were not knowledgeable about the application of MCA processes.

Summary of findings

- Staff were caring. We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Relatives and carers told us they felt involved and informed. The environment and availability of gowns did not always ensure that patient's dignity was protected.
- There were significant and ongoing typing backlogs in the gynaecology administration department, this could pose a risk to patient safety.
- Patients experienced unacceptable waits for some outpatient services trust wide. There were backlogs in some outpatient specialities, which clinicians had not fully prioritised, and for some diagnostic scans.
- There was a clear vision and strategy for the service, which was shared by most staff and most of the leadership team were visible and well respected.

We saw several areas of outstanding practice including:

- A new automated closed-loop unit dose medicine administration system was in operation on the renal wards.
- New starters who were nurses recruited from EU countries 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 clinical service risk assessment booklet also included a range of risk assessments. This meant that all assessment records were bound together.

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

Importantly, the trust must:

Medicine

- The trust must take action to ensure nursing staff adhere to trust guidelines for the completion and escalation of the early warning scores (EWS) which may indicate a patient is deteriorating.
- The trust must ensure that where patients met the trust's criteria for sepsis screening, they were screened in accordance with national guidance.

Surgery

- The trust must ensure venous thromboembolism (VTE) assessments are re-assessed after 24 hours.
- The trust must ensure hazardous substances are stored in locked cabinets.

Summary of findings

- 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 provider must ensure that staff complete consent forms appropriately for patients who lack capacity and were made in line with the Mental Capacity Act 2005.

Critical Care

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

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. We found:
- Midwifery staffing ratios did not meet current recommendations.
- 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.
- 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.

End of life

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

Outpatients & diagnostic imaging

- The trust must ensure that all equipment, especially safety related equipment is regularly checked and maintained.
- The trust must ensure building maintenance work is carried out in a timely manner to prevent roof leaks
- The trust must ensure patient notes are securely stored in clinics.
- The trust must ensure action is taken to comply with single sex accommodation guidance in diagnostic imaging changing areas and provide sufficient gowns to ensure patient dignity.

In addition the trust should:

- The trust should ensure infection prevention control is given sufficient priority on ward two.
- The trust should ensure all staff are aware of the arrangements in place to respond to emergencies and major incidents.
- The trust should consider the impact the uncertainty of the future of endoscopy services is having on staff within this area.
- The trust should ensure the pre assessment pathway is streamlined to ensure all high-risk anaesthetic patients are pre assessed.
- The trust should ensure they develop an action plan for managing cancelled operations due to a lack of high dependency beds.
- The trust should ensure they develop an audit process for the World Health organisation (WHO) five steps to safer surgery checklist.
- The trust should ensure medication storage in anaesthetic rooms is consistent across all areas.

Summary of findings

- The trust should ensure medical teams have sufficient time for handovers at the end of each shift.
- The trust should consider the clinical management groups (CMGs) develop ways of sharing new ideas and best practice.
- The trust should ensure that the actions initiated after the recent never event include re-enforcing the importance of the timely reporting of all incidents.
- The trust should ensure it continues to work to meet the existing areas of non-compliance with the D16 National Service Specification for Adult Intensive care. More specifically, the shortfall in allied health professional support and NICE guidance.
- The trust should consider extending the critical care outreach team to cover each 24 period.
- There should be constant use of patient diaries across the trust for patients in critical care units.
- The trust should consider how it can reduce the number of delayed discharges in critical care.
- The trust should consider how it is going to reduce the number of cancelled elective surgery cases due to the lack of availability of critical care beds.
- The trust should consider how it is going to reduce the number of cancelled elective surgery cases.
- Intravenous fluids should be securely stored to ensure the risk of tampering or contamination is minimised.
- The trust should ensure that safeguarding pathways and procedures protect patients from avoidable harm.
- The trust should ensure that all staff are aware of their responsibilities under the missing baby policy.
- The trust should ensure that all staff are aware of their responsibilities under the major incident policy.
- The trust should ensure that all maternity and gynaecology risks are added to the risk register to ensure mitigation and oversight.
- The trust should ensure that in maternity and gynaecology the culture promotes supportive and respectful behaviour between all grades of staff.
- The service should consider the reporting quality of the maternity and gynaecology dashboard data at a site level and set RAG targets for all outcomes to ensure greater oversight of outcomes and trends.
- The trust should consider the investigation and coding of puerperal sepsis, wound infections and sepsis of unknown origin.
- The trust should consider the appropriateness and robustness where incidents are down-graded.
- The trust should ensure there are systems in place to ensure that staff demonstrate competence to operate different types of equipment.
- Should locate, monitor and track the syringe drivers across the trust.
- Review the leadership arrangements and focus on end of life care to ensure it is given sufficient priority at directorate and board level.
- Consider how to reduce in-clinic wait time for patients.
- Ensure clinic capacity is planned to meet patient demand.
- Ensure that patients requiring following up appointments are seen in a timely manner.
- Ensure where there are backlogs, patients have been assessed for clinical risk and prioritised accordingly.
- Consider how to ensure leaflets and information available in outpatient clinics are translated where appropriate into languages used by the local community.
- Address the reasons for hospital cancellations of outpatient clinics.
- Ensure information about how to complain is available to patients in outpatient clinic areas.
- Consider how to meet the needs of patients with a learning disability and reduce DNAs for these patients in outpatient clinics.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

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

Rating

Good



Why have we given this rating?

We rated medical care services as good overall. Safety of medical services was rated as requires improvement. Patients were at risk of not receiving the correct treatment in a timely manner. Nursing staff were not consistently adhering to trust guidelines for the completion and escalation of early warning scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately.

Potential risks to medical care services were anticipated and planned for in advance. However, not all staff were aware of the arrangements in place to respond to emergencies and major incidents.

There were systems, processes and standard operating procedures in infection prevention control, records, medicines management and maintenance of equipment which were mostly reliable and appropriate to keep patients safe. Patients were protected from abuse and staff had an understanding of how to protect patients from abuse.

We rated medical care services in effective, caring and responsive as good.

Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment. Where outcomes for patients were below expectations when compared with similar services action plans had been put in place.

Patient's symptoms of pain were effectively managed in both ward and department areas with good comfort outcomes for patients in endoscopy. Staff were proactive in assessing the patient's nutrition and hydration needs.

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

Summary of findings

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

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

We rated well led as good. There was a vision and strategy for this service and whilst it was very strategic staff were able to describe this to us during our inspection. Staff were consistent in delivering care and demonstrating behaviours in line with the trust vision and strategy. Staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support.

Surgery

Requires improvement



We rated surgery care services as requires improvement overall

Safety was not a sufficient priority, for example the delay in recognising and reporting a never event. Staff did not always recognise concerns, incidents or near misses for example not reporting missing medical notes, or the lack of computers in theatre. Venous thromboembolism (VTE) assessments were not reviewed after 24 hours for patients preparing for surgery.

Staff were unaware of the correct use of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) when caring for patients in vulnerable circumstances.

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

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

Summary of findings

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

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

There was strong local leadership with staff respecting line managers and feeling supported in their roles.

Critical care

Good



We rated critical care services as good overall. Safety thermometer data showed there was a high incidence of harm free care delivered to patients. We saw that evidence based best practice guidance was being used to determine care.

We saw patients, their relatives and friends being treated with dignity and respect. Staff demonstrated that they understood the impact of critical care on people and their families both socially and emotionally.

There was a vision and strategy for the reconfiguration of critical care service at Leicester General Hospital despite the current hold on progress being made as a consequence of financial pressures.

There was an effective governance structure in place which ensured that risks were recognised and discussed including mitigating actions, timescales and ownership.

There had been a delay in the timely reporting of a recent never event. Not all the staff on duty on the day of the inspection were aware of the never event and the subsequent changes to practice.

The environment fell short of the current Health Building Notes (HBN 04-02) for critical care.

.

There was a delay in patients being transferred out of critical care when their condition improved. The critical care outreach service was not provided 24 hours a day, seven days a week.

Maternity and gynaecology

Requires improvement



We rated the maternity and gynaecology service as required improvement.

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

Summary of findings

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

Women were at risk of not always receiving effective care and treatment as some midwifery staff did not have the competencies required when caring for women who were critically ill, following anaesthesia or when acting as theatre instrument practitioners.

Significant and ongoing typing backlogs in the gynaecology administration department could pose a risk to patient safety.

The majority of women, their partners and relatives were positive about the care they had received.

Most of the women we spoke with told us staff were kind and caring and that they were treated with dignity and respect and were happy with the emotional support they received. Staff involved patients in their care and treatment.

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

Care and treatment was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation; however, some midwifery staff did not have the competencies required when caring for women who were critically ill, following anaesthesia or when acting as theatre instrument practitioners.

The service provided a cohesive and sensitive bereavement service for women experiencing pregnancy loss, including the employment of a specialist midwife, dedicated bereavement rooms and postnatal records.

There was a clear vision and strategy for the service, which was shared by most staff, and most of the leadership team were visible and well respected.

The outcomes for women against trust targets were mixed; the normal birth rate was above the national average and rates of instrumental birth were better than trust targets but the rates for caesarean section and postpartum bleeding were worse.

We were also not assured that incidents were appropriately graded following discussions at clinical governance meetings. Clinical audits were

Summary of findings

undertaken but could be delayed because of staff availability to undertake them. We were not assured that results of audit were addressed in the action plans.

End of life care

Requires improvement



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

The medical staffing levels were not in line with the recommendations from the National Council for Palliative Care who recommend there should be one whole time equivalent (WTE) consultant for every 250 beds. The service had 3.5 WTE consultants and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended.

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

We looked at 12 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR) across the trust and found there were inconsistencies in how these were completed. We found that out of 12 DNACPR orders, six were completed correctly (50%). We found staff had not always followed trust policy when they completed DNACPR orders.

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

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

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

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

Summary of findings

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

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

A bereavement service was available to support family members with practical and support issues after the death of a patient. The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital, as well as their relatives.

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

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

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

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

Outpatients and diagnostic imaging

Requires improvement



We rated outpatient and diagnostic imaging services as requires improvement because: Patients experienced unacceptable waits for some outpatient services trust wide. There were backlogs in some outpatient specialities, which clinicians had not fully prioritised. In some clinics there were long wait times. Patients complained of multiple cancellations.

The risks associated with anticipated events were not fully recognised, assessed or managed. Leaders did not risk assess outpatient waiting list or

Summary of findings

backlogs in a timely manner. High risk patients and patients whose circumstances might make them vulnerable were not always identified before arrival in clinic. Some equipment checks at Leicester General Hospital were not up to date.

The trust was developing governance arrangements to better manage performance for outpatients however the impact on patient experience was not apparent when we inspected.

The dignity of patients was not always respected. For example, there were changing areas which male and female patients had to share.

Patients waiting for appointments were not routinely checked for pain, or offered refreshments if they had been waiting a long time.

Staff understood and fulfilled their responsibilities to raise safety concerns and report incidents and near misses; managers supported them when they did. If something went wrong, there was a thorough review or investigation involving all relevant staff and people who used services. Lessons were learned and communicated widely.

Feedback from patients who use the service, those who are close to them and stakeholders was positive about the way staff treated people.

Patients told us they were happy with the standard of treatment and care and that nurses and clinicians were kind and compassionate.

Care and treatment was planned and delivered in line with current evidence-based guidance, standards, and legislation. The services used local and national audit arrangements to maintain the effectiveness of treatment. Diagnostic imaging used diagnostic reference levels to check dosage.

Services used multidisciplinary team arrangements to benefit patients.

Leaders had a vision for the future of outpatient services and this was understood by staff.

Leicester General Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Leicester General Hospital	14
Our inspection team	14
How we carried out this inspection	15
Facts and data about Leicester General Hospital	15
Our ratings for this hospital	15
Action we have told the provider to take	148

Background to Leicester General Hospital

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 through the merger of Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. St Mary's Birth Centre provides care for pregnant women and their families for the trust.

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

There is no accident and emergency (A&E) department at Leicester General Hospital. We report on the trust's A&E services in the separate report for Leicester Royal

Infirmary which provides emergency care to the community served by the trust.

Leicester General Hospital has 394 beds and provides services which include a centre for renal and urology patients. As a teaching hospital it works in partnership with several universities including the University of Leicester, Loughborough University and De Montfort University, to provide teaching, research and innovation programmes for doctors, nurses and other healthcare professionals.

Leicester General Hospital has been inspected by CQC five times. The last inspection was conducted between 13-16 January 2014. At this inspection, Leicester General Hospital was rated overall as requiring improvement.

Our inspection team

Our inspection team was led by:

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

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

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

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

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

Facts and data about Leicester General Hospital

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester Royal Infirmary. The trust has 1,771 inpatient beds and 176 day-case beds. 975 inpatient beds and 66 day-case beds are located at Leicester Royal Infirmary.

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

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:







Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Medical care (including older people's care)

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

Information about the service

University Hospitals of Leicester NHS Trust provides medical care (including older people's care) at this hospital as part of three clinical management groups (CMG): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS), acute medicine / ED and specialist medicine and renal, respiratory and cardiovascular. Specialties include: gastroenterology, nephrology, stroke medicine, neurology and rheumatology.

The trust has 902 inpatient medical beds across the three sites; 84 inpatient beds and 29 day case beds are located within nine wards at Leicester General Hospital. During our inspection we visited eight clinical areas. These included; wards one (medical day case unit), two (neurological rehabilitation unit), three (stroke rehabilitation unit), 10, 15A (high dependency nephrology), 15N, the brain injury unit and endoscopy.

Between September 2014 and August 2015 there were 20,900 medical admissions to Leicester General Hospital. Of these, 5% were emergency admissions, 91% were treated as day cases and the remaining 4% were planned admissions. Gastroenterology admissions represented the largest number of admissions at 96%.

During our inspection of this hospital we spoke with 12 patients, five relatives and 30 staff. Staff we spoke with included junior and senior registered nurses, health care assistants, housekeeping staff, student nurses, nurse endoscopists, allied health professionals and junior and senior medical staff.

We observed interactions between staff, patients, and patient's relatives, considered the environment and looked at six medical and nursing care records and, reviewed 12 patient observation/sepsis screening pathways. Before our inspection, we reviewed performance information from, and about the trust.

Medical care (including older people's care)

Summary of findings

We rated medical care services as good overall.

We rated medical care services in effective, caring, responsive and well led as good. Safety required improvement.

Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment. Where outcomes for patients were below expectations when compared with similar services action plans had been put in place.

Patient's symptoms of pain were effectively managed in both ward and department areas with good comfort outcomes for patients in endoscopy. Staff were proactive in assessing the patient's nutrition and hydration needs.

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

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

However, we also found:

Safety of medical services was rated as requires improvement. Patients were at risk of not receiving the correct treatment in a timely manner. Nursing staff were not consistently adhering to trust guidelines for the completion and escalation of early warning scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately.

Potential risks to medical care services were anticipated and planned for in advance. However, not all staff were aware of the arrangements in place to respond to emergencies and major incidents.

There were systems, processes and standard operating procedures in infection prevention control, records, medicines management and maintenance of equipment which were mostly reliable and appropriate to keep patients safe. Patients were protected from abuse and staff had an understanding of how to protect patients from abuse.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



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

We found:

- Patients were not always protected from avoidable harm. Nursing staff did not always adhere to trust guidelines for the completion and escalation of early warning scores (EWS), the frequency of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated.
- Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of not receiving the correct treatment in a timely manner.
- Infection control was not always given sufficient priority. Patient-Led Assessments of the Care Environment' (PLACE) results were below the England average, hand hygiene audit results were low, on ward two the ceilings and floors were visibly dirty and the sluice sink was chipped and stained.
- Not all staff were aware of the arrangements in place to respond to emergencies and major incidents.

However we also found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and could demonstrate where changes to practice had been made as a result.
- Patients were protected from abuse and staff had an understanding of how to protect patients from abuse. Staff were able to describe what safeguarding was and the process to refer concerns.
- Systems, processes and standard operating procedures in records, medicines management and maintenance of equipment were mostly reliable and appropriate to keep patients safe.

- Nursing and medical staff were up to date in mandatory training and levels of staffing and skill mix of staff were managed appropriately with the use of bank and agency. An effective induction process was in place for locum, agency and bank staff.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- Without exception, all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- There were no never events in this service between March 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- The trust reported 44 serious incidents between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Medical care had the highest number of serious incidents reported at 13 (30%) with one serious incident reported at this hospital. This related to a reported positive Meticillin-resistant Staphylococcus aureus (MRSA) blood culture. MRSA is a bacterium responsible for several difficult-to-treat infections. During our inspection we were told of a recent serious incident that had occurred within nephrology.
- We reviewed the full investigation report for the positive MRSA blood culture and the initial review also known as a 72-hour report for the recently identified serious incident. Investigation reports were thorough and showed a robust review had taken place. Relevant staff and patients who use services were involved in the reviews or investigations. The investigation reports

Medical care (including older people's care)

showed lessons had been learned and actions had been identified. Patients who use services were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

- Medical services at this hospital reported 2191 incidents from March 2015 to March 2016. Of these, two resulted in major harm, 12 in moderate harm, 325 in minor harm and the majority, 1852 in no harm or injury.
- Of the 2191 incidents, 52 were reported as near misses. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so.
- The most frequently reported incident categories were appointments which generated 450 reports, slips, trips and falls and collisions where 254 incidents were reported and pressure ulcers, which resulted in 220 reports.
- Staff reported getting feedback from incidents through email, staff meetings, board 'huddles' and, during handovers. One ward sister told us they would request a 'read receipt' to assure themselves staff were accessing emails. All staff we spoke with were able to tell us of incidents they had reported and of more serious incidents that had occurred in other areas, including other hospital sites within the trust. A recent change put in place as a direct result of a serious incident included the introduction of a safety checklist for those patients nursed in side rooms.
- Mortality and morbidity meetings were held quarterly, as a minimum, across all medical specialties to discuss patient deaths. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Minutes we reviewed from meetings held for example, within renal and stroke medicine showed individual mortality reviews had taken place with evidence of shared learning and actions identified, where appropriate.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with had a good understanding about duty of candour. All staff we spoke with demonstrated a full understanding and gave examples of where duty of

candour had been applied appropriately. We saw example of where duty of candour had been applied appropriately and had been recorded as such within full investigation and 72-hour investigation reports.

- Prior to our inspection we asked the trust if they monitored the application of duty of candour to gain assurance that this process was consistently followed across all areas. Data received following our inspection showed for the reporting period April 2015 to March 2016, there had been no breaches of the duty of candour requirement.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein.
- Data for six medical wards from April 2015 to March 2016 showed an average harm free care rate of 93%, which was below the hospital average of 97%. For the same reporting period five wards all performed worse than the hospital average.
- Safety thermometer data was not publicly displayed on all of the wards or clinical areas we visited. This meant patients and the public could not see how the ward was performing in relation to patient safety. However, on ward 15N we did see a sign stating '607 days free of avoidable pressure ulcers' and on the brain injury unit we saw infection prevention control and pressure ulcer data displayed.

Cleanliness, infection control and hygiene

- Leicester General Hospital participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 91.8% which was worse than the England average of 95.5%.

Medical care (including older people's care)

- Trust wide there were 65 cases of clostridium difficile (c. difficile) infections between March 2015 and April 2016 with six cases occurring in the division of medicine. C. difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Trust wide between March 2015 and April 2016 there were 11 cases of MRSA reported at this trust with one case occurring in the division of medicine.
- Meticillin-sensitive staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between March 2015 and April 2016 there were 27 recorded cases of MSSA at this trust, of which two occurred within the division of medicine.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits against key policies. For example; hand hygiene, sharps safety and availability and appropriate use of personal protective equipment (PPE).
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for December 2015 for two elements of the audit; before patient contact and, after patient contact demonstrated 64% and 58% compliance respectively across five clinical areas within medical care services. This was better than the trusts overall compliance figures for before patient contact but worse than the trusts overall compliance figures for after patient contact and worse than the trust target of 90%.
- Throughout medical services we observed staff to be compliant with best practice regarding infection prevention and control policies. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons.
- Staff were consistent in isolating patients at risk of spreading infection to others. On wards two, three, 15a and the brain injury unit we saw five side rooms in use where it had been identified patients might present an infection control risk to others. In four out of five side rooms, doors were closed. Where one door remained open a risk assessment had been undertaken.
- In most areas 'I am clean' stickers were used to indicate where staff had signed to say equipment had been cleaned and was ready for patient use. However, on ward two we were not assured infection prevention and control had been given sufficient priority; we saw a bladder scanner that had no sticker to indicate it had been cleaned and was ready for patient use; the ceilings and floors were visibly dirty and; the sluice sink was chipped and stained.
- The seminar room on the brain injury unit was carpeted. Staff told us this room was occasionally used by patients and relatives for quiet meetings. This had recently been cleaned as part of the trust 'listening for action', however it remained heavily stained. We raised this with the unit sister who told us no clinical care was delivered in this room. However, patients with catheter and drainage bags may use the room and there was the potential for spillages to occur. HBN 00-09 Infection control in the built environment states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets should not be used.
- Precautions were taken in endoscopy when treating patients with suspected communicable diseases or patients at risk of spreading infection to others; staff in endoscopy told us these patients would receive their procedure at the end of a list. During our inspection of endoscopy there were no patients present who were at risk of spreading infection to others.

Environment and equipment

- Patients had access to pressure-relieving equipment. None of the staff we spoke with raised concerns regarding the provision and access to patient-care equipment.
- We checked the resuscitation equipment on four ward areas. The resuscitation equipment on the wards was clean. Single-use items on three out of four trolleys were sealed and in date, and emergency equipment had been serviced. We saw evidence on the wards that resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency. However, on ward 10 we found two packs of swabs and one pack of defibrillator pads that had expired and, an anaesthetic mask where the outer packaging had perished meaning the item was no longer sterile. These were immediately removed from use by the nurse in charge.

Medical care (including older people's care)

- We reviewed 20 items of patient-care equipment. Most were clean and ready for use. Most patient equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service. However on wards two and three we observed two items of equipment on both areas that had no sticker to indicate when it was next due for a service. Following escalation to the nurse in charge items were removed from use.
- Arrangements for the storage of consumables (single use sterile items) did not always keep patients safe. On ward 15A consumables were stored in unlocked cupboards within the clinical area. Immediately inside the unlocked store room we saw scalpels were stored on an open shelf. A scalpel is a knife with a small, sharp, sometimes detachable blade, as used by a surgeon.
- On ward 15N oxygen cylinders were stored on the floor in the clinical area. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored in a purpose-built trolley in a well-ventilated storage area and cylinders should be chained or clamped to prevent them from falling over.
- On ward two staff were not correctly segregating waste according to its classification. Staff were putting all waste into clinical waste bags even if it was not clinical waste which is not in accordance with Health Technical Memorandum (HTM) 07-01 Safe management of healthcare waste. This meant that waste was not safely managed and could incur additional costs for the hospital.
- There were local microbiology protocols for the administration of antibiotics and we saw these were followed. An antimicrobial pharmacist was also available to offer support and guidance.
- We looked at the prescription and medicine administration records for 19 patients across four wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them. If patients were allergic to any medicines this was recorded on their chart.
- Medicines, including intravenous fluids were stored securely and we saw controlled drugs were stored and managed appropriately. We did not see records to assure us that medicines were stored at the correct temperatures to ensure they would be fit for use. This was raised and addressed during our inspection.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them. Ward staff reported delays in accessing medicines out of hours but we did not see evidence of this impacting on patients receiving their medicines.
- A new automated closed-loop unit dose medicine administration system was in operation on the renal wards'. An independent evaluation of this was being undertaken by Loughborough University.
- Patients told us they were happy with the information they received about their medicines.

Medicines

- A paper based medicine administration record chart was in use at this hospital with the exception of renal wards who used an electronic prescribing system. Not all wards had regular pharmacist visit for the reconciliation of medicines on admission, on going clinical input for prescribing or patient education on discharge, although each ward had a contact number for pharmacy. Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines. Where pharmacists did visit wards medicines interventions by the pharmacists were recorded on the paper charts to help guide staff in the safe administration of medicines. There were arrangements in place to contact pharmacists for advice if needed and to obtain medicines out of hours.

Records

- During our inspection we reviewed six sets of medical and nursing care records and, 12 patient observation / sepsis screening pathways. Records were paper-based and held at the patient's bedside and in notes trolleys in the main ward corridors. Notes trolleys were stored securely and were in an area where they could be seen at all times by a member of trust staff.
- Records were mostly legible, accurately completed and up to date. Nursing care records included care plans for; breathing and circulation, pain, communication, pressure area / wound care, mobility, elimination and continence, nutrition and fluid balance, personal hygiene, rest and sleep, psychological and emotional well-being, promoting health and safe care and

Medical care (including older people's care)

discharge. However care records were not always completed or updated appropriately. For example, on ward 15N two patients fluid balance charts were not up to date.

- Patient records were multidisciplinary with entries made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists (SALT) and dietitians.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. All staff we spoke with were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads.
- Information received after our inspection showed as at June 2016 training compliance in safeguarding children was 96% and safeguarding adults 98%.
- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.
- Arrangements were in place to safeguard women or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

Mandatory training

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

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the national early warning score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required.
- Patients with a suspected infection or with an EWS of three or more, or those for whom staff or relatives had expressed concern were to be screened for sepsis, a severe infection which spreads in the bloodstream, using an 'Adult Sepsis Screening and Immediate Action Tool'.
- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- During our inspection of this hospital we reviewed 12 patient observation charts across three clinical areas. We found nursing staff did not always adhere to trust guidelines for the completion and escalation of EWS, frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always make clear plans for patients in relation to physiological parameters on the EWS chart.
- Frequency of observations was recorded in eight out of 12 observation charts. Eight out of 12 observation charts had full observations recorded including; blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output (where applicable). Two charts did not have urine output recorded (ward three).
- EWS had been completed at each time of recording the patient's observations on 11 out of 12 charts we reviewed.
- EWS scores had been calculated correctly in all of the charts we reviewed with the exception of four charts (two each on wards three and 15N) where urine output was not recorded.
- Three charts on the brain injury unit had a documented agreement not to escalate if a patient had triggered on their EWS. This had been written by the medical staff.

Medical care (including older people's care)

This allowed nursing staff to make decisions about escalating the deteriorating patients. However, where agreements were not in place EWS scoring did not always take place in line with trust policy.

- Patients triggering on their EWS were required to have further set of observations recorded within a set timescale for example from four hourly to hourly. Of the 12 charts we reviewed eight patients had not had observations repeated in line with the trust escalation of EWS monitoring in adult patients policy. This increased the risk of further deterioration for these patients.
- On ward three we saw a patient had triggered an EWS of seven at 6:55am on 30 June 2016, with the exception of a repeat set of observations at 7:10am there was no other evidence to suggest that the trust's response to clinical deterioration policy had been followed nor were they screened for sepsis. The trust's sepsis pathway states that patients scoring a EWS of three or above should be screened for sepsis. We raised this immediately with the matron for this ward who reviewed the patient and assured us they would contact the medical staff.
- On ward three we saw a patient had triggered an EWS of four at 7:45pm on 29 June 2016. A further set of observations was not recorded until 6:35am the following day, this was against trust's response to clinical deterioration policy; there was not a documented agreement not to escalate if a patient had triggered on their EWS. The trust's response to clinical deterioration policy had not been followed nor were they screened for sepsis in line with the sepsis pathway.
- On ward 15N a patient had scored an EWS of three at 3pm on 29 June 2016. Observation frequency was not recorded in line with the trust's response to clinical deterioration policy. This patient should have had observations recorded hourly for a minimum of two hours, the patient had observations recorded at 3:30pm and 7:25pm. The patient was not screened for sepsis in line with the trust's sepsis pathway. However, we discussed this with the nurse in charge who told us the patient was already having intravenous antibiotics and as such did not require a sepsis screen.
- On ward 15N we saw that a patient had scored an EWS of two at 7:10am on 28 June 2016, a further set of observations should have been recorded within one hour. The patient had observations recorded again at 5:05pm this was not in line with the trust's response to clinical deterioration policy.
- On ward three we saw that a patient had triggered an EWS of two at 3:10pm on 29 June 2016, a further set of observations was not recorded until 6:20am the following morning when the patient triggered an EWS of one. The response to clinical deterioration policy states an EWS of one to two should have a further set of observations recorded within one hour.
- Across three observation charts between wards three and 15N there were seven occasions where an EWS of one had been recorded and observations had not been repeated within an hour.
- On the brain injury unit we saw a patient scoring an EWS of six at 8:15pm on 28 June. This patient had all the appropriate interventions carried out in line with the trust's clinical deterioration interventions policy, this included specific patient parameters and screening for sepsis in line with the sepsis pathway had been considered.
- Compliance with EWS and escalation was incorporated into the clinical management groups (CMGs) nursing metrics data. We reviewed the nursing metrics data specifically for five medical wards at this hospital. Data from September 2015 to February 2016 demonstrated an overall average compliance score of 96.5%. This was better than the overall average compliance score for all medical wards which was 92%.
- Following the inspection, we asked the trust to provide more information about their plans to improve performance on the management of deteriorating patients as well as sepsis. The trust had a plan in place to improve their performance and they voluntarily offered to report this to us every week. We were satisfied they had adequate plans and governance processes in place to monitor and act on their data.
- At the beginning of October 2016 the trust had 95% of patients who had an EWS score of 0-2 and were appropriately managed; 90% of patients with an EWS of 3 or more were appropriately managed. Ninety two percent of patients with an EWS of 3 or more were appropriately screened for sepsis. The percentage of patients with red flag sepsis who received antibiotics within one hour was 46%.
- A critical care outreach team (CCOT) was available to the wards during the daytime, seven days a week. The team supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.

Medical care (including older people's care)

- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.
- Policies and guidance were available for the care of patients with a tracheostomy. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe. Where patients had a tracheostomy a patient specific tracheostomy box was available at the bedside. This provided all necessary equipment should an emergency arise.

Nursing staffing

- Across UHL since September 2014 all clinical areas had collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for England. It is important to note that this tool is only applicable to acute adult ward areas. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically and matrons and the senior nursing teams confirmed this data on board rounds as well as unannounced visits to clinical areas. The data was considered alongside staffing information from the electronic rostering system and patient information including admissions and discharges and additional tasks undertaken in different clinical areas.
- Staffing levels were displayed in all the clinical areas we visited and information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were 'gaps' in staffing bank and agency staff had been requested.
- During our inspection we found staffing levels in all areas to be sufficient to deliver safe care. None of the nursing staff raised concerns with the numbers of staff on duty or the skill mix. However, three senior members of staff did raise concerns around the recruitment process, describing it as "lengthy".
- On ward 15A there were nine beds for patients who required 'level one' and 'level two' care. Level two care is defined by the Guidelines for Provision of Intensive Care Services (GPICS) as; patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. GPICS standards suggest 'level two' patients require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care. Registered nurse staff levels on ward 15A allowed for a nurse/patient ratio of 1:2.2 during the day and 1:3 at night if all nine beds accommodated level two patients. However, these services were not led by a consultant intensivist and did not therefore have to meet GPICS.
- Planned nursing staffing levels across the nine clinical areas totalled 183.2 whole time equivalents (wte). Data for March 2016 showed actual staffing levels to be 153.4 wte giving a combined vacancy rate of 16%. Vacancies varied across clinical areas with vacancy figures of between 0.6 wte and 6.7 wte. The top three areas with the highest vacancy rates were; ward two (6.7 wte), haemodialysis unit (4.3 wte) and brain injury unit (4.2 wte). At the time of our inspection the brain injury unit reported 1.0 wte nurse vacancy and ward 15A reported 1.8 wte nurse vacancies.
- The average nursing agency usage for April 2015 to March 2016 across medicine was between 0.3% and 19.6%. However, agency use in neurology was between 15% and 27.8% across the same reporting period. Agency staffing was managed on a day to day basis with agency use 'shared out' across clinical management groups to mitigate the risk of high numbers of agency staff in any one ward area.
- A specific induction folder was used on the wards for bank and agency staff; 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration.
- We did not attend a nurse handover during our inspection of this hospital but we talked to staff in three ward areas specifically about nurse handover. Two wards described a shift handover that took place by the patient's bedside. Handover involved the named staff identified to care for a group of patients, and included half the staff on duty for the shift. This ensured a significant number of staff had an appropriate awareness of each patient on the ward.
- The third ward conducted handover away from the bedside. The ward sister, in this area, told us handover had been changed to this method as a result of patient

Medical care (including older people's care)

feedback regarding confidentiality. In all three, handover was used as an opportunity to discuss relevant patient safety information. For example, any recent falls or existing pressure damage.

Medical staffing

- The trust had a slightly lower percentage of consultants when compared to the England average. The percentage of junior grade staff was slightly higher than the England average.
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. None of the medical staff we spoke with raised concerns regarding the numbers or skill mix of medical staff available. All told us they felt supported in their roles.
- Within stroke rehabilitation there were two consultants who worked on a six-week rota covering stroke rehabilitation at this hospital and the acute stroke wards at the Leicester Royal Infirmary. Within nephrology, across four wards and the haemodialysis unit there were two junior and two middle-grade doctors supported by a consultant presence twice weekly on the general nephrology wards and daily on ward 15A.
- Consultant cover out of hours was through on-call arrangements only. Out of hours care was provided by a 'hospital at night' team which comprised of Junior Doctors, nurses and clinical support workers, with all patient-related tasks managed by a senior nurse who triaged the tasks and assigned each to a member of the team.
- There were medical vacancies in general medicine at this hospital. Data for March 2016 showed a vacancy rate of 50%.
- The average medical locum usage for April 2015 to March 2016 across medicine was noted to be between 3.7%. Average locum use in neurology was noted to be 9.3% for the same reporting period.
- Essential information and guidance was available for all temporary staff including bank, locum and agency. A specific induction folder was used in the clinical areas for locum staff; 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration.

Major incident awareness and training

- Evacuation training was included as part of fire safety training. Compliance in this training across all staff groups was 90%.
- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident.
- We talked to seven nursing staff across three ward areas specifically about their understanding of an emergency or major incident that may affect services at this hospital. We received mixed responses with four staff have little or no understanding of what their role would be. Two staff were unable to find a copy of the trust major incident and business continuity plans on the trust intranet. Both told us information technology problems affected accessibility to the intranet. One member of staff was unaware if there was a paper copy available in their ward area and one member of staff told us they were not familiar with the content of the plans.
- Only one out of the seven staff were aware of the availability of a 'back-up' phone system should the current system fail as a result of a power failure.

Are medical care services effective?

Good



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

We found:

- Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to National Institute for Health and Care Excellence (NICE) quality standards.
- Patient's symptoms of pain were suitably managed in both ward and department areas with good comfort outcomes for patients in endoscopy. Staff were proactive in assessing patient's nutrition and hydration needs.
- There was effective multidisciplinary working with staff, teams and services working together to deliver effective

Medical care (including older people's care)

care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively and staff were supported to maintain and further develop their professional skills and experience.

- Where patients were subject to the Mental Capacity Act (MCA) 2005, their rights were protected. We saw where Deprivation of Liberty Safeguards (DoLS) were applied appropriately.
- Where outcomes for patients were below expectations when compared with similar services we saw where action plans had been put in place.

However we also found;

- Endoscopy services at this hospital were not Joint Advisory Group (JAG) accredited, this meant aspects of this service had not met JAG standards.

Evidence-based care and treatment

- Patients had their needs assessed and their care was planned and delivered in line with evidence-based, guidance, standards and best practice. For example best practice was followed in line with the National Institute for Health and Care Excellence (NICE) quality standard CG35 Parkinson's disease in the over 20s: diagnosis and management. The National Parkinson's Audit data submitted by the trust audited services against NICE evidence-based standards.
- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). VTE is the formation of blood clots in the vein. We reviewed six patient care records. All six records demonstrated patients had received a VTE risk assessment and had preventative VTE medication if indicated.
- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection we saw a number of care bundles in place. Examples included; sepsis, dementia care, hypoglycaemia (low blood sugar level), enteral feeding (refers to the delivery of nutrition directly into the stomach) and acute kidney injury (AKI). Acute kidney injury (AKI), previously called acute renal failure (ARF), is an abrupt loss of kidney function that develops within 7 days.

- Medical staff told us a total of 76 guidelines were available in renal medicine 56 recently updated. Examples included guidelines for; vasculitis, air embolism and AKI. Medical staff demonstrated to us how to access some of these policies.
- Guidelines for starting and terminating haemodialysis, haemofiltration and plasma exchange were available in paper format in addition to being included as part of a bespoke professional development programme for nurses working within nephrology (the branch of medicine that deals with the physiology and diseases of the kidneys).
- British Society of Gastroenterology (BSG) guidelines were followed in endoscopy. For example, in Endoscopic Retrograde Cholangiopancreatography (ERCP). ERCP is a procedure that enables a doctor to examine the pancreatic and bile ducts.
- A 'delirium support tool' was used on ward 15A in accordance with NICE guidance CG103: Delirium: prevention, diagnosis and management.
- Local audit activity included audits in; infection prevention and control, nursing metrics and observation and early warning scores (EWS).

Pain relief

- The Faculty of Pain Medicine's Core Standards for Pain Management (2015); Standards two and three were implemented across the medical wards and relevant clinical areas. For example, nursing care records included care plans for pain, a 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder and pain was assessed and documented in all 12 patient observation charts we reviewed.
- None of the 12 patients we spoke with raised concerns about the management of their pain.
- Patient comfort during a colonoscopy procedure was measured using a five-point scale with zero equalling no discomfort through to five equalling very uncomfortable. Comfort scores for this trust between June 2015 and May 2016 indicated across 3,728 procedures, 5.2% of patients indicated a comfort score of greater than four.

Nutrition and hydration

Medical care (including older people's care)

- Fluid balance charts were used to monitor a patient's fluid intake and output. We reviewed six patients requiring fluid balance charts, two of these on ward 15N were not up to date or accurately calculated.
 - A nationally recognised screening tool was used throughout medicine to identify adults, who were malnourished or at risk of malnutrition. Staff used this tool to inform care planning and identify any specific dietary requirements. In all six nursing records we reviewed we saw where the patient had been appropriately assessed using this tool.
 - Protected mealtimes were in place across the medical wards. Protected mealtimes encourage hospitals to stop all non-urgent clinical activity on wards during mealtimes. During this time patients can eat their meals without interruptions and nursing staff are available to offer help to those who need it. On ward 15N red lids were used on water jugs to identify patients who needed assistance in addition to red tray signs behind the beds. Two patients on ward 15N gave us positive feedback about food and drinks they had received. The housekeeper on this ward told us the ward could provide a range of meals for different preferences and gave examples of halal, vegetarian and gluten free. We were also provided examples of where staff had prepared meals not on the menu when patients did not like any of the menu choices.
 - Staff had access to dietitian services Monday to Friday.
- ## Patient outcomes
- Neurological medicine participated in the United Kingdom Rehabilitation Outcome Collaborative (UKROC). This allowed the trust to benchmark their services against care and rehabilitation pathways nationally. UKROC is a 'payment by results' (PbR) improvement project set up by the Department of Health. Results for the reporting period April 2015 to March 2016 demonstrated this hospital was performing the same as similar services in other National Health Service (NHS) trusts.
 - A peer review carried out by the East Midlands Trauma Network in June 2015 identified the brain injury unit as the only Level one unit in the East Midlands. Level one care includes patients with a high physical dependency or, patients with cognitive / behavioural conditions who may be a danger to themselves or others, and/or at risk of absconding. The 2015 peer review was largely positive with no serious concerns or immediate risks identified.
 - 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 hospitals. High ratios of greater than 100 may suggest potential problems with quality of care.
 - The latest published Summary Hospital-level Mortality Indicator (SHMI) for October 2014 to September 2015 was 96. 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 on the basis of average England figures, given the characteristics of the patients treated there.
 - A clinical audit and quality improvement programme was available for 2015/16. National audits included for example; National Diabetes In-Patient Day Audit (NADIA), the National Parkinson's Audit, the Sentinel Stroke National Audit Programme (SSNAP) and the Myocardial Ischaemia National Audit Project (MINAP).
 - Leicester General Hospital did not have Joint Advisory Group (JAG) accreditation. JAG accreditation is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. JAG accreditation was revoked on 3 June 2015 following a visit on the 26 September 2014.
 - There were no specific areas within the JAG visit that referred to patient safety, although the issue of decontamination and issues regarding privacy and dignity were areas that contributed to the non-compliance. As a result measures had been put in place for example, daily monitoring of the decontamination area to ensure doors remain closed and quarterly monitoring by the infection prevention control team. With regards to the concerns around privacy and dignity all windows where clinical activity was being delivered had been frosted. Relatives were discouraged from visiting the endoscopy unit unless there were exceptional circumstances and they had been given permission by the nurse in charge. In addition, the administration of enemas on the unit had been stopped. In the longer term we were told of plans to move the endoscopy unit to the other two hospital sites.
 - Leicester General Hospital took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results demonstrated the hospital had six scores better than and 11 scores

Medical care (including older people's care)

worse than the England average. The indicator regarding 'meals timing' was significantly worse than the England average at 24.4% compared to 74.4% nationally. Results also demonstrated an increase in medication errors between the 2013 (38.4%) and 2015 (53.1%) audits. We did not see an action plan which assured us that suitable action was being taken to address the findings of the survey.

- 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.
- For the period August 2014 to July 2015, with the exception of elective rheumatology and non-elective gastroenterology, medical patients at this hospital had a higher than expected risk of readmission for elective and non-elective admissions. The elective specialty, nephrology, had the largest relative risk of readmission. Following our inspection we asked the trust for readmission rates for the reporting period August 2015 to May 2016. For the period August 2015 to May 2016 medical patients at this trust had a higher than expected risk of readmission for non-elective and elective admissions.

Competent staff

- Staff appraisal rates at the Leicester General Hospital for the reporting period April 2015 to March 2016 averaged 96% across all staff groups within medical services. This was better than previous years with appraisal rates at 93% for April 2014 to March 2015. As part of the appraisal process the learning needs of staff were identified.
- Quarterly monitoring of dementia training figures were undertaken as part of the National Dementia CQUIN. Dementia awareness training had been developed using a multi-agency approach and focussed on two categories; dementia category A (basic level, required by all employees) and dementia category B (enhanced level, required by staff working clinically with adult patients). Between January 2016 and March 2016

category A training had exceeded the trust target of 90% with 93% of staff having completed this training. For the same reporting period 89% of staff had completed category B training which was slightly lower than the trust target of 90%.

- The trust had employed a number of registered nurses from overseas. There was a comprehensive trust wide programme for overseas nurses which included an eight-week induction, followed by a minimum of four weeks supernumerary status within the clinical area. Ward sisters told us this could be extended if required.
- On the brain injury unit we were told all health care assistants (HCAs) had completed the Care Certificate. The care certificate is a set of standards that social care and health workers follow in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.
- Tracheostomy care training on the brain injury unit, was delivered by the trust critical care outreach team and brain injury unit's physiotherapist. Eight registered nurses and two senior HCAs had received this training since December 2015. The ward manager told us at least one member of staff, who had received tracheostomy care training, was on duty at all times.
- Within nephrology medicine there was a comprehensive training programme available which included access to an 'acute illness management' (AIM) course, 'in-house' competencies and access to renal specific courses through learning beyond registration (LBR). LBR is a scheme funded by Health Education East Midlands (HEEM).
- New staff 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.
- A consultant microbiologist provided teaching to medical staff on wards 15A and 15N. Medical staff we spoke with responded positively to this teaching opportunity. We spoke with a member of the medical staff who was working as part of an overseas rotational post. They told us they had received a good local and trust wide induction when they started at the hospital.

Medical care (including older people's care)

- An acute kidney injury (AKI) nurse specialist was available throughout the trust and provided 'face-to-face' training and education to the medical and nursing staff.
- Within endoscopy one of the nurse endoscopists was a Joint Advisory Group (JAG) accredited national trainer. This meant they were able to deliver Jag accredited training within this trust in addition to providing training within other healthcare organisations.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient's care and treatment, with involvement from general nurses, medical staff, allied health professionals (AHP) and specialist nurses. Most staff (28 out of 30) we spoke with told us that there were good lines of communication and working relationships between the different disciplines.
- Medical records demonstrated a MDT approach to the delivery of patient care. Throughout care records we saw input from relevant members of the MDT such as physiotherapists, consultants, dietitians, infection prevention control team, microbiologist, nurses, speech and language therapy (SALT) and specialist nurses.
- On ward three a weekly conference call took place with acute stroke services at the Leicester Royal Infirmary (LRI) and a daily 9am board round with SALT, physiotherapy and nursing staff to discuss existing patients and those waiting for transfer from the acute stroke wards at the LRI.
- On the brain injury unit a MDT meeting took place three times a week to discuss all patients. This included input from the hospital tracheostomy lead nurse and the specialist discharge sister.
- Decision making and planning within therapy services took place daily between nursing and allied health professional staff.
- A MDT meeting took place daily on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals such as physiotherapists, occupational therapists and speech and language therapists, 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.

- A weekly MDT meeting took place within nephrology and included input from the mental health services provided by a nearby acute mental health trust. Meetings included all patients in addition to discussions of concerns from nearby satellite dialysis units.
- Mortality and morbidity meetings took place monthly across all medical specialties. Minutes we reviewed from a sample of these meetings indicated a MDT approach to individual mortality reviews.

Seven-day services

- In nephrology a consultant and specialist registrar was available 8am to 5pm, seven days a week. A dedicated renal team was available overnight with access to consultant support through on-call arrangements
- There were scheduled consultant ward rounds at the weekend. All emergency admissions and patients whose conditions had deteriorated were seen on this ward round.
- A consultant microbiologist provided a weekly ward round on all nephrology wards in addition to being available daily for advice.
- Band three clinical support workers were available to take bloods which would then be sent to the Leicester Royal Infirmary for analysis. Medical staff were contacted through a bleep system if there was any abnormality, otherwise results would be sent electronically.
- X-ray services were available at night. A portable machine was on site. Nursing and medical staff told us this was a very responsive service with requests usually fulfilled within an hour.
- There was a consultant-led nurse supported system for managing acute gastrointestinal (GI) bleeds which was available 24 hours a day, seven days a week at this hospital. Trust wide there was an acute GI bleed 'on-call system'. Monday to Friday (9am – 5pm) a GI consultant triaged patients throughout the trust and arranged urgent endoscopy where required. Urgent endoscopies were booked onto an acute GI bleed list every afternoon, Monday to Friday at this hospital. Overnight there was an acute GI bleed consultant on-call who was available to endoscope patients who were acutely unwell. There was an on-call endoscopy nursing team who supported this activity. At weekends there was an

Medical care (including older people's care)

on-call GI bleed consultant who had a dedicated list every Saturday and Sunday morning for emergencies and was available throughout the weekend for acute bleeds.

- Dietetics, physiotherapy and occupational therapy were available 9am to 5pm Monday to Friday. Where support was required from physiotherapy out of these hours an on-call system was in place.
- Speech and Language Therapy (SALT) were available 9am to 5pm, Monday to Friday. There was no weekend or bank holiday cover. Staff within the brain injury unit (BIU) reported difficulties sometimes with accessing SALT and this had been identified in the East Midlands Trauma Network peer review for 2015. Additional SALT were provided through a 'service level agreement' with a neighbouring NHS trust.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included risk assessments, care plans and case notes.
- Information and guidance regarding specific procedures or conditions was available through the trust's intranet.
- Access to specialist referrals for example, physiotherapy, occupational therapy and dietetics; diagnostic test requests and diagnostic test results were made through an electronic communication system, with most healthcare staff having access. Medical and nursing staff we spoke with described this as mostly efficient. However, medical staff did comment that if a request for a routine diagnostic test was rejected they did not always hear about it in a timely way. Where urgent requests were rejected medical staff said this would be communicated to them immediately through a telephone call.
- On ward three, information for dietary needs and fluid thickener requirements was readily available for housekeeping and nursing staff.
- Discharge summaries were sent to the patient's GP on discharge to ensure continuity of care within the community. Summaries were sent on the day of discharge electronically, by post or given to the patient for them to hand to their GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions. Mental capacity means being able to make your own decisions.
- Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests. During our inspection we saw eight patients receiving care whilst being deprived of their liberty. We saw that the deprivation of liberty safeguards (DoLS) and orders by the court of protection authorising deprivation of a person's liberty were used appropriately for all eight patients and included mental capacity assessments.

Are medical care services caring?

Good



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

We found:

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

Compassionate care

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. All the staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.

Medical care (including older people's care)

- During our inspection, staff on all the wards were observed to be polite and courteous to patients. We observed staff responding compassionately when patients needed help, and saw a number of examples of good care. For example on ward 15N, we observed staff being helpful and supportive whilst assisting a patient to mobilise and observed staff introducing themselves to patients. Patients looked comfortable and relaxed, the atmosphere on the wards was calm and call bells were silenced promptly.
 - We spoke with 12 patients and five relatives during our inspection. Feedback from patients was consistent with all 12 patients commenting positively about every aspect of their hospital stay. Patients told us nurses were caring and kind, and the care was “excellent”. Another patient described the ward they were on as “like a hotel”.
 - Only one out of the five relatives we spoke with raised concerns about the care at this hospital.
 - We reviewed the NHS Friends and Family Test results (FFT) in medicine from March 2015 to February 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Results showed the average response rate to be 19%. This was worse than the England average of 26% for the same reporting period. Results from this reporting period showed ward 10 consistently scoring well; between 97 and 100% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care.
 - Wards included single-gender accommodation, which promoted privacy and dignity. From February 2014 to January 2016, there were no occasions reported when male and female patients were treated in the same bay at this hospital. Concerns regarding privacy and dignity had been identified during a JAG review of endoscopy in September 2014. Whilst the recovery area within endoscopy was separate for male and female patients, male patients did have to cross the main hospital corridor to reach the ‘male’ recovery area.
- Understanding and involvement of patients and those close to them**
- During our inspection we spoke with 12 patients about whether they felt involved and understood about their care. Most patients told us they felt involved in their care and had an understanding of their treatment. However, one patient told us their relative was concerned about their care and did not understand why things were being done.
 - 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. We observed posters and leaflets in the wards and clinical areas identifying how the carers charter could help patients and their carers. Staff we spoke with told us of ‘open visiting’ for carers, we saw where staff ‘signposted’ carers to specific support groups and were told of multidisciplinary team (MDT) meetings that included patients and their carers.
 - On ward 10 we observed a positive staff interaction with a staff member talking through an information sheet with a patient. The member of staff engaged with the patient. They gave a clear explanation, offered the patient choices, and explained how the patient could manage their diet once they were at home. The nurse left the leaflet with the patient to read through in addition to, writing their name and number on the sheet in case the patient needed further help.
 - On the brain injury unit there were scheduled family meetings to discuss on going care and discharge plans. We saw where a record of these meetings was recorded on the ‘discharge planning board’ in the MDT room.
 - On ward two there were scheduled meetings with families at admission as part of a care planning meeting, then on two further occasions to ensure families were aware of the care, condition, discharge planning and realistic expectations for the patient.
 - On ward three every Wednesday afternoon there was an open surgery for families of new admissions to be able to speak to the registrar and ward sister. Families were informed about these sessions by ‘word of mouth’ we were told they were not currently advertised on the information boards.
- Emotional support**

Medical care (including older people's care)

- Nursing care plans met National Institute for Health and Care Excellence (NICE) quality standard (QS15): Patient experience in adult NHS services. Patients had their physical and psychological needs regularly assessed and addressed, with care plans including an assessment of nutrition, hydration, pain relief, personal hygiene, rest and sleep, psychological and emotional well-being and promoting health and safe care.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, nephrology and neurology.
- On the brain injury unit a clinical psychologist was involved in care and would review patients whilst on the unit where required.
- Nursing and medical staff were available to offer emotional support and reassurance to patients and relatives.

Are medical care services responsive?

Good



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

We found:

- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.
- It was easy for patients to complain or raise a concern. Posters and leaflets were available in the wards and clinical areas these allowed members of the public to identify how they could raise a concern or make a formal complaint.
- Patients could access services in a way and at a time that suited them. For example, on ward 1 appointments could be arranged around personal commitments.
- There was a proactive approach to understanding and meeting the needs of individual patients and their families.

Service planning and delivery to meet the needs of local people

- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital. For example,

ambulatory clinics were provided for patients with a suspected first seizure (convulsion) who required urgent assessment and for patients requiring an urgent rheumatology assessment.

- Patients who had conditions affecting their kidneys had access to specialist medical and nursing support through a 24 hour telephone service 'helpline'.
- On the brain injury unit a 'discharge specialist sister' was in post. The discharge sister had close links with key individuals in the community and local Clinical Commissioning Groups (CCG) and was involved in applying for funding for community care and/or community rehabilitation requirements.
- Clinical Commissioning Group (CCG) funding for the brain injury unit and ward two was based on data submitted to the UK Outcomes Rehabilitation Collaborative (UKROC). Monthly data was submitted in relation to patient rehabilitation needs, the number of contacts received by the patient and patient outcomes.
- Bed capacity on ward two had increased to 16 beds. This enabled rehabilitation services to be provided earlier in the patient's recovery journey to a larger number of patients.
- With CCG approval, specialist nurses for a variety of clinical conditions were provided within neurological medicine. For example, multiple sclerosis, Parkinson's disease and epilepsy.

Access and flow

- Referrals to nephrology medicine were received by the on-call Specialist Registrar (SpR). Nephrology is a branch of medicine that deals with conditions affecting the kidneys. An SpR is a doctor who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant. Direct admissions to nephrology through the SpR or consultant accounted for 50% of admissions. Nephrology also took direct admissions from the dialysis unit and the nephrology outpatient clinic. Electronic referrals from GPs accounted for approximately 11 patients a week.
- Admissions to the brain injury unit were received from either within the trust for example patients discharged from critical care or from a major trauma centre within the East Midlands Trauma Network.
- On the brain injury unit, there were three side rooms and a six-bedded bay. As this unit was not exempt from providing mixed-gender accommodation the

Medical care (including older people's care)

configuration of beds did sometimes cause a delay in accepting a female admission. Senior nursing staff told us male admissions to the unit accounted for 70% of all admissions. As such, the six-bedded bay was used for male patients. However, there were times when male patients were nursed in a side room, for example, if they were at risk of spreading or acquiring an infection. At the time of our inspection a male patient with an infection was being barrier nursed in the six-bedded bay in order to allow for a female admission to a side room. This had been risk assessed and approved by the trust's infection prevention control team.

- Admissions to ward one were received from a variety of medical specialties throughout the trust, in addition to referrals from GPs. A number of day case procedures were carried out under a 'nurse-led' service with medical registrar cover as required. Ward one was open from 6am to 8pm to accommodate patients who had to go to work.
- There was a robust discharge planning process in place on the brain injury unit. The process included a multidisciplinary team (MDT) meeting led by a discharge planner, dedicated to the brain injury unit, and included the patient and significant family members and/or carers. Specific patient needs were identified prior to discharge to ensure the correct level of discharge support was provided.
- Ambulance transport was provided by an external company, delays were described as significant on ward one and for those patients waiting to be discharged from nephrology. Matrons told us transport issues were currently under review, with the external provider, by the clinical management group (CMG).
- Following our inspection, we asked the trust if they monitored delayed transfers of care in medicine. Data provided for December 2015 to May 2016 demonstrated there were 931 delayed transfers of care bed days reported at this hospital. Reasons for delayed transfers of care, and medical specialty were not provided.
- The average bed occupancy from April 2015 to March 2016 was 89.4%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- On average elective patients spent less time in medical care services than the national average. The average length of stay for non-elective admissions was worse than the England average. The average length of stay for elective patients at Leicester General Hospital from

March 2015 to February 2016 was 3.6 days, compared to 3.9 days for the England average. For non-elective patients, the average length of stay was 8.7 days, compared to the England average of 6.7.

- On ward three 'discharge information packs' to aid the discharge process for patients was available. A pack was provided for each named patient and contained all the discharge information in one place. Relevant staff used a tick list on the front of the pack to identify what part of the discharge process had been completed. For example, discharge medicines, GP Letter, and any plans for continuing healthcare.
- Trust wide activity in endoscopy had increased from 16,205 day cases in 2014/2015 to 19,280 by the end of March 2016. This increase was due to a 15% increase in referrals through gastroenterology services. The activity level for 2015/16 included an excess of 1,600 patients where the service had not delivered in terms of the six-week diagnostic target. As of December 2015 this figure had been reduced to 864 patients. This had been achieved by increasing endoscopy lists during the week and providing endoscopy lists at the weekends. The service had also referred patients to independent health care providers within the locality.
- Between April 2014 and December 2015, cancer waiting time standards for the two-week wait standard, the 31 day standard and the 62 day standard had not been achieved and was worse than the England average for every month. Cancer waiting time standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.
- From March 2015 to February 2016, 96% of patients' did not move wards during their admission, and 4% moved once or more.
- Between October 2015 and March 2016, 190 patients experienced transfers after 10pm with 75% of these transfers taking place from ward 15A. Staff within this area told us it was not uncommon to transfer patients out at any time, day or night in order to accommodate the admission of an acutely unwell patient.

Meeting people's individual needs

- A mental health triage team was available at the trust. Between 8am and 10pm the team would see any patients on the wards who had been admitted as a result of self-harm. The response time for ward referrals was four hours. Overnight support to the wards was

Medical care (including older people's care)

provided by the on-call duty psychiatrist. In addition to this service there was a Liaison Psychiatry service Monday-Friday from 9am to 5pm. Outside of these hours any patients who required a review by liaison psychiatry were assessed by the on-call duty psychiatrist.

- There was a system in place for identifying patients in the hospital who had diabetes. An automated daily report that included patient level detail and location of their inpatient stay was sent to key members of the diabetes team.
- A diabetes specialist nurse (DSN) service was available at this trust for the care of inpatients with diabetes. The service was supported by a Specialist Registrar (SpR) who was on call for the speciality. The team were contacted through an electronic referral system and/or bleep. The DSNs were proactive in attending the acute assessment areas every day to identify new admissions to the hospital. There was an 'Inpatient diabetes safety committee' which included a lead consultant, lead specialist nurse and a nurse consultant.
- Staff had access to an external interpreting service 24 hours a day, seven days a week. The service included the provision of British Sign Language (BSL). There was an interpreting and translation policy in the trust.
- On ward three there were many patients, as a result of experiencing a stroke, who experienced a significant lack of concentration as the day progressed. Where patients did not speak English, we saw the timing of the use interpreters had been used earlier in the day when patient's concentration levels could be maximised. Nursing staff told us it was important that the interpretation services were face-to-face and not over the telephone. Interpreters were used to assist patients with their rehabilitation as well as to gain consent. Nursing staff told us interpreters were easy to book however confirmation was not always received so there was a degree of uncertainty whether an interpreter would turn up.
- There were 2.5 whole time equivalent (wte) acute liaison nurses (ALN) that provided advice and support to patients admitted to the trust who had a learning disability. In addition to this a flagging system linked to the Leicestershire Learning disability register alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- Patients living with a learning disability were assessed using standardised nursing and medical documentation. Where patients had their own hospital

profiles they were asked to bring them into hospital with them. On receipt of notification of an admission the ALN would contact the ward and telephone assess the level of priority in terms of their visit i.e. patients with more complex needs may be seen more quickly. However all inpatients were to be seen or the ward contacted within 24 hours of admission. On attendance the ALN would assess what reasonable adjustments were required in addition to speaking to carers about the care needs of the patient.

- Between February 2016 and June 2016 trust wide, 230 patients recorded as having a learning disability were admitted into hospital. Of these, 19 were not seen by the ALN because the patient came in either as a day patient or over the weekend/bank holiday. The ALN service operates Monday to Friday, 8am to 5pm. Of the 211 patients seen 190 had a confirmed learning disability. Of the 190 patients seen 54% were seen by a member of the ALN team within 24 hours of admission. The reasons for not being seen within 24 hours were; the admission was at the weekend or bank holiday; the patient had not been identified to the ALN at the point of admission and the patient was admitted and discharged out of hours.
- In 2015 'Patient-Led Assessments of the Care Environment' (PLACE) were extended to include criteria on how well healthcare providers' premises were equipped to meet the needs of caring for patients with dementia. The assessment, of the premises for people with dementia, for this hospital demonstrated a compliance level of 72.4% which was slightly worse than the England average of 74.5%.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Clinical and cognitive assessments were undertaken as part of the dementia care pathway. Care pathways are multidisciplinary plans of anticipated care.
- The trust was committed to the implementation and delivery of service improvements for patients with dementia in Leicester's Hospitals. Person-centred care was individualised to meet the specific needs of each patient using the 'Know me Better' patient profile. The patient profile form allowed the patient to provide information to the health care team that detailed their psychosocial needs, concerns, and what was important to them during their hospital admission. The form was completed by the patient, with or without the assistance of their family. Open visiting was available to carers of patient's living with dementia. A bespoke 'meaningful

Medical care (including older people's care)

activity service' had been created and included reminiscence tea parties to encourage patients with nutrition and hydration. There was ongoing work to upgrade the environments to make them dementia friendly with quiet rooms / retreat rooms. A trust wide policy was in place to reduce the number of ward transfers for patients with dementia.

- Patients and carers were signposted to, and had access to, charitable organisations for additional support and information. Whilst in the trust, a dementia 'champion network' of staff with a particular interest in dementia supported patients.
- Outside facilities including a sensory garden for patients were available with an outside seated area available near the brain injury unit and further facilities available near wards two and three. The sensory garden had been designed and built for patients living with dementia, using money raised locally through a charitable appeal.
- Information leaflets were available in the clinical areas we visited. Examples included, details of local support organisations, information about dialysis and information about discharge. Leaflets were mostly provided in English with instructions on the back for ordering in other languages. However we did see leaflets provided in other languages on ward 10.
- On ward one 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.
- Gymnasium facilities were available on the brain injury unit and ward two for patient rehabilitation. Areas were accessible to all and there was enough space to accommodate a bed.
- Patients often remained an inpatient on the brain injury unit for several weeks. As such patient birthdays and family occasions were celebrated on the unit and families were encouraged to attend. Multi-cultural events were also celebrated. During our inspection we saw laminated posters that were available to advertise significant multi-cultural events.
- Pastoral, spiritual and religious support was available to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Islamic and Sikh chaplains, as well as the country's first paid non-religious carer who, focussed on meeting the needs

of patients who did not identify with a religious belief. The team was also supported by volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives. A 24 hours a day, seven days a week on-call service was provided and where possible a representative of the patient's own faith would attend. The service was widely publicised through posters, leaflets and the trust website.

- A Chapel and Prayer Room (with washing facilities) was available at this hospital and was designed to meet the diverse religious and spiritual needs of patients and staff. Rooms provided a quiet place for private prayer, meditation and contemplation and were open to everyone.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.

Learning from complaints and concerns

- Posters and leaflets were available in the wards and clinical areas we visited. These allowed members of the public to identify how they could raise a concern or make a formal complaint. We also saw 'message to matron' cards and boxes to allow patients and relatives to make comments or raise concerns which where possible could be dealt with locally.
- A Patient Information and Liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- Between March 2015 and March 2016 a total of 30 complaints were received in medical care services at this hospital. The top three themes for complaints within this service were; appointments (eight), communication (five) and waiting times (five).
- Senior nurses and ward sisters were aware of concerns and complaints raised within their areas. Information around concerns and complaints were discussed at team meetings, handovers and during morning 'board huddles'. Nursing staff told us of changes that had been made as a result of concerns or complaints. Examples included, taking steps to minimise noise at night, installing a cordless bell system in the day room on ward three and the introduction of 'afternoon tea' sessions and open surgeries to aid communication, also on ward three.

Medical care (including older people's care)

Are medical care services well-led?

Good



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

We found:

- There was a vision and strategy for this service and whilst it was very strategic staff were able to describe this to us during our inspection.
- Staff were consistent in delivering care and demonstrating behaviours in line with the trust vision and values.
- Staff satisfaction was mostly positive with staff reporting good support at a local level. Staff were engaged and empowered to raise concerns where necessary.
- Staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support

However, we also found:

- Departmental governance and risk management arrangements were not always effective and as such able to protect patients from harm. The process for identifying deteriorating patients, sepsis screening and infection prevention control issues had not been identified on the medical services risk register and key risks had not been addressed.

Vision and strategy for this service

- Medical care (including older people's care) was provided at this hospital as part of three clinical management groups (CMGs): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS), acute medicine / ED and specialist medicine and, renal, respiratory and cardiovascular.
- Most staff we spoke with were able to articulate the trust's vision and the values, which was to deliver 'Caring at its best' for everyone who visited the trust. Underpinning this was the trust values which were 'We treat people how we would like to be treated'; 'We do what we say we are going to do'; 'We focus on what matters most'; 'We are one team and we are best when we work together' and; 'We are passionate and creative in our work'.

- University Hospitals of Leicester NHS Trust had a detailed five year integrated business plan which covered 2014 to 2019. A two-year 'Operational Plan' was in place within Emergency and Specialist Medicine with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy. Some staff were aware of the details included within this operational plan and told us of the movement of specialist services to one of the other hospital sites within the trust.
- Operational plans were also in place within the Renal, Respiratory and Cardiovascular Clinical Management Group and CHUGGS clinical management group.

Governance, risk management and quality measurement

- A risk register was held within medicine with 32 risks identified. Risks included a description, controls in place to mitigate the risk and a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register and cited capacity, dialysis equipment, nurse staffing and medical outliers as their top three risks. However, the concerns we had identified regarding the process for identifying the deteriorating patients, sepsis screening and infection prevention control issues was not included on the risk register.
- Senior leads had a good knowledge of complaints themes within the service with their top three complaints aligned to our review of complaints.
- Staff received regular updates through email, on staff notice boards, during morning board rounds and at ward and department meetings. Updates included information such as incident and complaint themes, serious incidents, any safety thermometer information at ward level, medical device information and any relevant trust wide information. Staff we spoke with demonstrated a good awareness of incidents that had occurred within medicine in addition to changes that had been made as a result of incidents across other CMGs.
- Nursing staff reported good local escalation plans for governance arrangements within this hospital. Examples included monthly sisters meetings at Glenfield Hospital, monthly ward meetings, matron involvement in monthly mortality and morbidity meetings and involvement in review meetings for falls and hospital acquired pressure ulcers.

Medical care (including older people's care)

- We heard repeatedly of frustrations within medical care services which included capacity, staffing and recruitment (recruitment only commenced once an individual had left).

Leadership of service

- Leadership of the acute medicine / emergency department and specialist medicine clinical management group (CMG) was provided by a Head of Nursing, a Clinical Director and a Head of Operations. Leadership for cancer, haematology, urology, gastroenterology and general Surgery (CHUGGS) and renal, Respiratory and cardiovascular was provided by a head of service and a general manager.
- Locally, staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support. Many staff commented on the deputy lead nurse having an office at this hospital site and how this made them more accessible to staff. Some staff could not recall meeting the Chief Nurse or seeing them in their clinical area.
- All staff, both medical and nursing, were aware of the trust whistleblowing policy. Staff told us they felt listened to and felt empowered to raise concerns.
- We heard where ward leaders were appreciative and supportive of their staff and went 'the extra mile' to demonstrate this. Examples included; plans to hold an international food day for nurses employed from overseas and 'tea with matron' for all new starters and nursing students. Nursing staff we spoke with described immediate line managers as "passionate", "visible" and "supportive".

Culture within the service

- Staff mostly felt respected and valued, happy to work at the trust and felt part of their immediate team. However, uncertainty around the future of endoscopy services at the hospital had left a number of staff feeling anxious. Staff were aware of and accepted the unit would relocate but were concerned that they had no timeline for this happening.
- Agency staff told us they felt supported and felt part of a team when they worked at this hospital, often preferring to 'pick up shifts' at this site when they became available. Agency staff felt able to ask for feedback from staff. They also reported feedback given through the nurse agency.

- Medical staff including new starters reported feeling strongly supported by consultant colleagues and nursing staff.
- On all of the areas we visited staff spoke of patients being the focus of their work. We saw staff consistently delivering care and demonstrating behaviours in line with the trust vision and values.
- Duty of candour briefing sessions had been held in medicine for all levels and staff groups. Roadshows were undertaken at each hospital site to raise awareness of duty of candour. A duty of candour slide had been added to the complaints e-learning module that all staff were able to access through the electronic trust training portal. A duty of candour slide was also included on the trust induction programme for all new starters and on the Medical Directors induction slides for new trainee doctors to the trust. We also saw from meeting minutes where duty of candour had been discussed at a recent nephrology mortality and morbidity meeting. Without exception all the staff we spoke with had a good knowledge of duty of candour.

Public engagement

- The NHS Inpatient survey looked at the experiences of 83,116 patients who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust. Responses were received from 547 patients at this trust.
- With the exception of 'cleanliness of rooms or wards' the trust received a rating of 'about the same' on how performance compared with most other trusts. Cleanliness of rooms or wards received a rating 'worse than' most other trusts.
- 'Message to matron' cards and boxes and, 'You said, we did' posters were visible in all ward and clinical areas to encourage the public to comment on services provided. Changes as a result of feedback / public involvement included a dayroom so patients had somewhere to eat and a dignity / relative room.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- A local newspaper article from February 2016 praised the specialist care delivered by ward 1.







Medical care (including older people's care)

- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.
- Staff on the brain injury unit were being encouraged to suggest ideas for the trust wide development of the 'planning your discharge' documentation. On the same ward opportunities had been developed for staff to consider new link role positions. Link nurses act as a link between their own clinical area and their area of interest. For example, infection prevention control.
- On ward one, staff were encouraged to lead ward meetings and decide on certain agenda items.

Innovation, improvement and sustainability

- We spoke with 30 staff from a variety of roles. Most staff were engaged and felt able to raise concerns and felt empowered to suggest new ways of working within their areas. All staff were invited to attend a monthly chief executive officer (CEO) briefing. Staff told us this was an effective way to learn about current issues within the trust.
- Staff were engaged and felt empowered to suggest new ways of working within medical care services. A member of staff in nephrology was due to commence a review of the dietary needs of renal patients. This was being supported by the trust 'Listening into Action' initiative. Listening into Action allowed staff to share ownership and responsibility for improving care for patients.
- The renal unit was using a computerised individual dosing machine that was introduced to automate some of the medicines dispensing and administration activities to reduce risk of human error within these processes. We were told this was the first of its kind in the country and was an Italian product, the process of loading the machine and its maintenance was supported by a dedicated workforce from the providers of the system. Staff we spoke to were pleased with this innovation and an evaluation of patient outcomes was currently underway at Loughborough University. There were plans to roll this out to other wards within the trust.

Surgery

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

Information about the service

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

At this hospital, there are 216 inpatient beds across 16 surgical ward areas and 53 day case beds. Inpatient services include general surgical specialties, including colorectal, urology, transplant, hepatopancreaticobiliary and orthopaedics. Services for surgical patients are provided through outpatients, the pre-operative assessment unit, and day surgery and inpatient wards.

Leicester General Hospital has 17 theatres, eight of which were laminar flow (this is a type of air conditioning that reduces air borne infections) and two theatres for day case surgery. One theatre was available for emergency surgery 24 hours a day seven days a week.

Between April 2015 and March 2016, there were 27,820 episodes of care. Of these 33% were non-elective (emergency) admissions, 40% were day case procedures, and the remaining 27% were elective (planned admissions). Urology was the specialty with the largest percentage of episodes of care with, 42% admissions.

During our inspection, we visited the pre-operative assessment clinic, theatre admissions area (TAA), day surgery unit, operating theatres, recovery and 13 surgical wards.

Before the inspection, we reviewed performance information from and about the trust. During our inspection, we spoke with 19 patients and two visiting relatives. We spoke with 36 members of staff, including doctors, nurses, physiotherapists, occupational therapists, health care assistants, trainee doctors and senior managers. We received comments from people who contacted us to tell us about their experiences. We reviewed treatment and care records for 17 patients and observed staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources.

Surgery

Summary of findings

We rated surgical care services as requires improvement because:

- Staff did not always recognise, concerns, incidents or near misses for example not reporting missing medical notes, or the lack of computers in theatre.
- Venous thromboembolism (VTE) assessments were not completed in a timely manner or reviewed after 24 hours for patients preparing for surgery.
- Whilst we saw the World Health Organisation (WHO) five steps to safer surgery checklist being completed, the trust did not have a robust system in place for monitoring its effectiveness.
- Staff were unaware of the correct use of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLs) when caring for patients in vulnerable circumstances.
- Consent was not always obtained or recorded in line with relevant guidance or legislation. There was a lack of consistency in how people's mental capacity was assessed in relation to consent.
- The pathway for pre-operative and high-risk anaesthesia patients was not consistently followed causing potentially avoidable delays and cancellations. Some patients were not having pre-operative assessment despite being identified as high risk for anaesthetic.
- Some surgical specialties at this hospital did not meet the 90% standard of the proportion of patients waiting less than 18 weeks from referral to treatment time. These were general surgery, orthopaedics, and urology.
- Departmental governance and risk management arrangements were not robust and as such did not always protect patients from avoidable harm.

However, we also found:

- Nursing staff consistently followed trust guidelines for the completion and escalation of deteriorating physiological observations and early warning scores (EWS)
- On all the wards and departments we visited, we saw staff acting in a kind and caring way towards patients and the public. Relatives and carers told us they felt involved and informed.

- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour regulation.
- There was strong local leadership with staff respecting line managers and feeling supported in their roles.

Surgery

Are surgery services safe?

Requires improvement



We rated safe as requires improvement.

We found:

- There was inconsistent use of systems to record and report safety concerns, incidents and near misses. Some staff were not clear how to do this or were wary about raising concerns. The majority of staff knew how to report an incident, but all staff we spoke with were unsure about the classification system for identifying the seriousness of incidents and whether to report something or not.
- When things went wrong, necessary improvements were not always made. Whilst staff were aware of a never event at Leicester General Hospital the learning from it was not consistent. Staff did not know how to use the newly developed delirium tool.
- Systems and processes were not always reliable or appropriate to keep people safe. Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments completed in a timely manner or reviewed after 24 hours.
- Monitoring and audit of safety systems was not robust. There was no effective audit for the World Health Organisation (WHO) five steps to safer surgery checklist. Monitoring of safety systems relating to safe storage of medicines was not robust. Correct recording and monitoring of medicine refrigerator temperatures did not take place. Staff were not consistent in their understanding of the correct checking method.

However, we also found:

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

- When something went wrong, people received a sincere and timely apology. There was an effective process for the investigation of serious incidents and a good understanding and use of the duty of candour regulation.

Incidents

- Between May 2015 and April 2016, one never event had been reported within surgery at the Leicester General Hospital. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- The never event reported related to a fall from a poorly restricted window on ward 27. The incident investigation for this never event included root cause analysis (RCA), which identified failure to provide an appropriate level of supervision for a patient with post-operative delirium. Delirium is a change in a person's mental state or consciousness, which is often shown as confusion, difficulties with understanding and memory, or personality changes. The window was incorrectly restricted and did not follow the recommendations in the January 2013 Department of Health alert for estates and facilities. Immediate actions were taken to ensure all the windows on this ward and the neighbouring ward were made safe. An RCA is a method of problem solving used for identifying the causes of faults or problems.
- During our inspection, we found that windows had been fitted with restrictors in the majority of areas. However, windows in corridors outside wards had not. This meant there were still areas in the hospital that could pose a falls from height risk to patients.
- Following this never event, during March 2016 the trust introduced a delirium assessment tool to ensure patients were screened for delirium. However, during our inspection we found staff throughout the trust were not aware of its availability or how to use it.

Surgery

- There was a notice board on ward 27 dedicated to the delirium assessment tool but staff did not know how to use it. The ward sister was aware that further learning was required and informed us that the tool had been introduced by the trust with no formal training.
- We witnessed a patient on ward 27 with undiagnosed confusion/delirium that had not been assessed using the tool. This did not provide us with assurance that all lessons had been learnt. This was escalated to the ward sister and a review of the patient was conducted.
- During our unannounced inspection, we were shown an action plan to address the concerns we had highlighted. This included, resending the delirium tool and guidance to all staff and planning a teaching programme with the safeguarding lead. This provided reassurance that action was being taken to address the shortfalls in post incident learning in this case.
- Between May 2015 and April 2016, two serious incidents were reported in surgery services at the Leicester General Hospital (LGH): one categorised under 'slip, trips or falls and one categorised under Healthcare-associated infections (HCAI) /infection control.
- As a result of a serious incident within the trust, hourly checks of all patients in side rooms had been introduced. We saw documentation outside of all occupied side rooms confirming these checks.
- We saw a copy of the trust incident policy, which clearly outlined the process for reporting and managing incidents. We saw evidence of the process being followed in relation to the never event. The family of the patient were to be invited to a meeting with the surgical team to discuss the action plan and receive a formal apology.
- Incidents were reported through the trust's electronic reporting system. All the staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- Between April 2015 and March 2016, there were 1161 incidents reported in surgical areas at the LGH. Low or no harm incidents accounted for 77% of the incidents. There were 15 moderate incidents and 54 near misses. A near miss is an unplanned event, which did not result in injury, illness, or damage, but had the potential to do so. Two incidents were graded as 'major' one was the never event and one was a serious incident being investigated during our inspection.
- There were no incidents recorded that resulted in severe harm or death. Incident themes included falls, pressure ulcers and medication errors or omissions.
- Ward and theatre staff were unable to give specific examples of learning from incidents and most staff told us they received no feedback after reporting an incident. However, all ward sisters and managers said they provided feedback via email and newsletters. The electronic reporting system had a section for staff to request feedback.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff on most wards could describe an incident where duty of candour applied.
- Duty of candour briefing sessions were held in all clinical management groups (CMGs) for all staff groups. Roadshows had been undertaken at each hospital site to raise awareness of duty of candour. A slide was added to the complaints e-learning module that all staff were able to access via the Electronic University Hospital Leicester (E-UHL) training portal. This was also included in the UHL induction programme for new starters to the trust.
- Within the individual clinical management groups (CMGs) for the different surgical areas, morbidity and mortality (M&M) meetings were held monthly. These meetings reviewed patient deaths and treatment complications, in order to develop improvements to patient safety and aid professional learning. Minutes from these meetings demonstrated all unexpected deaths were reviewed and trends identified. However, senior staff we spoke with said there was no shared learning between the CMG's throughout the trust. Learning was shared through the clinical audit leads forum which met 4 times a year, individual cases were shared through LEG, RCA reports were circulated to all CMGs.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and harm free care. Data was collected on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers (PU), falls, and urinary

Surgery

tract infections in patients with a catheter (CAUTI), and blood clots or venous thromboembolism (VTE). VTE is the formation of blood clots in a vein. Each surgical ward collected information on a range of safety measures based on individual patient risk assessments. The results were part of each ward's performance monitoring and included information such as number of inpatient falls, number of hospital acquired pressure ulcers in each of the recognised pressure ulcer grading categories (grade 1 – 4, with 1 being superficial and 4 being deep).and number of medication administration errors. We did not see this information displayed within any of the wards. Patients and visitors could therefore not see how the ward was performing in relation to patient safety.

- Information provided by the trust showed between September 2015 and March 2016 the general surgery wards at LGH and surgical acute care (GSAC) provided 92-100% 'harm free care', reporting two VTEs, three pressure ulcers, (PUs) and two catheter acquired urinary tract infections, (CAUTIs). The trauma and orthopaedic wards provided 89 -100% 'harm free care', reporting six Pus and the urology ward provided 84-100% 'harm free care' with four PU's and five CAUTI's.
- Ward sisters and service leads attended a monthly forum and peer review meeting to discuss performance and plan actions for their areas in relation to safety thermometer results.
- Where an increase in patient harm had been identified in a ward area, ward sisters told us they would raise this with staff via email, newsletters and at ward meetings. However, some staff in theatres told us they were not aware of this information being collected and cascaded. Three staff told us the last two safety meetings had been cancelled. We were told this was due to staffing issues within the department and that they were to restart during the coming months. Information provided by the trust indicated there was no planned meeting in May 2016 and the June meeting was specific to our inspection.
- Ward G22 a female general surgery ward had recently achieved three years of no hospital acquired pressure ulcers. They reported monthly to the pressure ulcer group and performed regular RCAs for patients with pressure ulcers admitted on to their ward. The team was very proud of their achievement in reducing patient harm.

- The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 3, statement 1 states all patients, on admission, should receive an assessment of VTE and bleeding risk. The trust's performance report for March 2016 showed 96%of VTE assessments were completed on admission. Within surgery, completion was 95%. This met the trust's target of 95%. However our findings at inspection found VTEs were not always reviewed within 24 hours.
- Ward and theatre staff told us if VTE assessments had not been completed before surgery anti embolic stockings, (AES), were not applied. These stockings are designed to increase the blood flow in the leg veins by compression. Staff reported that in these instances AES were sent with the patient to theatre to be put on the patient in the anaesthetic room. Staff told us that occasionally patients had not had the prescription written prior to theatre. However all 12 admission VTE risk assessments we reviewed had been completed.
- The NICE QS3 statement 4 states that patients should be reassessed within 24 hours of admission for the risk of VTE and bleeding. In the 17 patient records we looked at, we could not see where a reassessment had taken place. This meant there was a risk of harm to patients.
- Documentation we reviewed during our inspection did not provide evidence that VTE prescriptions were reviewed after 24 hours of admission. This meant some patients were receiving anticoagulant (blood thinning) therapy for longer than necessary and could put patients at a higher risk of complications from this therapy.

Cleanliness, infection control and hygiene

- Leicester General Hospital (LGH) participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 92%, which was worse than the England average of 98%.

Surgery

- Trust wide there had been 67 cases of clostridium difficile (c. difficile) infections between March 2015 and April 2016 with four cases occurring at this hospital in the surgical areas. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between April 2015 and April 2016, there were 15 cases of MRSA with seven cases in the surgical areas.
- Patients were screened pre-operatively for MRSA and as soon as possible when admitted as an emergency. This was in line with local policy and national guidance.
- The trauma and orthopaedic wards were screened wards. This meant all patients were tested for MRSA prior to admission. Any patient found to be a carrier of MRSA would be treated before admission. This ensured that all patients requiring replacement joints were protected from unnecessary harm. Any patients transferred from other wards that had not been screened were isolated and treated for MRSA until swabs proved negative.
- The trust had reported one surgical site infection for the year 2015. A full investigation was carried out which concluded a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts although not all categories of surgery are required to be included. The trust reported on surgical site infections for hip and knee replacement surgery.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for December 2015 for two elements of the audit; before patient contact and, after patient contact demonstrated 51% and 63% compliance respectively across the trust. (Not specifically broken down for Surgery) This was better than the trust's overall compliance figures but worse than the trust target of 90%.
- There was access to hand washing and drying facilities on wards and a good supply of personal protective equipment (PPE), which included gloves and aprons. These items were used by staff and disposed of correctly afterwards. We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw staff followed best practice guidance when giving intravenous fluids and taking blood samples.
- We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw staff followed best practice for hand washing and remaining bare below the elbow to allow for effective hand washing.
- We saw patients with infections nursed in side rooms and appropriate signage was in place to alert staff and visitors of action they needed to take. Personal protective equipment was provided for staff. Visitors were advised about hand washing and wearing gloves and aprons as required. We witnessed staff on ward 22 appropriately caring for two patients in side rooms according to hospital policy.
- We observed staff following National Institute of Health and Care Excellence (NICE) Clinical guidelines [CG74] 2008 Surgical site infections: prevention and treatment within theatres. For example, there was alcohol foam on entry to anaesthetic rooms. Theatre staff were observed to adhere to best practice principles for 'scrubbing up', (rigorous hand and arm washing), prior to surgery and for the management of surgical equipment in the operating environment.
- On the surgical ward areas, pre-assessment rooms, operating theatres and recovery, we found the standard of cleanliness was visibly good. The trust produced a bed space-cleaning checklist, which was filed in patient notes as evidence of a pre admission clean. Whilst we saw this chart during our inspection, it had not been consistently completed by staff or filed in notes. Therefore, we could not always be assured a pre admission clean had taken place.
- On three out of seven wards we visited storerooms were not clean. We saw dust and debris on skirting boards and sills. This was brought to the attention of staff and rectified. During our unannounced inspection, we were

Surgery

told there was some discrepancy with the estates department over who was responsible for cleaning the sills and skirting boards in storerooms. We raised this with the matron who told us they address this.

- We saw that a range of equipment used by patients was visibly clean and appropriate for use. The trust used 'I am clean' stickers for staff to sign indicating where equipment had been cleaned. We reviewed 15 items of equipment; we did not see the use of 'I am clean' stickers on these items of equipment. Therefore, we were not assured equipment had been cleaned before patient use.
- Throughout the hospital, privacy curtains were a mixture of disposable and non-disposable. Nursing and housekeeping staff told us they were unsure what the schedule was for changing them but that they were changed if visibly soiled or following patient isolation. The disposable curtains had dates on them indicating when they were put up but staff suggested various time spans for routine changes between two and four months. This is contrary to Health Building Note 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.
- The local policy provided by the trust after our inspection, identified curtains in in-patient areas should be changed every six months. However, not all staff we spoke with were able to identify this. We were therefore not assured it was being completed as per local policy.
- The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow.
- We observed staff in all surgical areas at the LGH disposing of clinical, domestic and recyclable waste. However, not all wards and theatres reported having access to domestic and recyclable waste bags. In these areas, all waste was incinerated as clinical waste. Ward and theatre staff reported no training in relation to waste management.

- Senior nursing staff we spoke with were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes legionnaires disease. Infrequently used taps and showers were flushed three times a week and recorded on a computer system to monitor compliance.
- Staff told us water used to wash patients was disposed of in hand wash sinks. This was not in line with Health Building Note 00-09: Infection control in the built environment 3.63 and 3.64. Contaminated fluids such as patients' wash-water should not be emptied down clinical wash-hand basins in adjacent ward areas. Disposal facilities should be provided in areas where dirty wastewater is disposed (for example, dirty utility rooms and cleaners' rooms/areas for cleaning equipment). Staff were unsure what the correct procedure was and there were no signs above hand wash sinks advising staff not to dispose of patient waste water in this way. This meant there was an increased risk of hand and environmental contamination. However, on ward 22 the sister told us that wastewater was disposed of in the dirty utility sluice.

Environment and equipment

- There were single rooms available for use on each ward. Priority for these rooms was given to patients who were particularly unwell or needed to be isolated because of infection.
- Resuscitation equipment, including emergency medicines, was readily available in all surgical areas, including theatres. A difficult airway trolley, providing additional equipment for emergency use, was also available in the theatre suite. Records showed staff signed that daily checks of emergency equipment were completed in line with trust policy. We reviewed the records for previous months and were assured this was a consistent practice. Matrons carried out monthly audits of the checking procedure for cardiac arrest trolleys.
- Re-stocking of resuscitation trolleys was carried out after use or in the event of out of date stock. A central store for equipment was available. Staff completed a requisition with their cost code and then collected the item required in order to maintain fully stocked trolleys.
- Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made. We checked 15 pieces of

Surgery

equipment, for example; blood pressure monitors and hoists; all had been appropriately tested and were within their service date. Electrical equipment we checked had been checked annually as per portable appliance test recommendations.

- Bariatric (equipment for heavier patients) wheelchairs were available and staff would speak with the manual handling team if they required any further equipment for example specialist beds or hoists. Ward 22 had some bariatric equipment available on the ward for example chairs and a commode.
- Theatre staff reported having sufficient equipment to undertake their roles.
- The trust provided data which indicated equipment had been safety checked in line with trust standards. During our inspection, equipment appeared well maintained in wards and operating theatre areas. Equipment was appropriately checked and repaired when requested.
- Clinical areas had limited storage for equipment; however, an equipment library was available. This stocked and repaired regularly used items of equipment. The trust carried out preventative planned maintenance on all equipment stocked in the equipment library. This included items such as, syringe pumps and infusion pumps. Each ward had a set number of specific pieces of equipment that they used regularly these were topped up daily Monday to Friday. All returned items were cleaned and serviced on return to the equipment library. Equipment was available out of hours through the portering team who had access to the equipment stores. All staff reported good access to equipment from the library.
- During our inspection, there were a number of hospital beds stored along corridors. Beds stored on corridors are at risk of damage and a potential fire evacuation risk.
- On all wards we saw oxygen cylinders stored on the floor in storerooms. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored in a purpose-built trolley in a well-ventilated storage area and cylinders should be chained or clamped to prevent them from falling over. There was no signage on the doors to indicate the storage of oxygen in these areas. Medical gases Health Technical Memorandum 02-01 (HTM02) guidance states warning notices should be posted prohibiting smoking and naked lights within the vicinity of the store.
- Control of Substances Hazardous to Health (COSHH) was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids were not always stored in locked cabinets away from patient areas.
- The trust provided audit information from October 2015 stating that 92% of staff had been provided with the necessary information, instruction and training to ensure that they were able to use, transport, store and dispose of substances safely
- Ward sisters told us COSHH information was available on the intranet. However, they had no knowledge of any data sheets or information relating to what substances were on their wards and how they should be stored.
- Doctors we spoke with felt that the lack of office space for them on wards could pose a risk to patient safety and confidentiality due to constant interruptions. Ward 22 had two reception areas, one in the centre of the ward was used by staff for completing notes and using the computer. Its central position made observation of the open ward layout very effective.
- The pre-admission unit at the entrance to ward 23 was cramped and poorly ventilated. The ECG and blood taking area was next to the ward toilets making privacy and confidentiality difficult to achieve. The waiting area was small and staff told us they did not always have enough chairs for patients.
- Doctors and pre-assessment staff told us they found it difficult to provide a good patient experience in an area not fit for purpose. The unit staff had tried to improve the area by improving signage so that patients knew where to go on entry to the unit. However, the space was not fit for the purpose of a pre admission clinic, as it was the entry corridor to ward 23. This reduced the space for ward 23 and its staff and patients, causing privacy and dignity issues when accessing the male toilets whilst the clinic was in progress. Inpatients walked around a curtained area out of sight of ward staff and sometimes through an area where patients were being assessed by doctors and nurses.

Medicines

- Medicine errors, including those resulting in harm, were reported as part of the incident reporting process. Between March 2015 and March 2016, 107 of the 1161 reported incidents related to medicines.
- Seven areas out of 14 within the surgical division at this hospital had reported incidents related to medicines

Surgery

with trauma and orthopaedics and general surgery reporting the highest numbers. Reasons for raising incidents were largely due to prescribing omissions or follow-up and omission or delay in administration.

- Staff were able to discuss incidents where errors had occurred and describe the actions taken to help prevent a similar error. For example, medication charts were checked at all staff handovers to ensure missed doses or signatures could be identified immediately.
- Nursing staff confirmed they had access to regular pharmacy advice. The pharmacists visited the wards daily Monday to Friday, to check prescription records and raise any queries with doctors.
- There were local microbiology protocols for the administration of antibiotics. The pharmacist monitored antibiotic prescribing to ensure patients were prescribed antibiotics in accordance with these protocols.
- Medication charts for seven patients were reviewed and found to be complete, up to date, and reviewed on a regular basis by the pharmacist. Patient's weight and any allergies were also recorded. Records showed patients were getting their medicines when they needed them.
- Controlled medicines, (these are medicines controlled under the Misuse of Drugs regulations 2001 these legal controls govern how controlled medicines can be stored, produced, supplied and prescribed), on the wards and in theatres were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and these were in date and replaced by pharmacy when used.
- Disposal arrangements were in place for expired medicines, or medicines which were no longer required. Medicines were disposed of in sharps disposal bins or returned to pharmacy. There were denaturing solutions for use with controlled medications. Denaturing solutions render controlled medicines irretrievable and unfit for further use until they are fully destroyed by incineration.
- Intravenous fluids were stored in locked cupboards in treatment rooms on wards. This reduced the risk that intravenous fluids could be tampered with or accessed by unauthorised people. However, fluids containing potassium were stored in close proximity to other fluids resulting in a risk of selecting the wrong fluid.
- There were arrangements in place for the storage and management of medicines in surgical areas, including

theatres and recovery. However, some ward areas had small cramped clinic rooms. The clinic rooms felt warm and there were no room thermometers available therefore, we were not assured that the temperature in these areas was safe for medication storage. We spoke with the pharmacist on ward 27 who agreed that the temperature did feel warm particularly as the pharmacy store was temperature controlled in order to ensure the safe storage of medicines. We were told by the pharmacist that this would be raised with the senior pharmacy team.

- On our unannounced visit we noted the clinic rooms at Leicester General Hospital (LGH) had all been provided with room thermometers and a daily log book to monitor temperatures. Where storage temperatures rose above 25 degrees centigrade staff were aware they needed to inform pharmacy without delay.
- Medicines requiring refrigerated storage were not always stored at the correct temperatures to ensure they would be fit for use. On all of the wards we inspected, the temperature checks for the medication fridges were undertaken by the ward teams. Whilst current fridge temperatures were recorded, recordings of lowest, highest and actual were not recorded. Because of this, we could not be assured medicines were stored safely. None of the staff we spoke with said they had received any training concerning the recording process or how to check the fridge. This was also raised with the pharmacist on ward 27. Action was taken at the time of the visit to address deficiencies in monitoring (and confirmed in place on unannounced visits),
- We raised this with senior managers at the trust. During our inspection, a memorandum was sent to all areas with a new medicines refrigerator-checking sheet to be started immediately. At our unannounced inspection, a new fridge temperature-recording sheet was available and staff had been shown how to use the fridges in their areas and how to report out of range problems.

Records

- Patient's individual care records were mostly written and managed in a way that kept patient's safe.
- We reviewed 17 sets of medical and nursing records. All patients nursing risk assessment documentation were completed appropriately. For example, falls, bed rails,

Surgery

malnutrition scoring and pressure ulcer assessments. However, care plans were not individualised for each patient. This meant care may not be tailored specifically to each patient's needs.

- Pre-operative checklists were completed which included a record of consent. These checklists ensure certain safety elements are completed prior to any surgical procedure. For example patient identification, allergies, correct consent and the time of last food and drink.
- Throughout the wards and theatres, we saw patient identifiable information was stored securely. The wards were in the process of being provided with digitally locked trolleys; this had improved the timeliness of completing medical records, as the doctor did not have to spend time locating a key to open a locked trolley. All the staff we spoke with were aware of their responsibilities for the safekeeping of records and confidentiality of patient information.
- Whiteboards, (for essential patient information), on each ward were usually behind the nurses' station. Full names were not displayed. This meant that patient confidentiality was maintained.

Safeguarding

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

Mandatory training

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

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

- Information received after our inspection showed, as at June 2016 training compliance in surgical clinical management groups (CMG's) was greater than 90% across all subject areas. The trust target for mandatory training was for 95% completion. The mandatory training data was not split into specific staff groups.
- A formal system was used to monitor uptake and senior staff were seen to be proactive in prompting staff that needed to attend. Ward sisters and individual staff received an email approximately three months before training was required in order to allow time for booking it onto staff rotas.
- Staff told us they were given time to attend training sessions or complete on line training and we saw this in practice. Ward sisters at Leicester General hospital, (LGH), told us they allocated four hours per off duty to staff to maintain their mandatory training.
- Staff we spoke with confirmed they were up to date with mandatory clinical training, which included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- Clinical staff followed the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic procedures, operating room and recovery was managed safely. However, the use of this document was not effectively audited. Five patient notes were audited per month from an average of 1000. This small sample did not provide robust evidence for the trust to demonstrate compliance with the checklist completion.
- A National Early Warning System (NEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating. We saw NEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.
- The trust was rolling out the use of electronic observation devices (e-obs) to record patient

Surgery

observations. (A mobile device would be used by the nursing staff to collect and store patient observations, creating a score that can assist in making clinical judgments when treating a patient. This scoring can help indicate signs of deterioration for example sepsis and acute kidney injury. This enables a nurse to remain with the patient should their observations deteriorate, as alerts can be sent automatically to the responding teams who can then come and review the patient.

- Wards at Leicester General Hospital (LGH) were currently undergoing training prior to receiving the devices. Staff were unsure how long they would be waiting to implement the new system.
- During our inspection of this hospital, we reviewed 17 patient observation charts across seven clinical areas. Nursing staff mostly adhered to trust guidelines for the completion and escalation of NEWS. However, not all observation charts had frequency of observations recorded. All charts reviewed had full observations recorded which included blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Pain scores were recorded on all charts reviewed. NEWS had been completed correctly at each time of recording the patient's observations of the patients requiring fluid balance charts, all of these were up to date and accurately calculated. Patients scoring on their NEWS were required to have further set of observations recorded within a set timescale for example from four hourly to one hourly. Of the 17 charts reviewed all patients had observations performed in line with the trust 'escalation of NEWS monitoring in adult patients' with the exception of one patient who was not for escalation.
- We reviewed the observation charts for two patients who had scored a NEWS of three or above. Both patients were appropriately screened for sepsis in line with the sepsis pathway. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. Where specific interventions had been required we saw where the Sepsis Six Care Pathway had been completed in a timely way. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis, it consists of three diagnostic and three therapeutic steps, all to be

delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics. Sepsis Six has been associated with decreased mortality.

- Nursing staff used the SBAR tool to frame conversations requiring a doctor's immediate attention and action. The tool consisted of standardised prompt questions within four sections (Situation, Background, Assessment, Recommendation). This ensured staff shared concise and focused information and allowed staff to communicate assertively and effectively and reduced the need for repetition.
- Staff took the time to identify and respond to the changing risks of patients. For example, the inpatient care and risk document included a diabetes foot screening assessment. We reviewed four sets of notes belonging to diabetic patients were all appropriate assessments were completed and documented.
- Nursing and medical handovers were held each day on the wards to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most attention and allowed them to gain an oversight of the ward as a whole. A post ward round 'safety huddle' was observed on ward 27. This updated staff on any changes that may affect patient safety. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical an opportunity to understand what is going on with each patient and anticipate future risks to improve patient safety and care.
- The handovers were well structured and information discussed included patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments. Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests.
- An advanced recovery area was available for patients who did not need intensive care but would benefit from extended recovery within the theatre complex. For example, patients that have spent an extended time under anaesthetic or patients requiring more intense observation in the first few hours of recovery. This area was available until 10pm, however, on occasion patients might have to stay for longer periods if their condition

Surgery

warranted it or there were no beds available. These patients would have to be managed by recovery or theatre staff. Senior staff in the department were auditing this process as no data had previously been collected.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. Since September 2014 all clinical areas across UHL collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for England. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically. The data was considered alongside staffing information from the electronic rostering system and patient information including admissions and discharges and additional tasks undertaken in different clinical areas.
- Following a trust wide acuity assessment undertaken in June 2015 and January 2016, formal establishment reviews had been undertaken in each clinical management group (CMG). The reviews were led by the chief nurse and had full input from the deputy chief nurse, heads of nursing, head of midwifery, matrons and ward sisters/charge nurses. The outcome of this was to ensure 1:8 nurse to patient ratios on all surgical wards.
- Each ward at Leicester General Hospital (LGH) had a 'hot board' (safe staffing board) at its entrance displaying planned and actual staffing. During our visit, the majority of wards met the requirement of 1:8 nurses to patient ratio. However, staff on ward 22 felt the acuity of the patients on the ward was not reflected in the staffing numbers. Particularly if staff were moved to assist on other wards.
- Information supplied to us by the trust from June 2016 showed 58 whole time equivalent (WTE) vacancies for registered nursing staff and 26 WTE vacancies for healthcare assistants and other support staff. The trust had a rolling programme of recruitment, including recruitment from overseas. Staff turnover in surgery at LGH was 17.6%. The trust recommended average was 10%. Staff turnover refers to the number or percentage of workers who leave an organisation and are replaced by new employees.

- All staff reported the use of hospital bank staff rather than agency in order to provide 'cover by staff that knew the hospital'. The average use of bank nurses in surgical areas at LGH was 6% during the period April 2015 to March 2016. The highest use was in urology with 11.8% in the same reporting period. Ward sisters/charge nurses told us this was because of vacancies and sickness rates over the winter period.
- Senior staff in theatres told us it was difficult to cover some of the off duty, as policy stated they were unable to book Tier three-agency staff until 48 hours prior to the shift. Tier three agency is the most expensive. There was also limited bank staff availability for operating department practitioner (ODP) staff. Theatre staff told us there was a shortfall of ODPs due to a change in the training at a national level. To address this the trust had expanded the role of the recovery nurse with further anaesthetic training. However, theatre staff told us this was still not covering the rota.
- Senior nurses in main theatres told us there were 16 WTE vacancies at LGH. Information provided by the trust indicated 21 wte vacancies however, this also included orthopaedic theatres and day case theatres.

Surgical staffing

- The trust wide percentage of consultants, registrars (middle-ranking hospital doctor undergoing training as a specialist), and junior doctors were similar to the England average. Consultant staffing at the trust was 43% compared to an England average of 41%, registrar grade medical staffing at the hospital 40%, compared to an England average of 37%. There was a lower number of middle grade staff at 7% compared to an England average of 11%. Junior medical staffing at the hospital was 10% compared to an England average of 12%. This provided a stable team of medical staff in surgery.
- Surgical doctors, registrars and consultants from all specialities were on call to provide advice and care 24 hours a day. Junior doctors and registrars were available on site during the day, including at weekends. Consultants were on site during the weekdays and were available to attend the hospital out of hours when necessary. We were told on call staff were available when offsite within 20 minutes.
- Handovers took place daily, seven days a week for all general surgical and orthopaedic patients. The on call

Surgery

doctors (foundation year two or trust doctor level) had a 30-minute overlap in their shifts, which allowed for a handover of all admissions and any concerns regarding acutely unwell patients.

- A theatre meeting took place each morning attended by the anaesthetic team, theatre team, consultant and surgeon on call for the day to decide any changes to the lists. Medical handover for anaesthetics took place twice a day for theatres.
- Information supplied to us by the trust from June 2016 showed there were 13 medical staff vacancies at a rate of 7.8%.
- In the reporting period, April 2015 to March 2016 there was an average locum usage of 9% throughout surgical services at Leicester General Hospital (LGH). The highest use of locums was within transplant services with 27% in the same reporting period. Health Education England data showed there were no training posts available within this surgical speciality for 2015. This contributed to the difficulty in staff recruitment into this specialist area.

Major incident awareness and training

- All staff we spoke with were aware of the trust's major incident and business continuity plans. Staff were able to show inspectors where to find the major incident plan and could describe their responsibilities as part of it.
- The staff we spoke with were unaware of any major incident exercises, which had taken place in theatres or wards. However, the trust provided information in relation to training and 14 staff had attended the Leicester General Hospital (LGH) evacuation workshop as part of emergency planning. This included nurses and administration staff.
- Ward 28 had a group set up on a social media site of all staff in order to be able to contact staff in the event of an emergency or staffing issue. A message could go out instantly to all staff and the nurse in charge could see who was available.

Are surgery services effective?

Requires improvement



We rated effective as requires improvement.

We found:

- Deprivation of Liberty Safeguards (DoLS) were not always applied appropriately. In one instance, we saw no regard for the patient's level of mental capacity resulting in an unlawful application for a DoLS.
- Consent was not always obtained or recorded in line with relevant guidance or legislation. There was a lack of consistency in how a patient's mental capacity was assessed. For example, for patients requiring consent form four (for adults who were unable to consent to investigation or treatment) there was not always documented evidence a mental capacity assessment (MCA) had been carried out prior to the consent.
- Staff did not always have the complete information they need before providing care and treatment. For example, not all patients had a pre-operative assessment despite being identified as high risk for anaesthesia.

However, we also found:

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

Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered in line with national and best-practice guidelines. For example, the use of National Early Warning System (NEWS), complied with the recommendations within NICE guidance CG 50 acute illness in adults in hospital: recognising and responding to deterioration.
- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.

Surgery

- We saw examples of policies and procedures which were based on nationally recognised guidance. The inpatient care and risk document, completed for every patient, contained the malnutrition universal screening tool (MUST); this identified adults who were underweight or at risk of malnutrition. A nationally recognised screening tool was used to identify patients at risk of developing pressure ulcers and the 'diabetes foot screening assessment' was used to detect the development of foot problems in patients with diabetes.
 - Patients care needs were reassessed throughout their care pathway. Care and treatment was delivered in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal College of Nursing guidelines.
 - Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists guidance.
 - The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend patients with certain co-morbidities (multiple medical conditions) are reviewed pre operatively by an anaesthetist. Examples include age, heart disease (myocardial infarction and angina), heart failure, ischaemic brain disease (stroke and transient ischaemic attacks).
 - The majority of patients with multiple medical conditions or increased complications of anaesthesia were seen in a 'high risk anaesthesia' clinic. This ensured patients at high risk of complications were fully prepared for the procedure and an appropriate anaesthetic selected prior to surgery. For example, some surgical procedures were carried out under a spinal block eliminating the risk of general anaesthesia. We saw documentation and spoke with two patients who had attended this clinic.
 - Day surgery patients mostly received care in line with the best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011.
 - The Association of Anaesthetists guidance states it is best practice to have a dedicated telephone helpline for patients during the first 24 hours post day surgery. The day surgery unit did not have this in place. Patients were advised to contact a ward (depending on the surgical procedure) or their own GP if they had any concerns following discharge. A telephone advice sheet was available on wards to record calls received. However, these were not consistently stored in the patient record. This presented a risk to safety and continuity of care as all patient contact should be documented for each episode of care.
 - During admission, comprehensive care pathways were in place for patients undergoing anaesthesia for surgery, including localised and general anaesthesia. Care pathways are multidisciplinary plans of anticipated care and timeframes. This meant there was a standard system in place for each patient admitted.
 - An enhanced recovery procedure was in place for patients having hip, knee, spinal, or colorectal surgery. Enhanced recovery is an evidence-based approach that helps people recover quickly following major surgery. We saw a copy of the enhanced recovery checklist for colorectal patients, which included information for the patient on what they could expect before and after surgery and discharge information. This was also supported by an evidence based Colorectal Enhanced Recovery Guideline dated July 2013.
 - Surgical staff were observed to be following the National Institute for Health and Clinical Excellence (NICE) guidelines for the prevention and treatment of surgical site infections. The surgical site infection surveillance team (SSIS) monitored surgical site infection in the following areas, total knee replacement/revision and total hip replacement/revision.
 - Across the surgical division, we saw there were arrangements in place aligned to the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. Examples included a dedicated surgical assessment unit, a consultant-led service with consultant availability at all times for telephone advice, a dedicated surgical team free of elective commitments to cover emergencies and emergency theatre availability at all times.
 - University Hospitals Leicester (UHL) followed NCEPOD, (National Confidential Enquiry into Patient Outcome and Death) guidelines for patients requiring emergency operations after 10pm. This meant patients, operated on after 10pm, were recovered in theatre and then returned to a surgical ward. UHL reported zero occurrences of patients staying in recovery overnight.
- ## Pain relief
- Leicester General Hospital (LGH) fully complied with all of the standards set out by the Faculty of Pain Medicines Core Standards for Pain Management (2015). For

Surgery

example standardised assessment tools and clear protocols for the management of acute pain by ward staff. The trust were working towards implementation of all recommendations, particularly those in relation to managing pain in the community. They also regularly liaised with other local pain services through the midlands pain forum.

- A dedicated pain management team covering the hospital could be contacted by bleep/pager. The team included nursing and medical staff and covered all three hospital sites. They were available 8am-5pm Monday to Friday, over the weekends this service was covered by anaesthetists. All patients who required major elective surgery were referred to the pain nurse pre-operatively who then visited patients following their operation.
- The pain management team used a variety of pumps to administer analgesia (pain relief) to specific localised areas. These pumps were reviewed daily and medication doses adjusted if the patient was experiencing pain. We spoke with three patients using these devices, they all reported an improvement in pain control and increased mobility because of a portable pump.
- Following surgery, appropriate pain relief was administered in theatre recovery. Patients undergoing orthopaedic surgery had pre-planned pain relief plans. Pain control was discussed with patients pre-operatively and documented in the 'admission for adult surgery' documentation.
- National Institute of Health and Care Excellence (NICE) guidance 'Patient Group Directions (PGD)' (2013) was followed. This allowed registered nurses to supply some prescription-only medicines to patients, without individual prescriptions. However, the trust currently used only one PGD for pain relief trust wide. This was for paracetamol. This allowed for a timely response to some patients pain without having to wait for a doctor's prescription. The trust was considering using further PGDs to respond to patients requiring stronger analgesia.
- Four patients on wards 18, 19 and 22 told us nurses responded quickly to requests for pain relief and staff returned to ask if their pain had been relieved. During our inspection, we saw nurses on medication rounds asking each patient about their pain and administering analgesia as prescribed. In all seven medication records we reviewed pain relief medication had been prescribed and given appropriately.

- A pain aid tool was available for patients with cognitive impairment; we saw these on all wards attached to the blood pressure machines.

Nutrition and hydration

- Fluid balance charts were in place to monitor patients' hydration. We reviewed 17 fluid intake and output charts and found that all 17 were completed accurately. This meant that patients' fluid requirements were monitored accurately.
- All patients had their nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). The MUST tool calculates the overall risk of malnutrition. Patients were assessed as low, medium or high risk.
- An inpatient care and risk document was completed for all admissions. This included a section on nutrition and hydration. This was mostly completed in all of the 15 care plans we reviewed and stated dietary requirements for example 'diabetic' or 'vegetarian', whether any special utensils were required and whether the patient had any difficulties swallowing. However, patient food preferences were not always documented.
- Nutrition care plans were in place for each patient where risks were identified. We reviewed five food charts on ward 22, all were fully completed.
- At Leicester General hospital (LGH) there were specialist dietitians for certain conditions, hepatic (liver), pancreatic cancer and urology. In addition to these specialist dietitians, a general dietician visited each ward monitoring general day-to-day enquiries. For example relating to surgical patients not eating post operatively. Staff told us that dietitians were easily accessible and responded promptly to referrals from nursing staff.
- There were protected meal times in place on some surgical wards, which ensured staff had dedicated time to help patients. However, the system was not well established on all wards with no signage or guidance outside wards that it was a protected time. On ward 23, we were told the board kept falling down so it was removed.
- We observed staff serving lunch on ward 19. Food temperatures were checked before serving. This meant food was served at the correct temperature to reduce risks of food poisoning.
- Housekeeping staff handling food told us they had received food hygiene awareness training. However,

Surgery

nursing staff and ward sisters were also serving and preparing food (e.g. soup, toast); they told us they had not done any food hygiene training. The hospital policy Food Hygiene and Ward/Department Kitchens Policy 2016 and The Food Safety and Hygiene (England) Regulations 2013 require that all “food handlers” are trained and/or supervised and instructed in food hygiene. This meant staff were not adhering to regulations or trust policy.

- We saw patients being asked if they required any help with their meals. For example cutting food up or changing position in bed if unable to sit out to eat.
- Patients requiring assistance with eating and drinking were identified using magnetic pictures on the white boards behind their bed. This ensured they were assisted accordingly.
- The trust wide Friends and Family Test, (FFT), scored satisfaction for catering at 77% (against the England average of 88%). The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care.
- Patients told us that generally they were satisfied with the food provided at the hospital.
- Food was available on the wards throughout the 24-hour period. A range of diet choices was available including vegetarian, gluten free, kosher and halal. We saw housekeeping and nursing staff assisting patients with menu choices. Snack boxes were available for patients who missed a meal.
- Patients were given information about when they must stop eating and drinking before their operation. Depending on the surgical procedure, patients could drink up to two hours before surgery and eat up to six hours before surgery.

Patient outcomes

- Leicester General Hospital (LGH) does not take part in the National Hip Fracture Audit as this type of surgery was not performed at this site.
- The trust demonstrated good performance in the national bowel cancer audit 2015 and performed better than the England average for three of the six measures. For example, post-operative length of stay 74% compared to the England average of 69% and case ascertainment, (discovery of the disease) 102% against an England average of 94%.

- On average elective and non-elective patients spent a similar time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from April 2015 to March 2016 was 3.4 days, compared to 3.3 days for England. For non-elective patients (emergency), the average length of stay was 3.3 days, compared to 5.1 for the England average.
- The trust was an outlier nationally for the rate of readmissions within 30 days of discharge. In response, the trust had made a commitment for 2016/17 to reduce readmissions within 30 days to below 8.5%. The trust plans to reduce readmissions included, monitoring readmissions through their governance structure, focussing discharge resources on those patients at a higher risk of readmission and addressing clinical variations in consultant re-admission rates. The new project had been implemented throughout June 2016.
- Results from the patient reported outcome measures (PROMs) April 2015-March 2016 for groin hernia, hip replacement, knee replacement and varicose veins were similar to the England average. PROMs is data collected to give a national-level overview of patient improvement after specific operations
- Leicester General Hospital (LGH) had mixed performance in the national emergency laparotomy audit (2015). The audit rates performance on a red-amber-green scale, where green is best. Good performance (green) was shown for three out of the eleven indicators: preoperative review, consultant surgeon present in theatre and direct post-operative admission to critical care. The trust scored red against three measures: final case ascertainment, consultant review within 12 hours of emergency admission and assessment by a medicine care of the older person (MCOP) specialist.
- Trust wide one surgical site infection had been reported for the year 2015. A full investigation had been carried out and 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.

Competent staff

Surgery

- The trust had systems in place to ensure that the registration status of qualified doctors and nurses' had been renewed on an annual basis. There was a nominated responsible officer for medical revalidation. Nurses told us there were learning events to help with revalidation.
- Staff told us they attended a corporate induction and local induction when they commenced employment at the trust. The trust target for attendance at the corporate induction was 95%. Ninety-two per cent of relevant staff, within the clinical management groups (CMGs), had attended the trust corporate induction in the last year, which was slightly below the trust target.
- The trust recruited nurses from Europe including Spain, Portugal, Italy and Greece. These nurses were given a comprehensive 12-week induction including lessons to develop their English language; they were supernumerary on the wards to enable them to become familiar with nursing practice in England. During specific induction, these staff wore green name badges stating that they were supernumerary. At the end of the induction, they had to complete and pass a medicines management assessment before being allowed to work independently.
- A specific induction folder was used on the wards for bank and agency staff called a 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration. The logbook on the two wards we looked at was completed sufficiently to indicate bank and agency staff had been orientated to the ward or clinical area.
- Within the surgical division at Leicester General Hospital (LGH), from April 2015-March 2016, completed staff appraisals were reported to be 90%. This did not meet the trust target of 95%.
- All the staff we spoke with described their appraisal as a positive experience, which enabled them to identify their learning needs for the following year. For example, mentor training and assistant practitioner training.
- Staff told us whenever possible they were allocated time to attend training sessions or complete on line training and we saw this in practice. During our unannounced inspection, theatre staff arranged training at short notice after the cancellation of an operating list.
- We spoke to the resuscitation officer who had been in post since January 2016. Their role included staff teaching to ensure staff competence with emergency procedures, they also visited ward teams post cardiac arrest to offer pastoral support and a debrief.
- Advanced nurse practitioners (ANPs) were able to request ultrasounds. This ensured patients had timely access when medical staff were unavailable to request this procedure. One member of staff told us, "It has changed the way care is delivered". Additional nurse training and education has enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate.
- Four out of five junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. We observed good interactive learning taking place during a patient ward round between the consultant and a junior doctor and an ANP.
- Junior doctors told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- All of the patients who spoke with us reported a high level of confidence in medical and nursing staff with regard to their knowledge and their skills.

Multidisciplinary working

- There was good multidisciplinary (MDT) working across surgical areas. All three-hospital sites at the trust were trialling a teleconferencing system to improve MDT working within orthopaedics. This was to be used to support other NHS trusts that used these services.
- We observed physiotherapy staff assisting with patient therapy sessions encouraging mobilisation and self-care activities.
- Dietician staff contributed to daily MDT meetings on ward 22, which included the nurse in charge, a doctor and the bed co-ordinator. The MDT discussed each patient's condition and progress.
- Occupational Therapy staff told us there was effective communication and partnership working between the surgical/orthopaedic MDT. They met regularly to identify patients who required visits or to discuss any changes to the care of patients.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams, services or hospital sites, Surgery services was based at all three hospital sites of the trust.

Surgery

MDT working within specialist services for example, the pain team and the thoracic nurse specialists involved linking between the sites. All staff we spoke with felt that the services were available in a timely way despite not necessarily being based at the general hospital site.

- When patients were discharged, communication was generated electronically and printed off to be posted to the patients GP. This detailed the reason for admission, any investigation results and treatment undertaken.

Seven-day services

- Operating theatres were available seven days a week. An on call rota was in place for surgical and anaesthetic teams. These staff could attend within 30 minutes if needed in the out of hour's period between 1am and 8am.
- Surgical consultants worked an emergency on call rota, seven days per week. A consultant was on call 24 hours a day Monday 8 am to Friday 5pm then another one Friday 5pm to Monday 8am. This maintained continuity for patients within the clinical management groups (CMG's) and on the ward. Ensuring patients were reviewed over weekends and bank holidays.
- Seven-day access to an ortho-geriatrician is a key priority in NICE guidance CG124 (hip fracture management). Senior Staff told us that covering weekends with an ortho-geriatrician was extremely difficult, due to national shortages, but that it would benefit patients if it were available to reduce admissions at the weekend and to improve continuity of care across the service.
- The medical doctors we spoke with told us there was good access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making. For example interventional radiology had an on call system for covering trust sites including nurses and a vascular and non-vascular radiologist.
- In Lithotripsy, (this is a treatment, typically using ultrasound shock waves, by which a kidney stone or other calculus is broken into small particles that can be passed out by the body), triage they were proud of a new machine that was available 24/7 as opposed to the previous availability of every three weeks
- Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.

- Ward based pharmacists visited the wards Monday to Friday to review medication charts. The pharmacy department was open Monday to Friday from 9am to 5pm and on Saturday and Sunday mornings. A pharmacy on-call system was in operation outside of these hours.

Access to information

- Information needed to deliver effective care and treatment was not always available to relevant staff in a timely and accessible way. Some staff told us medical notes were often missing when patients were added to theatre lists at short notice. However, staff did not accurately record this or report it as an incident through the trust incident reporting system.
- Information we received after our inspection identified no incident reports specifically in relation to missing patient notes at Leicester General Hospital (LGH). However, because staff were not always reporting missing notes as an incident we were not assured the trust were fully unaware of the extent of the problem.
- The orthopaedic theatre arrivals area (TAA) had recently begun checking patients' medical notes a week prior to planned surgical cases in order that any missing notes could be requested. Staff told us that if notes were missing the patient's procedure could be cancelled.
- Information provided by the trust identified four cancelled operations in the two-week period from 6 June 2016 to 26 June 2016 as a result of missing medical notes. However the cancellations were not reported as incidents, so the trust was not monitoring the impact of missing records.
- Policies and procedures were accessible on the trust intranet. Staff told us they knew how to access policies and we observed a member of staff searching for a policy.
- We saw a range of up to date policies and procedures on the hospital intranet relating to patients with diabetes, these included pre and post-operative procedures.
- Information and guidance regarding specific procedures or conditions was available through the trust's intranet. For example diabetes management pre and post operatively. We saw information had been printed and included in the nursing notes to use as a guide.

Surgery

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- We saw in theatres where an online, real-time communication system was used. This allowed staff to track patient journeys through theatres and contributed to the management of theatre schedules. However, staff told us that real time inputting of data was sometimes not possible due to a lack of computers particularly in anaesthetic rooms. This meant we could not be assured theatre lists were accurate and up to date. However, staff told us they did not record this or report it as an incident through the electronic incident reporting system.
- Some elective surgery patients attended the preoperative assessment clinic where a number of investigations could take place, in an adjacent area. Comprehensive risk assessments were completed in the inpatient care and risk document. This meant all the information to deliver effective care and treatment was readily available to staff.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- GPs had direct access to the medical staff and could speak to a surgical consultant or other senior doctor for advice on the phone.
- Doctors we spoke with told us that overall referral letters, in triage areas, from GPs were comprehensive and available with the patient; this meant that informed decisions could be made about on-going care and treatment.
- Discharge summaries were sent to the patient's general practitioner (GP), on discharge to ensure continuity of care within the community. Summaries were sent on the day of discharge by e-mail, post or given to the patient for them to hand to their GP. The discharge letter detailed the reason for admission, any investigation results and treatment undertaken
- Staff told us they understood the relevant consent requirements of legislation and guidance and had access to the trust policy and procedures for consent.
- Where patients' had capacity to consent, consent was sought in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options about their care and treatment. We observed staff asking for consent both verbally and in writing. On checking five patient records (patients with capacity to consent), we saw copies of signed consent forms, which had been completed appropriately.
- Three patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and verbally consented to blood tests and scans.
- However, consent form four (a form used for the consenting of patients who lack capacity) was inconsistently completed in three out of four patient records (patients without capacity to consent). The Mental Capacity Assessment (MCA) had not been completed. This meant the patient had not been consented correctly.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training and updates were included as part of safeguarding training. However, most of the staff we spoke with had limited knowledge concerning MCA assessments. None of the nursing staff we spoke with felt they received sufficient training on undertaking MCAs. When questioned they did not understand who would carry out the assessment or when.
- Due to an increase in DoLS referrals from wards, we were told nurses completed applications with minimal training. However, there was a policy and a flow chart to assist them.
- During our inspection, we saw a DoLS application had been made for a confused patient on ward 27. However, prior to the DoLS application there had been no assessment of the patients' mental capacity, this constituted an unlawful deprivation of the patient's liberty. Staff we spoke with were not aware this was not the correct process. This incident was raised with the senior nursing team during our inspection and the patient's case was reviewed.
- During our unannounced inspection, because of information identified on our announced visit, an action

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

plan had been developed which identified further staff training was required for MCA and DOLs. The matron had asked the safeguarding lead for further training using examples, to develop staff education. However, this was a cancer, haematology, urology, gastroenterology and general surgery (CHUGGS) action plan so there was no assurance it would be shared across the other clinical management groups (CMG's).

Are surgery services caring?

Good



We rated caring as good because:

- Patients were treated with dignity and respect and were involved as partners in their care.
- Feedback from patients who used the service was positive about the way staff treated them.
- The trust achieved positive results and feedback from the friends and family test and in patient surveys.
- Patients were treated with dignity, respect and kindness during interactions with staff. On all the wards and departments we visited, we saw staff acting in a kind and caring way towards patients and the public.
- Relatives and carers felt communicated with and received information in a way that they could understand.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service, they have received to friends and family who need similar treatment or care. The overall FFT response rate for surgery was 31% for the period July 2015 to June 2016 with response rates varying between 22% and 54% across the surgical wards. The England average response rate for the same period was 30%. Ward 18 consistently scored well: 97-100% of monthly respondents would recommend the ward, scoring 100% in nine of the 12 months.
- The trust had good results for the Care Quality Commission (CQC) inpatient survey 2015. This survey

looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust.

- Responses were received from 547 patients at University Hospitals of Leicester NHS Trust. In all 11 questions, they were rated about the same as other trusts. There were three areas the trust were considered worse than other trusts, these were, cleanliness of rooms or wards and acknowledgment of patients, some of the respondents' felt that doctors and nurses talked in front of them, as if they weren't there.
- Seven Patients and three relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff
- During our inspection, we observed staff were kind, had a caring, compassionate attitude, and had positive relationships with patients using the service and those close to them. Staff spent time talking to patients. During lunchtime, we observed patients being provided with support. We observed staff were kind and respectful when supporting patients to eat and drink taking time to enable patients to eat their meals.
- Patients on ward 14 and 19 told us, "nurses always answer the buzzer quickly", "I can't fault them lovely people", and "excellent care, but food could be better". One patient on ward 19 told us how they had initially struggled with pain but that the staff had been great and "sorted it".
- We observed staff on ward 16 maintain patients privacy and dignity by using the curtains prior to any procedures and discussions. They asked patients how they preferred to be addressed and explained procedures.
- We saw patients treated with care, compassion and respect as we followed them through the peri-operative pathway.
- We observed staff caring for a distressed relative in the theatre suite, offering them support and re-assurance as the patient had gone into theatre for surgery.
- However, staff in main theatres highlighted the small space available for patients arriving in theatre. There was space for male and female patients divided by a portable privacy screen. Ambulatory patients were received here and patients on trolleys or beds would be seen in an adjacent area. The theatre porters also used this area. Due to the small space and the temporary partition the confidentiality, privacy, and dignity of

Surgery

patients could not be assured. The theatre co-ordinator explained that no private information was shared in this area. We visited the area twice during our announced visit and saw no patients in the arrivals area.

- During our unannounced visit we witnessed a patient waiting for surgery in the arrival area of main theatres. The surgeon spoke to the patient about private and confidential information in range of two porters, a receptionist and two inspectors. This lack of privacy and breach of confidentiality was reported by our inspection team. We were told the environment made it difficult to speak to patients in a private area and that usually these conversations were held in the anaesthetic room. However, we were not assured of this.

Understanding and involvement of patients and those close to them

- We spoke with six relatives. They all told us they had been kept informed of the patients' progress and staff were approachable if they needed to ask any questions. Staff on the wards were aware of patient confidentiality and told us they always checked with the patient if they were unsure of who was making the request for information. All members of the multidisciplinary team explained care and treatment in a way that could be understood. We observed a member of staff speaking with a relative to explain about the patient's care. We observed ward receptionists helping relatives with information requests and taking phone messages to patients from relatives.
- We observed good interactions between staff and patients in the theatre assessment area, (TAA), and the recovery suite of the main theatres. Staff spoke in a quiet calm manner to patients explaining what was happening to them and what was going to happen next.
- Patients told us they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them, doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- Information about surgery was shared with patients, and patients were able to ask questions. Patients and relatives said they were kept informed and felt involved in the treatment received.

Emotional support

- A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss. The bereavement services team produced an information leaflet to assist relatives/carers during the early days of bereavement.
- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- We saw documentation and spoke with two patients who had attended the high risk anaesthesia clinic. They were 'put at ease' by the consultation and felt more informed about the risks involved.
- Patients and staff had access to clinical nurse specialists across the surgical areas. For example, we saw that there were specialist nurses for colorectal, stoma, thoracic, breast care and the acute pain team. Clinical nurse specialists supported patients to manage their own health, care and wellbeing and to maximise their independence.

Are surgery services responsive?

Requires improvement



We rated responsive as requires improvement.

We found:

- Some patients were not able to access services for assessment. For example, the pathway for pre-operative and high-risk anaesthesia patients was not consistently followed. This caused avoidable delays and cancellations
- There were delays and cancellations to treatment. In a three week period in June 2016, 35 operations of cancer and non-cancer patients had their operations cancelled due to lack of critical care beds.
- Complaints were not always used as an opportunity to learn. Ward staff told us that some complaints raised by patients were dealt with by the ward, but were not always documented.

However, we also found :

Surgery

- The majority of surgical specialties met or exceeded the 90% target of patients being seen within the 18 week referral to treatment target. The exception to this was ear, nose and throat services where 75% of patients were seen within 18 weeks.
- Evidence collected showed that there were no mixed sex breaches in the surgical division, the average length of stay was better than the national average and that the number of cancelled operations remained low.
- Patients had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the patients it served and acted on these to plan, design and deliver services. For example, services include one-stop haematuria (blood in urine) and prostate assessment clinics, where patients were assessed, investigated and diagnosed at one visit to the hospital.
- The trust engaged with internal and external stakeholders including patients, governors, members, partners and staff to plan services. For example 'Better care Together' the Leicester, Leicestershire & Rutland (LLR) health and social care teams discussed plans for an integrated, high quality service, delivered in local community settings where appropriate. Amongst other things, they plan to address services that are geared towards responding to a crisis in order to develop services that help to prevent and manage conditions before problems occur.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally. For example, Leicester General hospital, (LGH), was the base for the regional hepato-pancreato-biliary unit. They provided a national specialist service for total pancreatectomy (removal of the pancreas) and autologous islet cell transplantation. (The introduction of a patient's own pancreatic cells into a vein of the liver. The cells then become lodged in blood vessels of the liver where they become active and begin producing insulin reducing the need for insulin after a pancreatectomy).
- Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room

where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities to reduce anxiety and disorientation in the patient.

- Patients being seen in outpatients needing sarcoma surgery (a type of cancer found in the tissue of the skin) were referred to a nearby NHS trust for their surgical procedure. A joint sarcoma MDT meeting was held in at the receiving trust and involved an oncology and orthopaedic surgeon from Leicester and the oncology-plastic surgeons from the nearby trust. This meeting ensured patients, initially seen in Leicester, were surgically managed in the nearby trust and then safely transferred back to Leicester for further out patient and postoperative follow up.
- However, patients with multiple medical conditions or increased complications of anaesthesia were seen in a 'high risk anaesthesia' clinic, as this clinic was held at the Leicester Royal Infirmary some patients did not have a pre-operative assessment at Leicester General Hospital (LGH). This caused problems on the day of admission sometimes leading to cancellations or last minute changes in the order of theatre lists. It also meant staff in pre-operative ward 20 might not receive the notes in a timely manner leading to last minute cancellations if the high-risk anaesthetic review recommended a post-op Intensive care or high dependency bed (HDU).
- During our unannounced inspection staff on ward 20 had two patients due to attend for surgery that required HDU beds post operatively however, as they had not been pre-assessed this was not identified until the night before surgery. Staff expected that both patients would be cancelled the next day.

Access and flow

- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care.
- The trust wide data for June 2016 showed that the majority of specialties met or exceeded the 90% standard of 90% of patients meeting their RTT.
- Fifteen theatres were available at this hospital providing emergency and elective surgery. Theatre utilisation (use) was reported to be low for January 2016 to March 2016. However, theatre three had high theatre usage

Surgery

across all three months with 100% usage in January and February 2016. Theatre two in day case had consistently low usage (42-51%) across the three months and theatre eight had the lowest (36.8%) monthly usage figure overall (March 2016). Senior staff in theatres could not explain these figures when we asked.

- A team leader worked across the theatres every day to recognise and trouble shoot problems such as capacity, overruns and staffing issues.
- Senior staff told us they made decisions about whether to cancel operations the day before the operation wherever possible. Surgical operations were graded one to three; those graded three were of lower priority and more likely to be cancelled. Patients with cancer were graded one and complex operations requiring surgeons from two specialities were grade two.
- Information from NHS England showed the total number of elective operations in University Hospitals Leicester, (UHL) cancelled on the day between January and June 2016, was 854. All but 92 of these were rescheduled within 28 days.
- Cancelled operations as a percentage of elective admissions performance was in line with the England average at this trust (0.8% - 1.4%) for the reporting period April 2015 to June 2016.
- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. Bed capacity meetings were held three times daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability. However, movement of patients out of the intensive care areas was affecting the management of theatre lists in relation to patients that required high dependency care post operatively.
- During times of high patient demand, elective patients were reviewed in order of priority to prevent urgent and cancer patients being cancelled. However, during our announced and unannounced inspections staff told us that due to a lack of high dependency unit, (HDU), beds cancer patients were being cancelled. During the week of our inspection staff told us that seven patients both cancer and non-cancer had operations cancelled. Staff we spoke with were aware of possible plans to address these issues but were not informed of any implementation progress.
- We requested cancellation information from the trust. Information provided for 6-26 June 2016 showed there

had been a spike in cancellations with 76 cancellations for non- clinical reasons, 27 of these were because of lack of theatre time and 35 because of lack of post-operative HDU or intensive treatment unit beds (ITU). The other 14 were due to the unavailability of resources such as staff and equipment.

- Leicester General Hospital (LGH) used a 'virtual bed process' for ambulatory surgery patients. This meant there may not be a bed available post operatively. Theatre recovery staff told us this could be a problem as patients could be left in the recovery area until a bed became available. This was not best practice and there were no toilet or washroom facilities for these patients. The trust was not currently monitoring this activity.
- The trust had procedures in place for surgical outliers. Outliers are patients cared for in an area outside of their speciality (for example, surgical patients on a medical ward). During our inspection, there were no surgical outliers.
- Bed occupancy at this hospital was 82% for March 2015 to April 2016. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- Wards and departments included single-gender accommodation, which promoted privacy and dignity. The trust performance reports from April 2016 showed there were no reported times when male and female patients had been treated in a mixed area at this hospital between April 2015 and March 2016. For example, we saw that male and female patients were able to have separate areas in the theatre assessment area (TAA).
- The Productive Operating Theatre programme 2014 recommends the lock down of theatre lists to ensure no alterations can be made which may reduce patient flow through theatres. For example, adding a patient to a theatre list, which may increase theatre usage and last minute cancellations of those patients, scheduled at the end of a list. Staff in theatres told us that operating lists were not locked down 24 hours prior to surgery; this led to last minute changes of lists. Staff felt that as this was a daily occurrence it had become normalised.
- Patients were admitted as emergencies through the surgical admissions unit, via their GP, or directly through the emergency department (ED). Patients sent to the surgical admissions unit would be seen in the triage area by a specialist nurse practitioner and a specialist registrar in order to re direct patients appropriately and

Surgery

reduce admissions. Staff told us that, of the patients admitted through the surgical triage approximately 50% would be discharged with the remaining patients admitted to the surgical assessment unit or another surgical area if necessary. To ensure patients were seen by the most appropriate consultant they would be triaged through either the Leicester Royal Infirmary (LRI) unit or the LGH unit. Specifically urology and hepatobiliary (liver and gall bladder) patients were sent to LGH for triage, as that is where that type of surgery is performed and managed.

- Patients undergoing elective orthopaedic surgery were admitted through the theatre assessment area (TAA). The TAA provided a facility for patients to be admitted on the day of their surgery, assessed by nursing staff and to meet their anaesthetist and surgeon. The operating theatres were adjacent to TAA. This meant patients were fully prepared prior to surgery. Staff showed us the criteria they followed for patients being admitted through TAA. For example, patients with mobility problems that affected their independence, patients with known infections or patients being admitted from nursing homes would not be suitable. Patients admitted to TAA were transferred to ward 18 post operatively and discharged from ward 18 mostly on the same day. If an overnight stay was required, they would stay on ward 18.
- Patients admitted for other surgical procedures were admitted through day case one and two. Patients were allocated to a day case area dependent on gender. Theatre staff told us that more complex surgery was being performed in day case theatres despite requiring a hospital overnight stay. Senior nurses explained this was to address the cancellation of patients on other theatre lists.
- Patients were advised to contact a ward (depending on the surgical procedure) or their own GP if they had any concerns following discharge. A telephone advice sheet was available within the trust to record calls received. However, these were not consistently stored in the patient record. This presented a risk to safety and continuity of care as all patient contact should be documented for each episode of care.
- Patients undergoing certain gall bladder procedures were telephoned 48 hours post operatively to review their pain control and offer further advice. This information was collected and documented within patients' notes. The trust provided us with an audit of this process, which indicated that not all patients were

receiving a telephone call but that a reduction in readmission had been identified. The audit was conducted in 2014 and had not been repeated, despite identifying improvements and areas for action.

- For the period March 2015 to June 2016 patients at this hospital had a higher than expected risk of readmission for elective (planned) admissions in general surgery and urology and a lower than expected risk of readmission for trauma and orthopaedics. The risk of readmission for elective general surgery was more than twice the England average. For non-elective admissions (emergency), patients at this hospital had a higher than expected risk of readmission in general surgery and urology and a lower than expected risk of readmission in hepatobiliary and pancreatic surgery. After our inspection, we requested information from the trust about plans to address readmission rates. The trust was currently an outlier nationally for the rate of readmissions within 30 days of discharge. In response, the trust had made a commitment for 2016/17 to reduce readmissions within 30 days to below 8.5%.

Meeting people's individual needs

- The trust provided a comprehensive interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Information could be translated into different languages on request. Large print and easy read material was available on request. The three most commonly requested languages for both written and spoken translation were Gujarati, Punjabi and Polish. The trust had an interpreting and translation policy. Staff we spoke with were aware of this service and the policy.
- During our inspection, we noted very limited signage in different languages to enable non-English speaking patients and visitors to find their way around the hospital site.
- The trust offered pastoral, spiritual and religious support to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains, as well as a non-religious carer. Volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish supported the team. A 24/7 on-call service was provided and where possible a representative of the patient's own faith attended.

Surgery

- The hospital had a chapel and prayer room (with washing facilities). Patients we spoke with were aware of the prayer rooms available to them.
- The Trust told us they liaised with local faith representatives through the chaplaincy and through representation on the trust's equality advisory group. This group advised on various faith issues including modesty and patient food.
- All patients were asked about their religious and spiritual preferences on admission and we saw evidence of completed nursing care documents to support this.
- Nursing care documents also contained an 'about me' section. This section captured general information about the patient such as sleep and rest patterns, communication and personal hygiene and allowed the patient to express any personal preferences. This document was especially useful in caring for patients living with dementia.
- The patient record identified diabetic patients. The trust had a team of diabetic nurse specialists who received daily reports of diabetic patients admitted to the hospital.
- There was no system within the trust for identifying if a patient was blind or deaf and the trust did not monitor the numbers of blind or deaf people treated at the hospital. This meant that these patients may not receive care tailored to their individual needs.
- The trust was able to identify patients with learning disabilities through an electronic flag on the patient record system. This enabled the trust to monitor the numbers of patients with a learning disability attending. This information allowed the trust to tailor services according to patients' individual needs. On receipt of notification of an admission, the learning disability specialist nurse contacted the ward to discuss the patient's individual requirements. Staff on all wards were aware of the Learning Disability Liaison team and contacted them if they had any questions or concerns. We did not observe any episodes of care in relation to this service during our inspection.
- Information provided by the trust reported between April 2015 and March 2016, 550 patients with a learning disability had used hospital services. The average number referred to the learning disability specialist (LDS) nurse per month was between 15 and 25. This meant on average 43% of patients with a learning disability were referred to the LD nurse. The trust did not provide any evidence of audit of this service in order to identify how many patients within surgery services had been referred to the learning disability specialist nurse.
- All patients with a learning disability were initially assessed using standardised nursing and medical documentation. Some patients had their own hospital profiles, (information booklets about their daily lives and their likes and dislikes), and were asked to bring them into hospital with them.
- Ward and theatre staff described adjustments, which could be made for patients with learning disabilities. These included single rooms with facilities for relatives or carers to stay overnight, being first on the theatre list, relatives staying with patients until they had received their anaesthetic, being given greater time and aiming for consistent nursing staff.
- The trust was committed to the implementation and delivery of service improvements for people with dementia in Leicester's Hospitals. Person centred care was individualised to meet the specific needs of each patient using the 'Know me Better' patient profile. Open visiting was available to carers of patient's living with dementia. Policies were in place to reduce the number of ward transfers for patients living with dementia.
- We saw all patients had a board on the wall above each bed, which displayed key information about their care needs and included symbols indicating whether a patient had significant communication difficulties. The information displayed was discussed with patients and permission was sought.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Clinical and cognitive assessments were undertaken as part of the dementia care pathway. Care pathways are multidisciplinary plans of anticipated care. The trust had no dementia specialist nurses. However, there were dementia nursing sisters who worked within the corporate team leading on practice development and improvements and a dementia 'Champion Network' of staff with a particular interest supported patients with dementia.
- Throughout the wards, staff were able to show us changes that had been made in relation to helping patients living with dementia and their relatives. Almost all wards had a retreat room for patients and relatives to use away from the ward area. On Ward 28, staff carried

Surgery

out fundraising and wrote letters to local businesses in order to re-furbish a retreat room. This meant patients and relatives had somewhere to relax away from the ward area.

- Those wards that did not have them were already working towards adapting suitable areas.
- Patients and carers were signposted and had access to charitable organisations for additional support and information.
- Patient led assessment of the care environment audits (PLACE) are assessments carried out by local people going into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance and dementia facilities. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The 2015 PLACE scores for Leicester General Hospital (LGH) showed the hospital scored lower than the England average for four out of the five areas. However, facilities for patients living with dementia equalled the England average at 72%.
- All ward areas had bathroom and toilet signage in order that patients living with dementia could assist themselves to the toilet where appropriate. Ward areas were also being painted in bright colours to help patients identify which bay they were in.
- Wheelchair access was good throughout the hospital. Disabled toilets were located at frequent intervals and were clearly signposted. However, a staff member's bicycle occupied the disabled toilet in main theatres. This was moved on our request.
- Departments at LGH were accessible however; on occasion patients might be expected to travel to the Leicester Royal Infirmary (LRI) for some treatments scans or consultations.
- However, the trust provided a bus service (at a small fee) for patients and relatives to access across hospital sites.
- The trust used the national NHS e-Referral Services system (previously known as choose and book) to assist patients in making, changing and cancelling appointments.
- When attending the preoperative clinics all patients were given an information pack to take home with them which included pre-surgery high calorie drinks,

information on quitting smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving. This was to ensure patients were as fit as possible prior to the surgery.

- Trauma patients with fractures not requiring immediate surgery were admitted to Leicester General Hospital (LGH) as a delayed transfer from Leicester Royal Infirmary (LRI), for surgery the following day. This ensured surgery occurred in a timely manner. This reduced the risk of recurrent theatre cancellations.
- Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities when relatives or carers stayed overnight in order to reduce anxiety and disorientation in the patient.

Learning from complaints and concerns

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

Surgery

- Between March 2015 and April 2016, there were 47 complaints in surgery services at this hospital. Themes included the attitudes of staff, poor medical and nursing care or treatment.
- Most staff told us they received feedback from complaints and concerns at staff meetings or through the monthly ward newsletter. We were shown staff newsletters that confirmed this.

Are surgery services well-led?

Good



We rated well led as good.

We found:

- The vision values and strategy had been developed through a structured planning process. With regularly reviewed objectives. The values of the trust were embedded in staff appraisal documents.
- There was strong local leadership with staff respecting line managers and feeling supported in their roles.
- Staff told us they felt valued and there was a culture of openness.

However, we also found:

- Departmental governance and risk management arrangements were not robust and as such were not suitable to protect patients from harm.
- There were insufficient governance in place to ensure there was learning from the never event to ensure patients with delirium were managed safely.

Vision and strategy for this service

- Surgical care was provided at Leicester General Hospital (LGH) as part of four clinical management groups (CMG): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS), critical care, theatres anaesthesia, pain and sleep (ITAPS), renal, respiratory and cardiovascular (RRCV) and musculoskeletal and specialist Surgery (MSKSS).
- University Hospitals of Leicester NHS Trust had a detailed five-year integrated business plan, which covered 2014 to 2019. A two-year 'Integrated Annual Plan' was in place within CHUGGS with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy. However, the

plan, whilst ambitious, appeared to focus largely on the strategic direction of the service. For example to provide services seven days a week and to continue surgical emergency ambulatory care service to support a reduction in length of stay, better outcomes for patients and supporting the emergency process.

- The CMGs had individual five-year strategies that were linked to the trust's strategy, aims and objectives. Each CMG had its own strategy. The strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.
- The trust vision was to deliver 'caring at its best' for everyone who visited Leicester's Hospitals. Staff were involved in developing the five values to work by. For example, 'We treat people how we would like to be treated', 'we are one team', and 'we are best when we work together'.
- We found the majority of staff were able to articulate the values of the trust and the CMG. Staff displayed them in their daily work and we observed them putting patients first by working as a team, leading and listening, striving for the best and trying to make a difference. Staff in all departments told us they understood there was a plan for moving and changing the services at Leicester General Hospital (LGH) but there was uncertainty from all staff about when this would happen.

Governance, risk management and quality measurement

- A risk register was held within surgery with 27 risks identified. Risks included a description, controls in place to mitigate the risk and, a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register and cited capacity, cancellations, referral to treatment times (RTT), staff skill mix and bed availability in the intensive care and high dependency units.
- CMGs held monthly quality and safety board meetings. We reviewed nine sets of meeting minutes and noticed good levels of attendance. There was evidence of key themes around incidents and lessons learnt, complaints and a review of risks in CMGs, however, there was limited evidence of lessons learnt being shared between CMGs.
- Where incidents had been identified, they had been investigated. This included undertaking external

Surgery

reviews. Recommendations were made and changes implemented however, training relating to the changes did not always follow in a timely manner. For example, a delirium tool was developed following a never event but staff had no training on how to use it so were unable to explain it to us during our inspection and were not using it effectively to assess patients.

- However, for example during this inspection service leads were not aware of nursing and medical staffs lack of understanding of the Mental Capacity Act 2005 or the use of the delirium tool introduced after a never event. This meant there was little assurance that changes introduced to prevent further never events were effective.
- Staff also reported not consistently raising incident reports in relation to missing medical notes, staffing levels, skill mix and lack of computers in theatre.
- Theatre staff at Leicester General Hospital (LGH) were concerned that no direct governance or quality meetings were being held. This meant actions and improvements were not being discussed with the whole team and learning opportunities' were not identified. We were told this was due to sickness and that they were to resume in July 2016.
- Individual CMGs identified different risks, incidents, and complaints within their areas but we did not see evidence to suggest that the CMGs worked together to share information and learning. This meant that opportunities for learning across surgery services within this Trust were limited. Information was shared through a network of meetings. Ward sisters attended monthly professional forum meetings. Main points from the meetings were cascaded to staff through ward meetings or ward bulletins. We saw copies of ward bulletins and staff described to us the type of information they received. The trust provided minutes of the professional forum meetings for each clinical management group. These all included topics relating to patient safety, recruitment, and changes to local guidelines/policies.
- There was awareness from the service leads regarding the concerns that we had identified as part of previous inspections. Staffing had been identified as a regulatory breach in January 2014 with lack of appropriate numbers of appropriately qualified, skilled and experienced staff there has been significant improvement due to ongoing recruitment programmes in this country and abroad.

Leadership of service

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

Culture within the service

- The NHS Staff Survey 2015 saw the percentage of staff recommending the trust as a place to work or receive treatment as higher than the 2014 survey at 3.6%. This was slightly lower than the national average of 3.7%.
- In five out of eight questions relating to job satisfaction, the trust scored better than the national average for other NHS trusts 91% of staff felt that their role makes a difference to patients compared to 90% as a national average.
- Most staff felt respected and valued. All members of staff we spoke with were proud to work in the trust and they spoke positively about teamwork and the care they

Surgery

provided to patients. However, five senior staff we spoke with felt the lack of investment at the LGH led to low morale and negativity at times although they all said this did not affect the care and compassion given to their patients.

- Another senior nurse we spoke with said, “When the trusts plans get shelved things go on the back burner and opportunities to change things at LGH don’t get re-visited”. For example, the pre-operative assessment area and the clinic room on ward 27.
- Staff conveyed a strong open and honest culture in all areas visited during our inspection.
- Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers. However, some staff were unsure of what exactly a reportable incident. For example, missing medical notes and environment concerns relating to medicine storage or pre-assessment areas.
- The senior managers within the surgical division had high praise for their staff and recognised the challenges staff within the surgical division faced especially with the increasing demand on surgery.
- Staff felt supported to develop their skills and progress their careers. Many staff we spoke to had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.

Public engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at the professional forums and meetings and within wards and teams. Patient experience, including compliments and complaints, and the results of the FFT were displayed within the wards on ‘how are we doing’ notice boards.
- ‘Message to matron’ cards and boxes, were available in all ward and clinical areas to encourage the public to comment on services provided. ‘You said, we did’ posters were visible however; completion of them was not consistent.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the Trust’s Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- The trust produced a range of publications for the population it served. These were published for the

members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust’s progress against its objectives and priorities, one year into the plan. • In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations

Staff engagement







- Almost all staff responded positively to an initiative known as ‘Listening into action’(LiA)
- LiA is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of the organisation, in a way that makes them feel proud. Staff showed enthusiasm for this initiative and told us they were given the opportunity to come up with ideas to improve patients and staff experience.
- In the University Hospital Leicester, UHL, pulse, check survey (short engagement surveys sent out several times a year. They help trusts to measure engagement more frequently) there had been an increase in positive findings in 8 out of 16 measures including quality and safety of patient care and recommending the trust to family and friends. There were three measures, which showed a reduction in satisfaction including effectiveness of communication with senior managers and staff feeling organisational structures and processes help them to do their jobs.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through their ‘caring at its best awards’. The award winners were staff who had demonstrated going the extra mile for colleagues and patients. There were six award categories, reflecting the trust values and aims to provide caring at its best. The five categories allowed staff to nominate colleagues for work and positive caring attitudes going beyond expectations. A sixth category allowed patients and public to nominate a member of staff who had touched their lives and provided the best care to them or their loved ones. Staff had been nominated as a result of initiatives they had been involved in for example, raising money through cake sales and tea party events to raise money to decorate retreat rooms.

Surgery

Innovation, improvement and sustainability

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

Critical care

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

Information about the service

The critical care service at Leicester General Hospital is delivered in a 16 bedded critical care unit that is divided into two distinct areas. The main unit contains 12 beds with funding for nine level 3 beds. There were four additional beds in an adjoining annexe. The additional four beds had recently been opened to increase capacity and reduce the number of cancelled elective surgery cases. On the day of our visit these four beds were not being used.

The critical care unit used its capacity flexibly to care for both level 3 and level 2 patients. Level two patients are those requiring observation that is more detailed or intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all patients requiring support for multi-organ failure.

The critical care service at Leicester General Hospital admits around 900 patients a year and is an active member of the Central England Critical Care Network. The management and governance of the critical care service sits in the Intensive Care, Theatres, Anaesthesia and Sleep (ITAPS) clinical management group of University Hospitals Leicester NHS Trust.

During our inspection we spoke with relatives and 15 staff of all grades including nurses, doctors, consultants and allied healthcare professionals. As part of our inspection we observed interactions between staff, patients and their

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

A review of critical care would normally encompass any level 2 patient areas that lie outside the intensive care unit. Throughout the trust there are a number of so called 'high dependency' or 'high care' areas that manage patients with a higher acuity than those normally found on a ward. In Leicester General Hospital there was such an area caring for patients with renal conditions and dialysis. The acuity of the patients within these areas was determined using the critical care minimum data set criteria and the staffing allocated accordingly. The care in these areas was not led by intensivists and they were not subject to the management and governance processes of critical care. They were managed by their respective speciality and consequently have not been included in the critical care core service report.

Critical care

Summary of findings

We rated critical care services at Leicester General Hospital as requires improvement overall.

We found:

- There had been a delay in the timely reporting of a recent never event. This meant actions to learn from the never event were not implemented as quickly as they could have been.
- Not all the staff on duty on the day of the inspection were aware of the never event and the subsequent changes to practice.
- The environment fell short of the current Health Building Notes (HBN 04-02) for critical care.
- The trust was not compliant with all aspects of NICE guidance 83 'Rehabilitation after Critical Illness'.
- The Intensive Care National Audit and Research Centre(ICNARC) figures for July 2015 to September 2015 showed that 58% of patients experienced a delay in their discharge. For 44 patients their delay was greater than 24 hours.
- During 2015, 46 patients had their elective surgery cancelled due to critical beds not being available.
- The critical care outreach service was not provided 24 hours a day, seven days a week.

However, we also found:

- Safety thermometer data showed there was a high incidence of harm free care delivered to patients.
- We saw that evidence based best practice guidance was being used to determine care.
- We saw patients, their relatives and friends being treated with dignity and respect.
- Staff demonstrated that they understood the impact of critical care on people and their families both socially and emotionally.
- There was a vision and strategy for the reconfiguration of critical care service at Leicester General Hospital despite the current hold on progress being made as a consequence of financial pressures.

- There was an effective governance structure in place which ensured that risks were recognised and discussed including mitigating actions, timescales and ownership.

Critical care

Are critical care services safe?

Requires improvement



We rated critical care services as requires improvement for safe.

We found:

- There had been a delay in the timely reporting of a recent never event.
- Not all the staff were aware of the never event and the subsequent changes to practice.
- Where daily checks were required for the checking of emergency and resuscitation equipment, staff had not always signed to indicate that this had been done.
- The temperature of the drug fridge had been recorded sporadically or not at all for the past two months.
- Intra-venous (IV) fluids had been left out in the unused four bedded annexe. This meant there was a risk that the IV fluids could be tampered with.

However, we also found:

- There was a robust approach to hand hygiene. Antiseptic hand gels were available for all staff and visitors. Staff routinely used hand gels and wearing personal protective equipment (PPE) when delivering personal and clinical care.
- Safety thermometer data showed there was a high incidence of harm free care delivered to patients.
- There was a low incidence of hospital-acquired infections in comparison with similar critical care units.
- There were effective systems and processes in place to safeguard patients as an internal system for raising safeguarding concerns.

Incidents

- The trust had an incident reporting policy, which included an incident grading system and requirements for reporting internally and externally. Incidents, accidents and near misses were reported through the trust's centralised electronic reporting system in line with this policy.

- Staff knew how to report incidents and were able to give examples of when they had used the incident reporting system. Staff also described how they learnt about incidents that had occurred within the trust. Incidents were discussed at shift handover and staff meetings.
- There had been one recent never event within critical care at Leicester General Hospital (LGH). Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. This had involved the incorrect reconstitution of a medicine and its subsequent administration. When we discussed the never event with staff it was apparent that there had been a delay of several days in reporting the incident. A comprehensive investigation was currently underway using a root cause analysis (RCA) approach. In the meantime a series of immediate actions had been implemented. This included a change of practice, where red trays were being used to draw up controlled drugs, with a double check being made by two nurses at the controlled drug cupboard. We were told that it was agreed that controlled drugs were not to be prepared for administration at the bedside. However, the cramped lay out and lack of clinical space in the unit at Leicester General Hospital prevented drugs being safely drawn up by the drug cupboards/nurses station, so on occasions drug preparation was still taking place by the bedside. Best practice is for intra venous medications to be prepared in a dedicated clean medicines area to avoid the potential for cross contamination.
- Between March 2015 to March 2016, data provided by the trust showed there had been 62 incidents reported from the critical care unit at Leicester General Hospital. These incidents included a range of events such as, medication errors, blood transfusion related errors and the development of pressure ulcers.
- Of the total 62 reported incidents, 23 were reported as causing minor harm with the remaining 39 reported as causing no harm or injury.
- Mortality and morbidity meetings were held monthly to discuss patient deaths. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed the minutes of recent mortality and morbidity meetings and saw that incidents were also discussed.

Critical care

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

Safety thermometer

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

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean and tidy.
- Green stickers were being used to indicate that equipment had been cleaned and was ready for use.
- The trust had infection control policies and procedures in place, which were easily accessible for all staff.
- Isolation rooms were available for those patients suspected of being infectious to others, or for patients who were at risk should they acquire infections.

- As part of the inspection we observed staff washing their hands appropriately, using anti-septic hand gels and wearing personal protective equipment (PPE) such as aprons, gloves and masks. We saw staff adhering to the 'bare below the elbows' policy when in clinical areas.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. The results of a trust wide hand hygiene audit published in May 2016 showed a variable level of compliance with hand hygiene practice.
- There had been an audit across the trust of standard infection prevention and control measures and adherence to Methicillin resistant *Staphylococcus aureus* (MRSA) policies. The results were reported per clinical management group and broken down by staff group. For the intensive care, theatres, anaesthetics, pain and sleep clinical management group (ITAPS) overall there had been an 8% reduction to 79% in compliance with the use of PPE from quarter 2 to quarter 4. There had been a 12% reduction to 78% in compliance with source isolation (barrier nursing to prevent the spread of infection), policy and 26% reduction to 49% with MRSA policy compliance. This shows a decline in performance for these areas.
- The sharps safety audit was reported as being up 7% to 93% so this was improving.
- For the critical care service at Leicester General Hospital, the most recently validated ICNARC data supplied by the trust for July 2015 to September 2015 showed very low numbers of unit acquired infections when compared with similar units. The intensive care national audit and research centre (ICNARC) Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland.

Environment and equipment

- The critical care unit was divided into three areas with a total of 16 beds. The main unit comprised eight bed spaces, which were used primarily for level 3 patients. There was also an area to the side of the main unit where four level 2 beds were situated side by side. In addition there was a four bedded bay in an adjoining

Critical care

annexe, which had been opened recently to increase the number of level 2 beds. The main unit had three side rooms, which were being used to isolate patients. They were not purpose built and did not have gowning lobbies. A lobby acts as an air lock between the outside unit and the patient isolation area. Along with a balanced supply and extract air change rate this can help prevent against airborne organisms moving from circulation areas to the isolation room itself.

- All bed spaces were equipped with the equipment required to care for a critically ill patient.
- Staff competency in the use and management of critical care equipment was assessed. They were supported by equipment technicians.
- The critical care unit was not purpose built and was 'tired' in its appearance and décor. There was limited space around the bed areas, especially around the four level 2 beds and the unit did not meet the latest Department of Health building note guidance clinical spaces in critical care. This was listed on the risk register, in the longer term plans for critical care on the Leicester General Hospital site were under review.
- In the four bedded annexe, there was one hand wash sink and the bed spaces did not have disposable curtains in use.
- There were no bathroom, shower or toilet facilities for patients on the critical care unit. When required patients were taken to use facilities in an adjoining ward area.
- There was a lack of storage space on the unit, so storage racks for disposables were kept within the corridor walkways. This meant sterile supplies and consumables were stored in publicly accessible areas.
- We saw that resuscitation equipment; including defibrillators and airway management trolleys and drugs were available. The records for daily checks of trolleys showed all were generally being checked daily, although there were some gaps in signing. Between January and July 2016 there were 13 days when the daily check record for the cardiac arrest trolley had not been signed. We also found one electro-cardiograph machine (ECG) that had gone past the indicated service date of May 2016. This was reported to the nurse in charge and promptly dealt with. The ECG machine was removed from use and taken for service.
- We saw a purpose built patient transfer trolley and associated equipment which was checked on a daily basis.

Medicines

- The trust had medicines policies which were readily accessible to all staff via the trust's intranet.
- All medication cupboards were appropriately locked and the keys were kept securely. The controlled drug keys were kept on the person of the nurse in charge of the shift and the controlled drugs were recorded as being checked on each shift. We randomly checked the stock levels of controlled drugs and they were correct. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs which require special storage and recording systems to be in place.
- Staff and patients had access to a critical care pharmacist although the pharmacy service to the unit did not fully meet with the D16 service specification. D16 is the NHS standard service specification for adult critical care. The March 2016 critical care risk register cites the pharmacy service to all three critical care units across the trust as a risk. The issues included; delays in supply and pharmacy advice and a reduced attendance on the daily consultant unit rounds.
- The March 2016 critical care risk register cites the pharmacy service to all three critical care units across the trust as a risk. The issues included; delays in supply and pharmacy advice and a reduced attendance on the daily consultant ward rounds. Clinical pharmacy attendance at multi-disciplinary ward rounds increases the effectiveness of the service as recommended in the Intensive Care Society standards.
- There were five reported incidents relating to medicines in critical care at Leicester General Hospital between March 2015 and March 2016. These predominantly related to administration errors.
- Records indicated that drug fridge temperatures were only sporadically recorded over the past two months. We were told by staff that the unit was waiting for a new thermometer although the fridge was still being used for the storage of emergency drugs. In order to ensure the safety and integrity of medicines they should always be stored as indicated by the manufacturer. Staff told us the drug room temperature was also being monitored but there was no evidence of it being recorded so we not assured of the frequency this was completed or that the temperature was within acceptable limits. This was

Critical care

raised with the nurse in charge during the visit. Action was taken at the time of the visit to address deficiencies in monitoring (and confirmed in place on unannounced visits),

Records

- We looked at two sets of patient records at Leicester General Hospital and they included the time and date of decision to admit to critical care.
- The critical care records were paper based and kept at each patient's bedside. These included a range of clinical assessments, records and care plans. For example; nutritional risk, falls assessment, capacity assessments, pain scores and various evidence based care bundles. A care bundle is a structured way of improving patient care and outcomes based on a number of evidence based steps. Staff were able to talk us through the paper work relating to their patient(s).
- Although entries in the records were usually legible, signed and dated, the author's name was not always printed alongside their signature.
- The nurse caring for each patient recorded physiological parameters on a large chart located by the patient's bed space. This brought together all the patient monitoring and observations onto one chart so that ventilator settings, fluid balance and physiological monitoring could all be reviewed in one place.

Safeguarding

- There were trust wide safeguarding policies and procedures in place, which were readily available on the trust's intranet site.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse and neglect.
- Safeguarding training formed part of the trust's mandatory training programme. A safeguarding assurance paper from May 2016 reported that the compliance with safeguarding training across the ITAPS clinical management group was 96.4% for adult safeguarding and 91.7% for children's safeguarding. Children were not cared for within the critical care unit but may on occasion visit patients.

Mandatory training

- A mandatory training record was held for all staff working on the critical care unit. Nursing staff within the unit were divided into teams and their team leader

encouraged them to keep up to date with their mandatory training programme. Individual nurses were contacted by email to remind them of mandatory training due dates.

- Mandatory training included moving and handling, infection prevention, fire safety, equality and diversity, information governance, conflict resolution and safeguarding adults and children.
- There was a unit-based, full time clinical nurse educator. The Intensive Care Society standards suggest that there should be one whole time equivalent clinical nurse educator for every 75 members of staff, responsible for coordinating the education, training and continuing professional development framework for critical care staff and pre-registration students. The practice based educator on the critical care unit at Leicester General Hospital did have some wider teaching responsibilities within the trust but did spend time on the unit supporting staff through their critical care competencies.
- We requested mandatory training rates for critical care services from the trust but did not receive these.

Assessing and responding to patient risk

- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- The hospital had introduced a range of initiatives to improve patient safety. These had been developed following a review of incidents and focused on five key areas of practice. These were known as the 'five critical safety actions'. They were; improving clinical handovers, acting upon results, attention to early warning systems (EWS) and triggers, senior clinical review and the Implementation and embedding of mortality and morbidity reviews.
- There was a critical care outreach service (CCOT) from 8am to 8pm, seven days a week provided by nurses with critical care experience who worked closely with the unit. The team worked closely with the nursing and medical teams in the intensive care unit and supported ward staff in the detection and management of critically

Critical care

ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area. The outreach nurses attended the handovers at each end of the day to keep appraised of patients on the unit who may be ready to step down to the ward. They were also able to contribute information about any deteriorating patients on the wards who may require critical care input or admission.

- The critical care outreach staff also formed part of the cardiac arrest response team when on duty and responded to cardiac arrest throughout the hospital. Out of hours the responsibility for monitoring deteriorating patients rested with the night nurse practitioners who received a handover from the CCOT at the beginning of their shift

Nursing staffing

- The matron for critical care at the Leicester General Hospital was also responsible for the unit at the Leicester Royal Infirmary. Staff told us that the time the matron spent on site at Leicester General Hospital varied week to week.
- The staffing establishment was calculated using the intensive care society guidance 'Levels of Critical Care for Adult patients'. This meant that one trained nurse would usually care for one or two level two patients, with level three patients being looked after on a one to one basis.
- At the time of inspection, there were adequate and appropriate numbers of nursing staff on duty to ensure that patients received safe care and treatment. There were registered nurses on duty plus a band 6 nurse in charge, who was supernumerary. In addition, there was a band 7 nurse working in the office on a management day, and two health care assistants. Included in the numbers were two nurses who had been brought from other areas within the trust. The staffing numbers had been increased to support the additional four beds in the annexe that were not being used on the day of inspection. As a consequence the unit had sent two trained nurses to assist in the critical care unit at Leicester Royal Infirmary.
- We spoke with every nurse on duty and were told that it was commonplace for the supernumerary shift to be lost as that person often had to take a patient.

- The nursing establishment was divided into teams, usually led by a band 6/7 and would comprise a mix of band 5 and 6 nurses plus health care assistants. Staff reported that they felt supported by the team framework.
- It was a common occurrence for nurses to move across all three trusts critical care units, working flexibly to cover staff shortfalls.
- Recruitment and retention was an issue and the trust was currently revising and reviewing its recruitment processes. There had in the past been a recruitment drive for international nurses for critical care, which staff told us had been successful.
- The unit used electronic nurse rostering and also used a 'closed' Facebook page for staff where they could negotiate shift changes or swaps. We were told this worked well. There was internal rotation of nurses between days and nights and the day shift was 07.30am until 8pm.
- Very little agency staff were used and when they were it tended to be agency nursing staff that had been to the unit before and whose competencies were understood.
- There was a handover at the end of each shift which involved all the incoming nursing team. At this handover, we were told that important messages were shared such as incidents and changes to practice. After the general group handover, a patient specific bedside handover took place between the relevant outgoing and incoming nursing staff. Medical staff were involved in their own separate shift handover.
- Alongside the performance metrics there was also an up to date display of the planned versus actual staffing numbers on duty. On the day of the inspection the actual numbers matched the planned numbers of staff on duty.

Medical staffing

- ITAPS had a designated clinical director and the critical care unit at Leicester General Hospital also had a designated consultant clinical lead and a deputy clinical lead.
- We were told that there was currently one consultant vacancy, which meant that the on call rota for general critical care was one in eight.
- There were two consultant intensivists on duty from 8am with the rotas running from Monday through to Thursday afternoon and then from Thursday afternoon

Critical care

until Monday evening. This provided continuity of care and decision making. Support was provided by registrar and airway trained middle grade medical staff throughout the day and night.

- When assigned to critical care, consultants had no other clinical responsibilities within the hospital.
- A structured medical handover took place at the beginning of each shift, this usually included attendance by a member of the outreach team.

Major incident awareness and training

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

Are critical care services effective?

Good



We rated the effectiveness of critical care services at Leicester General Hospital as good.

We found:

- We saw that evidence based best practice guidance was being used to determine care.
- Pain was being managed in accordance with UK pain management core standards.
- Nursing band 6 clinical skills supervisors provided support to nursing staff in the clinical setting.
- The unit was providing an opportunity for band 3 health care assistants to develop by enabling them to undertake additional training and expand their critical care competencies.

However, we also found:

- The trust was not compliant with all aspects of NICE guidance 83 'Rehabilitation after Critical Illness'.
- The percentage of trained nurses who had undertaken a post registration qualification in critical care was around 30%. This did not meet guidelines for the Provision of Intensive Care Services (GPICS) standard which states a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing.

Evidence-based care and treatment

- The critical care service used a combination of national and best practice guidance to determine the care they delivered. This included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE) and the Intensive Care National Audit and Research Centre (ICNARC).
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance, these were easily accessible via the trust-wide intranet.
- The unit was not compliant with all aspects of NICE guidance 83, 'Rehabilitation after Critical Illness'.
- The trust audit against D16 service specifications for adult critical care reported in 2014 that none of the trust's three critical care units were compliant with this standard that states 'each patient must have an assessment of their rehabilitation needs within 24 hours of admission to critical care and all NICE 83 eligible patients must have a rehabilitation prescription on discharge from critical care.' The actions stated in the review document were to establish a service level agreement for allied health professionals. It is not known if the required service level agreement has yet been implemented.
- There was a delirium policy and there were posters displayed on the corridor noticeboard which clearly highlighted the factors associated with delirium in a critical care setting.

Pain relief

- In accordance with the Core Standards for Pain Management Services in the UK (2015), acute pain management was supervised by consultants and specialist nurses with the appropriate training and competencies.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain

Critical care

management. This included observing for the signs and symptoms of pain. Staff also used a paper based pain scoring tool, this was complete in the two sets of patient notes that we examined.

- The pain management team gave support and advice to staff and patients in critical care in relation to the management complex pain as well as the management of epidurals and patient controlled analgesia (PCA).
- The pain management team was represented at critical care team meetings.

Nutrition and hydration

- Dietetic input and advice was available although the dieticians did not always attend the multi-disciplinary ward round.
- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- All patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using the Malnutrition Universal Screening Tool (MUST).
- Nutritional risk scores were updated and recorded appropriately in the patient notes we reviewed.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.

Patient outcomes

- The critical care unit submitted continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant that the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- For the period April 2015 to December 2015, ICNARC data for the critical care unit at Leicester General Hospital showed a risk adjusted acute hospital mortality of 0.7, which was lower than expected when compared with similar units.
- For the period July to December 2015, ICNARC data showed that 67% of admissions were as a result of planned surgery with the majority being level 2 patients for at least for the first 24 hours of their stay.
- For ventilated admissions, the average length of stay was less around five days and the incidence of unit-acquired infections in blood was zero.
- For patients admitted with severe sepsis the length of stay was shorter than similar units at around five days.

- For admissions for patients with pneumonia there had been an increase in both unit and hospital mortality figures in quarter one of 2015. However for the period July to December 2015 both unit and in hospital mortality had reduced to be in line with similar units.
- For elective surgical admissions, the average length of stay was two days, which was comparable with similar units and the incidence of unit acquired infections in blood was zero.
- For emergency surgical admissions the unit, and in hospital mortality rates were lower than similar units and the average length of stay at four days was comparable with similar units. For admissions with trauma, perforation or rupture the average length of stay was better than similar units.
- The latest ICNARC data also showed that for early, late readmissions and post-unit discharge deaths the unit was performing better than similar units. Early readmissions are classified as patients that are subsequently readmitted to the critical care unit within 48 hours of their discharge. Post unit deaths are classified as patients that die before ultimate hospitals discharge.
- There were regular service reviews of the effectiveness of care and treatment through a process of local audit.
- Sedation breaks were used where appropriate. A sedation break is where the patient's sedation is stopped to allow them to wake, this has been shown to reduce mortality and the risk of developing ventilator related complications. The sedation is then re-started if the patient becomes agitated, is in pain or in respiratory distress.

Competent staff

- Competency records showed that staff were appropriately trained, competent and familiar with the use of critical care equipment.
- Staff new to the unit undertook a supernumerary period before they were included in the staffing numbers. The length of this period varied according to prior experience of critical care. New staff also started to work through their competencies, again the length of time taken to progress this varied according to experience.
- The critical care unit at the Leicester General Hospital had input from a practice-based educator who also had teaching responsibilities in the wider trust.

Critical care

- The band 6 nurses all had additional responsibilities as clinical skills supervisors. This gave them a formal educational role within the team for seven hours each week, where they each led on a specific area.
- The critical care unit had a band 3 health care assistant, who had been able to develop professionally by taking a diploma and had demonstrated critical care competencies. This enabled them to look after uncomplicated level 2 patients and carry out all care aside from the administration of medicines. They were always supported by an experienced nurse.
- The percentage of trained nurses who had undertaken a post registration qualification in critical care was around 30%. This did not meet guidelines for the Provision of Intensive Care Services (GPICS) standard which states a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing. There were plans for additional staff to undertake this specific training during the next intake. The department had doubled the number of staff supported in undertaking the critical care modules this year in order to meet the standard outlined. Going forward this number of nurses needed to support will be reviewed each intake to sustain the 50%. This needed to be balanced against funding and ability to support study leave. Critical care delivered an in house training program for staff to ensure staff are developed and competent.
- The staff involved in the recent never event had been subject to a review and refresh of their medicines management competencies.
- When agency nurses were used, the unit tried to obtain nurses who had regularly worked on the unit to provide some consistency. Agency staff new to the unit went through an induction and had their competencies assessed before they worked unsupervised.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC).
- At the time of the inspection, 98% of nursing staff had received their annual appraisal.
- The care and treatment of the patients on the unit was intensivist led but multi-disciplinary in its approach to care. There was effective communication between the nursing staff, parent teams and the intensivists. The parent team are the medical staff of the speciality under which the patient was originally admitted. For example, surgery or medicine.
- Our observations showed that medical and nursing staff worked together as a team for the benefit of patients. We saw minutes of the multi-disciplinary meetings that were held regularly.
- There was an critical care outreach team available on site 8am to 8pm, seven days a week. They liaised closely with the critical care team in respect of patients due for potential step down as well as deteriorating patients on the wards.

Seven-day services

- A consultant intensivist was available seven days a week, 24 hours a day.
- All patients were reviewed by a consultant at least twice daily.
- All admissions were seen by a consultant within 12 hours of their admission.
- The physiotherapy team provided a seven day service to the critical care unit during the day, with an on call service out of hours.
- Dietetic, pain management, speech and language therapy, and pharmacy services were available Monday to Friday, 9am to 5pm and an on-call service was provided out of hours and at weekends.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend. Staff did not highlight any problems accessing services out of hours.

Access to information

- Critical care notes were kept in a file by the patient's bedside.
- All the patient's physiological parameters, assessments, fluid balance and ventilator settings were recorded on a large critical care observation chart situated by the bedside.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to

Multidisciplinary working

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

Critical care

deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information.

- The unit had a white board display which gave an overview of the current activity in the critical care unit. It showed the individual bed spaces and the acuity of the patients therein as well as the overall unit acuity or dependency. It also displayed staffing numbers per shift along with anticipated admissions and discharges or step-downs.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated an understanding of the issues around consent, mental capacity and deprivation of liberty standards.
- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient. The CAM-ICU (Confusion Assessment Method) is a tool widely used by non-psychiatric clinicians for diagnosing delirium. Care plans stated that the CAM-ICU should be completed twice every shift. The two patient records we looked at showed that this was carried out twice daily. The rationale being that delirium prolongs critical care and has long-term consequences. Early detection meant earlier treatment. The CAM-ICU uses yes/no questions for use with non-speaking mechanically ventilated patients.

Are critical care services caring?

Good



We rated critical care services as good for caring.

We found:

- Critical care staff were caring, compassionate and committed.
- We saw patients, their relatives and friends being treated with dignity and respect. Staff communicated well patients and their families so that they understood their care and treatment.

- Staff understood the social and emotional impact of critical care on people.
- Care was person-centred and patients were treated as individuals.

Compassionate care

- Staff took the time to interact with patients and their relatives, in a respectful and considerate manner.
- Staff communicated with patients and those close to them so that, where possible, they understood their care and treatment.
- Staff were encouraging, sensitive and supportive in their attitudes.
- Patient's privacy and dignity was maintained during episodes of physical or personal care. Privacy curtains were drawn around people with relevant explanations given prior to care being delivered.
- Friends and family test results were displayed on the noticeboard at the entrance to the unit and reported 100% satisfaction.
- We saw the results of a 'You said. We did' satisfaction survey. In response to feedback that the unit was noisy at night, staff reduced the volume of equipment alarms, introduced quietly closing bins and offered the use of earplugs to patients as appropriate.

Understanding and involvement of patients and those close to them

- Without exception, relatives were spoke with were positive and praising of the nursing and medical staff on the critical care unit. They told us they had been kept informed of everything that was going on with their relative.
- Initial and on-going face-to-face meetings were undertaken by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- Some critical care units in the trust used patient diaries however; they were not in use at the Leicester General Hospital so there was inconsistency in practice. Research has shown that patient diaries often help the individual better understand and make sense of their time in critical care and help to prevent anxiety, depression and post-traumatic stress.

Critical care

- There was a senior nurse for organ donation in post who worked closely with the critical care unit staff in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families.
- Bereavement services were offered to families and they were invited back to the hospital for a 'day to remember' event. This was an opportunity for bereaved families to talk to other families and relatives. They released memorial balloons and had an opportunity to revisit the critical care unit should they wish to.

Are critical care services responsive?

Good



We rated the responsiveness of critical care services at Leicester General Hospital as good

We found:

- All patients were admitted to critical care unit within a four time frame of the decision to admit.
- Care plans demonstrated that patient's individual needs were taken into consideration when planning and delivering care and treatment.
- There had been no formal complaints raised about the critical care service at Leicester General Hospital between March 2015 and March 2016.
- The unit had facilities to accommodate patients' relatives and friends.

However, we also found;

- The critical care outreach team (CCOT) was not provided 24 hours a day, seven days a week.
- There were no formal follow up clinics held at present for discharged patients.

Service planning and delivery to meet the needs of local people

- The future plans for critical care services at Leicester General Hospital were set out in detailed business plans, which were tied into the reconfiguration of services across the trust. Should the plan be implemented this

would lead to a decrease in the critical care capacity on the Leicester General Hospital site. However, the reconfiguration plans were currently on hold due to a lack of available capital funds.

- Trust wide bed management meetings were held throughout the day to monitor and review the flow of patients through the three hospital sites and the availability of critical care beds.
- There were facilities for relatives to wait or stay on the unit if they wanted to. The facilities included a 'quiet room' where private discussions took place between the critical care staff and patient's friends and family. Food and drink facilities were also available for relatives.
- There was a nurse led critical care outreach service. This was provided from 8am to 8pm at Leicester General Hospital. The team comprised experienced critical care nurses.
- There were no formal follow up clinics held at present for discharged patients. The aims of a follow up clinic are to provide support and guidance for those patients who have usually had an extended stay in critical care. This was included on the trust risk register.

Meeting people's individual needs

- Care plans demonstrated that patient's individual needs were taken into consideration when planning and delivering care and treatment. For example, considering the diverse local population, there was a need to reflect the differing cultural and religious needs of patients.
- Each of the bed spaces had a white board at the head of the bed which displayed a welcome message and personal information about the patient including their name' and the name they (the patient) wished to be called by' and their preferences. In addition, there was a laminated bed book to provide information about the unit to the patient.
- Interpreting services were available within the hospital if required. There was a range of patient information leaflets explaining aspects of critical care.
- Staff knew how to access copies in an accessible format for patients living with dementia or learning disabilities and in braille for patients and relatives who had a visual impairment. The leaflets were also available in a range of languages.

Access and flow

Critical care

- In 2015 there were 837 admissions to the critical care unit at Leicester General Hospital. The largest percentage of admissions comprised patients whose admission was planned following elective or scheduled surgery (67%).
- The critical care unit collected data locally about bed occupancy and patient flow and also contributed data to the intensive care national audit and research centre (ICNARC). ICNARC publishes a validated quarterly report where the unit at Leicester General Hospital was compared with similar units nationally.
- Bed occupancy varied between a high of 114% in July 2015 through to 77% occupancy in March 2015. Bed occupancy in excess of 100% is recorded where a bed is vacated and then occupied by a second patient on the same day.
- Patients should be admitted to critical care within four hours of the decision to admit. In 2014, the critical care service undertook a benchmarking audit against the key standards in the D16 national service specification for adult critical care. This showed that 100% of patients were admitted to the unit within 4 hours of the decision being made to admit. The audit also showed that 100% of patients received a medical review within 12 hours of that admission by a consultant qualified in intensive care medicine.
- Daily conversations about bed availability in critical care were held as this impacted on the cancellation of electives surgical cases. We saw that both medical and nursing staff were constantly responding to phone calls asking for updates from bed managers, ward and surgical teams about the critical care bed status. This took up considerable amounts of the supernumerary nurses' time during their shift.
- ICNARC data for April 2015 to December 2015 shows that 3% of patients experienced a delay to their discharge of more than eight hours.
- Of the 837 admissions, data from the trust showed that 44 (5.3%) experienced a delay in their discharge greater than 24 hours.
- Data provided by the trust for 2015 also showed that there were 46 cancelled electives for the period.
- ICNARC data for the reporting period April 2015 to December 2015 showed seven patients (1.3%) experienced a discharge out of hours. This was worse than the national average of similar units (1.1%) but better than all units (2.3%).

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

Learning from complaints and concerns

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

Are critical care services well-led?

Good



We rated the leadership of critical care services at Leicester General Hospital as good.

We found:

- There was a vision and strategy for the reconfiguration of critical care service at Leicester General Hospital despite the current hold on progress being made as a consequence of financial pressures.
- There was an effective governance structure in place which ensured that risks were captured and discussed.
- There was strong clinical and managerial leadership at management group level.
- The critical care service engaged with its staff and patients to inform the improvement and development of its delivery.

However, we also found:

Critical care

- Plans for reconfiguring and developing the capacity of the critical care service were on hold as a consequence of financial pressures being felt across the NHS.
- There was no full time on site presence of a nurse matron. The matron's role is to focus on the provision of high quality, visible, professional leadership. The matron should have a clear role in setting and maintaining standards and improving outcomes.

Vision and strategy for this service

- In 2014, the trust published a five year business plan, which set out the trust's vision. This vision was underpinned by a set of corresponding values, which were designed to encapsulate the behaviours and actions that the trust as a whole and each member of staff needed to embrace to make the vision a reality.
- The trust had commissioned an external review of its critical care service which reported the trust was under resourced for both level 2 and level 3 beds. The trust's five year plan (2016 – 2021) would see the expansion of critical care services at both the Leicester Royal Hospital and Glenfield Hospital sites with an associated reduction in the critical care service at Leicester General Hospital.
- The expansion of critical care service at Leicester Royal Infirmary and Glenfield Hospital alongside rationalisation of the critical care beds on the Leicester General Hospital site was tied in with a reconfiguration of services. This was described as having the following benefits; 'maximises clinical safety and quality and minimises risk' over all increases level 2 and level 3 capacity in the trust and consequently reduces the cancellation of elective surgical cases, eases staffing and recruitment pressures and improves the patient journey and experience.

Governance, risk management and quality measurement

- Critical care services was provided at this hospital as part of the intensive care, theatres, anaesthesia, pain and sleep (ITAPS) clinical management group (CMG).
- There was an effective governance structure in place which ensured that risks to the service were captured and discussed. The governance framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and raising concerns to the trust board.

- Critical care had six identified risks recorded on their risk register dated 31 March 2016. Four of the risks related to the critical care units at all three sites and related to bed capacity, lack of clinical support services, recruitment to consultant vacancies and access and flow. For each risk on the register there were details of the issues alongside existing controls to mitigate the risk. Each risk had an action plan and a date for review.
- A range of governance meetings were held regularly, including mortality and morbidity meetings, staff meetings for all grades and ITAPS quality and safety board meetings. We looked at minutes of the mortality and morbidity meetings from December 2015, January 2016 and February 2016 and saw that each patient death was reviewed and learning points were noted and shared with relevant teams. The meetings were multidisciplinary in attendance.
- Staff understood and acknowledged the access and flow pressures in critical care. Senior staff worked daily in collaboration with peers across the hospital and the wider trust to monitor, anticipate and try to alleviate the associated patient flow pressures throughout the critical care units.
- The critical care unit was a member of the Central England Critical Care Network. We did not see a copy of any network review of the critical care service but we did see the results of a benchmarking exercise, where the unit was measured against the D16 Service Specification for Adult Critical care. The copy of the review we saw was not dated and showed varying levels of compliance across the standards. The main shortfalls were reported as being; the lack of a full time nurse educator for the unit, lack of a rehabilitation prescription in accordance with NICE clinical guidance 83 and the absence of any critical care follow up service post discharge.
- Staff sickness and absence rates were closely monitored alongside the management of competency and capability. The sickness rate was 3.6% against the trust's target of 3%.

Leadership of service

- The critical care unit had a designated consultant clinical lead. The nurse matron was shared with the critical care unit at Leicester Royal Infirmary.
- The critical care unit was led and staffed by a team of experienced nurses.

Critical care

- There was a clear and strong leadership at management group level with staff who had the skills, integrity, capacity and capability to lead the service effectively. Senior staff were visible in the critical care unit, leading and supporting their teams.

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care. Staff told us the unit was busy and there were occasions when staff had to support other units, however staff were proud to work in the critical care service.
- Staff were encouraged to report incidents and raise concerns.
- Staff told us how supported they felt by the team approach to managing the critical care unit.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- We spoke with all the staff on duty during the day of the inspection who told us there was uncertainty about the future of the critical care service at Leicester General Hospital.
- Staff understood the implications of duty of candour and we were given examples of where shortfalls in patient experience or care had been shared with relatives in accordance with duty of candour principles.

Public engagement

- The trust website included details about the critical care service at Leicester General Hospital.
- The trust produced a range of printed and electronic publications for the population it served. These 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, 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 taken to avoid cancelling operations. The forum was advertised in the trust magazine 'Together'.

- The critical care service had adopted the use of 'Patient Partners'. Patient partners are members of the public who could provide patients' or 'lay' perspective on the experience of being cared for at the trust. Patient partners are encouraged to get involved in a wide range of issues, for example in changes to services and advising on new developments and reviewing patient information leaflets.







Staff engagement

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

Innovation, improvement and sustainability

- Staff expressed concerns about the uncertainty of the future for critical care at Leicester General Hospital. Proposed future plans indicated that the on-going provision at Leicester General Hospital would be predominantly a level two facility with the ability to care for a level three patients for short term stabilisation. This would enable safe transfer to either Leicester Royal infirmary or Glenfield Hospital, depending upon their clinical needs. Much of the uncertainty was due to whether the changes would now take place in the light of the current financial constraints.

Maternity and gynaecology

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

Information about the service

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

At the LGH 4492 babies were born between June 2015 and May 2016.

The services available to women include home birth, a four bed midwifery led unit (MLU), an eight roomed consultant-led delivery suite which also includes seven beds including two for enhanced care, one bereavement delivery room and a four bedded observation bay. Antenatal clinics including ultrasound scanning, a midwifery assessment unit and triage (MAU), and one mixed antenatal and postnatal inpatient ward (ward 30) make up the remainder of the service at this hospital. Specialist midwives are available to support the women and midwives.

Community midwives (CMW) are employed by UHL maternity services. They provide a home birth service for women who are assessed to be low risk. Ten CMW teams

working in partnership with general practitioners (GP), health visitors (HV) and children's centres all promote healthy lifestyle choices during the woman's pregnancy and following the baby's birth.

The gynaecology service at LGH provides an elective gynaecology service. There is a surgical admissions and day-case unit (ward 11) and an inpatient ward (ward 31). There is gynaecology services unit (GSU) which included the gynaecology outpatients clinic and pre-assessment. The trust offers a termination of pregnancy service at LGH which includes medical and surgical procedures. Surgical terminations are carried out within the main surgery theatres. All emergency gynaecology care is provided at the LRI.

We used a variety of methods to help us gather evidence in order to assess and judge the provision of maternity and gynaecology services at the Leicester General Hospital. Prior to the inspection we held focus groups for all staff groups and we gave women and visitors an opportunity to comment on the services. During the inspection we visited all the wards and departments relevant to the service and interviewed the service leads. We spoke with 11 women, and 40 members of staff individually with an additional three staff in focus groups including registered midwives and nurses, midwife support workers, health care assistants, junior and senior doctors and housekeepers. We observed interactions between women, their relatives and staff, considered the environment and looked at 19 sets of medical and nursing records. Before our inspection we reviewed performance information from and about the hospital and the service.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology at Leicester General Hospital as requires improvement overall.

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

- There were insufficient medical and nursing staff to ensure safe care and treatment. Midwifery staffing levels did not always meet minimum acceptable numbers for the unit and one-to-one care in labour was not always achieved. Women told us that lack of staff on delivery suite meant care did not meet their expectations. Consultant obstetric cover on the delivery suite did not meet current recommendations and there was a lack of junior doctors to cover the service out of hours.
- The service had been an outlier for puerperal sepsis since 2013 and had recorded increasing rates of puerperal sepsis, wound infection and pyrexia of unknown origin.
- Significant and ongoing typing backlogs in the gynaecology administration department could pose a risk to women's safety.
- We were not assured that the grading of serious incidents was always appropriate.
- Women were at risk of not always receiving effective care and treatment as some midwifery staff did not have the competencies required when caring for women following anaesthesia or when acting as theatre instrument practitioners.
- The leadership, governance and culture in maternity and gynaecology did not always support the delivery of high quality person-centred care. Departmental governance and risk management arrangements were not robust and led to poor oversight of some outcomes.

However;

- The majority of women, their partners and relatives were positive about the care they had received. Most of the women we spoke with told us staff were kind

and caring and that they were treated with dignity and respect and were happy with the emotional support they received. Staff involved women in their care and treatment.

- The number of babies born in the midwifery-led birth centres was one of the highest nationally and the rates of normal birth and instrumental delivery were better than the national average.
- There was effective multi-disciplinary working across maternity and gynaecology.
- Staff effectively supported women with complex needs and in vulnerable circumstances and provided an extensive range of specialist maternity and gynaecology services, including a specialist bereavement service.
- We saw and women told us their pain symptoms were well managed.
- Staff supported women to breastfeed in line with UNICEF Baby Friendly accreditation.
- There was a robust system for monitoring, processing and learning from complaints.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



We rated Leicester General Hospital Maternity and Gynaecology services safety as requires improvement because women were not always protected from avoidable harm.

We found:

- We were not assured that the grading of serious incidents was always appropriate.
- The service had been an outlier for puerperal sepsis since 2013 and had recorded increasing rates of puerperal sepsis, wound infection and pyrexia of unknown origin. Whilst some of the rates had been attributed to coding errors, we were not assured that steps had been taken to rectify these errors or that all of the infections had been thoroughly audited.
- We were not assured that staff followed the trust safeguarding processes and pathways on gynaecology ward 11. We saw an example of where ward staff had not addressed a significant safeguarding concern and could not fully explain the correct pathways and processes.
- Midwifery staffing levels did not always meet minimum acceptable numbers for the unit, and one-to-one care in labour was not always achieved. Women raised concerns about lack of staffing on delivery suite.
- Consultant obstetric cover in the delivery suite was 72 hours per week.
- There was a lack of junior doctors to cover the service. The service had tried to mitigate the risks and were actively recruiting, but there were gaps in the medical staffing rota. This could lead to delays for women waiting to be reviewed in all areas which could pose a risk to women's safety
- Most staff were unaware of their responsibilities in relation to the trust's missing baby and major incident policy.

However, we also found:

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

- The environment was visibly clean and staff generally followed good infection control principles.
- Medicines were generally stored appropriately in all areas.
- Emergency equipment was regularly checked and ready for immediate use.

Incidents

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Leicester General Hospital (LGH) reported two serious incidents in 2015 to the NHS strategic executive information system (STEIS) for the maternity service. There was one incident reported for the gynecology service. None of the serious incidents were classified as Never Events. (Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers). Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Following these serious incidents, we saw where root cause analysis investigations had taken place. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We requested the serious investigation reports for one of these incidents and saw there had been full investigations. This included input from a multi-disciplinary team including a consultant anaesthetist, consultant obstetrician, midwifery matron, clinical risk and quality co-coordinator, supervisor of midwives and maternity clinical educator. Learning from the incident was recorded along with agreed actions. This included the development of an escalation pathway for nursing and junior medical staff and a requirement for junior medical staff to escalate concerns if the surgical recovery pathway was not as expected. We saw that learning from incidents was shared trust wide for example we saw feedback from an incident at the Leicester Royal Infirmary was shared with staff at the LGH.
- Data provided by the trust for the period March 2015 to March 2016 showed there were 969 maternity incidents reported that were specifically for LGH, and 10 incidents related to both LGH and Leicester Royal Infirmary (LRI).

Maternity and gynaecology

In the same period there were 337 gynaecology incidents that related specifically to LGH and two incidents related to both LGH and LRI. For maternity, there were 714 incidents that resulted in no harm (73%), 211 in minor harm (21%), 52 in moderate harm (5%) and two resulted in major harm (less than 1%). For gynaecology there were 291 no harm incidents (86%), 44 minor (13%), five moderate (less than 1%) and one incident resulting in a death. At the time of our inspection across both sites there were 106 maternity and 37 gynaecology open incidents, the oldest from April 2016. This gave assurance that staff recognised the importance of incident reporting, and incidents were dealt with in a timely manner.

- Data from reported incidents were co-ordinated by the patient safety team for maternity and gynaecology as part of the corporate risk team. The team tracked overdue incident investigations or actions. We reviewed copies of emails from the clinical risk manager to the head of midwifery to ensure actions were taken in a timely manner. Staff were able to tell of learning from incident investigations. For example, there had been cases of pressure ulcers developing on women's backs due to the use of fetal monitoring straps and in the sacral area due to sitting on damp incontinence style pads. This had led to review of the straps and use of pads and pressure area assessments and we saw that staff were attending learning sessions with the tissue viability nurses.
- Specific cases and incidents were discussed at the gynaecology or perinatal risk management meetings. We reviewed three sets of minutes from the trust-wide perinatal risk management group where there was multidisciplinary staff in attendance. Cases were discussed and learning actions agreed. However, following discussions some incidents were re-graded, we were not assured that the downgrading of some incidents was appropriate. For example, a woman had significant bleeding during birth which was classified as a poor outcome and poor management; this had been downgraded to a minor incident. Another example was an incident where a woman had a serious, life changing complication post procedure, it was classified as a poor outcome managed appropriately, and this also was downgraded to a minor incident.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good understanding of the term and their responsibilities under the duty of candour. We reviewed the April 2016 minutes of the trust wide gynaecology risk group meeting of and saw evidence that a duty of candour letter had been sent following an incident investigation.

Safety thermometer

- Maternity and gynaecology services at LGH took part in the national safety thermometer scheme. Data was collected on an identified day each month to indicate performance in key safety issues. This included four key areas, pressure ulcers, falls, urinary catheter related infections and blood clots. We looked at safety thermometer results from April 2015 to March 2016, which included data for the maternity inpatient ward 30 and the gynaecology elective surgical ward 31. During this reporting period, ward 30 provided 99% harm free care and ward 31 provided 100% harm free care.
- We saw safety thermometer data was displayed on the maternity wards.
- The service did not take part in the national maternity safety thermometer scheme. The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. Data was collected on a single day each month to indicate performance in key safety areas. The maternity safety thermometer measures harm from perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. This meant their harm free care rates were not monitored.

Cleanliness, infection control and hygiene

- The majority of areas we visited were visibly clean and staff demonstrated a good understanding of infection prevention and control. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately.
- Staff wore visibly clean uniforms and observed the trust's policy of being bare below the elbow. Women we spoke with were happy with the cleanliness of the environment.
- We saw bed space cleaning checklists, which were stored in women's medical records.

Maternity and gynaecology

- Equipment had 'I am clean' stickers on them, which were easily visible and documented the last date and time they had been cleaned. The meant equipment was ready for use.
- We saw a 'you said – we did' board on the maternity ward 30 for women's suggestions and concerns. One concern raised on the board was cleanliness of the ward. An item had been included on the risk register regarding the ward 30 due to the presence of mould in side rooms. The ward manager told us she had worked with the housekeepers to improve the cleanliness. We observed these rooms were being renovated, the mould had been removed and the ward appeared visibly clean and uncluttered.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.
- The latest CQC intelligent monitoring report (May 2015) recorded one maternity outlier for this trust: puerperal (infection following childbirth or miscarriage) sepsis and other puerperal infections. Maternity outliers are where the trust performs worse than the national average. The trust provided us with a copy of their action plan which commenced in October 2013 and a copy of the trust wide directorate quality dashboard from June 2015 to May 2016, which included data on puerperal sepsis. We requested that the data be split into the two separate locations but the trust were unable to do so.
- During this reporting period there were 49 cases of puerperal sepsis (a 12% increase from the previous year), 216 cases of wound infection (about the same as the previous year) and 597 cases of pyrexia of unknown origin (an increase of 5% from previous year). Pyrexia of unknown origin is defined as a persistent temperature of more than 38°C for more than 24 hours. The trust had not set targets rates for these outcomes and they were not RAG (red, amber, green) rated which is considered good practice (RCOG, 2008). This meant the trust would not be alerted to an increase in cases.
- We discussed these results with the service leads. Service leads acknowledged there had been no investigation into wound infection rates. We were told that incorrect coding was the reason for the puerperal sepsis cases, although high numbers of cases were still being recorded on the dashboard. The trust performed an audit presented on 3 June 2016 of 54 cases, which had been coded as pyrexia of unknown origin for cases in July 2015 and found 14 of the 54 cases would meet the criteria for this coding. We could not be assured that the service were auditing and responding to women's outcomes appropriately.
- Compliance with hand hygiene was audited. We looked at the audit results for wards 11, 30 and 31. The audit looked at the five moments for hand hygiene. The five moments for hand hygiene focuses on five moments when hand hygiene should take place, these are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings. An audit took place in November 2015 and the trust target compliance rate was above 90%. Four members of staff were observed on ward 11, seven staff on ward 30 and eight on ward 31. Some of the moments of care were not observed on each ward. The audit showed that compliance with the five moments of hand hygiene was inconsistent.
- An action plan had been created to improve hand hygiene compliance. Subsequent audits in June 2016 showed continued poor compliance with hand hygiene practices.
- The trust reported no cases of Meticillin Resistant Staphylococcus Aureus (MRSA) for maternity and gynaecology services for the reporting period March 2015 to April 2016. MRSA is a bacterium responsible for several difficult-to-treat infections.
- Staff accessed mandatory infection prevention training through an e-learning package. Average compliance for medical and nursing staff for maternity and gynaecology was 91% against a trust target of 95%.
- Cleaning audit data was displayed on the wards that we visited. The trust target was to achieve 90% or above in the audits. Data displayed on the maternity inpatient ward 30 showed results of cleaning audits were consistently above 90%.
- The trust had collated "share your experience" patient surveys from September 2015 to February 2016. The average score for cleanliness on the delivery suite across both sites was 95 against a possible score of 100. On the maternity postnatal wards this figure was 85.

Environment and equipment

- Most staff told us that adequate equipment was available to run the service safely. We reviewed a

Maternity and gynaecology

sample of equipment on delivery suite, the maternity inpatient ward and the gynaecology assessment unit and found equipment had been serviced and safety tested.

- We looked at Cardiotocography equipment (CTG) on the delivery suite. CTG equipment can be used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked had been checked and labelled when the date of the next maintenance check was due. We saw that pinard stethoscopes were readily available and midwives told us they used them. (A pinard stethoscope is a cone shaped tool that midwives use to manually listen to the heartbeat of a baby during pregnancy). There was a pinard stethoscope on each of the CTG machines we looked at in accordance with National Institute for Health and Care Excellence (NICE) guidance.
- Staff checked the adult resuscitation trolleys and baby resuscitaires daily (a resuscitaire is a warming platform used to assist in the resuscitation of new-born babies). We observed that the checklists were completed, dated and signed on the majority of days and the majority of equipment and consumables stored on them were sterile and within the expiry date. This meant safety equipment was available in the event of an emergency. However, we found the laryngoscopes (used for checking babies airways were clear) ready for use on the baby resuscitaires had blades attached and unwrapped. This meant that there was no assurance they were clean and might pose an infection risk to babies.
- The two bed high dependency area on the delivery suite had limited space and was cluttered which may impede staff in an emergency.
- Each pool room in the birthing centre had pool evacuation net for water birth. Training for pool evacuation had been given to staff supporting women having a pool birth during the mandatory skills drills day (MOT).
- Specialist equipment was available for women with a high body mass index (BMI). This included slings, beds and larger chairs. We were told that specialist equipment was identified for gynaecology women during pre-assessment checks for elective surgery. This meant that equipment was ready on the ward when they were admitted.
- In order to maintain the security of women and babies, doors to maternity inpatient wards and delivery suite areas were locked and visitors were required to use a

CCTV buzzer system to gain entry. Staff used specific key codes to enter areas they were authorised to enter. Babies had electronic tags which set off an alarm if the baby was removed from the ward, providing an additional safety measure.

Medicines

- Medicines were managed, stored and administered appropriately. We checked drug cupboards and ward trolleys and found them to be locked and secure. Intravenous fluids were stored in locked rooms in all areas this minimised the risk of them being tampered with. The temperature of fridges used to store medicines was regularly checked. This meant staff could be assured that medicines were being stored at the correct temperature. A medicines storage audit was undertaken by the trust's pharmacy staff in June 2016 and the maternity and gynaecology areas were found to be generally compliant.
- Controlled drugs (CDs) were stored appropriately in all of the clinical areas we inspected. (CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register). A controlled drugs audit was undertaken by the trust's pharmacy staff in March 2016 and included the gynaecology wards 11 and 31 and the maternity inpatient ward 30, which were generally compliant.
- The hospital used paper prescription and medication administration record charts for women. We looked at 11 prescription charts. The records were clear and fully completed. The records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. These meant women were receiving their medicines as prescribed.
- If women were allergic to any medicines this was recorded on their prescription chart.
- Staff were able to refer to their medicines policy, the up to date British National Formulary (BNF) or ask for pharmacy support if necessary.

Records

- Women's care records were in paper format. Staff stored medical records securely in restricted areas or in lockable trolleys in clinical areas in line with data protection policies.

Maternity and gynaecology

- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. The hospital also held medical records relating to each woman.
 - Child health records known as 'red books' were given to mothers for each new born baby following the completion of new-born and infant physical examinations.
 - A review of the minutes of the directorate specialist areas nursing and midwifery board minutes highlighted a common theme for incidents with documentation was the unavailability of notes for theatre lists. Although the trust produced monthly reports to show notes that were produced late (i.e. after the required date and time) the data was not split specifically for obstetrics and gynaecology.
 - The combined antenatal and intrapartum hand held records included a page for the recording of antenatal screening tests offered, accepted or declined, the date of the screening test and any results. The records we reviewed were completed in full, dated, timed, with a signature and identifiable name.
 - The trust undertook a comprehensive trust wide documentation audit of 212 maternity records in April 2014 against 67 standards. There were mixed results and areas for improvement included; completion of choice and domestic violence section, filing of test results, legible writing in notes, drug charts and surgery details, completion of the women's record of labour and perineal repair page, use of abbreviations and alterations and use of the SBAR (situation, background, assessment, recommendation) to handover information. Since this audit was conducted, the trust had changed the format of the notes used in labour and were in the process of repeating the audit. However, we found the writing in some notes was illegible, particularly that of medical staff.
- in 2015. Service leads had recognised maternity specialist safeguarding midwife capacity was not sufficient to provide the frequency of supervision required for clinical staff and level three training hours. To meet the increased demands the trust had recruited an additional band seven specialist safeguarding midwife who was due to start following our inspection.
- We reviewed a set of patient records on the gynaecology admissions and day-case unit (ward 11); and saw safeguarding and domestic violence concerns had been highlighted by a general practitioner (GP) in the referral letter. These concerns had not been addressed by ward staff and it was unclear if any safeguarding referral had been made by the GP or the trust. Senior staff were unable to clearly explain the correct processes and pathways for safeguarding concerns. We did not have assurance that staff were following the trust processes and pathways in relation to safeguarding. We escalated our concerns immediately to the director responsible for safeguarding.
 - There were named leads for maternity safeguarding and adult safeguarding for gynaecology. We were told that the named safeguarding leads for the trust met monthly to discuss cases and share learning on a monthly basis. We were told that safeguarding leads received one to one supervision through the commissioners of the service.
 - Community midwives made referrals into a specialist clinic for women who had experienced female genital mutilation (FGM). We were told safeguarding referrals were made for all women with FGM. The trust's annual safeguarding report for 2014-2015 stated there were approximately 10-15 new cases of FGM seen in the trust per month, which were reported under the statutory duties introduced in September 2014 for all organisations. Mandatory safeguarding training for both midwives and doctors included FGM, and also covered child sexual exploitation, modern day slavery, and honour based violence.
 - Clinical nurse specialists were able to describe the trust's protocol for when children under the age of 14 presented to the termination of pregnancy service. These women were referred to the gynaecology assessment unit (GAU), and staff involved in their care worked closely with safeguarding leads.
 - Midwives, nurses within gynaecology and support workers received safeguarding training to level three as part of the mandatory study day. Data provided by the

Safeguarding

- There were processes for safeguarding mothers and babies. The service had a dedicated, full-time band seven specialist midwife responsible for safeguarding children and vulnerable adults. They liaised with multi-agency safeguarding teams across the catchment areas. The service operated Monday to Friday from 9am to 5pm. The trust's annual safeguarding report for 2014-2015 reported that the number of safeguarding alerts or referrals had increased from 825 in 2014, to 951

Maternity and gynaecology

trust for maternity services showed 94% of midwives and 91% of support workers had completed the training session against a trust target of 95%. Level three training had been included for gynaecology staff since April 2016 and 66% of nurses and 52% of support workers had completed the training.

- The trust had a 'Missing Baby' guideline, which provided the process to follow in the event of baby abduction or missing baby within the maternity service. Junior staff we spoke with were unaware of the guidelines and their responsibilities in the event of a baby going missing from the ward.

Mandatory training

- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution, basic life support and safeguarding vulnerable adults and children. Safeguarding training was provided at an appropriate level depending on the requirements of the staff group.
- The majority of mandatory training for staff was done as e-learning. Staff were able to log-in to the on-line system to access any learning that was due. All staff that we spoke with confirmed that they had completed all of their mandatory training.
- Data provided by the trust showed that most of the gynaecology nurses, midwives and maternity support workers had completed the basic life support training. Basic life support training had been completed by 79% of gynaecology support workers, 78% of medical trainees and 83% of consultants. This did not meet the trust target of 95%. Other mandatory training data was reported at a directorate level and could not be separated further into maternity or gynaecology for the staff groups.
- There was a mandatory, annual maternity emergency drills day which included midwives, obstetricians and anaesthetists which was organised by the clinical educators.
- There were two mandatory study days for nursing and midwifery staff. The first was for maternity and gynaecology nursing staff, care assistants and housekeepers and covered breastfeeding, adult basic life support and fire. The second was specifically for midwives and included infant mortality, smoking cessation, diabetes, ante-natal and new-born screening and perinatal mental health.

Assessing and responding to patient risk

- Midwifery staff used a 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 to a woman whose health was deteriorating and summon additional medical support if required. The risk assessment booklet included an SBAR tool, a sepsis screening tool, a venous thromboembolism (VTE) assessment tool which also had a body mass index chart. Venous thromboembolisms are blood clots in the deep veins of the legs. There was also a peripheral intravenous cannula care bundle, a urinary catheter care pathway and assessment tools for nutrition, manual handling and a pressure ulcer risk score.
- Most of the observations on the MEOWS charts were undertaken by maternity health care assistants (HCAs). Data provided by the trust showed that 67% of HCAs had been assessed as competent to undertake, record and calculate MEOWS observations against a trust target of 100%. There was not a process in place to alert staff as to who had been assessed as competent to undertake this task. There was a risk that assessments may not always be accurate. Records we reviewed during our inspection contained appropriately completed MEOWS tools for all women.
- Nursing staff in the gynaecology areas used a paper based early warning score (EWS) tool to identify and respond to women who required additional medical support. Data provided by the trust showed that 97% of health care assistants (HCA) within gynaecology had been assessed as competent to complete the EWS. All of the records we reviewed for gynaecology contained appropriately completed and calculated EWS tools. We also saw that staff were correctly escalating concerns for women with a raised EWS.
- There was a daily maternity safety team meeting, called a "huddle". This included ward co-ordinators, delivery suite co-ordinator, on call medical staff including obstetrics and anaesthetic consultants and registrars and the theatre team. Safety issues were discussed at these briefings, including staffing, high risk women, bed

Maternity and gynaecology

states and discharges. We observed the delivery suite co-ordinator briefing the multi-disciplinary team at handover. This ensured that care and staffing was prioritised and focused to where needed.

- Obstetric theatres used a Five Steps to Safer Surgery safety checklist prior to and during each procedure. This is a process recommended by the National Patient Safety Agency (NPSA) for every woman undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. For each woman's procedure, the checklists were followed and completed in full. We observed the theatre team completing the Five Steps to Safer Surgery throughout the sign in before induction of anaesthesia, to the sign-out as the woman left theatre. All stages were completed correctly. There had not been any recent audit of compliance with the surgical safety checklist at LGH. A review of trust wide safer surgery policy was underway with the aim of making surgery safer at every step of the surgical pathway. This included reviewing best practice from other organisations, paperwork and process redesign and staff training, and was due for implementation in December 2016.
- During the initial booking appointment, pregnant women were given hand held maternity notes which included both antenatal and labour care. Midwives took a full medical, obstetric, social and family history, which included an assessment of emotional well-being. This assessment was used to classify the woman as with low or high risk. Low risk women continued with midwifery-led care, whilst high risk women were referred to consultant-led care. This assessment was repeated at 36 weeks of pregnancy, and again when being admitted to delivery suite, at a home birth or if there were any changes in pregnancy.
- The trust provided monthly audit data of women's observations and assessments for the period September 2015 to February 2016. The maternity inpatient ward 30 provided data for five out of the six months and the average compliance of correct completion of women's observations was 87%. The average compliance for delivery suite was 90%. Data was also provided for correct completion of fluid balance charts for which ward 30 was 100% compliant; delivery suite was also mostly 100% compliant with the exception of January 2016 at 80%. The trust expectation for correct completion of both women's observations and fluid balance was 100%.
- Service leads told us there was a pathway for women with a body mass index (BMI) of 40 and above. Women with a raised BMI have additional pregnancy related risks. The pathway included ultrasound scanning and monitoring of diet and weight at a joint consultant and midwife clinic. Risk assessment for manual handling and VTE were carried out and women were reviewed by a consultant anaesthetist in clinic. In addition, women with a BMI of 50 or above were offered a six week postnatal clinic appointment.
- Staff told us there were significant delays in the gynaecology correspondences to women due to clerical backlogs which had been ongoing for over a year. We saw that this had been added to the directorate risk register and was due to be cleared by 31 July 2016 however; the data supplied did not indicate the date the item had been added to the risk register. Service leads told us the backlog was around eight weeks and action was being taken to reduce the backlog. In addition we were told systems were in place to ensure letters marked as urgent were typed as a priority. However, no absolute assurance could be given that women's safety was not being compromised. The trust target for typing of letters was ten working days. We checked the electronic typing management system on 22 June 2016 and there were 1400 letters waiting to be typed that were over the ten day target. We saw the oldest letter was from 29 March 2016, which was a delay of 12 weeks. The oldest letter marked "urgent" was from 21 May 2016, which was a delay of four weeks. Service leads told us a card system had been introduced for the medical notes of colposcopy women to ensure clerical delays were not affecting women's safety. However, clerical staff told us the system was not fail safe. We were not assured that clerical backlogs were not affecting women's safety by delays in referral and prompt treatment.

Midwifery staffing

- The maternity department used the National Birth-Rate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National Institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a patient)
- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in

Maternity and gynaecology

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 had a ratio of 1:29.5 births so did not meet the recommendations. Birth Rate Plus 2014 suggests ratios of midwives is nearer 1:29.5 although it is individual to each service. The staffing ratio included specialist midwives that held a caseload, of which there were just over three WTE trust-wide.

- Maternity matrons told us that there were just under seven WTE midwife vacancies at Leicester General Hospital (LGH) and just over four WTE within community staff. Recruitment was underway and there was a plan to recruit additional midwifery staff over and above the establishment.
- The trust had a midwifery and support staffing policy, reviewed in May 2016. This policy made provision for the use of a midwifery staffing "red flags" system (which is a warning sign that something may be wrong with the level of midwifery staffing) as recommended by NICE. However, senior staff told us the service was not currently using the "red flag" system. There were plans in place following our inspection to introduce a new information technology (IT) to allow this data to be collected. Incident data provided by the trust showed that there were 146 incidents reported relating to a lack of maternity staff at the LGH in the period March 2015 to March 2016.
- Service leads told us women received one to one care when in labour. We were told that this was not audited because it was felt it was fully embedded into practice. The service also moved staff from other areas to delivery suite or transferred women between the two sites when possible to support safe care in labour. However, staff we spoke with on the birthing centre told us that women did not always receive one to one care, and that they would often have to look after postnatal women together with labouring women.
- The trust collated "share your experience" patient surveys from September 2015 to February 2016. The number of women completing the questionnaires for maternity was variable; for labour and birth the range was 31 to 79. The ideal satisfaction score from these patient surveys was 100; for one to one care in labour the average score was just below the ideal score at 98.
- The trust midwifery staffing policy stated that the preferred staffing level for the whole unit for the day shift at Leicester General Hospital was 20 midwives

during the day and 16 midwives for the night shift.

However, minimum acceptable numbers on each shift were 12 midwives for both day and night. We reviewed a copy of the e-roster for two weeks commencing 13 June 2016 and saw that none of the shifts during those two weeks met the preferred staffing level. One day shift (15 June 2016) was under the minimum acceptable number with 11 qualified staff on the rota.

- We spoke with two postnatal women and their partners on the ward who were unhappy with the level of care they had received on the delivery suite. One of the women believed her care had been delayed because of a lack of staff; we reviewed her records and saw this was correct. The other woman told us the delivery suite room she was in had uncovered sharps, spilled bodily fluids and her partner had changed her soiled sheets five hours after her baby had been born because staff were unavailable.
- Gaps in the rota were filled with bank staff or staff doing extra hours. Agency staff were not used in maternity services.

Medical staffing

- From February 2015 there had been 72 hours of consultant cover per week on the delivery suite. This was not in line with the Royal College of Obstetricians and Gynaecologists (RCOG) 2007 guidelines which recommend that a unit which has between 4000 and 5000 births a year should have 98 hours of consultant presence.
- Consultant obstetricians were resident on the delivery suite from 8am to 8pm Monday to Friday and from 8am to 2pm at weekends. Outside of these hours the consultants worked a non-resident on-call system.
- The maternity assessment unit (MAU) had dedicated senior house officer (SHO) (foundation year one or two medical trainee) Monday to Friday from 9am to 5pm and a consultant obstetrician presence from 1pm to 5pm. However, midwifery staff told us there was not always a consultant allocated to this session, which made it harder to access medical reviews for women. We reviewed the medical staffing rotas for the four weeks prior to our inspection and saw there had been no consultant allocated to the MAU for the whole week commencing 30 May 2016.
- Consultant gynaecologists were present from 9am to 5pm, Monday to Friday to cover the elective gynaecology service.

Maternity and gynaecology

- Junior doctors worked a full shift pattern and covered both maternity and gynaecology services. Monday to Friday, 8am to 5pm there was a specialist registrar and an SHO (foundation year one or two trainee) to cover delivery suite. In addition, there were four SHOs to cover the maternity and gynaecology wards and services. However, we reviewed the medical staffing rotas for four weeks commencing 30 May 2016 and saw there were 22 morning and 30 afternoon slots unfilled in the rotas. Out of hours and at weekends the trainee doctors covered both obstetrics and gynaecology and we saw that these rotas were adequately covered.
- The lack of middle grade doctors to provide adequate cover had been added to the risk register. Service leads told us this was a national problem and they were in the process of recruiting from overseas. They told us they were mitigating the risks by paying their own medical staff locum rates for extra hours worked and by consultants “stepping down” as necessary to cover the gaps in the rotas. However, staff we spoke with from all areas including the inpatient wards and maternity assessment unit (MAU) told us that it was often difficult to get medical reviews for women out of hours and weekends, which meant long delays for women and which could be a risk to women’s safety. Neither maternity nor gynaecology used the “hospital at night” service available in the rest of the hospital.
- Data provided by the trust from the incident reporting system showed that there were 19 maternity and seven gynaecology incidents reported relating to a lack of medical staff at the LGH between March 2015 and March 2016. All incidents were low harm with the exception of from one maternity incident rated as minor harm. It related to a delay of more than 12 hours for an emergency caesarean section. The baby was born in a poor condition; this was attributed to lack of medical staffing.
- Consultant anaesthetists provided 10 sessions and two clinic sessions per week for obstetrics and just over 25 sessions for gynaecology per week. Consultant obstetric anaesthetists were resident on the delivery suite from 8am to 6pm, Monday to Friday. There was a specialist registrar anaesthetist resident on delivery suite 24 hours a day and a non-resident on-call consultant anaesthetist.
- Appropriate anaesthetic cover was available 24 hours per day for elective and emergency care.

Major incident awareness and training

- There were arrangements to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding quickly and effectively to any major incident.
- Some of the staff we spoke with were unaware of the plan and their responsibilities.

Are maternity and gynaecology services effective?

Requires improvement



We rated Leicester General Hospital Maternity and Gynaecology services effectiveness as requires improvement because women were at risk of not receiving effective care or treatment.

We found:

- The rates of caesarean section, and post-partum haemorrhage (bleeding after birth) were worse than the trust target. Action plans from audit of post-partum haemorrhage did not address all of the issues highlighted by the audit.
- Midwifery staff had not received anaesthetic recovery training and competency assessment. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) guidelines.
- Midwifery staff were acting as theatre instrument practitioners (scrub nurse) out of hours. They were unable to demonstrate formal competencies or that they received ongoing training, which did not comply with current guidance.
- Rates of appraisals for medical and gynaecology nursing staff were low.

However we also found:

- Women told us they were able to access pain relief in a timely manner.
- The maternity service had achieved level two UNICEF Baby Friendly accreditation and rates for breastfeeding initiation were above trust targets

Maternity and gynaecology

- The normal birth rate was above the national average and the number of babies born in the midwife-led birthing centre was one of the highest (best) nationally. The number of babies born by instrumental delivery was lower (better than) the trust target.
- There was effective multi-disciplinary working across maternity and gynaecology.

Evidence-based care and treatment

- Local policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, termination of pregnancy for fetal abnormality guidance were also followed.
- We reviewed five clinical guidelines. These were all in date, were easily accessible on the trust's intranet and referenced to NICE or RCOG guidance. The guidelines we reviewed included induction of labour, group b streptococcus, intrapartum care, fetal monitoring and perineal care. We also reviewed trust policies that were based on national guidelines including safeguarding and the disposal of fetal remains. The trust policy for disposal of fetal remains was in line with Human Tissue Authority guidance (2015).
- We reviewed the trust's postpartum/major obstetric haemorrhage guideline. The guideline outlined certain predisposing factors for women that might be a risk of bleeding. To reduce this, it was recommended that these women be commenced on an intravenous drip to reduce this risk. However, these risk factors were not separately printed and displayed for midwives working on the delivery suite. Midwifery staff were reliant on the medical staff writing in the intrapartum care plan or being told by the delivery suite co-ordinator that it was required. We were not assured staff would always be aware that it was required.
- 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 being missed). An audit of fetal heart rate monitoring had last taken place in May 2014. The audit looked at various aspects of CTG monitoring from documenting the name of the woman to the outcome being documented on the CTG trace. There were elements of the audit that showed full compliance, and areas where improvements were required. For example 44% of the CTGs did not have the indication for monitoring either on the CTG or in the notes. It was found that 13% of CTGs did not have the time and mode of delivery documented on the CTG and 21% of CTGs had been categorised as suspicious and did not have an obstetrician review documented in the notes. The lack of data meant there was not always assurance that care had been appropriate. However, the audit showed that all CTGs that were classified as abnormal were appropriately reviewed and action taken. A further audit was planned at the time of the inspection, incorporating new NICE guidance issued in December 2015. We looked at five CTG recordings and found that all were documented according to trust policy.
- In April 2014 the trust conducted an audit of women requiring either elective or emergency caesarean section who were at risk of requiring a general anaesthetic. However, the clinical audit summary form did not specify whether this audit was conducted at LRI, LGH or both. These women should follow the starvation and antacid guidelines, to reduce the likelihood of potentially fatal gastric aspiration during the procedure. The audit found the trust was compliant in three out of the four outcomes audited in line with the Royal College of Anaesthetist guidelines, and made a recommendation for additional training and for an acid prophylaxis guideline to be introduced. This was subsequently incorporated as part of the Intrapartum care guideline.
- We reviewed antenatal hand held records, and saw that fetal growth was routinely measured using the symphysis fundal height and recorded on a fundal height chart. Fundal height is a measure of the size of the mother's uterus to assess how well the baby is growing and is measured from the top of the uterus to the top of the mother's pubic bone. This which was in line with MBBRACE-UK (2015) and NICE guidance. We were told that there was a clear pathway for abnormal findings.
- The service performed audits in line with the women's/maternity clinical audit and quality improvement programme 2015 -2016 and produced action plans for each audit. However, it was acknowledged that some audit projects had been delayed due to capacity of the

Maternity and gynaecology

junior medical staff. For example, the audit of post-partum haemorrhage (bleeding after birth) was delayed because the junior doctor allocated had left the trust.

- The trust is required to report on its compliance with NICE guidance, and service leads were able to give assurance they were reviewing new guidance as and when published to check they were included in their own guidelines.
- Staff we spoke with were able to demonstrate their practice was evidence based. Midwives were able to discuss NICE guidelines and how they were embedded in their own practice and told us they maintained current knowledge.

Pain relief

- Women were able to access pain relief during birth and post operatively in a timely manner for both maternity and gynaecology. Pain relief was regularly offered and women told us their pain was well managed.
- Pain was assessed and recorded on women's maternity modified early warning score (MEWS) chart or on the nursing early warning score for gynaecology (EWS). Staff on the gynaecology ward 31 told us they were well supported by the hospital pain team if required.
- There were two birthing pools in the midwifery-led birthing centre that women could use as pain relief in labour. No birth pools were available on the obstetric-led delivery suite.
- Entonox (a pain relieving gas) was piped in all labour rooms in both the birthing centre and the delivery suite. Stronger painkiller by injection was also available for women who required stronger pain relief in both areas.
- Epidurals (an injection of anaesthetic into the spinal area) were available for women on delivery suite 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. The service did not audit this data therefore, we have no assurance that epidurals were provided in a timely manner.
- Data provided by the trust showed that 96% of elective caesarean sections and 87% of emergency caesarean sections were performed under regional anaesthesia which is in line with the RCOG Safer Childbirth Guidelines 2007.

Nutrition and hydration

- The maternity service had achieved UNICEF Baby Friendly accreditation level two in November 2013 and was due to undergo reaccreditation later in 2016. (The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding). The service had failed to achieve level three accreditation in June 2015 and reassessment was planned for October 2016. The trust had produced an action plan to assist with accreditation.
- The monthly average of women who started breastfeeding across the trust for April 2015 to March 2016 was 75.4%, in keeping with the target of 75%. The trust employed two specialist infant feeding midwives who were able to refer women to a specialist-feeding clinic held at the Leicester General Hospital.
- The malnutrition universal screening tool (MUST) was used to screen women for their risk of malnutrition throughout gynaecology. We looked at nursing records and found that the majority were completed. We also saw that fluid balance charts were used appropriately to record fluid intake and urine output. Maternity staff used a nutritional assessment included in the maternity risk assessment booklet to record dietary needs and assess women's risk relative to their body mass index (BMI).
- Women all had access to drinking water beside their bed unless they were nil by mouth.
- A choice of meals was available and women completed menu choices for the day.
- Women told us there was a good choice of food of good quality, including one woman that required a special diet. The trust collated "share your experience" patient surveys from September 2015 to February 2016. The number of women completing the questionnaires was variable; for the postnatal wards the average was around 360 per month. Against an ideal score of 100, the women's scores for rating of the food on the postnatal wards averaged 63, which was much worse than the ideal score.

Patient outcomes

- At the time of the inspection, the maternity service was indicated as a maternity outlier for maternal infections diagnosed within six weeks of birth. (Maternity outliers are where the trust performs worse than the national average).

Maternity and gynaecology

- There were no maternal deaths reported for the service in the period June 2015 to May 2016.
- Between June 2015 and May 2016 there had been 4492 births at the Leicester General Hospital (LGH) excluding home births and babies born before getting to hospital. The normal birth rate for the whole trust within this reporting period was 61.2%. This was above the England average of 60%.
- Trust wide, between June 2015 and May 2016, 11.2% of babies were delivered by medically assisted instrumental delivery (by using forceps or vacuum assisted delivery). This was lower (better than) the trusts target of 13.4%.
- The trusts average home birth rate was 1.2% of the total deliveries recorded for the trust between June 2015 and May 2016. This was lower (worse than) than the national average of 2%, however the most recent figure for May 2016 was 1.9%. The trust had not set a target on their dashboard.
- Of the total of babies born at LRI between June 2015 and May 2016, 22.9% were delivered in the midwifery-led birth centre, which is one of the highest rates nationally.
- The average caesarean section rate between June 2015 and May 2016 was 28%, this was slightly worse than the trust target of 26.3% for 2015-2016. No target was set for 2016-2017. Of these caesarean sections, 10.5% were planned and 17.5% were unscheduled. Planned caesarean section rate was slightly lower (better than) than the England average of 11%. Unscheduled caesarean sections was higher than (worse than) the England average of 15%.
- In the period June 2015 to May 2016, the average percentage of women trust wide who had a vaginal birth after a previous caesarean section was 23.7%, which was lower than the trust target of 33% for 2015 -2016. No target had been set for 2016 -2017.
- Trust wide, between June 2015 and May 2016, the average percentage of women who experienced a major obstetric haemorrhage (bleeding following birth) of 1500mls or more was 3.7%. This was worse than the trust target of below 2.7%.
- We reviewed a trust audit from June 2015 which stated that the incidence of all post birth bleeding of 500mls or more was 19.3% which was higher than the rate of 13.2% in the Midlands area. The audit suggested that national standards were not being met, however, we were not assured the action plan addressed the issues raised within the audit. In addition we reviewed an audit of post birth bleeding data for a six month period in 2013. We found the action plan was not compiled until March 2016. We discussed these finding with one of the deputy heads of service who had limited awareness of the audit findings and actions.
- Trust wide, between June 2015 and May 2016, nine women who had a normal delivery experienced serious perineal trauma (fourth degree). This was below (better) the trust target of less than three per month with the exception of February 2016 when the number of women was four.
- In the period April 2014 to March 2015 there were 762 medical and 123 surgical termination of pregnancies carried out at Leicester General infirmary.
- Between June 2015 and May 2016, maternity services across the trust had experienced 51 stillbirths (8.8 per 1,000 births). The trust had not set a target; however, there had been no increase from the previous year. The England average for stillborn rates for 2015 was 4.4 births per 1,000 births so the trust rate was significantly higher.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. In the period January 2016 to March 2016 the trust met acceptable levels in four of the six KPIs. The trust provided a copy of their action plan and we saw that steps had been taken to improve performance, for example, community midwives had set up postnatal clinics in the community to reduce the number of avoidable repeat newborn blood spot tests.

Competent staff

- There were 25 Supervisors of Midwives (SoM) within the maternity service at University Hospitals Leicester NHS Trust. SoMs help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for caseloads for SoMs was 1:15. The service was not compliant with national expectations with a current ratio of 1:18. Whilst the trust had identified midwives who wished to be trained as SoMs, there were no training places available because of the national uncertainty about the future of supervision.
- The local supervising authority (LSA) had audited the SoM service and had produced a report with a number of recommendations for improvements. The recommendations related to the processes for reviewing

Maternity and gynaecology

midwifery practice concerns, the SoM ratio, the use of supervisory investigation toolkits, the recording of annual reviews and evidence on their database. It included recommendations around working with the trust and the head of midwifery to have more contact with the executive board and women using the service. It was also suggested there should be a part or full time SoM. We saw a copy of the SoM action plan in response to this report, with appropriate actions against each recommendation, none of which were overdue.

- Midwives received updates in caring for women with epidurals and the deteriorating woman, but had not had anaesthetic recovery training and competency assessment. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) or the Obstetric Anaesthesia Guidelines 2015 which states that 'a midwife with no additional training is not adequately trained for recovery duties'.
- The midwifery clinical educator told us recovery training was being included in the preceptorship package for newly qualified midwives and the service was working towards a further programme for recovery and high dependency care training for other midwifery staff. However, although senior staff were supporting the process, the issue had not been identified as a risk, or added to the risk register.
- Scrub nurses (sterile instrument practitioners) were provided for the obstetric theatres Monday to Friday, 8am to 4pm. Outside of these hours, midwives acted as scrub nurses. This did not comply with the consensus statement of the Royal College of Midwives, College of Operating Department Practitioners and the Association of Perioperative Practice. Midwives we spoke with who acted as scrub nurses were unable to demonstrate that they had ongoing training and formal competencies.
- Midwives told us there were three mandatory study days per year. Day one was also mandatory for nurses within gynaecology and included adult basic life support, fire and safeguarding. On day two they received updates about the latest research and innovations from specialist midwives. The third was a multi-disciplinary learning skills and drills day, which covered a CTG presentation and test, updates on epidurals, sepsis and the deteriorating woman and bereavement. The day

was also attended by junior medical staff, consultant obstetricians and anaesthetists. The day concluded with emergency drill scenarios in both home and hospital settings including neonatal resuscitation.

- Staff told us there was no formal training for equipment used within the service. Staff were shown how to use new equipment but there were no arrangements for updates or competency checks to ensure that staff remained competent to operate the different types of equipment. This posed a risk to women's safety.
- Nurses and midwives were required to pass a three-year medicines maths test so that the trust could be assured that staff could safely administer medicines and correctly complete documentation. For gynaecology, 43% of nurses on ward 11, 100% of nurses on ward 31 and 79% of specialist nurses had completed the assessment. Almost all staff across all areas of the maternity unit had completed the assessment.
- Data provided by the trust showed within gynaecology 69% of nursing staff had received an appraisal within the financial year 2015 – 2016. Within maternity for the same period 96% of midwives and 67% of medical staff had received an appraisal. These rates showed an improvement for midwifery staff for the same period 2014 – 2015 but a decline for gynaecology nurses. All staff we spoke with confirmed they had received an appraisal within the past 12 months.
- Newly appointed staff completed the trust induction programme. Newly qualified midwives we spoke with told us they were following a preceptorship programme, which had to be completed before progressing to a higher grade.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working trust wide, which included antenatal services, outpatient services, midwives (hospital based, community and specialists), obstetricians and gynaecologists consultants, anaesthetists, theatre and recovery staff, medical staff from other specialities, the neonatal unit, physiotherapists, dietitians, general practitioners (GP), health visitors and social services.
- We saw staff from the LGH worked together with those at the Leicester Royal Infirmary (LRI) to co-ordinate the gynaecology service across the trust. The multi-disciplinary team included specialist nurses, gynaecologists, anaesthetists, theatre and recovery staff

Maternity and gynaecology

in both the gynaecology and surgical day case operating theatres, GPs, community and specialist safeguarding midwives, physiotherapists, dietitians and an independent provider of terminations of pregnancy.

- Consultant obstetricians worked collaboratively to plan and co-ordinate the care of high-risk women. For example, women with complications related to kidneys were seen in a tertiary renal clinic, held jointly with a specialist midwife and professors of nephrology.

Seven-day services

- There was a 24 hours a day, seven days a week emergency gynaecology service at the Leicester General Hospital. The gynaecology services unit (GSU) was open Monday to Friday from 7am until the last woman had been seen, usually around 5pm.
- The maternity assessment unit (MAU) was open from 7am until 7.30pm. When the MAU was closed, calls were transferred to delivery suite.
- Community midwives were available 24 hours per day, seven days per week to facilitate home births.
- A supervisor of midwives (SoM) was available 24 hours per day, seven days per week through an on-call rota. This on-call system provided support to midwives at all times and was also available to women. The front page of the hand held antenatal records included details of how to contact the on-call SoM.
- Consultant obstetricians, gynaecologists and anaesthetists were either resident on the unit or on-call 24 hours per day, seven days per week.

Access to information

- Women's care records were in paper format. In both gynaecology and maternity areas we saw medical records were kept in filing trolleys that were protected by a security code. This meant only authorised staff had access to the records. On the maternity wards, the inpatient risk assessment booklet, which included the MEOWS, was kept either by the women's bedside, or centrally at the midwives station.
- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. These records included risk assessments, ultrasound and blood test results. This meant all the information needed to deliver care and treatment was readily available to staff.
- Records were readily available to staff to refer to during the time of a woman's admission.

- GPs were able to make direct referrals to the gynaecology service.
- The service had devised a new notification to health visitor form which had improved communication between midwives and health visitors.
- Hospital staff could access policies and procedures via the trust's intranet system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- The trust had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy, together with consent to examination, or treatment policy.
- Consent, MCA and DoLS was part of mandatory training for all staff, provided through e-learning. Data provided by the trust for June 2016 showed, within the women's and children's directorate, 45% of doctors, 74% of non-qualified clinical staff and 71% of nurses and midwives had completed the training. This did not achieve the trust target of 95%.
- Patients gave informal consent for their care and treatment, and this was clearly documented in women's records. We observed staff asking for consent prior to undertaking care such as physiological observations.
- The trust's consent to examination or treatment policy supported making the woman's best interests central to the process of obtaining consent. If a young person was under 18 and wished to consent to their own treatment, for example if they wished to undergo a termination of pregnancy, staff followed Gillick Competency assessments and Fraser guidelines to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options. (Gillick competency and Fraser guidelines are used to help assess whether a child under the age of 18 has the maturity to make their own decisions and to understand the implications of those decisions).

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good



We rated caring at Leicester General Hospital Maternity and Gynaecology services as good because women were supported, treated with dignity and respect and were involved as partners in their care.

We found:

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

Compassionate care

- Women, their partners and relatives were positive about the care they had received. All of the women we spoke with told us staff were kind and caring and that they had been treated with dignity and respect. One woman told us staff were “amazing, absolutely incredible”.
- We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited in to the room, or behind the curtains around the woman’s bed space.
- Between January 2015 and February 2016 a high percentage of women recommended the antenatal services, postnatal ward and birth services. The scores were similar to the England average. More than 90% of women recommended each of the services in every month.
- The trust collated “share your experience” patient surveys. For the period September 2015 to February

2016 women’s scores for being treated with privacy and dignity averaged 96 during the antenatal period, 97 for labour and birth and 94 for the postnatal wards against an ideal score of 100.

- Leicester General Hospital (LGH) scored worse than the England average in three out of five categories of the PLACE (patient led assessments of the care environment) survey in 2015. Categories included cleanliness, privacy and dignity and facilities.

Understanding and involvement of patients and those close to them

- Staff involved women in their care and treatment. We observed staff discussing care plans with women and ensuring they understood their treatment and condition. Women and those important to them we spoke with told us staff gave them enough information about their care and treatment. One woman told us “the medical staff are so open and honest and explain everything to me”.
- Partners we spoke with were very happy with the care and their involvement.

Emotional support

- Women and relatives were given emotional support whilst on the units. We observed friendly and open conversations between staff and visitors.
- We observed a distressed woman in the gynaecology services unit exiting a toilet cubicle. We saw that staff very quickly came to comfort her, and escorted her to a more private area.
- Women considering termination of pregnancy should have access to pre-termination counselling. All of the women undergoing termination of pregnancy at Leicester General Hospital were offered pre-termination counselling by a trained counsellor employed by the trust. Women who were anxious or unsure about their decision were provided with extra support.
- Staff dealt with bereavements compassionately. They provided support to parents, relatives and each other. Staff offered the multi-faith chaplaincy service to women to provide extra support.
- Staff told us of an occasion when they provided a birthday cake for an inpatient on ward 31 and staff gathered to sing happy birthday to her.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good



We rated Leicester General Hospital Maternity and Gynaecology services responsiveness as good because women's needs were met through the way services were organised and delivered.

We found;

- The service employed a range of specialist midwives for women with complex care needs or for those in vulnerable circumstances.
- There was a wide range of specialist antenatal and gynaecology clinics.
- The service provided a cohesive and sensitive bereavement service for women experiencing pregnancy loss, including the employment of a specialist midwife, dedicated bereavement rooms and postnatal records.
- The service had a robust system for monitoring, processing and learning from complaints which ensured that responses were sent in a timely manner. Themes and trends were identified and learning was disseminated to staff.
- We saw good examples of care and support for women with learning disabilities.

However, we also found:

- There were significant and ongoing delays in gynaecology due a backlog in typing of women's letters. Service leads could not give absolute assurance women's safety was not compromised as a result.

Service planning and delivery to meet the needs of local people

- The trust employed specialist midwives for women with complex needs and in vulnerable circumstances. There were 1.6 whole time equivalent (WTE) teenage pregnancy specialists who provided care to a high-risk population of teenagers up to 20 years of age. There were also full time specialist midwives for both substance misuse and women in vulnerable circumstances including asylum seekers, immigrants

- and the homeless. There was a consultant midwife specialising in public health, a diabetic specialist midwife, a bereavement specialist midwife and a renal and hypertensive disease specialist midwife.
- There was a range of antenatal clinics offered at the Leicester General Hospital (LGH). There were four general consultant led clinics per week. Consultants led clinics for fetal medicine, maternal medicine, which included mental health and a post-natal perineal clinic. The midwife-led 'birth choices' clinic was for women who were making choices for the birthing of their baby for example women considering a vaginal birth after a previous caesarean section. The service held a joint consultant/specialist midwife antenatal clinics for women with renal conditions (kidney related) and another clinic for women with diabetes. Additional antenatal clinics were offered at the Leicester Royal Infirmary which included hypertension teenage pregnancy, substance misuse, multiple pregnancies, prematurity prevention, blood born infection, and female genital mutilation (FGM).
- There was a range of specialist gynaecology services offered at the LGH in addition to the general gynaecology clinics, which included endometriosis, uro-gynaecology, gynaecology-oncology and menopause. There were hysteroscopy clinics and colposcopy clinics. Specialist nurse-led termination of pregnancy clinics were held on Tuesday afternoons.
- Service leads had introduced and were developing an ambulatory gynaecology service, which enabled women to receive treatment for minor procedures in the gynaecology outpatient clinic. The service was offered for such procedures as removal of polyps (small growths), and treatment for post-menopausal bleeding.
- The service offered robotic surgery for treatment of gynaecological cancers, which had been proven to be a more precise operating method.
- Women assessed as low risk at the onset of labour were automatically directed to the birthing centre for midwife-led care. However, if they became more high risk during the labour, or required an epidural for pain relief they would be transferred to the main delivery suite. This default pathway for low-risk women contributed to the high proportion of births in the birthing centre and, as a result, had attracted research interest from a leading university.
- Induction of labour (artificially starting labour) for both low and high risk women was offered at LGH. Women

Maternity and gynaecology

who were assessed as low risk attended the antenatal ward one for assessment and remained there until labour was established and could be transferred to the delivery suite. Women who were more high risk were admitted into a dedicated bay on the delivery suite where they stayed until discharged to the postnatal ward.

- The new-born and infant physical examination screenings (NIPE) were performed on the maternity postnatal ward by the paediatricians. This could lead to delays in discharges if there were a number of checks to do. Therefore, a cohort of midwives were undertaking a NIPE training course with a local university, due to qualify in September 2016. It was anticipated that more staff would complete the training in the future. This would mean more staff would be competent to complete the checks and would help with discharge flow from the wards.
- The trust has been piloting a project to measure the oxygen levels in new-born babies (pulse oximetry). This service has not been commissioned by local clinical commissioning groups but the project was continuing as service leads recognised its value for identifying “at-risk” babies. The trust had purchased mobile electronic devices to input data onto the national NIPE database.

Access and flow

- Medical terminations of pregnancies were offered to women under nine weeks of pregnancy. Most surgical terminations were performed at the Leicester General Hospital (LGH), however women under 14 years of age or who were less than 13 weeks gestation with other medical issues were referred to the Leicester Royal Infirmary (LRI) for surgical termination. All other women were referred to another independent termination of pregnancy service.
- Termination of pregnancy clinics were run by the infertility control specialist nurses within the gynaecology services unit (GSU) at LGH. Referrals were made either by general practitioners or by another NHS provider.
- Women could self-refer to the maternity assessment unit (MAU), or be referred by the GP and community midwives. Staff told us that there were sometimes

difficulties finding inpatient beds for MAU women requiring admission. During our inspection, we observed a midwife having difficulty locating beds for two antenatal women.

- Elective caesarean sections were performed at Leicester General Hospital. There were daily theatre lists, with three slots per day. The procedures were carried out in one of two operating theatres on the delivery suite. This meant an additional theatre was available for emergency procedures if required. However, the elective list was not separately staffed which might cause delays to some women.
- All gynaecology surgical women attended the pre-admission clinic in the gynaecology services unit (GSU) where MRSA swabs and blood tests were taken. Both day case and major surgical women were initially admitted to ward 11 and were taken to theatre by ward staff. Day case women returned to ward 11 and discharged home unless there were complications or slow recovery, in which case they would be transferred to the gynaecology inpatient ward 31. Major surgery women were taken direct from theatre recovery to ward 31. Ward 11 and ward 31 were at opposite ends of the hospital which staff told us was inconvenient for nursing and medical staff, and unpleasant for the women. We walked from one ward to the other and the journey time was seven minutes. If a woman required transfer to a different ward to the one to which they were admitted, this meant a long transfer route between ward 11 and ward 31 for women having undergone major surgery.
- Surgical termination of pregnancy women were performed as day cases. Medical terminations women were cared for on the GSU. Women experiencing problems in early pregnancy were seen at the Leicester Royal Infirmary.
- Pathways had been developed for insulin dependent diabetic women who had been prescribed steroid treatment. Steroid treatment can affect a woman's blood sugar levels and previously women needing this treatment had been admitted for an insulin sliding scale regime. The new pathway adjusted the woman's own insulin regime, which meant less women were admitted for the treatment. In addition, the service did not routinely use the insulin sliding scale for women booked for elective caesarean section. For women whose diabetes was well controlled, the basal insulin rate would be adjusted the night before.

Maternity and gynaecology

- Leicester General Hospital closed the maternity unit 52 times between April 2015 and March 2016. Closure times ranged from one hour to 15 hours. There was an escalation policy for unit closures. Women would be diverted to the LRI or to other neighbouring units where possible. Service leads told us that it was rare for both LRI and LGH to be closed at the same time and women booked into the UHL maternity service, rather than a specific hospital and were advised early on in pregnancy that if one hospital was closed they would be sent to the other. Data provided by the trust showed that from June 2015 to May 2016 there had been no occasions when both maternity sites had been closed.
- In the period April 2015 to March 2016 there were 15,437 gynaecology outpatient attendances and 4,553 gynaecology oncology attendances. For the same period there were 22,020 attendances at obstetric outpatient clinics.
- Data provided by the trust showed there were 1206 gynaecology women on the waiting list for a new clinic appointment as of 31 March 2016. No woman had been waiting longer than nine weeks. Staff told us the service sometimes operated a Saturday elective list in order to reduce the waiting lists.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of women's legal right to start treatment within 18 weeks of referral to consultant-led care. As of 14 June 2016 the operational standard of 90% for admitted pathways was met for gynaecology and gynaecology oncology with 95.4% of women being seen within 18 weeks.
- Staff on the gynaecology inpatient ward 31 told us of a woman who was profoundly deaf. Staff had arranged for a sign language interpreter to communicate with her.
- Staff told us of a recent example of an adult woman with learning difficulties who attended the GSU with a relative seeking a termination of pregnancy. Nursing staff spoke with the woman without the relative being present to gain consent and found the woman felt under pressure to terminate the pregnancy but did not really wish to do so. The woman received support from a specialist midwife and continued her pregnancy.
- Women were screened for conditions such as anxiety and depression as part of the maternity booking process.
- The women's dining room on the gynaecology inpatient ward 31 was spacious with a central garden area that women could access.
- Although there were fixed visiting hours, staff on the gynaecology inpatient ward 31 told us women's relatives were allowed more flexible visiting.
- Data from the 2015 Maternity Experience Survey found that women reported the response time to the call button was in line with England average, scoring 7.6 out of 10.
- The birthing centre was available to women identified as carriers for the Group B Streptococcus (GBS) bacteria providing there were no other risk factors. (GBS bacteria may pass to new-born babies and cause a serious infection).
- Waterproof cardio tocography (CTG) leads were available and used in cases where vaginal birth after caesarean (VBAC) women wished to use the birth pools within the birthing centre provided an antenatal plan had been made and agreed with the woman.
- The delivery suite had a bereavement suite called the 'Garden Room', which included facilities for partners to stay and cots for women who wished to keep their baby with them. In addition there was a suite of rooms called the 'Alex Suite' on the maternity inpatient ward for women who had experienced pregnancy loss to stay until they were ready to go home. This room looked out onto a garden. We saw that a woman had been discharged on the day of our visit, and had used the room for five days.

Meeting people's individual needs

- Leaflets were generally available in English; however, they were available in other languages on request. We saw that menus were printed in five other commonly spoken languages. Information leaflets were also downloadable from the trust's website. Of the 22 maternity leaflets available, three were provided in a different language. None of the gynaecology leaflets were in another language on the website.
- Staff told us there was a diverse range of languages spoken by staff within the service, who would be asked to translate for women where possible. Staff told us they would book face-to-face interpreters when needed or make use of a translation phone service.

Maternity and gynaecology

- There were no separate entrances on delivery suite or the maternity inpatient ward for women experiencing pregnancy loss, however the 'Alex Suite' was situated very near the ward entrance and was not adjacent to any other inpatient areas
- A full time specialist bereavement midwife worked across the trust to provide support for women and staff. Staff felt well supported to care for women and families. Women were signposted to local charities that provided support for bereaved parents.
- The service provided postnatal records known as 'Dandelion' records for women who have experienced pregnancy loss which were sensitive records specifically designed for these clients.
- The trust's scores in the 2015 CQC Survey of Women's Experiences of Maternity Services were very good. The trust scored 'better than other trusts' in the question 'looking back, do you feel that the length of your stay after the birth was appropriate', and 'about the same as other trusts' in the remaining 16.

Learning from complaints and concerns

- A Patient Information and Liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- The trust standard was that complaints were acknowledged within three days and a comprehensive response sent within 25 days. The response time could be extended to 45 days for more complex cases but only with the agreement of the complainant. The clinical risk and quality manager told us they were currently 100% compliant with the trust standard for complaints.
- Data provided by the trust showed that from March 2015 to March 2016 there were 63 formal complaints about the service provided by Leicester General Hospital; 28 complaints for maternity and 35 for gynaecology. During our inspection, we were told the service also monitored verbal complaints and concerns raised by staff and other agencies for example CCGs, GPs, adult and social care and the NHS Ombudsman. We reviewed a copy of the quality and safety report to the directorate quality board for activity during May 2016 and saw that 13 verbal complaints had been recorded for that month; five for maternity and eight for gynaecology across the trust.
- We reviewed the quality and safety report for May 2016 and saw the top five themes from formal complaints

data; these were complications of treatment, professionalism of staff, nursing care, waiting times and medical care. A training DVD relating to communication skills and behaviour was being shown to all staff in response to a number of complaints that included communication and attitude as a factor.

- Service leads told us that learning from complaints was cascaded as part of a weekly newsletter that was sent to all staff. We reviewed the programme for the mandatory study day that maternity and gynaecology staff attended and saw time allocated to the quality and safety team to cascade learning from investigations and complaints. Staff expected to attend these sessions included registered nurses and midwives, medical staff, housekeepers and nursing and midwifery support staff. Staff told us complaints were discussed at team meetings.

Are maternity and gynaecology services well-led?

Requires improvement

We rated the leadership of Leicester General Hospital Maternity and Gynaecology services requires improvement because the leadership, governance and culture did not always support the delivery of high quality person-centred care.

We found:

- Whilst there was a clear governance structure and use of a quality dashboard, junior staff were not involved in the process and had a poor understanding of the dashboard. Some of the dashboard outcomes were reported trust-wide and some were not RAG (red, amber, green) rated against trust targets, which meant we were not assured that service leads had good oversight of the outcomes for women at both sites and may not be able to appropriately identify trends in poor performance.
- Lines of communication between the clinical director and other service leads were not always robust.
- The risk register was reviewed and regularly updated, however, not all recognised risks were added to the register, for example lack of recovery and care of the critically ill woman training for midwives.

Maternity and gynaecology

- Midwives on the maternity inpatient ward told us of unsupportive and disrespectful behaviour from some delivery suite co-ordinators.

However, we also found:

- Heads of service were visible and respected and there was generally good local leadership.
- Staff were generally positive about the service and were proud of the care they provided.

Vision and strategy for this service

- Maternity and gynaecology services were provided at this hospital as part of the women's and children's clinical management group (CMG).
- The maternity and gynaecology service leads had a clear vision of the development of the service, demonstrated by the 'Project Initiation Document – Women's services December 2015'. The objectives were clear with actions driven by both national and local directives. This was aligned to the trust's five-year strategy and the 'Better Care Together' programme. However, this vision was dependant on trust wide reorganisation and movement of services. The aim of the project was to consolidate all of the women's and neonatal services onto a single site possibly Leicester Royal Infirmary (LRI) subject to public consultation. The size of the project meant external funding would be required and had been a long-term goal.
- All of the staff we spoke with understood the vision and strategy, although some staff expressed a degree of doubt that it was achievable.

Governance, risk management and quality measurement

- There was a clear governance structure in place for the CMG. Quality and safety issues including incidents, complaints, risks and women's outcomes were discussed at separate monthly maternity and gynaecology clinical governance meetings. Serious concerns could be fed into the trust board through the executive quality board and the CMG quality and safety meetings. In addition, there were regular meetings of the delivery suite forum and the nursing and midwifery board. We reviewed a selection of minutes from these meetings, and saw these were multi-disciplinary and attended by senior staff from both sites, however there were no junior medical or nursing/midwifery staff included in these meetings. Staff we spoke with were

either not aware they could attend, or did not have time to attend. The agenda included the risk register and incidents together with complaints and the quality dashboard.

- Data from reported incidents were co-ordinated by the patient safety team for maternity and gynaecology as part of the corporate risk team. It included a band eight clinical risk quality manager, a band seven clinical risk quality co-ordinator, a band seven quality and safety midwife, a band five complaints coordinator and administration staff. Members of this team sat on the monthly clinical governance meetings for maternity and gynaecology, the specialist nursing and midwifery board meeting for their directorate, and the clinical risk meetings for both maternity and gynaecology where incidents were discussed and reviewed. The team were part of the East Midlands Risk Management Network and were therefore able to share concerns and learning from across the region. Staff in the team had direct access to the head of nursing and the head of midwifery and reported to the quality and safety board.
- Staff discussed specific cases and incidents at the gynaecology or perinatal risk management meetings. We reviewed minutes of a perinatal risk management group meeting from May 2016, which was multi-disciplinary, and we were not assured that incidents were not being inappropriately downgraded. We also reviewed minutes of the maternity governance meeting of November 2015 where grading of incidents related to post-partum haemorrhage was discussed and which said staff were uncomfortable with incident downgrading.
- The service maintained a women's services quality dashboard, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. However, we did not see this document on display for staff and members of the public. The data provided was trust wide. Following our inspection, we asked the trust for the data at location (hospital site) level. The trust was unable to provide this.
- The service used a quality dashboard that was reviewed on a monthly basis, which used a red, amber, green (RAG) flagging system to highlight areas of concern. However, apart from the number of births, the data on the dashboard was for the service as a whole. Junior nursing and midwifery staff we spoke with had a poor understanding of the quality dashboard.

Maternity and gynaecology

- We were not confident that actions were taken if trends were identified. For example when the caesarean section rates had increased unexpectedly the service performed an urgent review of all emergency cases during that period, with all of the consultants looking at a proportion of medical records, however no themes emerged from the review and the rate had returned to an expected level at the next review.
- We saw that the maternity risk register was reviewed and updated regularly. Actions taken were visible and the process completed by removing risks from the register. Some issues identified during our inspection had already been highlighted on the service risk register. The lack of appropriately trained staff in maternity for anaesthetic recovery and care of the critically ill woman had not been recorded as a risk despite being discussed during clinical governance meetings.
- The service performed an audit for compliance with the legal documentation for abortion services at University Hospital Leicester (UHL) in September 2014 and found 100% compliance with completion of consent forms, HSA1 and HSA4 forms (a requirement of the department of health) and fetal tissue disposal forms.
- Some nursing staff in gynaecology told us they did not have regular meetings and were not involved in the decision making process for their hospital and clinical area. We were told that their suggestions for service improvement were ignored.
- Consultants spoke highly of the clinical service leads. Junior doctors told us they felt well supported by consultants throughout the maternity and gynaecology service.
- We learned that lines of communication from the CD to the other service leads were sometimes poor. The HOM had to obtain copies of executive board meetings from the chief nurse as they were not routinely circulated by the CD and was not well informed about trust board level discussions that affected the maternity and gynaecology service.

Culture within the service

Leadership of service

- The chief nurse for the trust was the executive board lead for obstetrics and gynaecology.
- The women's and children's CMG was led by a clinical director (CD). Two clinical service leads, one each for maternity and gynaecology, supported the CD. The deputy clinical director had recently moved to a different service and had not yet been replaced. There was a directorate head of operations and deputy, general managers and service managers. The head of midwifery (HOM) was also the head of nursing (HON) for the directorate and was responsible for four midwifery matrons and one gynaecology matron who organised the day to day running of the obstetrics and gynaecology service.
- There was strong local leadership on the wards. Staff told us the HOM/HON was visible and approachable and they felt supported by ward managers and managers with the exception of staff within gynaecology, who felt that the gynaecology matron was not as visible.
- We saw staff consistently delivering care in line with the trust vision. Midwives, nurses and medical staff spoke positively about the care they provided for women.
- Some of the staff we spoke with reported positive working relationships and we observed that staff were respectful towards each other. However, we spoke with staff on the antenatal inpatient ward 30 and were told that some delivery suite co-ordinators were not always supportive. These band six midwives told us they felt some of these band seven staff were disrespectful towards them and would not listen to them, for example they would put the phone down on them mid conversation. The matron was aware of these issues and told us this was being addressed at the monthly band seven meeting and by rotating band seven staff to work on the ward. However, although issues had been identified, there was no formal action plan.
- The government had commissioned an independent investigation into maternity and neonatal services at Morecambe Bay (the Kirkup report, 2015), to examine concerns raised by the occurrence of serious incidents. Good practice would be to benchmark against the recommendations. Data provided by the trust demonstrated the service monitored compliance with some of the key elements of the Kirkup report such as staffing, multi-disciplinary working and the maintenance of good working relationships between all groups of staff.

Public engagement

Maternity and gynaecology

- The maternity lead, head of midwifery, consultant midwives, midwifery matrons and community midwives attended meetings of the Leicester, Leicestershire and Rutland Maternity Service Liaison Committee (MSLC) on a quarterly basis. The MSLC is a forum for maternity service users, providers and commissioners of maternity services to come together to design services, that meet the needs of local women, parents and their families. For example, minutes of the meeting in September 2015 stated there were discussions around strategy, ante-natal pathways, public health, mandatory staff training and women's outcomes.
- We saw 'message to matron' cards and boxes in wards and clinical areas to encourage the public to comment on services provided.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.
- Over the last year, several engagement events had been run by the Trust's Women's Service. The events aimed to explore the aspirations of local people for their women's services. They had been used as "pre-engagement" to inform the wider Better Care Together consultation.

Staff engagement






- Staff understood the value and importance of raising concerns. Most staff we spoke with said they could approach their ward sister or matron about any issues on the ward. Managers and ward sisters demonstrated to the inspection team their desire and willingness to listen to staff.

- We reviewed minutes of a support staff meeting held in February 2016, which was attended by health care assistants (HCA) and housekeepers and was one way that support staff could raise issues and concerns. We saw that staff discussed mandatory training and appraisals as well as concerns about workload.
- We saw a recent copy of a maternity newsletter which was available to staff within the unit. Managers used the newsletter to keep staff updated about staffing, learning from incidents, feedback from patient surveys and study days.
- The majority of staff we spoke with in both maternity and gynaecology were proud of their hospital and the service that they offered and thought that it was a very good place to work.

Innovation, improvement and sustainability

- The consultant midwife for public health and a senior research midwife won an award sponsored by a midwifery journal for their work setting up a dedicated midwifery research team and for publishing a study into pregnancy and wellbeing.
- Although there was a weekly "birth choices" midwife-led clinic for VBAC (vaginal birth after caesarean section) women, the team planned to set up a specific VBAC clinic and were organising a visit to another similar NHS maternity unit who were willing to share good practice.
- The service had devised a new notification to health visitor form, this had improved communication between midwives and health visitors.
- The ambulatory gynaecology service allowed women to receive treatment for minor procedures in the outpatient's clinic.
- The service used robotic surgery for the treatment of gynaecological cancer.
- The routine use of oximetry for non-invasive early detection of heart defects during the new-born and infant physical examination screenings (NIPE) checks.

End of life care

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

Information about the service

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

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

The specialist palliative care team who supported ward staff to deliver care to patients at the end of their life, are available 7 days a week 9am-5pm. The full team works Monday-Friday 9am-5pm and a clinical nurse specialist works across all 3 sites on Saturday and Sunday 9am-5pm. Out of hours advice is provided by a dedicated telephone advice service based at the nearby hospice, LOROS. (Leicester Organisation for the Relief Of Suffering).

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

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

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

The specialist palliative team see patients with incurable disease at any point between diagnosis and the time they die. Referral criteria include difficult pain and symptom control, complex psychosocial problems and/ or specialist needs related to end of life care.

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

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

We visited ten wards and departments at the hospital including the intensive care unit, cardiac wards, the surgery wards, the mortuary, the hospital chapel, and, the urology ward. We spoke to 21 members of staff including nurses, doctors, health care assistants, mortuary, bereavement and chaplaincy staff. We also spoke to three patients who were at the end of their life and six relatives.

We reviewed six medical and nursing care records of patients at the end of life and 12 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders. We observed the care provided by medical and nursing staff on the wards. We received comments from the public listening event, which was held before our inspection and from people who contacted us separately to tell us about their experiences.

End of life care

Summary of findings

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

- The medical staff levels were not in line with the recommendations from the National Council for Palliative Care who recommend that there is one whole time equivalent (WTE) consultant for every 250 beds. The service had 3.5 WTE and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended.
- The trust had 82 syringe drivers trustwide that were in line with best practice guidelines, though many were missing. This meant only ten were ready for use trustwide. This meant another syringe driver was being used instead, which did not meet the NHS patient safety guidance.
- Out of 12 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR), six were completed correctly (50%).
- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust scored lower than the England average for all five Clinical KPIs.
- The trust had undertaken an audit in April 2016 in response to the National Care of the Dying Audit 2016, and an action plan had been developed to address the KPI's that had not been achieved.
- The service does not have its own risk register and the incidents were not on the trust wide risk register.
- There was no strategic plan for end of life care throughout the trust.
- The service did not have a non-executive director representing end of life care at board level.

However:

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

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

End of life care

Are end of life care services safe?

Requires improvement



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

We found:

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

However, we also found:

- Care records were maintained in line with trust policy. Patient records were kept securely when not in use.
- Staff understood their responsibilities in following safeguarding procedures.
- All the members of the palliative care team we spoke with were knowledgeable about the Duty of Candour.
- The trust had implemented individualised care plans for patients requiring end of life care. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2014.

Incidents

- We looked at the trust incident reporting policy which was up to date.
- The specialist palliative care team told us they were familiar with the process for reporting incidents, near misses and accidents using the trust electronic incident reporting system. Any serious incidents would be investigated through the use of root cause analysis and where necessary further training would be arranged.

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

Medicines

- The trust used syringe pumps for patients who required a continuous infusion of medication to control their symptoms. However, not all of the syringe pumps met the current NHS Patient Safety Guidance which recommends the use of syringe pumps that have specific alarm features and are tamperproof.
- At the time of our inspection, the trust had a shortage of syringe pumps that met current NHS patient Safety Guidance and the SPCT told us there were only ten of these pumps for patients throughout the trust.
- The shortage of syringe pumps meant staff were using an alternative syringe pump that was not tamperproof and did not have the recommended alarm features. This was not in keeping with the trust policy.
- Two nurses from the specialist palliative care team were non-medical prescribers and one was undertaking

End of life care

training to become a non-medical prescriber.

Non-medical prescribers are nurses that are able to prescribe any medicine for a health condition, within their field of expertise.

- The trust had a protocol for the prescribing anticipatory medication. Anticipatory medicines are prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as a patient reaches the end of their life.
- We reviewed the medicines administration records of six patients who were receiving anticipatory medicines. We found these medicines had been appropriately prescribed and administered.
- End of life care services at this hospital followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS61. This quality standard defines clinical best practice about how people are prescribed antibiotics in accordance with local antibiotic formularies. Additionally, nurses followed the standards set out in the nursing and midwifery council (NMC) standards for medicine management.
- We saw a palliative care pharmacy protocol on the hospital's intranet system. The pharmacist told us if a palliative care patient is flagged on the system, then a quick list of standard prescriptions was highlighted. The pharmacist said this reduced the likelihood of an error, as a medication list was available for the doctors to prescribe from.

Records

- We examined six sets of patient records for end of life care patients throughout our inspection; all of them were clear, legible and up-to-date.
- Patient records were kept in secure trolleys at the end of each bay or near the nurses' station. These records were clear, legible and up to date. Records included completed risk assessments for example, falls, nutrition and pressure relief. Patients were cared for using relevant plans of care to meet their individual needs.
- The trust had created emergency healthcare plans for patients known to them. Staff working in the community could view these but not update them electronically. The GPs could amend them by manually entering the care plan into their electronic system and then making amendments on this new electronic care plan or handwriting amendments onto the plan the hospital produced.

- The SPCT had a daily huddle, during which they reviewed the records of their patients to ensure continuous assessment of their needs.
- The bereavement office issued medical certificates of cause of death which enabled the deceased's family to register the death. We found the death certificates had been issued within 14 days of death or cremation and the forms had been signed in accordance with the Births and Deaths Registration Act 1953.

Safeguarding

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

Mandatory training

- There was variability in the levels of compliance with mandatory training within the specialist palliative care team. Up to the end of April 2016, staff had achieved 100% compliance with infection control, equality and diversity and safeguarding children modules. Fire, health and safety, were recorded at 81.3%, moving and handling at 87.5%, information governance, conflict resolution, safeguarding adults and health and safety were all recorded as 93.8% and resuscitation training which was recorded as 81.3% compliance.
- End of life care training was not mandatory but some staff were mandated to complete end of life training as part of 'essential' for role training. The specialist palliative care team had devised a comprehensive end

End of life care

of life care training schedule for nursing staff which they delivered on a weekly basis. Each training session was ten minutes long, in order to ensure it did not interfere with workloads.

Assessing and responding to patient risk

- We reviewed the nursing records of six patients receiving end of life care at this hospital. Risks such as falls, malnutrition and pressure damage were assessed. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to assess a patient's malnutrition risk and the Waterlow risk assessment tool was used to assess patients' risk of pressure damage. All of the records we saw were completed correctly.
- The trust had an individualised care plan for the last days of a patient's life. During our inspection we found that patients when entering the last days of life, were placed on the individualised care plans appropriately.
- Nursing staff used an early warning score (EWS), to record routine physiological observations such as blood pressure, temperature and heart rate. This score was used to monitor patients and prompt staff to follow clear procedures, should a patient's vital signs fall out of expected parameters. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care. We saw examples of care being escalated when a patient's condition had deteriorated. We saw evidence of a treatment escalation plan in the patient's records. Treatment escalation plans outline the level of intervention required should the patient's condition deteriorate.
- Intentional rounding took place for all patients receiving end of life care. Dependent on the individual patient's level of risk, these checks were conducted between one to four hourly intervals. Intentional rounding was an organised process where nurses carry out regular checks with individual patients at set times, normally hourly.
- The trust had devised the 'BEST SHOT' assessment, which was an additional pressure area checklist that was completed at the same time as intentional rounding documentation. This could only be completed by a registered nurse.

Nursing staffing

- There were no dedicated palliative care beds at the trust, which meant that end of life care was provided

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

- There were 15 palliative care nurses in the specialist palliative care team, equating to 12.93 whole time equivalent (WTE) nurses. However, due to sickness and absence the specialist palliative care team staffing levels were reduced to 10 nurses, or 8.93 WTE nurses.
- The SPCT told us the reduction in staff meant that ward/department based training on end of life care had reduced.
- There were 22 end of life care champions attached to most of the wards throughout the hospital. End of life care champions were responsible for developing, in conjunction with the specialist palliative care team, standards and quality of care for palliative and end of life care patients.

Medical staffing

- There were five palliative care consultants in the specialist palliative care team equating to 3.5 WTE staff members. This did not meet recommendations by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care, which states there should be a minimum of one consultant per 250 beds. This meant that the trust would require 7.0 WTE doctors and the trust is currently running at 50% of the recommended medical staff rate.
- We asked the trust what actions they were taking to meet the recommendations of the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care. The trust told us that at present they had 3.5 WTE consultants, and were aware this was far short of the recommended numbers. The trust had undertaken a business case for two WTE consultant posts, however, they were aware this would still not be in line with Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care requirements
- End of life care patients were reviewed on the wards on a daily basis and sometimes more than once a day as needed.
- We spoke with four doctors, all told us they had good access to and support from, the consultants within the specialist palliative care team.

End of life care

- Weekend and out-of-hours on-call advice for staff was provided by a consultant through the advice line at the local hospice. Staff could use this facility to access specialist advice and support if a patient was identified as at the end of life.

Major incident awareness and training

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

Are end of life care services effective?

Requires improvement



We rated the effectiveness of end of life care services at Leicester General Hospital as requires improvement.

We found:

- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs) and the trust scored lower than the England average for all five Clinical KPIs. The trust did not have a lay member on the trust board with a responsibility for end of life care and there was a lack of formal training in relation to communication skills for staff.
- Out of 12 Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR), six were completed correctly (50%).
- The Specialist Palliative Care team told us they had not received any training on The Mental Capacity Act 2005. Nursing staff we spoke with had a basic awareness and understanding of Deprivation of Liberty Safeguards, but not of The Mental Capacity Act 2005.

- We requested from the trust any audits from the last 12 months on the specialist palliative care team completing mental capacity assessments. The trust told us they had not undertaken any audits of this nature.

However:

- All of the records we reviewed demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13.
- Staff were using the trust's end of life-individualised care plans consistently where patients had been identified as end of life to ensure they received evidence based end of life care.
- Patient's symptoms were managed and anticipatory medication was prescribed (medication that patients may need to take to make them more comfortable).

Evidence-based care and treatment

- Staff assessed patients' needs and delivered care and treatment in line with National Institute for Health and Care Excellence (NICE) guidance.
- All of the records we reviewed demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This guidance defines clinical best practice within end of life care for adults.
- Following the withdrawal of the Liverpool Care Pathway, the trust had developed and implemented individualised care plans for patients on the end of life care plan. The individualised care plans recognised the five priorities for end of life care as set out by the Leadership Alliance for the Care of Dying People (2014).
- Staff were using the trust's end of life-individualised care plans consistently where patients had been identified as end of life to ensure they received evidence based end of life care.
- The specialists palliative care team was able to tell us about the current guidance relating to end of life care.
- The trust participated in the Transforming End of Life Care in the Acute Hospitals programme (Transform programme). The programme aimed to improve the quality of end of life care within acute hospitals across England. It focuses on both the quality of care provided by acute hospitals, as well as the role acute hospitals have that provide care for people who are approaching end of life.

End of life care

- One of the key elements of the Transform programme is the AMBER Care Bundle, this is a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.
- Across the three hospital sites, 44 wards were using the AMBER Care Bundle. End of life care facilitators within the specialist palliative care team had launched the AMBER Care Bundle and had supported staff in its implementation.

Pain relief

- Patient's symptoms were managed and medication was prescribed for anticipatory medicines (medication that patients may need to take to make them more comfortable). We checked two medication administration records and found that both records demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms.
- Patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief.
- We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- We saw the core standards for pain management services were being met in all of the medical notes we reviewed. The core standards for pain management in England are a comprehensive index of recommendations and standards for pain management. For example on one ward we inspected, we saw in the patients' medical notes an entry that stated if the patient deteriorates, they were not for escalation. The medication chart had an entry which showed all non-essential medication had been withdrawn and that anticipatory medication had been entered correctly.
- However, we saw documentation that showed the trust had not undertaken any audits on pain relief during 2015 or that any staff had received practical training on the use of syringe drivers for end of life care patients.

The trust stated a training video had been produced for staff to view as a refresher and 'how to' when the specialist palliative care team were not available to support them in person.

Nutrition and hydration

- We reviewed six sets of nursing records for patients in the last days of life and found patients were screened for their risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify patients who are malnourished, at risk of malnutrition and to ensure those who were nutritionally at risk were identified accordingly.
- Patients were encouraged to eat and drink as and when they are able to and for as long as they were able to in their last days of life. Families were also encouraged to support and help their relatives to eat.
- We looked at the menu on each ward we visited. The menu had a main section and one for cultural meals which included kosher, halal, vegetarian and vegan options. Staff told us that patients receiving end of life care could also order from the children's menu, this was because there were some end of life care patients preferred the children's menu choices.

Patient outcomes

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

End of life care

- The trust scored worse than the England average for all five clinical KPI's. Where the trust had scored worse than the England average this was because the trust did not perform well against documented evidence at the end of a person's life.
- The trust had undertaken an internal audit in April 2016 in response to the findings of the 2016 National End of Life Care Audit – Dying in Hospital. An action plan was developed to address the KPIs that had not been achieved. Staff told us they were currently working to improve outcomes for patients at the end of their life.
- In January 2016, the trust started a review of patients' preferred place of care and preferred place of death. This was the first time the review had been undertaken.
- The trust did not contribute to the National Bereavement survey. The National Bereavement Survey aims to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country and to different groups of patients.
- As a response to the results of the National Care of the Dying audit, the lead consultant for end of life care had commenced a trust wide audit. The audit made multiple recommendations and specified these should be integrated into clinical practice, education and training for all staff involved in providing care to patients who are dying. In addition, there were eight recommendations identified as fundamental for the trust in improving end of life care. The specialist palliative care team told us they were currently working to improve outcomes for end of life care patients which had been recognised as part of the audit.
- We saw documentation that showed all members of the specialist palliative care team received appraisals as well as clinical supervision and these were up to date.
- The specialist palliative care team clinical nurse specialists were able to access clinical supervision from a local hospice. A palliative medicine consultant led these supervision sessions on a bi-monthly basis.
- The trust did not participate in the Gold Standards Framework accreditation scheme (GSF). The GSF is a systematic, evidence based approach to improving care for all patients approaching the end of life.
- The specialist palliative care team undertook regular teaching every week on a number of subjects for trust staff. An example of this was training undertaken recently for palliative and end of life care ward link nurse champions.
- Training was also undertaken on AMBER care bundles, QELCA, communication skills training, included breaking bad news, the five priorities for care and individualised end of life care plans. Quality End of Life Care for All (QELCA) is an education programme, delivered by hospices for nurses working in other healthcare settings.
- The specialist palliative care team provided 'shadowing' opportunities for all levels of staff. This allowed more inexperienced staff to work alongside a member of the specialist palliative care team to develop their own skills and knowledge.

Multidisciplinary working

- Patients receiving end of life care received support from an end of life care multidisciplinary team (MDT). This included the specialist palliative care team consultants, nursing staff, occupational therapists, physiotherapists, oncologists and other relevant professionals. The chaplain and the bereavement team were also part of the MDT for end of life care patients.
- The specialist palliative care team staff told us that members of the team, tried to attend as many multidisciplinary team meetings as possible. These were undertaken to help identify and coordinate care for patients approaching the end of their life or requiring supportive care.
- The specialist palliative care team attended the cancer multi-disciplinary meetings and either received or self-referred patients from the meeting.
- The specialist palliative care team had a good and effective relationship with the local hospice and

Competent staff

- At the time of our inspection, there were 22 end of life care champion link nurses trustwide who championed end of life care. Link nurses or champions promote good practice for end of life care and have undertaken specific training relevant to their roles.
- The specialist palliative care team had undertaken the Quality End of Life Care for All (QELCA) training. The training is concerned with end of life care education. QELCA training was undertaken in conjunction with a local hospice four times a year for ward sisters and matrons.

End of life care

ensured that patients nearing the end of life, who had expressed a wish to be referred to the hospice, were referred in a timely way. However, the trust did not audit these referrals to the hospice.

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

Seven-day services

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

Access to information

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not see any end of life or palliative care patients deprived of their liberty during this inspection.
- Patients and relatives told us that staff did not provide any care without first asking their permission.
- Signed consent forms were evident in all the patient records we examined. This demonstrated that staff obtained consent to treatment appropriately
- Nursing staff we spoke with told us they had not received training on the MCA. They had a basic awareness and understanding of DoLS, but not of the MCA. The MCA is a piece of legislation applying to England and Wales, its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The DoLS is part of the MCA. DoLS aims to make sure that people in care homes, hospitals', and supported living are looked after in a way that does not inappropriately restrict their freedom. Anybody under a DoLS application must first have had a mental capacity assessment and be found to lack mental capacity to make a decision with regard to the situation they find themselves in. The trust informed us that MCA, DoLS and consent training was delivered together and staff had to complete an assessment to demonstrate understanding of this. Staff were unaware they had completed this training.
- We requested from the trust any audits from the last 12 months on staff completing mental capacity assessments and any recent audits on DoLS applications for the End of Life Care Service.
- The trust stated they had not undertaken any audits, but instead had embarked on a Mental Capacity awareness project which had commenced in December 2014 for the purpose of improving awareness,

End of life care

understanding and compliance from staff with both the Mental Capacity and the Deprivation of Liberty DoLS legislation. The project contained details of mandatory training modules to cover consent, MCA and DoLS and teaching undertaken on the 'Intensive Support Week'. The project was expected to be completed by mid-2016. The project had not been completed at the time of our inspection.

- The 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were kept at the front of the patients medical notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All of the DNACPR orders were easy to read.
- We looked at 12 DNACPR forms at Leicester General Hospital and found there were inconsistencies in how these forms had been completed.
- Out of 12 DNACPR forms we looked at, six were completed correctly (50%).
- Do not attempt cardio pulmonary resuscitation' (DNACPR) orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity and lack of information regarding the discussions held with patients and/or their families.
- Of the six not completed accurately, none of them had not been discussed with the patient, even though on one DNACPR it stated 'patient has capacity'. Where the reasons was given for not discussing with the patient was 'lacks capacity', core morbidities or brain injury, none of these DNACPR orders had a mental capacity assessment undertaken.
- We asked the trust for a copy of their Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy. The policy states 'The trust has a legal duty to consult with and inform patients if a DNACPR order is placed in their notes (and relevant others if the person lacks capacity to be involved in the process)'.
- This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not being followed.
- The trust did not routinely audit DNACPR forms but told us this was being considered as part of the 'last day's audit' for deaths in 2016.
- We discussed our findings with the safeguarding lead for the trust, who agreed there was a need for staff training on undertaking mental capacity assessments.

Are end of life care services caring?

Good



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

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

Compassionate care

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

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered. We saw that staff discussed care issues with patients and relatives where possible and these were clearly documented in patient's notes.
- We saw staff discuss care issues with patients and relatives where possible and these were generally clearly documented in patient's notes. An example of

End of life care

this was we sat in on a meeting between the doctor and the family where the doctor gave bad news about the life expectancy of the patient to the family; this was done in a clear, concise and compassionate manner.

- We spoke with the family after the doctor had left and they were very complimentary about their loved ones care and said the doctors and nurses had kept them informed and involved in their relatives care since admission to hospital.

Emotional support

- The chaplaincy service held communion at the patient's bedside if patients were too ill to attend the chapel. The chaplain told us they conducted last rites and blessed the deceased in the mortuary as required.
- The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress. There were a number of thank you cards in the multi-faith chapel thanking the staff for their support during times of bereavement.
- The clinical nurse specialists (CNS) from the specialist palliative care team spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The team acknowledged the importance of supporting not only the patient but their relatives and friends throughout the dying process.
- Chaplaincy, bereavement and mortuary staff demonstrated empathy for the relatives and friends of the deceased, stating the need for a holistic approach to the emotional needs of those left behind.
- The chaplaincy service was not licensed to conduct weddings for end of life care patients. They told us they were able to facilitate this with one of the community registrars who would conduct weddings. The service employed 80 volunteers who would sit with end of life care patients as required.
- The trust provided memorial services for relatives of patients who had died at the hospital.

Are end of life care services responsive?

Good



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

We found:

- Patients who were referred to the specialist palliative care team were seen according to their needs.
- The specialist palliative care team were committed to ensuring that patients receiving end of life care services had a positive experience.
- The referral data provided by the trust demonstrated that specialist care was being provided for patients with other life shortening conditions with 26% of patients seen not having cancer.
- There were process in place for the reporting, management, response and learning from complaints.

However:

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

Service planning and delivery to meet the needs of local people

- The specialist palliative care team had established links with community palliative care services and the local hospice LOROS (Leicestershire and Rutland Organisation for the Relief of Suffering) Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care.
- Referrals to the specialist palliative care team for the period April 14 to March 15 were 1571 cancer and 435 non-cancer. As a percentage this equates to 78% cancer and 22% non-cancer. total referral 2006 for this period
- For the period April 2015 to March 2016 to total referrals for cancer patients were 1672 and for non-cancer patients it was 600. As a percentage, this equates to 74% and 26%.

End of life care

- Data showed that for the period 2014/15 98% of patients were seen within 24 hours of referral to the specialist palliative care team.
- The trust had a rapid discharge home to die pathway which could be facilitated within four hours. However, this was not audited.
- Ward staff said the specialist palliative care team normally responded within 24 hours to referrals.
- There were no facilities available for the bereaved to wash the deceased. The mortuary manager told us that by agreement, all ablutions of the deceased were carried out in the community.
- The mortuary had an 'urgent release policy', when the deceased is released within 24 hours and was used regularly with regard to cultural and religious beliefs.
- The mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious, spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.

Meeting people's individual needs

- There were no dedicated palliative care beds at this hospital. Patients identified as being in the last days or hours of life were mostly nursed on general medical and surgical wards. Nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. This was not always possible and was dependent upon the patient capacity on the wards.
- The trust had introduced the blue butterfly initiative. This is where a blue butterfly was placed on the curtain or door of a person who was at their end of life and remained there when they had died.
- The picture of the blue butterfly was on a number of different features, for example, when someone died, the loved ones are given a booklet from the bereavement service, with a blue butterfly picture on called 'Helpful, information following a death'. The blue butterfly picture is also part of the individualised end of life care plan.
- Blue butterfly bereavement cards were sent to families and loved ones; these were hand written by the staff who had taken care of the patient. They had contact details on them if families wanted get in touch with the bereavement follow up service nurse.
- One nurse showed us her white plastic card with a blue butterfly on called 'Care after death guide'.
- Nurses told us, if there was an end of life care patient, then visiting hours were not observed and family could stay for as long as they wished and all through the night.
- The mortuary had a viewing suite where families could visit their relatives and loved ones. We visited the area and saw the viewing suite was divided into a waiting room and a viewing room.
- The mortuary accommodated all faiths and worked closely with Muslim and Jewish undertakers to ensure deceased patients were cared for following their cultural and religious requirements.
- Information was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen.
- There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life. These were also available in different languages other than English.
- The chaplaincy team, which included 80 volunteers, visited the wards every day, and where requested, visited the patients who had been placed on the individualised end of life care plan.
- Within the chapel, there were separate prayer rooms with prayer mats and washing facilities for Muslim prayer.
- There were separate prayer rooms for other faiths such as Sikhs and Buddhists, as well as non-faith material.
- The service employed 80 volunteers who would sit with end of life care patients as required. In January 2016, the trust had employed the first non-religious chaplain.
- As part of the individualised care plan there was a booklet called 'Information for relatives and friends'. The booklet explained in plain English what to expect when someone close to you is very ill, such as medication, changes that occur before death and the last days of the care plan.
- We saw leaflets for relatives with regards to the withdrawal of treatment in intensive care. There were leaflets in both the bereavement office and the mortuary concerned with help for the bereaved and what actions to take when someone dies.
- There were leaflets on the trust website about the bereavement service. They advised how to arrange a

End of life care

funeral, what to do when your baby has died, information on the chaplaincy service and what to do after the funeral. Information on the hospital accommodation for relatives was also available.

- The trust although did not have a specialist end of life care dementia care plan, told us there was palliative care representation at the dementia implementation group.
- The 'Last days of life' booklet had been adapted for intensive care patients, for example, what to expect if the patient is on a ventilator in the last days and hours of life.
- Bereavement support was offered to relatives (adult inpatient deaths), aiming for contact six to eight weeks post-bereavement. Documentation showed that between January and March 2016 49% of relatives took up the offer of bereavement support. Feedback from 104 relatives in March 2016 rated the quality of care as good to excellent for the majority 82%. 11% of relatives rated the care as 'ok', with 4% rating the care as 'poor'. 3% of relatives stated they were 'unable to say'.
- The trust used a translation service when required for those patients who could not speak English or English was not their first language. This was either undertaken face to face or a phone line could be used at the bedside

Access and flow

- The service had a patient register that trust staff could access via the trust's centralised, electronic patient co-ordination system however, there was no electronic flagging system for end of life care patients on admission. This meant the specialist palliative care team were reliant on staff to refer end of life care patients to them.
- Referrals to the specialist palliative care team could be made at any time from the patient's diagnosis. This meant the specialist palliative care team could be involved in the patient's care at an early stage.
- The specialist palliative care team had established links with community palliative care services and the local hospice. Staff told us this promoted shared learning and expertise and facilitated consistent care for patients who transitioned between services. Patients had timely access to the specialist palliative care team. Data showed between April 2015 and March 2016 they had 813 follow up patients and 273 new referrals.

- Audit results demonstrated 98% of patients had been seen within 24 hours of a referral being made to the specialist palliative care team.
- The specialist palliative care team worked closely with the specialist discharge team to discharge people to their preferred place of dying if they were not on the rapid discharge plan. The hospice at home service was able to provide short- term care to support patients who wanted to go home. Documentation was available to provide guidance to the nursing staff. Copies of the document were placed into the end of life resource box available on all of the ward areas.
- The specialist palliative care team undertook rapid end of life care discharges for patients who wished to return to the community or a 24 hour care facility. Rapid discharges are normally undertaken for patients who have rapidly deteriorating condition, which may be entering a terminal phase.
- We asked the trust for information concerning rapid discharges and how many patients had been discharged successfully this way. The trust told us they do not collect data on the timescales, but were anticipating reviewing this in the future.
- The specialist palliative care team had undertaken a review of 30 patients who were part of their caseload at the time of death or within 30 days of death in January and February 2016. The results showed that 83% of patients, who identified their preferred place of death, were supported to die there. Where this had not been achieved, it was due to the patients being assessed as too unwell to transfer home.
- The review had four recommendations. It recommended that earlier discussion of preferred place of death should be undertaken with patients referred to the specialist palliative care team.
- The SPCT were fully aware of the outcomes of the review and were undertaking the recommended actions.

Learning from complaints and concerns

- For the period 2015 to 2016, the trust had received eight complaints relating to end of life services. Four of these complaints related to Leicester General Hospital
- The clinical lead would investigate formal complaints relating to end of life care and palliative care patients.
- Staff we spoke with told us if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.

End of life care

- The specialist palliative care team said all complaints about the service would be reviewed and actions would be taken and lessons learnt for the future.

Are end of life care services well-led?

Requires improvement



We rated the end of life care services at Leicester General Hospital as requires improvement.

We found:

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

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

However:

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

Vision and strategy for this service

- End of life care was provided at Leicester General Hospital as part of four clinical management groups (CMGs): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS).
- The trust did not have a fully developed end of life care strategy that included prioritised time bound actions with appropriately allocated leads.
- We asked the trust for its policy and strategy on end of life care. We were told the trust had developed guidance for the care of patients in the last days of life and this was updated following publication of NICE guidance in December 2015. We saw the trust had incorporated guidance on the five priorities for care of the dying person.

Governance, risk management and quality measurement

- The trust did not have a risk register specifically for recording end of life care as an area of concern. Instead the service used the trust's general risk register. However, information received from the trust showed there were three incidents raised in 2015, concerning the lack of the correct syringe drivers, but there did not appear to have been any actions undertaken and this was not identified on the trust's overall risk register. The trust had developed a system where all incidents, concerns and complaints relating to end of life care are centrally collated and thematically analysed in addition to the usual process of reviewing and developing actions from these issues. This was to ensure that patterns and learning were accurately collected across the trust. The results were shared and additional actions developed at the End of Life and Palliative Care committee
- General ward staff on the wards where end of life care patients were nursed, had limited awareness about the trust's audit strategies in relation to end of life care. For example, none of the staff on the wards we inspected were able to tell us about the audit schedule of key processes, or if one was in place.
- The specialist palliative care team had regular team meetings in which issues and general communications were discussed. For example staffing levels at the weekends and the teaching that was being undertaken
- We saw the action notes of the executive quality board for April 2016 which discussed the national report for England 2016 End of Life Care Audit – Dying in Hospital. The audit showed that when compared to other trusts in England; the United Hospitals Leicester consistently ranked in the bottom 20, for two of the five clinical indicators and was classified in the bottom ten compared with the national average for England. It was accepted the trust recognised dying later and the interval between recognition of dying and death was shorter.
- In almost all areas of the case note review undertaken within the trust it was agreed that when determining why discussions did not take place, there was a higher incidence of 'no reason recorded' documented for UHL than nationally, therefore suggesting documentation of end of life issues was poor and required improvement.

End of life care

- In response to the audit, the trust had an interim at the end of life plan which had since been reviewed to improve usability. However, we could not see an end of life care strategy that included prioritised, time bound actions with appropriately allocated leads.
- The specialist palliative care team leads had started attending other speciality mortality and morbidity meetings to identify if there were any end of life care issues which still needed to be addressed.
- End of life care services were discussed at board level. The specialist palliative care team had recently started presenting end of life care patient stories to the board. Staff told us this was to raise the importance of end of life care with the view that all board members would have responsibility and acknowledge the importance of end of life care.
- Staff within the specialist palliative care team spoke positively about the service they provided for patients and were passionate about their work.
- Ward staff were positive about the support provided by the specialist palliative care team
- Staff reported positive working relationships, and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- There was good team working between the specialist palliative care team the bereavement service and the chaplaincy service.
- Most staff we spoke to said they felt confident to whistle blow or raise concerns with their managers.
- Staff said they had regular staff meetings where concerns were raised and discussed. We also saw documentation from the trust which showed this.

Leadership of service

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

Culture within the service

Public engagement

- We saw that patients experience stories were discussed at the board of directors meeting.
- There was representation from Healthwatch on the End of Life Care committee which ensures that patients and the public are represented and can contribute to the end of life services in the trust.
- The chaplaincy service had recruited 80 volunteers of differing faiths who worked with patients and their families throughout the three hospital sites.
- Bereavement support was offered to relatives (adult inpatient deaths), aiming for contact six to eight weeks post-bereavement. Documentation showed that between January and March 2016 49% of relatives took up the offer of bereavement support Feedback from 104 relatives in March 2016 rated the quality of care as good to excellent for the majority 82%. 11% of relatives rated the care as 'ok', with 4% rating the care as 'poor', 3% of relatives stated they were 'unable to say'.
- 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.

End of life care


Staff engagement

- There was a process in place to feedback information to staff via newsletters, emails and staff meetings. Staff were informed about the outcome of complaints and incidents within their area of practice.
- The chaplain was part of the multi-disciplinary team who worked in end of life care and supported patients, families and staff as required.
- Most wards had a designated end of life 'champion' in place with responsibility for promoting the use of the end of life AMBER care bundle when this was appropriate.
- The mortuary no longer contributed directly to the EOLC policy; however they did provide input for the last offices policy.

Innovation, improvement and sustainability

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

Outpatients and diagnostic imaging

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

Information about the service

University Hospitals of Leicester NHS Trust (UHL) was the seventh largest provider of outpatients' services in England from September 2014 to August 2015. Leicester Royal Infirmary (LRI) had 58% of outpatient activity, whilst Leicester General Hospital (LGH) and Glenfield Hospital (GH) had 25.5% and 16.7% respectively. The remainder of outpatient appointments are held in the trust's smaller outlying hospitals within Leicestershire and Rutland.

The specialities with the highest outpatient attendances are: ophthalmology, dermatology, gynaecology, rheumatology and urology. Dermatology, gynaecology. Rheumatology and urology, clinics take place at LRI and LGH.

The trust offers a range of diagnostic imaging services at Leicester General Hospital. These include; x-ray, ultrasound, computerised tomography (CT) scanning, and magnetic resonance imaging (MRI).

At Leicester General Hospital, we visited a range of clinics including the orthopaedic, gynaecological, rheumatology, diabetes, urology and neurology clinics. We also saw x-ray, computerised tomography (CT) scanning, ultrasound and magnetic resonance imaging (MRI) diagnostic facilities at the LGH site.

Seven different clinical management groups (directorates) managed outpatient specialities. For example, cancer, palliative care, urology, gastrointestinal, and general surgery were in the cancer, haematology, urology, gastro intestinal and general surgery (CHUGGS) clinical management group; ophthalmology, orthopaedics,

plastics, breast care, maxillofacial, oral surgery, and ear, nose and throat (ENT) reported to the musculoskeletal and specialist surgery (MSK) clinical management group. The clinical support and imaging clinical management group (CSI) had responsibility for diagnostic imaging, medical records management and the booking centre.

During our inspection of Leicester General Hospital (LGH) we spoke with 12 patients, one consultant, three managers and senior radiographers, three nursing sisters, two band seven nurses, six band four nurses, four health care assistants or equivalent, and one clinic coordinator.

Outpatients and diagnostic imaging

Summary of findings

Overall we rated outpatient and diagnostic imaging services as requires improvement because:

We found:

- Patients experienced unacceptable waits for some outpatient services trust-wide. Four patients waited for 52 weeks to be seen. There were backlogs in some outpatient specialities that clinicians had not fully prioritised. In some clinics, there were long wait times. Patients complained of multiple cancellations.
- The risks associated with anticipated events were not fully recognised, assessed or managed. Leaders did not risk assess outpatient waiting list or backlogs in a timely manner. High risk patients and patients whose circumstances might make them vulnerable were not always identified before arrival in clinic. Some equipment checks at Leicester General Hospital were not up to date.
- The trust was developing governance arrangements to better manage performance for outpatients however the impact on patient experience was not apparent when we inspected.
- Patients waiting for appointments were not routinely checked for pain, or offered refreshments if they had been waiting a long time.
- The dignity of patients was not always respected. For example, there were changing areas where male and female patients had to share. In a mixed sex computerised tomography (CT) imaging waiting area, there were insufficient gowns to assure patient's dignity.

However:

- Staff understood and fulfilled their responsibilities to raise safety concerns and report incidents and near misses; managers supported them when they did. If something went wrong, there was a thorough review or investigation involving all relevant staff and people who used services. Lessons were learned and communicated widely.
- Feedback from patients who use the service, those who are close to them and stakeholders was positive

about the way staff treated people. Patients told us they were happy with the standard of treatment and care and that nurses and clinicians were kind and compassionate.

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, and legislation. The services used local and national audit arrangements to maintain the effectiveness of treatment. Diagnostic imaging used diagnostic reference levels to check dosage. Services used multidisciplinary team arrangements to benefit patients.
- Leaders had a vision for the future of outpatient services and this was understood by staff.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated the service as requires improvement for safe:

We found:

- The hospital had not fully implemented World Health Organisation (WHO) five steps to safer surgery checklist in outpatient services.
- Systems and processes were not always reliable or appropriate to keep people safe. Equipment checks were not up to date, including emergency equipment. The environment was not always maintained to an acceptable standard.
- Medical records were not always stored securely.

However, we also found:

- Staff learned from safety incidents and there was a positive culture of reporting incidents.
- Staff complied with mandatory training and were trained on safeguarding.
- Medicines were stored, and managed securely.
- Diagnostics imaging staff were clear about what to do in a major incident.

Incidents

- There were no never events at Leicester General Hospital (LGH) between April 2015 and April 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- LGH diagnostic imaging reported one serious incident between July 2015 and June 2016. An incident in August 2015 was classified as a surgical/invasive procedure and involved a kidney lesion which had not been detected prior to donor surgery. (A donor is a person who provides an organ for transplantation). The trust learned from this incident and developed an action plan so the same event could not happen again. The renal

department invited radiologists to their multidisciplinary team meetings and revised the computerised tomography (CT) (a 3D x-ray) scanning protocol and donor pathway.

- Learning was shared through a bulletin found on the trust's patient safety portal, through morbidity and mortality meetings, clinical management board meetings and quality and safety meetings. Services investigated incidents and planned actions to learn from them.
- Outpatient specialities learned from mortality and morbidity meetings. For example, minutes from the joint clinical governance meeting of diabetes and endocrinology included information relating to the treatment of patients with an indwelling catheter (a tube into the bladder). The advice followed an outcome of an incident investigation. Specialist diabetes nurses attended these meetings.
- Nursing staff in outpatient clinics knew how to report incidents although not all health care assistants (HCAs) were sure how to report incidents on the electronic reporting system. However, they told us they would escalate to a senior nurse.
- As a result of ultrasound incidents over two years ago, the service had recognised the lack of leadership structure within the ultrasound service. At the time, the service did not audit its practices. Since then, it recruited a screening sonographer to lead on audits. A sonographer is a specialised healthcare worker who performs diagnostic ultrasounds. An ultrasound is a device that uses high frequency sound waves to create an image of some part of the inside of the body.
- The service had guidance on types of incident which were reportable. Diagnostics staff knew which incidents were Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R) reportable. Imaging services provided examples of incidents and how they learned from them. They alerted referrers if they requested imaging on the wrong patients and wrong body parts. They reported a high volume of low grade incidents (incidents of low importance did not require feedback) and staff corrected the mistake at the time. Between March 2015 and April 2016 the clinical support and imaging (CSI) clinical management group reported 796 incidents trust wide, mainly concerning diagnostic imaging. The trust did not give us site-specific information, so we could not report on how many of these came from Leicester General Hospital.

Outpatients and diagnostic imaging

- Staff received feedback if they reported an incident. They reported them onto the electronic incident reporting system. They were able to see that their manager dealt with their incident and invited them to speak with the manager for further feedback.
- The diagnostic imaging department had a departmental radiation protection notice board. This displayed charts referring to Ionising Radiation (Medical Exposure) Regulations IR(ME)R compliance audits such as the 'patient identity' audit and the 'date of the last menstrual period to avoid x-raying a foetus, along with dose reference levels, and personal protective equipment' audit results.
- The hospital had not fully implemented World Health Organisation (WHO) five steps to safer surgery checklist in outpatient services when we inspected. Clinicians performed minor operations in dermatology, ophthalmology, gynaecology, ear, nose and throat (ENT), orthopaedics, urology and restorative dentistry and used an adapted version of the five steps to safer surgery checklist. The trust had not audited the use of the document for compliance.
- Outpatient clinics did not consistently display dashboards which reported on quality, safety, and patient satisfaction levels. We saw some patient satisfaction information on clinic noticeboards but no comprehensive quality or safety monitoring reporting.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' We saw from incident investigations that incident investigators involved patients and their families throughout the investigation process.
- Knowledge about the duty of candour was not embedded. Staff were aware of it, but it was an informal understanding. Staff in outpatient clinics and in diagnostic imaging services explained to us what the duty of candour was. They said they were open and honest about mistakes, but could not remember a specific time when they used the duty. They had not had any specific training and the trust did not audit the effectiveness of training or understanding of the duty.
- We checked outpatient clinic four which was visibly clean. There was a hand gel dispenser on entry. Staff told us cleaning had improved since the cleaning services had been moved back in-house. We observed daily cleaning records in each clinic room which were up to date. Cleaners were in the clinic area for two hours each evening Monday to Friday. No environmental audits were displayed and there were no 'clean' labels to show when equipment had been cleaned, to reassure patients.
- In clinic four, the clinic area had been recently painted however there was an area in consulting room three where plaster was missing above a sink, this meant this area could not be cleaned effectively and this was an infection control risk.
- Toilets were visibly clean. In the gynaecology clinic, toilets were visibly clean but had an unpleasant odour and toilet paper on the floor. The female toilet in clinic four was visibly clean. The male toilet in clinic three was visibly clean although a bit worn and dated. The disabled toilet was visibly clean but with some tissues and paper towels on the floor.
- We saw a cleaning schedule on the clinic wall which included daily, weekly and quarterly tasks. There were no toilet cleaning schedules completed for outpatient clinics. We noticed one schedule on a toilet wall but it had not been completed to indicate this area had been cleaned.
- There was a schedule for daily equipment cleaning. Cleaning scores were displayed on a noticeboard in the waiting area to reassure patients that equipment had been cleaned.
- We observed clinicians using hand gel before approaching patients. In diagnostic imaging, we noticed staff washed their hands before and after every episode of direct contact or care. Nurses and doctors we saw observed the 'bare below elbow' rule. The trust did not audit hand hygiene for outpatient clinics. The infection prevention team told us they focused on in-patient areas where there was a greater risk of healthcare-associated infection.
- Diagnostic imaging had arrangements for patients who were at risk of spreading infection to others. The radiographers and the patient would wear protective masks. They would scan or x-ray the patient at the end of the day, to minimise the risk of cross contamination

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

and spread of infection. Imaging services had their own staff to clean the scanners and to carry out safety checks. We observed them using personal protective equipment.

Environment and equipment

- Some items of equipment had not been safety tested. In outpatients three, we saw a defibrillator which had not been safety tested on its due date in April 2016. Staff took immediate action when we pointed this out to them. We observed a blood pressure machine, a thermometer and two urilisers (diagnostic apparatus) which had not been safety tested by the required date.
- Some areas used by patients needed maintenance. There was a roof leak by the diagnostic imaging reception area. Staff put a yellow container underneath to catch the water and stop the floor getting slippery. This was also reported on in the findings of our last inspection from January 2014 but had not been rectified. There were lifted floor tiles in between diagnostic imaging waiting areas C and D. Diagnostics imaging staff had bought some hazard tape using petty cash to put on the floor so that patients were aware of the risk.
- The gynaecology waiting room was small and it was difficult to ensure privacy. The reception desk was at the entrance to the room and close to the seating. At one point there were seven women queuing at reception, very near to the desk.
- Poor soundproofing between consulting rooms meant we were able to hear consultations in adjacent rooms while we accompanied a patient during a consultation.
- Resuscitation trolleys were checked daily in orthopaedic, gynaecology, rheumatology, diabetes, urology and neurology clinics we inspected. This ensured key equipment was available if a patient needed resuscitating.
- The blood glucose monitoring equipment to monitor diabetic patients was stored correctly and the checklist was signed to record the checks were completed. A box for treatment of hypoglycaemia (low blood sugar) was available in the diabetes outpatient clinic. All staff were trained to use and maintain the contents of the box.
- Facilities in the urology clinic were appropriate for their purpose with a specific room for flow rate testing and an ultrasonic scanner for measuring residual urine. A flow rate test measures how fast a patient passes urine.

- There were signs in the diagnostics imaging waiting areas informing people about rooms where radiation exposure took place. These rooms automatically locked when an x-ray procedure was under way, which protected staff and patients.

Medicines

- All medicines for outpatient clinics were stored in clinic outpatients one. Medicines were held in locked cupboards in a locked room with keypad access. Drugs were transferred in trays to other clinics where they were kept in the clinic room under the supervision of a doctor.
- Arrangements were in place to ensure the safe storage and use of FP10 prescription pads. Outpatients department one held FP10 prescription pads and allocated them to individual nurses in the clinics. The numbers were recorded on a sheet and then returned to outpatients one at the end of each clinic. There was access to the pharmacy for the issue of prescribed medications.
- The pharmacy team included non-medical prescribers in specialist clinics (for example, rheumatology). This ensured timely access to medicines. Non-medical prescribers are health professionals who can prescribe medicines, dressings and appliances in the absence of a doctor.
- We identified that fridge temperatures were not recorded correctly; single daily temperatures were recorded rather than maximum and minimum levels. This did not demonstrate a consistent temperature had been maintained to assure the safety and effectiveness of the medicines. Action was taken at the time of the visit to address deficiencies in monitoring (and confirmed in place on unannounced visits),

Records

- We observed patients' medical notes stored on trolleys outside clinic rooms in outpatients four. The notes were not locked away and were left unattended. This meant a patient's medical notes could be accessed by an unauthorised person.
- Non-compliance with records systems caused problems. There was a system for ensuring that medical records were available for clinics and records were tracked electronically. However, not all staff complied with the system and medical staff sometimes had to search for records.

Outpatients and diagnostic imaging

- Last minute additions to patient lists meant staff could not find patient records in time for a clinic. Appointments for the same patient in different clinics were sometimes booked within a short time of each other so there was little time for the records to be transferred to the next clinic or hospital. In many cases, doctors saw patients even if medical records were missing. For example, in gynaecology, staff estimated that there were two to three sets of notes missing from every clinic list (clinic lists varied from 12 to 30 patients). However, the gynaecology clinic had its own computer system which held all the patient details. This provided patient details if the medical records were missing.
- The trust generated monthly reports to track when notes arrived too late for a patient appointment. Information was shared at clinical management group assurance meetings (CMGs). CMGs did not review this information by type of hospital activity or by hospital site, so were unaware of how information affected outpatients at a particular hospital. The percentage of late notes trust wide varied between 3.7% and 5.3% for April 2015 to March 2016.
- Specialities cancelled around 10% of requests for notes, which reflected the high level of hospital cancellations.
- The trust had started to implement an electronic patient record system but then stopped as some clinicians could not find the records easily enough. A task and finish group was working to develop an action plan to complete this project.
- All qualified and unqualified nurses in outpatient clinics had up to date adult safeguarding training and level one or two safeguarding children. Level one safeguarding for children introduces the concept of abuse and the legislative framework that underpins safeguarding children and should be undertaken by all healthcare staff. Level two is for staff who have clinical contact with children. Level two training educates staff how to recognise, respond and record possible abuse of children.
- In diagnostic imaging, staff were clear on what to do if they were concerned about safeguarding. Staff told us they completed on-line training and knew what to look out for concerning patients who were vulnerable as a result of their circumstances. Band four and five radiographers explained safeguarding processes to us but had not had to refer anyone.
- Some diagnostic imaging safeguarding policies were not up to date. For example, 'guidelines for providing written and verbal statements to the police in safeguarding cases' was dated 2007 and the policy for children accompanying patients written in 2006 had not been reviewed since 2008.
- Gynaecological outpatient services received training on Female Genital Mutilation (FGM) and how to handle situations sensitively and alert the safeguarding team if necessary. FGM is defined as the partial or total removal of the female external genitalia for non-medical reasons. Patients with FGM received help from a specialist counsellor. The service held a specialist FGM clinic once a month.
- There was a procedure in place to ensure patients received the right radiological scan at the right time. This included identity checks (name, address, date of birth) at reception and before scanning. Before scanning, staff carried out checks to confirm the correct side of the body, which area to be scanned, the patient's scanning history and their pregnancy status.

Safeguarding

- Clinics did not necessarily receive an alert about patients with multiple or complex needs. This meant services could not prepare in advance to care for patients who were vulnerable as a result of their circumstances in the best way possible. Staff in outpatient clinics were aware they might be the first to identify people at risk. They told us they would tell the senior nurse on duty and inform the safeguarding team, and ensure the patient's individual needs were reflected in their records.
- We spoke to nurses and imaging staff who had a good awareness of protecting patients who were vulnerable as a result of their circumstances and could give us examples of when they had applied this. Staff received safeguarding training by e-learning. They were aware of their responsibilities and would escalate any concern to their line manager and the safeguarding team.

Mandatory training

- Almost all diagnostic imaging staff (98%) were up to date with their radiation protection training. The diagnostic imaging service had a staff record training database which stored up to date records of Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000 e-learning, Ionising Radiations Regulations (IRR 99) e-learning and compliance with equipment training. Training records were comprehensive and accessible.

Outpatients and diagnostic imaging

- Training compliance rates in most clinical management groups within outpatient clinics met the trust's 95% targets. Exceptions were training compliance rates for consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards where 67% of qualified nurses in specialist medicine complied. Compliance rates for non-qualified nurses in cardiac and gynaecology were 83% and 88% compliant respectively.
- In specialist medicine, 83% of qualified nurses did basic life support and conflict resolution training. This meant not all staff were trained on key areas, and there was scope to improve training compliance, particularly for consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. Managers had access to training performance data for their teams.
- The imaging service had a range of local policies to minimise risk to patients. These included procedures for identifying patients correctly and minimising unintended radiation doses. The service also had a policy for identifying referral practitioners which had been approved in March 2015. This allowed nurses, allied health professionals and health care scientist to request x-rays under delegated arrangements, if they received the relevant training. The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) policies were monitored by the Imaging Radiation Protection Group.
- Imaging had a policy for acute kidney injury (AKI) and contrast induced nephropathy (CIN). There was a system to check patient creatinine levels before injection, in order to ensure that their kidney function could cope with contrast medium. AKI is sudden damage to the kidneys that causes them to not work properly. CIN is defined as the impairment of renal function within 48-72 hours of intravenous contrast administration.
- Diagnostic imaging had a radiation safety policy which outlined all safety areas overseen by the Radiation Protection Committee and specified measures to keep doses to patients as low as reasonably possible and to minimise staff radiation exposures.
- The service identified and acted on risks to patients and the public from the nuclear medicine service, and other clinical areas where there could be a security threat.

Assessing and responding to patient risk

- The cancer, haematology, urology and gastroenterology (CHUGGs) risk register included risks such as the age of equipment resulting in suboptimal radiotherapy treatment; the risk of the backlog of unreported CT and MRI images leading to a clinical incident, lack of outpatient follow up appointments available, insufficient middle grade doctors in women and children's services and insufficient staffing in ultrasound. However, it did not identify specific backlog risks in specialities where there was a risk of harm to patients.
- Outpatient specialities had some waiting list backlogs and they had not completely assessed the patient's risk of harm. For example, there was a rheumatology follow up backlog of around 190 patients when we inspected which was awaiting clinical prioritisation.
- Staff in outpatient clinics knew what to do if a patient's health suddenly deteriorated. They would call the emergency team if they suspected a cardiac arrest and knew where the nearest resuscitation trolley was. A cardiac arrest happens when your heart stops pumping blood around your body.
- The trust's Ionising Radiation (Medical Exposure) Regulations 2000 policy outlined arrangements to meet IR(ME) R regulations. It detailed roles and responsibilities, the need for clinical audit, correct maintenance of equipment, training and compliance arrangements in order to minimise risk. The diagnostic imaging service had appointed radiation protection supervisors for each clinical area and staff knew who they were.

Nursing staffing

- The trust did not use a nursing tool to assess how many nurses should staff an outpatient clinic, and there are no national standards for nursing levels in outpatient clinics. Services assessed the needs of each individual clinic with the speciality to determine the level of nursing support needed, based on specialty and complexity of case mix. Each outpatient clinic had a trained nurse to deal with any situation that might arise, for example, patient collapse, patient becoming unwell and needing extra-support such as oxygen. Nurses did not express any concerns to us about staffing.
- The clinical support and imaging clinical management group (CSI) supplied administrative and health care assistants and outpatient specialities supplied nursing staff clinics themselves.

Outpatients and diagnostic imaging

- Bank nurse staffing usage at Leicester General Hospital was 4.7%, in March 2016 which was the latest month we received figures for. This was higher than Glenfield Hospital (1%) and Leicester Royal Infirmary (2.7%)
- CSI estimated there were 0.8 whole time equivalent (wte) band five nurse and 1.2 wte bands one and two vacancies at Leicester General Hospital.

Medical staffing

- Medical staff worked across sites when clinics were planned in different hospitals. There were seven consultant neurologists and nine consultant gynaecologists.
- The diabetes and endocrinology service had six diabetologists working across all sites and endocrinologists who also dealt with diabetes.
- Diagnostic imaging had a plan to recruit to their service which was having an impact. They had attracted five new starters through recruitment across the United Kingdom. The service was also recruiting overseas and had recruited 11 imaging consultants. They had created extended roles to upskill staff and had started to offer magnetic resonance imaging courses. Efforts to recruit into ultrasound management jobs were ongoing.
- Band four and five radiographers highlighted staff shortages at Leicester General Hospital. They told us management were doing everything they could. Most recently they had locums in the department and one locum had been employed on a permanent basis.

Major incident awareness and training

- The Trust had a business continuity management policy and clinical management groups had procedures and service incident response plans. As outpatient staff reported to different clinical management groups, their understanding of what to do in an emergency varied.
- Diagnostic imaging staff knew where to find the relevant plan and could give us a brief summary of what they would do if there was a major incident.
- The service had flowcharts for staff to follow in case of accidental exposure to radiation due to equipment failure, and accidental spillage in nuclear medicine. They had measures in place in case of a radiation or radioactivity incident occurring. The trust's Ionising radiation and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) policies described arrangements at a high level.

- The trust had a procedure for reporting adverse incidents on its electronic incident reporting system. The nuclear medicine service had a quality management system which included contingency plans for spillages which included prioritising injured people and decontamination arrangements; syringe failure and what to do in the event of a fire, theft or loss. They had a policy and procedure for reporting adverse events, which included what to do in the case of extreme events in and outside of normal working hours.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate



We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

We found:

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, and legislation. The services used local and national audit arrangements to maintain the effectiveness of treatment. Diagnostic imaging used diagnostic reference levels to check dosage.
- The hospital had comprehensive pain management clinic arrangements.
- Staff were competent and had the skills they needed to carry out their roles effectively and were supported to maintain and further develop their skills and experience.
- Services reviewed complex cases in multidisciplinary teams. Consultants communicated and sent out letters promptly after appointments
- Diagnostic imaging services were available seven days a week.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.

However, we also found:

- The outcomes of patients who use services were not always monitored regularly or robustly.
- The services did not routinely ask if patients who were waiting for appointments were in any pain.

Outpatients and diagnostic imaging

Evidence-based care and treatment

- We saw some evidence that local medical policies were based on national best practice. For example, we saw dermatology practices were based on National Institute for Health and Care Excellence (NICE) and British Dermatology Society guidance. The dermatology service used the baseline assessment tool for NICE guidelines on psoriasis (CG153). Psoriasis is a skin condition that causes red, flaky, crusty patches of skin covered with silvery scales.
- The rheumatology service audited its compliance with NICE guidance on a specific drug (used to treat osteoporosis) and established a new proforma to be completed for every patient. The service planned to re-audit the guidance in 2017, to ensure that staff were using the proformas. Osteoporosis is a medical condition in which the bones become brittle and fragile from loss of tissue.
- The hospital audited its compliance with NICE QS 90 – Urinary Tract infections in adults in June 2015. It fully met the criteria.
- The hospital audited itself against NG17 NICE guidance for type 1 diabetes in adults. This led to action planning in the education of patients about their condition and improving paperwork about hyperglycaemia (high blood sugar levels). It audited its practice on NG19 foot care in diabetic patients. It mostly met these guidelines, and guidelines for Type 2 diabetes guidance NG28 were fully met.
- The hospital carried out a baseline assessment for gallstones (CG188) which included diagnostic imaging and upper gastrointestinal specialities. In 2014 it met all of the NICE criteria.
- The gynaecology service developed local audits. They started a database of human immunodeficiency virus (HIV) patients with the aim of creating their own guidelines for these patients. For other patients they followed the NHS No 21 guideline book. They audited vaginal pre-cancers and the 'test of care' to assess care after treatment following smears and viral tests. They started an endocervical audit in 2016 to look at borderline squamous cancers, to help them continuously improve the service for these patients. Squamous cancers are uncontrolled growth of abnormal cells forming in the squamous cells, which compose most of the skin's upper layers.
- The diagnostic imaging service could demonstrate learning from audits. For example, following the 'accuracy of renal tract ultrasound in the detection of renal scarring compared to DMSA audit', training on how to detect renal scarring had been introduced". A DMSA scan is a radionuclide scan that uses a radioactive tracer in assessing the structure and function of a kidney. These audits resulted in improvement actions, such as training on how to detect renal scarring, for the renal tract ultrasound audit.
- The diagnostic imaging service had an audit programme which complied with Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) guidance. They chose a different audit each month to review at the radiation protection board. They audited processes such as checking the patient's identity and the correct site on the patient's body. They also audited how well they worked with others. There was a radiology audit of appropriate use of the multidisciplinary team (MDT), which resulted in actions to improve MDT effectiveness for patients.
- Diagnostic imaging had a procedure for the use of local diagnostic reference levels (the dose set at the average of a group of patient doses). This included gathering the data and establishing the level for patients within a weight tolerance, and displaying the data in the imaging control area. The service identified three cases trust wide where doses differed from regional practice. Imaging practice was evidence based, and staff referred to an online database for good practice.
- The imaging service had a comprehensive suite of policies. There were also protocols and proformas in clinics for staff to follow and refer to. For example, staff used proformas for pulmonary (lung) rehabilitation referrals and to record clinical data on heart failure, respiratory function and pulmonary rehabilitation. This ensured staff applied the same standards to each patient and helped with the collection of data to look at patient outcomes.

Nutrition and Hydration

- Arrangements were in place to provide food and drink for patients who were in the department for any length of time. Some clinics had water fountains and food and drink vending machines available for patients. However, staff did not routinely offer food or drink to patients who

Outpatients and diagnostic imaging

had been waiting a long time for their appointments. This could mean that patients who needed to eat on a regular basis, for example patients who were diabetic, may have been at risk.

Pain relief

- In outpatient clinics the pain of an individual patient was not always assessed and managed appropriately. Staff did not routinely ask waiting patients if they were in any pain, or review pain using a pain assessment tool.
- Outpatients one at Leicester General Hospital stocked paracetamol if patients needed pain relief. A doctor could prescribe stronger medication if needed. This could be collected from the pharmacy.
- The trust had a specialist multidisciplinary pain management service. It ran clinics on paediatric pain, facial pain, pelvic pain, drug -addiction pain and ran complex pain management programmes. The multidisciplinary team consisted of pain consultants, nurses, physiotherapists, occupational therapists and health care assistants and was available at all three hospital sites.

Patient outcomes

- The outcomes of patients who use services were not always monitored regularly or robustly. Nor did the service benchmark against similar services. This meant they were unable to identify what actions needed to be taken to improve the service provided. Outpatient services did not display dashboards which reported on quality, safety, and patient satisfaction levels. We saw some patient satisfaction information on clinic noticeboards but no comprehensive quality or safety monitoring reporting.
- The trust had started to monitor outpatient clinic efficiency. Outpatient specialties had performance scorecards which included performance indicators such as booking slot utilisation and they monitored cancellations by the trust and by patients.
- Diagnostic imaging services had not yet implemented the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff working in

safe environments. Services acquiring ISAS accreditation are required to work to specific standards. The annual plan showed the team intended to work on this accreditation in 2016/2017.

- Imaging had a departmental radiation protection notice board with charts referring to Ionising Radiation (Medical Exposure) Regulations IR(ME)R compliance audits such as the patient identity checks audit, last menstrual period and with dose reference levels, and personal protective equipment audit results. The diagnostic imaging service ensured radiation incidents fed into risk management, and took steps to avoid excessive radiation exposure to patients.

Competent staff

- The trust had identified a lack of competent staff to arrange outpatient's bookings to meet the 18-week waiting list target. To address this an e-learning module for the processes for the referral to treatment standard (waiting time of less than 18 weeks) had been developed. The effectiveness of the e-learning package had not yet been evaluated.
- The trust had an appraisal process and staff told us this was useful. From April 2015 to March 2016, 94% of diagnostic imaging and outpatient staff at LGH had received an appraisal, this exceeded the trust's target of 90%.
- Managers in diagnostic imaging encouraged and supported staff to further develop their professional skills and experience. The imaging service operational meeting notes showed the trust had provided additional funding for two radiographers to train in musculoskeletal magnetic resonance reporting and for two people to train in a computerised tomography head course.
- Radiographers volunteered to be trained for the mobile lithotripsy unit. Lithotripsy is a treatment, using ultrasound shock waves, by which a kidney stone or other calculus is broken into small particles that can be passed out by the body.
- A radiographer/nurse service undertook hysterosalpingograms. This is a radiologic procedure to investigate the shape of the womb and the shape and patency of the fallopian tubes. This added to the staff member's skills and meant the service could offer a greater range of gynaecological scans.

Outpatients and diagnostic imaging

- Diagnostic imaging had a practice learning team. They aimed to develop assistant practitioners in radiography and to give students the best possible training. Student numbers had increased over time and other trusts had copied this practice.
- New radiographers explained there was a good induction process in place with a period of observation/preceptorship, and there was always a more experienced radiographer on duty 24 hours a day for advice and support. The departmental manager set learning targets to be achieved within certain timescales which ensured staff developed.
- Levels of specialist skills varied. The nephrology service felt they had scope to develop nurses with specialist skills. Nephrology is the branch of medicine that deals with the physiology and diseases of the kidneys. In the diabetes clinic, 11 out of 21 staff members were competent to handle a diabetic pump. Other specialisms had specialist nurses, which meant they could potentially help run a broad range of clinics.

Multidisciplinary working

- Consultants involved other services immediately if it was in the patient's interest. For example, we observed a consultant who organised a thyroid function test for a patient immediately after receiving unrelated computerised tomography (CT) scan results which showed an enlarged thyroid.
- Multidisciplinary teams reviewed complex cases to find the best solutions for patients. For example, in gynaecology this took place every month and specialist nurses and consultants attended. This meant that a team of different experts reviewed women with complex problems in order to find the best solutions for them.
- Some clinicians felt isolated from the rest of University Hospitals Leicester (UHL). The acute services at Leicester General Hospital had closed over recent years. Clinicians found it difficult to get an opinion from other specialists (for example, cardiac) for renal patients at Leicester General Hospital and vice versa. Consultants stated it slowed things down and felt it had an impact on patient care, although there was no evidence of delayed treatment.
- The kidney speciality worked effectively with other specialities. At Leicester General Hospital (LGH) the 'consultant nephrologist of the week' was available 8am

Monday to 5.30pm Friday to give opinions on kidney patients to clinicians who worked in other services. Two kidney transplant coordination nurses worked with other services to organise transplant care.

- Specialities used specialist nurses well. A variety of services such as dermatology, diabetes, and pain management had specialist nurses. The neurology clinic had three specialist nurses who ran four or five clinics a week and saw patients who had for example, Parkinson's disease, epilepsy and multiple sclerosis. The urology clinic had four specialist nurses who assisted specific consultants and two helped patients with continence needs. The specialisms could offer a broader range of services because of the skills of their nurses.

Seven-day services

- Diagnostic imaging services were available seven days a week.
- Some outpatient specialities held additional Saturday morning clinics to meet the increasing demand on the service, for example in orthopaedics and cardiac rehabilitation.
- The trust provided a pharmacy service across all three sites, which was available Monday to Friday, with an on-call service out of hours. The site pharmacy at LGH was open for 4 hours Saturday and Sunday in addition to services described.

Access to information

- The diagnostic service provided electronic access to results to other services in the hospital in a timely manner. This meant other services could make appropriate decisions about care and treatment for patients in a timely manner. The diabetic clinic told us they could access patient notes electronically if a patient had been admitted at the Leicester Royal Infirmary.
- Consultants told us they expected letters to be sent out after clinic appointments within a few days for urgent biopsies and no more than four weeks for non-urgent matters.
- We checked six sets of patient notes in the dermatology clinic. All had letters sent to patients two days after attending the clinic. A consultant in dermatology told us they would hand-write a letter or send by facsimile if a GP needed notifying quickly.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff in clinics (95% of non-qualified nurses and 97% of qualified nurses) had received e-learning training on consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were local dementia champions who told us patients living with dementia were treated at the start of a clinic. Staff told us they knew where to locate a dementia champion if they had questions.
- Staff in gynaecology told us they had recent experience of a mental capacity issue and explained to us the action they took.
- Consultants told us they would ask for consent with carers present or ask for those with lasting power of attorney to sign. A lasting power of attorney (LPA) is a way of giving someone the legal authority to make decisions on a person's behalf if they lack mental capacity at some time in the future or no longer wish to make decisions for their self.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good.

We found:

- Feedback from patients, those who are close to them and stakeholders was positive about the way staff treated them. Patients told us that they were happy with the standard of treatment and care. We observed doctors and nurses speaking to patients in a kind and compassionate manner. Patients felt positive about their involvement in their own care.
- Staff helped patients and those close to them to cope emotionally with their care and treatment. Key services offered emotional support and patients had access to counselling.

However, we also found:

- The changing areas in diagnostic imaging were shared between male and female patients. This suited a few patients who arrived in a family group, but for many people it was not dignified.
- The lack of patient gowns in the computerised tomography (CT) waiting/changing room at Leicester General Hospital did not ensure patient privacy and dignity was respected.
- Communication and administration processes were not always efficient and caused confusion and anxiety for some patients.

Compassionate care

- Patients in gynaecology, renal, urology and neurology clinics told us staff were 'brilliant' 'conscientious', 'compassionate and kind'. We observed clinicians introduced themselves and put patients at their ease.
- Patients fed back on 'Message to Matron' cards. Many comments were positive however recurrent negative themes at Leicester General Hospital (LGH) were waiting times, appointment cancellations, making it clear what to expect, toilets, parking and clinic time overruns as well as privacy of consultations.
- We reviewed the NHS Friends and Family Test (FFT) results from October 2015 to March 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. In most specialities only a small percentage of respondents had completed the survey. For some specialities, over 90% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care. Specialties with less than 85% satisfaction were; gastroenterology (83%), urology (81%), dermatology (80%), endocrinology (81%), rheumatology (78%), maxillofacial (76%), plastic surgery (71%), allergy (83%) and vascular surgery (67%). The trust did not give us further information to explain why some services had lower scores. In May 2016, the outpatients Friends and Family Test (FFT) survey showed 95% of patients overall would recommend the NHS service they had received to friends and family who may need similar treatment or care.
- At the diagnostic imaging reception, the 'Share your experiences' touch screen was out of order so patients could not leave feedback.

Outpatients and diagnostic imaging

- There was a trust chaperone policy and staff acted as a chaperone for any intimate examination. Staff told us health care assistants acted routinely as chaperones. There were no notices displayed in the gynaecology clinic or any other clinics to make people aware they could request a chaperone during a consultation, however, diagnostic imaging told us they would routinely provide a chaperone for transvaginal imaging.
- Changing area D in diagnostic imaging was shared between male and female patients. This suited a few patients who arrived in a family group, but for many people it was not dignified. Male and female patients waited in the same area whilst wearing gowns and waiting for scans. The trust recorded this on their risk register and the service was trialling different arrangements, such as holding separate sessions for male and female patients to solve this problem
- The lack of patient's gowns in the computerised tomography (CT) waiting/changing room at Leicester General Hospital compromised patient's 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. The waiting area was mixed sex, which further compromised the patients dignity.
- Patients could not always speak confidentially to the gynaecology receptionist. The gynaecology outpatients waiting room at Leicester General Hospital was small and it was difficult to assure privacy for patients when there was a queue. We noticed a queue of six patients at 10am. Due to the confined space, it was difficult for queuing patients to allow the person in front sufficient space to speak confidentially to the receptionist.

Understanding and involvement of patients and those close to them

- The hospital carried out an electronic survey of outpatient care from September 2015 to February 2016 and 290 patients completed the survey. From 93 to 99% of patients responded positively to questions about their involvement in decisions about their own care and privacy and dignity.
- Patients told us they received a copy of letters sent between the hospital and their GP. Diabetes patients told us they were able to make follow-up appointments when leaving the clinic.
- However, some administrative processes detracted from patient care. Patients were not informed if there was a

change of consultant. Following the appointment, patients did not necessarily know when their next appointment date would be and they told us they would sometimes have to contact the hospital to find out.

Emotional support

- Consultants and nurses took the time to explain diagnostic imaging results to patients and allowed time for questions. They were open and explained care options to patients.
- The urology clinic had an oncologist and a full time counsellor who saw any patients with a cancer diagnosis. They supported patients with information about their condition and where to access more help.
- There were no clinical psychologists on site for diabetic patients but nurses told us they could access one if needed. The diabetic nurse specialists talked to patients but nurses felt because of the rise of diabulimia (a condition which occurs when insulin-dependent diabetics skip injections in order to lose weight) in young diabetic women, staff thought increased psychological support for these patients would be useful.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated the outpatients & diagnostic imaging service as requires improvement for responsiveness.

We found:

- Service planning was generally not based on an analysis of local needs; demand for outpatient treatment and diagnostic processes was in excess of supply.
- Patients experienced unacceptable waits for some specialties trust-wide. Four patients had waited for 52 weeks to be seen. There were backlogs in some outpatient specialties and for some diagnostic scans. The trust did not meet its two week cancer wait target in April 2016 and risked not meeting its referral to treatment waiting list target in June 2016 because of ear, nose and throat (ENT) and orthopaedic performance challenges.

Outpatients and diagnostic imaging

- In some clinics there were long wait times. Patients complained of multiple cancellations.
- The services lacked a comprehensive approach to meeting the needs of diverse patients.

However, we also found:

- The trust had met its 18 week referral to treatment time (RTT) target for both inpatients and outpatients in May 2016. It had also met its diagnostic response time target.
- Some specialties learned from complaints and patient feedback.
- There were clinic level initiatives to reduce wait times and to gather appropriate management information.

Service planning and delivery to meet the needs of local people

- Service planning was generally not based on an analysis of local needs. The trust realised demand for outpatient treatment and diagnostic processes was in excess of supply. For example, for dermatology and orthopaedics. These services were working with commissioners and other local trusts to take services out into community locations in Leicestershire and Rutland. This approach would better meet the needs of local people.
- Because of a higher than average incidence of tuberculosis (TB) in Leicester the trust provided an infectious diseases clinic. TB is a bacterial infection mainly affecting the lungs.
- A dermatology skin camouflage clinic run by a specialist nurses showed people how to cover their skin conditions cosmetically, and helped boost patient's confidence.
- Telemedicine, which is the use of technology to provide clinical services when the consultant and patient are not in the same place, was used in gastroenterology, neurology and gynaecology. Telephone consultations saved patients a journey to the clinic.
- Car parks had a pay and display system which was not user friendly when clinics overran as patients could run the risk of receiving a fine.
- Joint working arrangements with partner organisations did not ensure good performance for patients. Patients sometimes waited a long time for transport from an external company to arrive to take them home after outpatients or imaging appointments. Two patients, one of whom had complained in writing, told us that although they received treatment in the morning, they did not get home until late in the evening because of

patient transport. Outpatient staff sometimes waited with patients until 8:45pm, and imaging staff checked on patients until late. Staff highlighted that patients from care homes who arrived in ambulances sometimes waited in excess of four hours or a whole day for transport to arrive to take them back to the care home after scans or treatment. Staff were concerned about patients living with dementia or patients who had pressure ulcers and they recorded delays on the electronic incident reporting system. The trust had not agreed an action plan to address this with contractors when we inspected.

Access and flow

- Patients did not always have timely access to treatment or diagnosis. At the end of July 2016 there were 2400 chest and abdomen plain film x-ray images that needed reporting on across the trust. We saw evidence that the numbers of x-rays in the backlog had been coming down month by month. There was a plain film backlog recovery plan in place which was a combination of additional clinic sessions, increased reporting radiographers and outsourcing to other providers of care. From the information that was provided to us following the inspection we were satisfied the trust was taking the appropriate actions and progress was being made.
- Trust wide, four patients across three different specialties waited more than 52 weeks to be treated in May 2016. The trust had responded to this when the issues was raised and ensured that the patients were treated. The trust had management arrangements to keep performance for outpatients on track. However, when we inspected, not all patients were seen in a timely way. The trust had not assessed capacity and demand across the range of outpatient specialties.
- Diagnostic imaging had waiting lists of patients waiting for their scan. In May 2016, there were 1012 magnetic resonance imaging, 655 computerised tomography and 139 ultrasound patient scans waiting to be authorised. Nine of each category were urgent two week wait referrals, for suspected cancer or similar.
- Trust wide, diagnostic imaging did not meet its own target of 80% of cancer imaging achieved within seven days. It achieved 62.3% in May 2016. Magnetic

Outpatients and diagnostic imaging

resonance imaging scans also missed 3% of scans which should have been undertaken within six weeks. The trust did not record imaging performance by each hospital site within the trust.

- Administrative processes were sometimes unreliable. Patients told us they were invited to the wrong clinic, given the wrong time or sent a follow up letter when they had not had their first treatment. The trust recognised this as a risk and was recruiting to vacant administrative posts and training their staff.
 - In-clinic wait times could be lengthy. We checked clinic appointment schedules and clinic finish times for orthopaedics. These were not filled in for four out of eleven clinics. All of the remaining seven clinics finished after their scheduled time. Afternoon orthopaedic clinics overran by between one and two hours. A staff member informed us, one orthopaedic consultant frequently did not arrive until 9:45 am for a clinic where the first appointment was 9 am, and most orthopaedic clinics started late. We spoke with patients waiting for urology appointments in clinic three. Their appointments were overrunning by 50 minutes. In clinic four, pain management patients were unhappy about the wait time as the clinic had overrun by 30 minutes. Two urology clinics overran by 3 hours 50 minutes and renal clinics were also between one and two hours late.
 - The trust had carried out its own analysis of wait times and causes in October 2015. Patients and clinic coordinators completed a questionnaire per clinic identifying delays in patients being seen. The data showed 46% of patients were seen within 15 minutes of their appointment time. At Leicester General Hospital (LGH) 25% of patients waited more than half an hour and the average wait time was 25 minutes. The reasons for delay were: 21.4% of clinics were overbooked; 10.8% of doctors were late to clinic; 19.6% patients arrived late to clinic; 19.6% patients became unwell during clinic; 7.2% medical staff teaching and 21.4% 'other'. According to the analysis, the longest waits at Leicester General Hospital were in cardiovascular, renal, and orthopaedics specialities.
 - Overbooking of out-patient clinics (booking more than one patient to the same appointment slot) created problems because sometimes there were up to four patients waiting for one appointment time.
- Overbooking was common in dermatology and orthopaedic clinics. At 15:30, 15:40 and 16:10 when we visited, we noticed that two patients were booked for the same doctor in orthopaedics.
- Staff explained appointments were overbooked because patients sometimes did not attend (DNA) their appointments and there were not enough clinic slots available. However, between April 2015 and March 2016, the trust wide average percentage of appointments which patients did not attend was 5% (Hospital Episode Statistics) This is below the England monthly average of 7%.
 - Overbooking of clinics did not conform to the trust's policy. The trust's 'outpatient's clinic template management UHL policy' stated that "all patients will be scheduled to attend at a realistic time to avoid several patients attending simultaneously for an individual appointment time and then having to wait". Clinical need was the only basis for adding patients to a clinic which was already full.
 - Some services did not overbook appointments. Gynaecology and rheumatology staff told us they booked one patient per appointment slot. They advised patients to complain if they had an excessive in-clinic wait time. They changed some consultant's clinic schedules to ensure they had sufficient time with patients.
 - The trust cancelled outpatient appointments more than the England average. From April 2015 to March 2016 the England average was 7% whereas the trust cancelled 16% of patients, and Leicester General Hospital cancelled 17%. overall. Cancellation data from June 2015 to May 2016 showed Leicester General Hospital (LGH) cancelled 28% of neurology, 40% of gastroenterology, 23% of dermatology and 26% of urology clinics. Overall, cancellations at 20.8% were highest at the LGH compared with the other two hospital sites. The trust did not tell us why clinics were cancelled or show us action plans to address this. We spoke with patients who had their appointments cancelled three or four times. This created patient dissatisfaction, a need to clinically re-assess in some cases, and complications with rebooking.
 - Staff told us clinics could be cancelled due to lack of consultants or staff on leave and other specialities

Outpatients and diagnostic imaging

would not know the clinic space was available. Clinic space at LGH was sometimes underused on Thursdays and Fridays. The trust was introducing clinic booking software to try and improve the situation.

- Some clinics did not help patient flow to diagnostic imaging. The orthopaedic speciality sent multiple patients for x-ray, for example, 26 patients in 30 minutes, at the start of the clinic, and especially on Tuesday and Thursday afternoons. This led to a lack of space in the diagnostics imaging waiting area.
- However, the trust met its waiting list target of 92% of patients being treated within 18 weeks in May 2016, but were at risk of not achieving the target in June 2016. This was due to ear nose and throat (ENT), allergy and orthopaedic waiting times. Some orthopaedic clinics were held at Leicester General Hospital. This target covered both the outpatient and inpatient journey. The earlier patients were seen in outpatients, the quicker they would be seen for inpatient treatment such as an operation if this was needed. The specialities had action plans to address the underperformance but when we inspected it was too early to assess its impact. Most patients waited less than 14 weeks for their first appointments (the target is 18 weeks for first definitive treatment). Patients in specialities which held clinics at LGH such as, dermatology, diabetic medicine, endocrinology, ENT, gastroenterology and general surgery often had to wait longer.
- The trust was working to improve cancer appointment wait times. There was timely access to dermatology services when needed. Diagnostic imaging helped deliver the cancer two week target by creating extra slots to meet demand. They had employed two people to take bookings before the patient left the hospital. Positron emission tomography/computerised tomography (PET/CT) scans had a seven day turnaround, which benefitted the cancer pathway. PET/CT imaging is used to detect and manage recurrent cervical cancer. The gynaecology service offered same day colposcopy appointments if needed. This meant cancers and pre-cancers could be identified quickly.
- Performance for non-urgent scan patients was improving. In April and May 2016 less than 1% of non-urgent patients had to wait more than six weeks for their diagnostic test, showing an improvement from 2015/2016,
- In-clinic waiting time within the diabetes clinic was reduced by a HbA1C machine (to test whether diabetes

is under control). This could carry out a test in six minutes. The clinic also had a 'diasens' which received information from an insulin pump and blood glucose meters to give recent results and improve the management of diabetes.

Meeting people's individual needs

- Outpatient clinics could pre-book an interpreter from an external company if needed. They could access a telephone interpreting service at any hour of the day and during weekends.
- Clinics had started to meet the needs of patients who were overweight. They had ordered bariatric scales for patients up to 250kgs and some specialities had special examination couches.
- Leaflets and information to help patients were mainly in English and displayed in clinics where patients could read them. However, in the gynaecology clinic we noticed a leaflet which a drug manufacturer had supplied on overactive bladders; this was written in Arabic.
- Buggies were available for patients with mobility difficulties. This was a voluntary service and posters in the waiting rooms advertised them to patients.
- The hospital had started to adapt its communication to individual needs. The orthopaedic clinic sent text reminders to patients to ensure they did not miss their appointment.
- The trust had difficulty meeting the needs of patients with a learning disability. The May 2016 clinical support and imaging safeguarding committee discussed high rates of DNAs for patients with a learning disability. Staff thought this was because care home staff were unable to attend with the patients or because of patient illness. Outpatients staff did not know if patients had a learning disability unless it was stated in the GPs letter. This limited the ability of outpatient clinic staff to prioritise this patient group. If staff knew that a patient had a learning disability, they found a calm, private place for them to wait and arranged for them to be seen at the start of the clinic.
- Staff were in the process of being trained about dementia. Some staff had received training but not all. The trust did not supply us with the completion rate.

Learning from complaints and concerns

Outpatients and diagnostic imaging

- Patients told us they would know how to make a complaint, and they would go to the clinic receptionist in the first instance, or speak to the radiographer in charge. We did not see any posters or leaflets explaining the process to patients.
- Over half of formal complaints to the trust concerned outpatient clinics trust wide. We reviewed formal complaints from March 2015 to March 2016, and 58% concerned outpatients clinics across all three sites (457 complaints out of 787), with 5% (43) about diagnostic imaging services.
- The complaints about Leicester General Hospital (30% of outpatient's complaints) focused on in-clinic delays, cancellations, waiting time, administration of appointments and communication.
- There were 11 complaints (25% of imaging complaints) about diagnostic imaging at Leicester General hospital. Staff attitude, waiting times and communication were common themes. Staff had received some customer service training but other actions to address patient concerns were still in progress.
- The gynaecology service learnt from patient feedback. We saw a poster in a number of languages inviting feedback. Patients complained about waiting times so consultants adjusted their templates/timetables for clinics to offer longer consultations.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated leadership as requiring improvement.

We found:

- Departmental risks, issues and poor performance were not always dealt with appropriately or in a timely way. Arrangements to manage outpatient clinic performance were in development and this had not yet resulted in better patient experience. Clinical outpatient services lacked regular and publicly reported dashboards to show performance against quality, safety activity and financial indicators.
 - Clinical management group level plans were not always specific, measurable, timed or explicit about how they would match capacity with demand for outpatient services.
 - Governance arrangements for third party providers (contractors) were not fully developed.
 - There was high staff sickness and high turnover of staff.
- However, we also found:
- Staff spoke highly of local and board level leadership. They understood the vision for the services.
 - Quality and safety governance arrangements in diagnostic imaging to meet radiation protection requirements were effective.

Vision and strategy for this service

- There was a clear trust wide vision and quality and safety were the top priority. The trust had a five year plan; 'delivering care at its best.' The trust aimed to provide safe, high quality patient-centred care and deliver services which consistently met national access standard. This would include ensuring patients were treated within 18 weeks.
- Diagnostic imaging staff understood the short term vision for delivery of their service. Part of this was joining the East Midlands radiology service (EMRAD) in August 2016. This was a project to set up new shared imaging arrangements between East Midlands hospitals with shared staff, services and resources. This aimed to provide services 24 hours a day, seven days a week.
- The trust planned to relocate outpatient booking and clinics to Glenfield Hospital and have satellite clinics in Leicestershire and Rutland towns in a 'hub and spoke' model. Clinicians understood and supported the idea of moving general clinic consultations out to the community, to the smaller Leicestershire local hospitals. This would mean services could meet local demand. They recognised that this needed some assessment of capacity and demand, so that they could ensure there were enough consultants to run the clinics.
- The clinical support and imaging clinical management group (CMG) annual plan stated how it would contribute to trust annual priorities. Amongst its annual plan priorities it listed: acquiring new machines in 2016/2017 combined with seven day working on existing machines, achieving 'Imaging Services Accreditation Scheme' accreditation and further centralisation of outpatient bookings to a central booking centre and having clear information about which clinic rooms were in use. The CMG board meeting reviewed progress on annual plans under a standing item 'strategy update' on the agenda.

Outpatients and diagnostic imaging

- Most outpatient staff knew about the trust's values and the priorities. They understood the values such as: 'we treat people how we would like to be treated' and 'we do what we say we are going to do.' Some were aware there was a vision to centralise outpatients at Glenfield; however, they did not feel involved in the plans and were unclear about their role and timescales.

Governance, risk management and quality measurement

- The governance arrangements for outpatient clinics were complex. The clinical and support and imaging (CSI) clinical management group included diagnostic imaging, the booking centre and medical records departments for all three sites. Other CMGs managed some bookings, the number of appointments per clinic and doctors and specialist nurses.
- A framework was in place to coordinate improvement actions towards Department of Health performance targets for outpatient treatment and diagnostic imaging. An outpatient programme board with representatives from the clinical management groups focused on cost and efficiency improvement initiatives. This group programme managed improvements such as centralising outpatients bookings, improving the uptake of the Friends and Family Test by patients and shortening in-clinic wait times.
- The trust had a weekly access meeting to monitor performance on the 18-week waiting list target. It aimed to find solutions for patients who had waited a long time, and deal with any limitations on performance, for example staffing shortages. However, when we inspected, this had not solved the long waits for appointments or late running clinics.
- The trust provided action plans for commissioners which detailed how it would improve waiting list times. Commissioners monitored waiting list performance on a monthly basis. We saw action plans for orthopaedic surgery including outpatients which included weekly reviews of all patients without an appointment date, and staff training on the 18-week waiting list target. For the allergy service their action plan included diverting resources from the ward to outpatients, setting up dietician and nurse clinics, and refining the pathway of referrals from the emergency department. When we inspected, it was too early to assess the impact. The trust also had an ear, nose and throat (ENT) and cancer recovery plan. This included; outsourcing extra clinics to locum medical staff in May and June 2016, outsourcing urgent scans for cancer patients to locums and recruiting more head and neck consultants to ensure there was sufficient capacity in the service for the future.
- There were quality and safety meetings at clinical management group senior level and nursing staff also discussed quality in their own teams. Nursing staff at all levels attended a monthly meeting where they reviewed incidents and patient feedback. We saw their action plans on learning from incidents and spoke to staff about their understanding of this.
- The trust was improving its data collection processes to performance manage outpatient services more robustly. It did not have reliable timely information about the availability of clinic space but was planning to implement clinic booking software to address this. Staff collected clinic booking information at a local level to enable better planning of services. External consultants were assessing capacity and demand in specialities. Staff had started to monitor in-clinic wait times. This was reported back to CMG board level. This enabled clinics to see when rooms were cancelled and how they were used.
- Managers put in place a scorecard and had meetings to monitor outpatient clinic performance. Each speciality had a performance scorecard which included booking slot utilisation, new to follow up ratios, cancellations by patient and hospital and did not attend (DNAs) and reported key information to the weekly access meeting. A programme management board oversaw this and improvement initiatives, such as centralising outpatient bookings, improving the uptake of FFT and shortening in-clinic wait times. However, these initiatives were in the early stages, and we did not see any benefit for patients in the clinics we inspected.
- Risk management systems were not effective. Departmental risks, issues and poor performance were not always dealt with appropriately or in a timely way. Specialities did not have reporting arrangements to manage their own quality and performance, for example, quality/safety dashboards. Managers did not set targets at clinic level for wait times, appointment slots available or percentage of patients surveyed for Friends and Family Test feedback. We did not see cleaning audits displayed consistently or 'You say, we did' information. The trust's risk management of outpatient services was not effective. It did not identify

Outpatients and diagnostic imaging

risks to follow up patients in specialities such as the eye clinic or rheumatology so that managers could take preventive action. However, the trust had a risk register and reviewed risks regularly at CMG boards.

- CMGs reviewed incidents, safety issues and complaints at quality and safety and board meetings. Assurance meetings were run by service rather than site, for example, diagnostic imaging had their own meeting. Staff understood their roles and responsibilities in delivering quality.
- The trust had specific governance arrangements for cancer services. The cancer action board met monthly and included representatives from theatres, imaging, oncology, radiotherapy and chemotherapy. This reviewed patient progress on an individual basis and investigated if a cancer patient had to wait more than the target time. The director of performance telephoned underperforming services daily, such as lung cancer and urology, to ensure appropriate action was taken for patients.
- The diagnostic imaging service checked the quality of their services for example, CT scanning of the breast or colon. They had a programme of audits for x-ray, computerised tomography and magnetic resonance imaging and were developing audits for ultrasound. The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) policies were monitored by the imaging radiation protection group. They reviewed quality and safety issues at the CSI clinical management group board meeting.
- Radiation protection committee meetings were quarterly and chaired by the director of quality and safety. There was also a medical exposure committee chaired by clinicians which reviewed dose reference levels and benchmarked against national statistics and in- hours standards. Any changes to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) related procedures were ratified by the monthly imaging service quality and safety and strategic Meeting. Imaging services shared learning with staff and colleagues. They held a briefing for staff in February 2016 to share lessons about performance, quality and safety from serious incidents and a coroner's case.

Leadership of service

- Nursing sisters and matrons had the skills, knowledge experience and integrity they needed to lead effectively. They could identify the challenges to good quality care

and the actions needed to address them. Reporting lines for outpatient specialities were spread across several clinical management groups (CMGs), but waiting list management was coordinated at the weekly access meeting, led by the head of operations for clinical support and imaging.

- Staff told us board level leaders were visible and approachable, Staff noticed a positive culture change in the last two years to a more 'can do' approach. The chief executive was proactive in the initiative to find new bone marrow donors, for example.
- Diagnostic imaging leaders encouraged supportive relationships among staff and tried to encourage effective team working. They identified the areas where team building was necessary and tried to resolve problems, by creating meetings so assistant radiographers could learn from each other for example.
- Leadership was successfully strengthened in diagnostic imaging. The restructure had led to team leaders who learned from each other and who were mutually supportive. Sick leave and turnover had improved, and accountability was clear. Staff told us they were happy with the arrangements.
- Outpatient services created roles to provide leadership on particular themes, for example there was a diabetes clinical champion in the clinical support and imaging clinical management group. This improved knowledge of diabetes issues in the service.
- Because of staff shortages, some band four and five radiographers were trained to work without direct supervision because other staff were completing mobile x-rays and theatre examinations. There was clear guidance to allow them to do this.

Culture within the service

- There were mixed views about the working culture at Leicester General Hospital (LGH). Some staff members told us the culture was not always supportive if mistakes were made due to stress or by accident.
- Sickness levels among diagnostics imaging and outpatients staff at LGH were high. There was 6.2% staff sickness, (6.2% of full time equivalent days available to be worked were taken as sick leave), which was above the trust average of 3.8%. Staff turnover at LGH in diagnostics imaging and outpatients was significantly higher at 16.5%. There was a high vacancy rate of 17.7%. This indicated that staff were leaving and posts were difficult to fill.

Outpatients and diagnostic imaging

- Staff sometimes felt remote from Leicester Royal Infirmary and Glenfield Hospital. However, they could not tell us if this impacted on patient care. The renal service reported good relationships with cardiology and respiratory related services. Some services such as diabetes and gynaecology worked across sites.
- Band four and five radiographers told us clinical support and imaging was a good service to work in. They felt appreciated and valued and had been offered flexible working conditions. They spoke highly of their departmental manager.

Public engagement

- The trust used the local press to be open with the public about the delays for outpatients. It publicised the issue in the local newspaper, explained what it planned to do, and invited local patients to get involved in improvement initiatives.
- Some clinics surveyed patients about patient preferences. Senior staff in outpatients four responded to patient feedback from 'message to matron' cards and boxes by providing a television and newspapers in the waiting area.
- Diagnostic imaging made changes as a result of patient feedback. The service introduced solid cubicles in patient changing facilities when patients complained about curtains.
- The trust surveyed patient's experiences in the outpatient department but did not give them a free choice about what they fed back. It surveyed outpatients with closed questions with yes/no answers about care, treatment and involvement. Between September 2015 to May 2016. There was no text box to allow patients free choice to comment on whatever aspect of service they would like.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan. • In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement

- The trust adopted an NHS staff engagement initiative called 'listening into action.' Each outpatient speciality set up 'link teams'. They created resource folders with reference information, for example how to prepare the clinic, information on patients' needs, and doctor's preferences. This led to rotas for the cleaning of specialist trolleys and equipment for outpatient clinics. This increased staff knowledge and confidence to work in new clinics, because they could readily access the reference information.

Innovation, improvement and sustainability

- Diagnostic imaging at University Hospitals Leicester had an internationally recognised forensic service and the service had a good reputation for cardiac and vascular imaging work.
- Specialist nurses at Leicester General Hospital set up innovations such as contacting young people through skype and coffee shop meetings. This aimed to reduce the 'did not attend' (DNA) rate for young people in the diabetes transition service, which is the service which helps young people through the transfer from children's to adult's services. We requested the data to show the DNA rate but the trust did not provide this.
- The services and individuals within them were recognised for their achievements. A diagnostics imaging manager received an award for work in shortening internal processes, so that patients had a shorter wait.
- Leaders and staff focused on improving services. The outpatient improvement board started a project on the 1 April 2016 to improve outpatient experience. This aimed to increase the numbers of patients accessing clinics through: increasing booking slot utilisation (BSU); reducing 'did not attend' (DNA) to a trust level target of 5% and standardising number of slots available for each clinic within a speciality.
- However, there was little sharing of best practice across all outpatient specialties in the trust and the services did not routinely benchmark or network with other trusts to share best practice.

Outstanding practice and areas for improvement

Outstanding practice

- A new computerised individualised dosing system was in operation on the renal wards.
- New starters who were nurses recruited from EU countries 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.
- 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 an 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.

Areas for improvement

Action the hospital MUST take to improve Medicine

- The trust must take action to ensure nursing staff adhere to trust guidelines for the completion and escalation of the early warning scores (EWS) which may indicate a patient is deteriorating.
- The trust must ensure that where patients met the trust's criteria for sepsis screening, they were screened in accordance with national guidance.

Surgery

- The trust must ensure venous thromboembolism (VTE) assessments are completed in a timely manner and re-assessed after 24 hours.
- 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.

Outstanding practice and areas for improvement

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

Critical Care

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- There had been a delay in the timely reporting of a recent never event.

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. We found:
- Midwifery staffing ratios did not meet current recommendations.
- 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.
- 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.

End of life

- The trust must ensure 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms are completed appropriately in accordance with national guidance, best practice and in line with trust policy.

- The trust must ensure there are sufficient numbers of suitable syringe drivers with accepted safety features available to ensure patients would receive safe care and treatment.

Outpatients & diagnostic imaging

- The trust must ensure that all equipment, especially safety related equipment is regularly checked and maintained.
- The trust must ensure building maintenance work is carried out in a timely manner to prevent roof leaks
- The trust must ensure patient notes are securely stored in clinics.
- The trust must ensure action is taken to comply with single sex accommodation guidance in diagnostic imaging changing areas and provide sufficient gowns to ensure patient dignity.

Action the hospital SHOULD take to improve

- The trust should ensure infection prevention control is given sufficient priority on ward two.
- The trust should ensure all staff are aware of the arrangements in place to respond to emergencies and major incidents.
- The trust should consider the impact the uncertainty of the future of endoscopy services is having on staff within this area.
- The trust should ensure the pre assessment pathway is streamlined to ensure all high-risk anaesthetic patients are pre assessed.
- The trust should ensure they develop an action plan for managing cancelled operations due to a lack of high dependency beds.
- The trust should ensure they develop an audit process for the World Health Organisation (WHO) five steps to safer surgery checklist.
- The trust should ensure medication storage in anaesthetic rooms is consistent across all areas.
- The trust should ensure medical teams have sufficient time for handovers at the end of each shift.
- The trust should consider the clinical management groups (CMGs) develop ways of sharing new ideas and best practice.

Outstanding practice and areas for improvement

- The trust should ensure that the actions initiated after the recent never event include re-enforcing the importance of the timely reporting of all incidents.
- The trust should consider how it is going to meet the existing areas of non-compliance with the D16 National Service Specification for Adult Intensive care. More specifically, the shortfall in allied health professional support and NICE guidance.
- The trust should consider extending the critical care outreach team to cover each 24 period.
 - Patient diaries should be consistently used across the trust for patients in critical care units.
 - The trust should consider how it can reduce the number of delayed discharges in critical care.
 - The trust should consider how it is going to reduce the number of cancelled elective surgery cases due to the lack of availability of critical care beds.
- The trust should consider how it is going to reduce the number of cancelled elective surgery cases.
 - Intravenous fluids should be securely stored to ensure the risk of tampering or contamination is minimised.
 - The trust should ensure that safeguarding pathways and procedures protect patients from avoidable harm.
 - The trust should ensure that all staff are aware of their responsibilities under the missing baby policy.
 - The trust should ensure that all staff are aware of their responsibilities under the major incident policy.
 - The trust should ensure that all maternity and gynaecology risks are added to the risk register to ensure mitigation and oversight.
 - The trust should ensure that in maternity and gynaecology the culture promotes supportive and respectful behaviour between all grades of staff.
- The service should consider the reporting quality of the maternity and gynaecology dashboard data at a site level and set RAG targets for all outcomes to ensure greater oversight of outcomes and trends.
- The trust should consider the investigation and coding of puerperal sepsis, wound infections and sepsis of unknown origin.
- The trust should consider the appropriateness and robustness of the down-grading of incidents.
- The trust should ensure there are systems in place to ensure that staff demonstrate competence to operate different types of equipment.
- Should locate, monitor and track the syringe drivers across the trust.
- Review the leadership arrangements and focus on end of life care to ensure it is given sufficient priority at directorate and board level.
- Consider how to reduce in-clinic wait time for patients.
- Ensure clinic capacity is planned to meet patient demand.
- Ensure that patients requiring following up appointments are seen in a timely manner.
- Ensure where there are backlogs, patients have been assessed for clinical risk and prioritised accordingly.
- Consider how to ensure leaflets and information available in outpatient clinics are translated where appropriate into languages used by the local community.
- Address the reasons for hospital cancellations of outpatient clinics.
- Ensure information about how to complain is available to patients in outpatient clinic areas.
- Consider how to meet the needs of patients with a learning disability and reduce DNAs for these patients in outpatient clinics.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>Regulation 9(2)</p> <p>Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">The trust did not have an audit system in place to ensure 'Do Not Attempt Cardio-Respiratory Resuscitation' decisions were always documented legibly and completed fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005.
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>Regulation 10 (1) (2) (a)</p> <p>Ensuring the privacy of the service user</p> <p>Service users must be treated with dignity and respect ensuring the privacy of the service user.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">The 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.

Requirement notices

- 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.
- Medical records were not secured so there was a risk patients confidentiality could be breached.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11(1)

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

How the regulation was not being met:

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

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

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:

Requirement notices

- There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients. Nursing staff did not consistently adhere to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always documented a clear plan of treatment if a patient's condition had deteriorated.
- Where patients had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance.
- Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments completed in a timely manner or reviewed after 24 hours.

Regulation 12 (2)(c)

Care and treatment must be provided in a safe way for service users by ensuring that persons 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:

- 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.
- Midwives did not have the necessary training in the care of the critically ill woman and anaesthetic recovery in line with current recommendations.

Regulation 12 (2)(d)

Care and treatment must be provided in a safe way for service users by ensuring the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

How the regulation was not being met:

Requirement notices

- 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.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 15 (1) (e)

All premises and equipment used by the service provider must be suitable for the purpose for which they are being used

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

Requirement notices

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)

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

How the regulation was not being met:

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- Midwifery staffing ratios did not meet current recommendations. 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.