

University Hospitals of Leicester NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement	
Are acute services at this trust safe?	Requires improvement	
Are acute services at this trust effective?	Good	
Are acute services at this trust caring?	Good	
Are acute services at this trust responsive?	Requires improvement	
Are acute services at this trust well-led?	Good	

Summary of findings

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Summary of findings

Overall summary

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.

The trust provides over 1700 beds for a population of 330,000 people in the city and county of Leicestershire. The largest of the locations is Leicester Royal Infirmary, which provides the trust's only A&E service. This hospital is in the city centre and surrounded by housing, businesses and the local rugby and football grounds. This makes expansion at this site very difficult. The two other hospitals sit a few miles east and west of Leicester Royal Infirmary. Leicester General Hospital provides emergency and planned surgery, medicine, maternity and outpatients services. The trust has expanded this location from its original building built in 1910. The Glenfield Hospital site is a purpose-built unit and provides cardio vascular and respiratory medicine and surgery as its specialities. Each hospital has its own culture despite the trust managing services across the trust. Therefore within the location reports references are sometimes made to the trust or service data as this was not always available by location.

Prior to and during our inspection we heard from patients, relatives, senior managers, and all staff about three issues which impacted on the service provided at this hospital. These were:

Staffing

We met with the trust prior to the inspection and were informed that the trust was increasing the amount of nursing staff throughout the trust. The executive team had doubled the number of staff vacancies at the trust to ensure that patients received a quality service and that the use of ad-hoc staff was reduced. The trust had recently undertaken interviews in Portugal and Spain to recruit staff to the 500 vacancies that they had in the nursing workforce. During our inspection the first of these overseas recruits arrived in the country. By undertaking

recruitment at home and overseas, the trust had reduced the number of vacancies to 250. However, the impact of the recruitment exercise had yet to be felt on some of the ward and department areas. Many staff talked about the nurse staffing shortages and the impact that they felt this had on patient care. The trust had put in a management system, whereby nurses were moved to wards where the shortage was felt to be impacting on patient care.

Medical staffing vacancies had been reduced from 30% to 5% as a result of increased recruitment. Other areas of the paramedical staff have also seen reductions in numbers of staff and, with the increase in nursing and medical staff, may need to be reviewed.

Pressures in the A&E department

This is one of the key challenges at the Leicester Royal Infirmary, and has been for some time. Successive management teams have been unsuccessful in resolving the issues of patient flows through the hospital. The current management team have put in place operational meetings, which occur three times a day and are attended by senior consultants to decide on the appropriate treatment for patients. Bed management meetings are also held three times a day to review patients who are fit for discharge on the ward areas. Senior managers, along with stakeholders such as social workers and pharmacists, work together to resolve the issues that prevent an appropriate discharge. The single point of access through the urgent care centre has reduced A&E attendances by 30% and refers patients to the most appropriate forms of treatment. These measures may be starting to have an effect on the hospital attaining the four-hour wait target set by the government. During the period June to September 2013, the number of patients waiting more than four hours had improved, although was still below the national target. A significant number of planned operations had been cancelled due to the pressures on beds in a number of different areas, including critical care, surgery and children's services.

Services contracted out

The provision of meals, catering and cleaning had been outsourced from the trust's own staff to an independent

Summary of findings

company. There had been significant issues in the level of service delivered through this contract. Patients' meal times were delayed significantly through the new process for providing hot meals and the availability of some food stuffs was reduced. The senior managers at the trust assured us that negotiations with the external company had resulted in some improvements to this and we saw and heard from ward staff and patients that this was starting to get better. We saw that the hospital was generally clean in most areas. However, new

arrangements for porters were causing delays for ward staff in providing appropriate treatment and care. Examples of this include porters not arriving to move patients to theatre, causing delays. We also heard a significant amount about patient transport issues and how this affected patients accessing the service. While this service is not managed by the hospital, it did delay services especially on discharge and in the outpatients department.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

We found that services at the University Hospitals of Leicester NHS Trust were safe but improvements need to be made. We found that appropriate actions were taken when an incident occurred and lessons learned were implemented. However, some staff reported that, for some incidents, the reporter did not receive individual feedback.

We found that the ward and departments were short of nursing staff, which at times impacted on delays in patient care. We did not see any examples where wards or departments were unsafe during our inspection. We were aware that the trust has launched a large recruitment campaign and staff throughout the hospital were able to discuss this with us and the effect that this would have on their area.

We found the resuscitation service required some support to ensure that all staff were focused on safety and that the service was consistent across all sites. We found that staff lacked ownership of this service and did not fully understand their responsibilities in its provision. While we found deficiencies in the service, we could not ascertain what effect this was having on patients, as recording systems did not measure events effectively.

The new management team at the trust has a number of plans in place to ensure that, where there are issues which could impact on safety of patients, action is being taken. However, some of these plans will be realised in the future.

Requires improvement



Are services effective?

We found that the care provided by University Hospitals of Leicester NHS Trust was effective. We saw that national guidelines were in use in a number of areas and that this enhanced care. We saw that the trust had taken action to address areas where care was less effective and that this was having a positive impact for patients.

The trust provides a wide range of specialist services across its three main sites. Services contributed to national audit programmes and was performing above expected in many areas, although acknowledges that its stroke services at the Leicester Royal site are still in need of some improvement.

Multidisciplinary working was evident throughout the trust both internally and externally with stakeholders. The trust has good working relationships with external stakeholders to ensure appropriate discharges. This has assisted in the timely discharge of patients and improving patient flows.

Good



Are services caring?

Overwhelmingly we were told that staff were caring. At the listening event we heard that some staff were difficult to understand and some were rude, but

Good



Summary of findings

when asked if staff cared, the answer was 'yes'. Patients reported that they were treated with compassion and their dignity was respected. Despite the lack of capacity impacting on the availability of beds, patients felt that staff worked hard to ensure that they were treated with dignity and respect.

We examined data from the trust, including the Care Quality Commission (CQC) inpatient survey, NHS Friends and Family Test, NHS Choices website and the Cancer Patient Experience Survey. The Friends and Family Test showed that inpatients generally scored the trust lower than patients treated in the accident and emergency (A&E) department. NHS Choices rated the trust at 3.5 stars out of 5, and the trust performed in line with the national average on the inpatients' survey.

Are services responsive to people's needs?

The trust staff at all levels are aware of the issues it has in responding to the needs of the community it serves. These issues were raised with us prior to the inspection by all stakeholders and included the pressures on the A&E department, waiting times for outpatient appointments (particularly in ophthalmology) and lack of staff. The senior management team have a number of immediate and long-term plans to address the issue of being responsive to the needs of patients. Some of these have been implemented and were seen to be increasing the responsiveness of the trust.

At a ward level, healthcare professionals were seen to meet the needs of patients and to adapt their service in light of feedback from patients. Translation facilities were, in general, not used as a number of staff could communicate with patients in their first language. Intentional rounding (comfort rounds or round-the-clock care) was in place in most of the hospitals we visited. Seating for patients, their families or friends was often in short supply in busy areas such as the clinical decisions unit and in outpatients.

Requires improvement



Are services well-led?

The trust recruited a new chief executive officer in January 2013. At the time of our visit, he had been in the post one year. We found that he and his team had had a significant impact on a number of staff. Staff were excited by the new direction for the trust and welcomed the visibility and openness they saw from the chief executive and the chief nurse.

Most staff felt more able to raise concerns and were confident that these would be listened to. Access to the senior management team was greater through the restructuring of the way the trust manages its services. New initiatives were understood by staff we spoke to who were also aware of the challenges the trust faced.

Good



Summary of findings

What people who use the trust's services say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust can be seen to be under the England average for the inpatient component of the test, while the A&E score is significantly higher than the national average.

Analysis of data from the CQC's Adult Inpatient Survey 2012 shows the trust performed about the same as other trusts in all 10 areas of questioning. The trust performed worse than other trusts on two questions: these related to patients being involved in their own discharge from hospital.

Areas for improvement

Action the trust MUST take to improve

- The trust must review resuscitation practice and equipment to ensure the safety of patients.
- All staff must adhere to infection prevention and control practices. (Leicester Royal Infirmary and Glenfield Hospital – Regulatory action being taken)
- Patients must receive appropriate care delivered in a timely way that meets their needs. (Leicester Royal Infirmary – Regulatory action being taken)
- Patients were not protected from the risks associated with unsafe equipment as equipment was found in the medical wards which was dirty. (Glenfield Hospital – Regulatory action being taken)
- People who use services and others were not protected against the risks associated with receiving unsafe care in the clinical decisions unit due to inappropriate admissions from the main A&E site. (Glenfield Hospital – Regulatory action being taken)
- Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients. (Glenfield Hospital and Leicester General Hospital – Regulatory action being taken)
- Patients were not protected from the risks associated with unsafe or unsuitable buildings in that a roof was found to be leaking, access to OPD was difficult and other rooms were found to be too small to accommodate the service. (Leicester General Hospital – Regulatory action being taken)
- Staff were not supported in their role as they did not receive appropriate training, professional development and supervision. (Leicester General Hospital – Regulatory action being taken)

Action the trust SHOULD take to improve

- The trust should continue to address areas where staff are afraid to speak out.
- All staff should work to the trusts standard operating procedures for the transfer of care between locations.
- Some of the older buildings posed challenges for staff in providing care to patients.
- Having different medication systems in different hospitals made tracking patients medications difficult at times.

Good practice

Our inspection team highlighted the following areas of good practice.

- Use of champions in specialist areas to improve the quality of care for groups of patients.
- Meaningful activities co-ordinators to provide care for patients with dementia.
- Use of falling leaves to denote patients at risk of falling and actions taken to support these patients.
- Actions taken as a result of clinical audit to enhance the experience of patients at the trust.
- Dissemination of the vision for the trust.
- Accessibility of the senior management team to all staff in the organisation.

Summary of findings

- The provider had an extensive team of specialist midwives, who supported care for the more vulnerable people within the community. We saw specialists for bereavement, safeguarding and female genital mutilation (female circumcision).
- The intensive care unit at the Glenfield Hospital had a quiet room and a sitting room for relatives. As the unit provides care and treatment for patients who live further afield than Leicestershire, a display screen provided information about the local area, amenities and facilities.
- The trust held a thoracic surgery patient experience day, at Glenfield Hospital, in November 2013 to gather more details about the experiences of patients.
- We observed care being delivered on the brain injury unit and saw staff delivering excellent care, including using touch to help calm patients, and treating patients with great care, respect and warmth. Staff celebrated with patients after they achieved success in undertaking daily living tasks.
- Patients who are at the end of life care are offered the opportunity to carry a summary of their record and wishes so that information is shared with all care givers.

University Hospitals of Leicester NHS Trust

Detailed findings

Hospitals we looked at: Leicester Royal Infirmary, Leicester General Hospital, Glenfield Hospital and St Mary's Birth Centre.

Our inspection team

Our inspection team was led by:

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

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

The team of 37 included CQC inspectors and analysts, doctors, nurses, patients and public representatives, experts by experience and senior NHS managers. We also had observers from the Dr Foster programme which provides research and healthcare information.

Background to University Hospitals of Leicester NHS Trust

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. As a teaching trust it works in partnership with several universities, including the University of Leicester, Loughborough University and De Montfort University, to provide teaching, research and innovation programmes for doctors, nurses and other healthcare professionals. It also manages the St Mary's Birth Centre, which is a midwife-led unit based at St Mary's Hospital in Melton Mowbray and provides care for pregnant women and their families before, during and after birth. The trust headquarters are located at Leicester Royal Infirmary.

The trust undertakes a wide portfolio of patient-centred research involving almost every aspect of specialist medicine and surgery. Several of their research teams are recognised as international leaders in their field. They include: cardiovascular disease, respiratory disease,

Detailed findings

diabetes, cancer, renal and infection. The trust cares for around 222,222 inpatients a year, 143,097 A&E admissions and 767,000 outpatients. The trust has around 1,773 beds and an annual budget of £745m.

The trust was chosen for inspection as they were rated as high risk in CQC's new Intelligence Monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. The issues raised as part of this [Intelligent Monitoring] risk identification model were: pressures in the A&E department, outliers in maternity, paediatric and general surgery services.

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

Since registration, five of the trust's sites have been inspected: the three main sites at Glenfield Hospital, Leicester General Hospital and Leicester Royal Infirmary, St Mary's Birth Centre and the Peterborough Renal Unit. This report reflects those inspections undertaken using the new methodology and include Leicester Royal Infirmary, Glenfield Hospital, Leicester General hospital and St Mary's Birth Centre. The trust provides five dialysis services across neighbouring counties. The trust was served a warning notice in July 2012 but was found to be compliant with the requirements of this in November 2012. At the time of our inspection, all locations were compliant.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. We chose this trust because it was considered to be a high-risk service.

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit between 13 and 16 January 2014. During the visit we held focus groups with a range of staff in the hospital, nurses, doctors, physiotherapists, occupational therapists, administrative and clerical staff. We talked with patients and staff from all areas of the hospitals, including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the trust. An unannounced visit was carried out on 31 January 2014 at the Leicester Royal Infirmary site.

Are services safe?

Summary of findings

We found that services at the University Hospitals of Leicester NHS Trust were mostly safe but that improvements were needed to maintain safety at all times. We found that appropriate actions were taken when an incident occurred and lessons learned were implemented. However, some staff reported that, for some incidents, the reporter did not receive individual feedback.

We found that the ward and departments were short of nursing staff which, at times, impacted on delays in patient care. We did not see any examples where wards or departments were unsafe during our inspection. We were aware that the trust has launched a large recruitment campaign and staff throughout the hospital were able to discuss this with us, including the effect that this would have on their area.

We found the resuscitation service required some support to ensure that the service was consistent across all sites. We found that staff lacked ownership of this service and did not fully understand their responsibilities in its provision. While we found deficiencies in the service, we could not ascertain what effect this was having on patients, as recording systems did not measure events effectively.

The new management team at the trust had a number of plans in place to ensure that, where there were issues which could impact on safety of patients, action was being taken. However, some of these plans will only be realised in the future.

happen again. However, some staff told the inspection team that they may become complacent about reporting incidents as they do not always receive feedback on what happened as a result of reporting.

Learning and improvement

The NHS Safety Thermometer measures a series of indicators which may help to predict performance of a trust. These indicators include: new pressure sores, venous thromboembolism (blood clots), catheters and urinary tract infections and falls with harm. The trust was slightly outside the expected limits in respect of new pressure sores and urinary tract infections. During the inspection, we spoke with the infection control and tissue viability teams, nurses and doctors on the wards and with patients. Healthcare professionals at all levels were able to describe systems and processes put in place to monitor, assess and treat pressure sores and infections. We noted that the chief nurse oversees a monthly remedial action plan for the reduction in avoidable pressure ulcers and we saw the action plan which is due for review in January 2014. We noted on wards and in theatres that appropriate pressure-relieving equipment is in place. One ward we visited told us they had been free from pressure ulcers for 298 days due to the 'Best Shot' initiative, which involved the nominated person undertaking visual inspection of all pressure areas and reviewing risk assessments at least twice daily. This is a ward-based initiative and staff said they felt this was the reason for a reduction in the number of pressure sores.

The trust's performance for four of the Royal College of Physicians 'National Audit of Falls and Bone Health in Older People indicators' was found to be either worse than expected or tending towards worse than expected. For all other indicators it was found to be performing within expectations, except for the question 'Was an attempt made within 24 hours of surgery to mobilise the patient (Hip)?', for which it was found to be tending towards better than expected. The proportion of patients suffering falls with harm at the trust, both among all patients and among patients over 70, shows a similar pattern of below England average rates, until rates rise significantly in patients over 70 from February 2013. Rates have fallen since April 2013. We reviewed documentation and spoke with ward staff about management of falls. We were informed that all staff routinely assessed patients pre- and post-operatively for falls risks, we saw this in the pre-op assessment document

Our findings

Safety and performance

The trust had reported three Never Events, which are incidents that are so serious that they should never happen. These occurred at Leicester Royal Infirmary and Leicester General Hospital. During our inspection, we asked staff about these incidents and the lessons learned from them. Staff at the sites were able to discuss these incidents and the actions taken to ensure that they do not happen again. Staff were clear on reporting incidents and their role in taking action to ensure that the incident does not

Are services safe?

'Green for Go' and we were informed that a large number of falls occurred due to the patients' perception of their ability to mobilise post-operatively despite being given this information before their operation.

Systems, processes and practices

Overall, we found that there was sufficient equipment available for staff to use to care for patients. Staff in maternity at Leicester Royal Infirmary described an issue with equipment. However, this was not found elsewhere. Although the trust were having issues with the main contractor for cleaning, we found that, overall, the hospitals we inspected were clean. We found some issues with dirty equipment at Glenfield Hospital, but staff took the appropriate action once informed. Medicines management at the hospital was effective, with some small exceptions which we have highlighted in the individual reports for the hospitals.

Across the three main hospitals inspected, we found issues with the resuscitation equipment and staffing of the cardiac arrest team. We found resuscitation trolleys which were either overstocked or understocked as well as some that were dusty. We spoke with the resuscitation officer who informed us that a recent audit of the provision of resuscitation equipment had been undertaken and a proposal had been submitted to standardise these across the trust. This would ensure that staff who worked across the sites would be familiar with the resuscitation trolley and the equipment on it, regardless of which location they were in. This would increase the performance of the cardiac arrest team. However, despite submitting a proposal, this had not occurred.

Monitoring safety and responding to risk

The trust acknowledged that there was a shortage of nursing staff vacancies in the trust. To increase staffing establishments throughout the trust, the number of vacant posts was doubled by the current chief executive. The trust had undertaken a recruitment campaign in Portugal and Spain and a number of nurses arrived during the week of our visit. Staff at the hospital locations we inspected were aware of these initiatives and staff remained positive that action was being taken and were flexible to meet the needs of their ward or department in the short term. The impact for patients was that they said they had to wait longer for appointments, and for care staff to answer their call bell. However, this was usually qualified with exclamations that the staff were very caring.

Anticipation and planning

As described above, the trust's new management team were recruiting to nursing vacancies. They also recognised that this will have an impact on other areas of staffing within the hospital and were currently recruiting to medical staff posts. The ancillary staff employed by the trust were undergoing a restructuring exercise and this impacted on individuals' workloads which was seen by some as excessive.

The trust had a number of plans in place to address its key issues. This included the creation of an emergency floor at Leicester Royal Infirmary, investment in the backlog of patients in ophthalmology outpatients awaiting appointments and a new IT strategy to ensure that all IT systems work in harmony across all hospital sites. These plans will contribute to the safety of patients and the effectiveness of the trust as a whole.

Are Services Effective?

(for example, treatment is effective)

Summary of findings

We found that the care provided by University Hospitals of Leicester NHS Trust was effective. We saw that national guidelines were in use in a number of areas and that this enhanced care. We saw that the trust had taken action to address areas where care was less effective and that this was having a positive impact for patients. The trust provides a wide range of specialist services across its three main sites. Services contributed to national audit programmes and was performing above expected in many areas, although acknowledges that its stroke services at the Leicester Royal site are still in need of some improvement.

Multidisciplinary working was evident throughout the trust both internally and externally with stakeholders. The trust has good working relationships with external stakeholders to ensure appropriate discharges. This has assisted in the timely discharge of patients and improving patient flows.

Our findings

Using evidence-based guidance

The trust provides a significant amount of specialist services across the three sites. Both Glenfield and Leicester General are known nationally for their heart and lung disease care and renal services respectively. NICE guidance use was evident throughout most of the core services we inspected and the trust had overall mortality outcomes in line with national expectations.

Performance, monitoring and improvement of outcomes

The trust participates in most of the national audits that concern the services it provides and across the eight core services that we inspect. Glenfield hospital was performing as well as expected for four out of the five indicators measured in the Myocardial Ischaemia National Audit

Project and was trending towards better than expected for the fifth. The trust performed within expectations and better than average for healthcare acquired MRSA, hospital mortality and unplanned readmissions within 48 hours.

The stroke service provided at the Leicester Royal site was performing significantly below expectations with regards to the percentage of patients being moved to a stroke unit within four hours of admission. (52% compared with a target of 90%). The trust was aware of this and had put in place a stroke escalation policy which had led to some improvement by the time of our inspection.

Staff, equipment and facilities

We saw that the trust had introduced dementia and older person's champions. We spoke to a number of these staff. They were, without fail, enthusiastic, passionate and motivated about this role. They were keen to provide advice to others on their wards or on other wards so that patients who were elderly or had some degree of dementia received safe and effective care.

We saw that there were issues with the effectiveness of care when patients were transferred to different departments within the trust. Although operating policies were in place for areas such as the discharge lounge and the Fielding Johnson ward at Leicester Royal Infirmary, these were not always known to staff. Therefore, patients were sometimes inappropriately transferred to that area, impacting on the care they received. We also noted that electronic prescribing was only available at the Leicester Royal Infirmary site, and when patients were transferred across to other sites, their previous medication history could not always be reviewed.

Multidisciplinary working and support

We saw some good examples of multidisciplinary working, both between hospital staff and with external bodies. We saw that doctors and nurses worked together to expedite appropriate care for patients and that pharmacists and other allied healthcare professionals were involved in making decisions about the provision of care and treatment.

Are services caring?

Summary of findings

Overwhelmingly we were told that staff were caring. At the listening event, we heard that some staff were difficult to understand and some were rude, but when asked if staff cared, the answer was 'yes'. Patients reported that they were treated with compassion and their dignity was respected. Despite the lack of capacity impacting on the availability of beds, patients felt that staff worked hard to ensure that they were treated with dignity and respect.

We included data from the trust, including the CQC's Adult Inpatient Survey 2012, NHS Friends and Family Test, NHS Choices website and the Cancer Patient Experience Survey. The Friends and Family Test showed that inpatients generally scored the trust lower than patients treated in the A&E department. NHS Choices rated the trust at 3.5 stars out of 5, and the trust performed in line with the national average on the inpatients survey.

Our findings

Compassion, dignity and empathy

We observed some good practice regarding privacy and dignity – for example, use of red 'privacy pegs' and use of 'care in progress' notices on bed curtains. We saw evidence of cultural diversity being addressed throughout the hospital on posters and in information leaflets given to patients. We also saw charts posted outside ward bays to remind staff of things to ask the patient and duties to be completed at specific times, for example, reminding patients to drink and offering assistance, and checking that the call bell was within reach.

We heard and saw care staff undertaking intentional rounding at set times, to enquire about the basic needs of patients. This ensures that patients are moved, offered toileting facilities and have adequate food and drink.

Involvement in care and decision making

Some people who attended the listening event told of experiences when doctors and nurses had not listened to them and they did not feel involved in their care. We made this a priority for our inspectors to investigate when speaking with patients. The patients and relatives we spoke to on site reported that they felt involved in care planning and decision making. Relatives were able to give examples of where they had been involved in care.

Analysis of data from the CQC's Adult Inpatient Survey 2012 shows the trust performed about the same as other trusts in all 10 areas of questioning. The trust performed worse than other trust's on two questions: these included noise at night and being involved in their discharge from hospital. However, we found that patients and relatives we spoke with told us that they felt involved in discussions about their care.

Trust and communication

Before and during the inspection, we received reports from patients about the lack of pain control while in the hospital. However, inpatients told us that their pain was well controlled and felt they could say if they were in pain and action would be taken. Patients said that they were kept informed about any new medicines prescribed or any changes to their treatment.

Emotional support

We found emotional support was provided, not only in the areas where you would expect it such as critical care and end of life care, but also that staff in all areas were prepared to 'go the extra mile' to ensure that patients and their relatives were supported throughout their admission and discharge from the hospital.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The trust staff at all levels were aware of the issues it had in responding to the needs of the community it serves. These issues were raised with us prior to the inspection by all stakeholders and included the pressures on the A&E department, waiting times for outpatient appointments, particularly in ophthalmology, and lack of staff. The senior management team had a number of immediate and long-term plans to address the issue of being responsive to the needs of patients. Some of these had been implemented and were seen to be increasing the responsiveness of the trust.

At a ward level, healthcare professionals were seen to meet the needs of patients and to adapt their service in light of feedback from patients. Translation facilities were, in general, not used as a number of staff could communicate with patients in their first language. Intentional rounding (comfort rounds or round-the-clock care) was in place in most of the hospitals we visited. Seating for patients, their families or friends was often in short supply in busy areas such as the , clinical decisions unit and in outpatients.

requiring admission and further meetings are held twice daily regarding patient discharges. Ward staff discussed patients who were medically fit for discharge and sought assistance from others at the meeting in order to expedite the discharge. At times this meant that others at the meeting sought resolutions with care home providers or that take home medication was ordered in a timely way. This meant that patients were discharged in a timely way with appropriate support in place.

In general, we found that most wards and departments were meeting the needs of patients. However, the pressure on beds meant that some operations were cancelled, some on the day of admission, and some undesired practices were occurring. While these practices were safe, they did affect the performance of the trust. Examples included the use of the recovery area in theatre for patients awaiting a bed and extra patients being admitted to the nephrology ward to provide dialysis.

Vulnerable patients and capacity

We spoke with staff about safeguarding policies and procedures. Staff knew the correct procedures to follow in the event of suspected abuse. Staff knew about the Mental Capacity Act 2005 and associated deprivation of liberty safeguards. This meant that people who lacked capacity would only have their liberty deprived following a 'best interest' assessment carried out in accordance with the Mental Capacity Act 2005.

Access to services

The trust provided a service to a diverse population. While the county is more affluent and has a lower ethnic population, the city is made up of a high percentage of ethnic cultures and is the 25th most deprived area in the county. This gives the trust challenges with the availability of information in a number of languages. We saw that some signage in some areas was available in different languages, as were information leaflets. We spoke with staff about how they communicated with people whose first language was not English. They told us they had access to a telephone interpreter service (Language Line) and that many staff were bilingual or multilingual and could be used to interpret. We did not see evidence that communication was an issue at this trust.

Leaving hospital

The trust had undertaken a number of actions to improve the patient flow through the hospital. These included discharge lounges, an elderly frail unit, a short stay older

Our findings

Meeting people's needs

The hospital was failing to meet the target of 95% of patients in A&E being seen, treated, and discharged or assessed within four hours. However, the hospital performed better than average for patient admissions, waiting between four and 12 hours to be admitted. Arrangements put in place in July 2013 for all walk-in patients to be seen by the urgent care centre, (run for the trust by George Elliot NHS Trust) had decreased attendances to A&E by 30%.

The trust had implemented a number of strategies to ensure good patient flows within the department. The times for ambulance handovers was within the expected limits and staff started a patient's assessment in a timely manner. An operational meeting was set up with clinicians to review patients to ensure that flows remained good. Bed management meetings occurred three times a day and helped ensure that beds were available for those patients

Are services responsive to people's needs?

(for example, to feedback?)

person's ward and movement of patients to wards which would provide care for people with reduced care needs prior to discharge. The patients and families we spoke with were informed and included in their discharge. There were policies in place for the safe discharge of patients which described times after which patients would not be discharged to care homes and community hospitals. Trust staff told us that patients would not be discharged to care homes after 7pm. However, we found instances where this had not been adhered to. The bed management meeting ensured that discharges were appropriate to meet the needs of the patient, through use of positive challenge to staff and ready support being available from the multidisciplinary team. That said, the failure for the trust to consistently meet the four hour target demonstrates that work needs to continue to improve flow.

Learning from experiences, concerns and complaints

We saw that 'message to matron' boxes were situated in most hospital areas. Patients were asked to fill in patient experience questionnaires. We saw that there was information about the patient experience survey in all the wards and departments. The trust employed non-clinical patient advisors one of their roles is to provide information to patients about the trust.

During our inspection we met with the complaints and Patient Information and Liaison Service. The team was

based at Glenfield Hospital but travelled to other sites within the trust. Complaints were investigated by the clinical management group responsible for the service being complained about; if a particular member of staff was named, they would be informed of the complaint. The draft response to the complaint was then quality assured by a corporate team which included a patient safety manager. The trust set a 95% response target for complaints within set timescales. At the time of our inspection, 86% of complaints were responded to within 10 days which demonstrated a good performance. Outcomes of complaints clearly demonstrated learning and actions taken to prevent a repeat of the incident. Staff we spoke with during the inspection told us that they were kept informed of complaints involving their department.

We were told about an initiative known as Listening into Action which encourages front line staff to engage with management to improve quality outcomes and patient experience. Staff attended meetings and were able to put forward their concerns and ideas. A staff member told us how attending this meeting had resulted in additional equipment being purchased for the emergency department. A number of other wards and departments were also able to provide examples of where action taken following a Listening into Action meeting had enhanced patients' experience.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust appointed a new chief executive officer in January 2013. At the time of our visit, he had been in the post one year, and we found that he and his team had had a significant impact on a number of staff. Staff were excited by the new direction for the trust and welcomed the visibility and openness they saw from the chief executive and the chief nurse.

Most staff felt more able to raise concerns and were confident that these would be listened to. Access to the senior management team was greater through the restructuring of the way the trust manages its services. New initiatives were understood by staff who were also aware of the challenges the trust faced.

Our findings

Vision, strategy and risks

The new chief executive had a clear vision for the hospital which is called Caring at its Best. This includes providing safe and innovative care. Staff could tell us about what the vision meant to them. They told us that this vision includes having a professional, passionate and valued workforce who are creative in their work. Key objectives included staff training and development, better employment, and encouraging innovation.

The trust had processes in place to enhance the services it offers while achieving a challenging cost improvement plan. However, systems are in place to ensure that while making cost savings, the quality of service provision is not reduced. Staff were able to articulate the plans of the trust and recognised that some of these would take some time to come to fruition. However, they were confident that the new management team could deliver against its promises.

Governance arrangements

The new management team had recently reviewed the way the trust is organised. The chief executive explained that previously there was a tall thin structure with many layers of management between himself and the ward floor. This had recently been changed to reflect specialities or clinical business units (CBU). This meant that, while there were more CBU's, the reporting mechanisms were flatter and broader allowing the chief executive and management

team to have more understanding of the issues at a patient level. Staff told us that the new, flatter structure for clinical management had improved the way issues were escalated and managed. They were able to identify changes that had been made as a result of this change, including: nurse to bed ratios, increases in nurse posts advertised and ward managers being allocated one day per week for supervision. Further improvements included a strong focus on reducing pressure ulcers and improving falls management.

Leadership and culture

We received extremely positive feedback when we spoke to staff about leadership at a local and trust-wide level. The appointment of the new senior team was seen as positive and they were described as "inspiring" by one group of people we met. We were told that staff morale appeared to be improving since they were appointed. Clinical staff told us that they considered information was disseminated well from the chief executive and chief nurse and was well received. We were also informed that the chief executive was very visible, making himself available for staff discussions at 'Breakfast with the Boss' meetings, and he was open to receiving emails. He also held monthly briefings for senior staff with all staff expected to attend. These were described by one matron as an open forum, meaning that information flowed from the ward to the board.

The trust's sickness absence rates and agency staff budget are both lower than those for the East Midlands Strategic Health Authority. This indicates that the trust does not have serious issues with staff sickness. The results of the 2012 NHS Staff Survey indicated that the trust is performing well regarding to staff appraisals, staff witnessing/reporting harmful incidents and general staff satisfaction. We found that on most wards we visited there was a robust organisational structure lead by a matron, ward sister and a nurse in charge. We saw written evidence of staff receiving annual appraisals and regular supervision. We noted on a number of wards that staff training and deployment was highlighted on staff rotas seen. One matron told us that, due to certain periods in the shift being less busy, staff were encouraged to do some e-learning while on duty.

Patient experiences, staff involvement and engagement

We received a number of whistle-blowing emails, both before we attended the trust and while we were on site. We

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

spoke to a number of people who sent these. Some staff described a culture of bullying and harassment and feared speaking to us if their line manager was aware they were doing so. The fear of reprisal for these staff members was very real; they felt unsupported and unable to voice their concerns. We spoke with other members of staff about how they felt about raising issues and we were told by nursing and medical staff that they felt able to voice concerns without the fear of reprisal. They felt that the culture of the organisation had changed and once they had felt unable to voice concerns but they felt that the new senior team encouraged people to speak out.

We spoke with a senior member of the learning and organisational development team who told us that the trust had a plan to develop the organisation and embed a culture that matched its vision and values. This had been externally scrutinised and was found to be 'strong' and to have incorporated key recommendations from the Francis Report (the Mid Staffordshire NHS Foundation Trust Public Inquiry). The Listening into Action programme was being rolled out in a phased approach across the trust, specifically aimed at ensuring staff's concerns, ideas and issues are heard and acted on. Both programmes show that there is acceptance that improvement needs to be made across the trust in relation to staff morale and organisational culture, and that this change is happening. The recent staff survey showed a drop in the number of people reporting that they have experienced bullying or harassment at work.

Stakeholders reported that trainees were either left alone or forced to cope with problems beyond their competence

or experience on a regular basis. It was also reported that medical handovers were not adequate and that there were concerns about the experience patients were getting. We noted that, in certain wards, junior doctors were supervised by consultants who used ward rounds as teaching opportunities. We also were informed that junior doctors were encouraged to attend training and that consultants would adjust their schedules to accommodate this. We found no evidence of junior staff being left without supervision or inappropriate out-of-hours cover on wards visited. A junior member of medical staff informed us that, in specialised areas, they would be briefed and wholly supervised by a senior doctor while undertaking a procedure. They also received clinical education /supervision but documentation was not always completed to confirm this.

Learning, improvement, innovation and sustainability

When we met with the trust prior to our visit, we were informed of the 'super weekend' initiative which occurred on two weekends prior to our visit. The aim of this was to provide "normal working hours" service at the weekend. This meant having more senior staff on duty at the weekend so that patients were not delayed in treatment or discharge over the weekend. We discussed this with nursing, clinical and medical staff who informed us that, generally, it had been a good initiative but they could not comment on the outcomes or future intentions. The trust senior managers felt that a full review was needed, but that initial impressions were that this had been a success.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use the service.</p> <p>People who use services and others were not protected against the risks associated with unsafe or inappropriate treatment as resuscitation services were not consistent in provision, knowledge or equipment across all locations and as reflected in published guidance. Regulation 9 (1) (b) (iii)</p>
Maternity and midwifery services	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use the service.</p> <p>People who use services and others were not protected against the risks associated with unsafe or inappropriate treatment as resuscitation services were not consistent in provision, knowledge or equipment across all locations and as reflected in published guidance. Regulation 9 (1) (b) (iii)</p>
Surgical procedures	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use the service.</p> <p>People who use services and others were not protected against the risks associated with unsafe or inappropriate treatment as resuscitation services were not consistent in provision, knowledge or equipment across all locations and as reflected in published guidance. Regulation 9 (1) (b) (iii)</p>

This section is primarily information for the provider

Compliance actions

Regulated activity

Diagnostic and screening procedures

Regulation

Regulation 9 HSCA 2008 (Regulated Activities)
Regulations 2010 Care and welfare of people who use the service.

People who use services and others were not protected against the risks associated with unsafe or inappropriate treatment as resuscitation services were not consistent in provision, knowledge or equipment across all locations and as reflected in published guidance.
Regulation 9 (1) (b) (iii)

Regulated activity

Termination of pregnancies

Regulation

Regulation 9 HSCA 2008 (Regulated Activities)
Regulations 2010 Care and welfare of people who use the service.

People who use services and others were not protected against the risks associated with unsafe or inappropriate treatment as resuscitation services were not consistent in provision, knowledge or equipment across all locations and as reflected in published guidance.
Regulation 9 (1) (b) (iii)