University Hospitals of Leicester NHS Trust

Leicester General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires Improvement**
Medical care	**Good**
Surgery	**Requires Improvement**
Intensive/critical care	**Good**
Maternity and family planning	**Good**
End of life care	**Good**
Outpatients	**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.

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. We spoke to 65 patients and their relatives while visiting the wards and departments in the hospital. We also held a listening event on 13 January where we spoke with around 80 people who came to provide their views on this and the other hospitals managed by this trust.

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

Staffing

While staffing was of concern at this location this was felt less here than at the largest site, Leicester Royal Infirmary. The main issue was the lack of a regular substantive consultant cover on one medical ward.

Services contracted out

Staff and patients described catering and hot drink provision as "poor". We received many negative comments relating to poor service, cleanliness and poor infection control. We were informed that some repairs were taking eight weeks or more. This has left clinical and medical staff frustrated due to the inflexibility of the service and some commented that this had resulted in one instance in a ward failing cleaning/ infection control audits and, on another, the closure of a bay, increasing pressure on the bed/ward capacity.

Medicines management

Our Care Quality Commission (CQC) pharmacist found a number of medication storage issues as they inspected the Leicester General Hospital surgical site. On one ward, we found that a controlled drug used for spinal anaesthetic was out of date and the ward sister could not give a valid reason. On another ward we found that there were safety issues regarding the lack of a lockable room for storage of drugs. On a third ward, medication was seen open in a treatment room. Self-medication policies are in development and the provision of take-home medication is frustrating for staff and patients as it causes delays in discharge.

Environment

The hospital is an old building in parts and there are a number of challenges for the trust in ensuring that services are housed within effective buildings. The environment within the younger disabled unit was not fit for purpose. We saw that the roof leaked when it rained. The side room doors were too small, which made it difficult to get beds and wheelchairs in and out and access patients. One bathroom was unusable as the bath had been fitted incorrectly and there was only one toilet for six side rooms.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires Improvement

The Leicester General Hospital provided safe care for many of its patients. The trust has had two Never Events (mistakes so serious they should never happen) at this site and action has been taken to address the issues the investigation raised. The trust acknowledged the shortages in staffing and is actively seeking to recruit to the vacancies. However, gaps in medical staffing could have an impact on the care and safety of patients, were it not for the good will of staff working at the hospital.

The younger disabled unit required urgent action to ensure the safety of patients in this area. However, once this was highlighted, the trust took immediate action to remedy this issue. A side effect of the old building is the lack of storage space and this led to inappropriate storage of equipment which could lead to trip hazards.

Medications are not always stored safely, monitored correctly or available to affect a timely discharge.

Are services effective?

Good

Leicester General Hospital provides many specialised services and we found that these were provided effectively. We found that, in one ward, the lack of available medical staff could have reduced the effectiveness of the service.

We found that the trust did not always fully implement the learning from clinical audits of its services. However, we saw some positive actions taken. This included the use of 'falling leaves' indicators to show patients who were at high risk of falling, and also to identify champions for dementia and older patients.

Are services caring?

Good

We found that all staff were caring, despite being busy due to staff shortages. The NHS Friends and Family test shows that patients would recommend most of the wards to their family, which implies that they received caring treatment. We saw a number of staff 'going the extra mile' to ensure that patients' needs were met, and we saw some outstanding care in specialised areas.

Are services responsive to people's needs?

Requires Improvement

The trust had a number of systems and processes in place to ensure it received feedback from patients and their families. We were told of, and saw, a number of changes to practices and care as a direct result of patient's feedback.

Summary of findings

Patients experienced delays in care in some areas, including outpatients and planned surgery. Some of these delays resulted in cancellation of surgery or appointments, sometimes at short notice. This did not enhance the patients' experience of the hospital.

Are services well-led?

Good

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

Staff told us that there was a new, positive culture within the trust and that they were not afraid to raise concerns at this hospital. Staff felt that local managers were supportive and we saw some excellent team working. Staff received information from senior management and had appraisals to review their performance. Some staff in surgery and maternity services felt that their managers failed to communicate with them and did not feel supported.

Summary of findings

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

Medical care (including older people's care)

Good

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

Ward staff assessed patients' risk for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients' conditions were deteriorating. We found that, although staff were busy, they were available to meet people's needs.

We saw that care was planned on evidence-based guidelines, but not always delivered in line with it. A number of areas which had been identified through national and local audits were not fully implemented. The Mental Capacity Act was not fully embedded in all wards.

The wards/departments were generally well-led. However the lack of medical staff in some areas impacted on the support given to patients and to staff.

Surgery

Requires Improvement

Patients in all areas complimented staff on their caring approach and professionalism. At ward and theatre level we found that, overall, the provision of care was well-led but some staff felt pressured by the bed managers to make beds available for new admissions.

We found that staffing levels did not always meet the trust's agreed levels. Staffing is an issue on many wards and staff indicated that levels are insufficient to ensure personalised patient care.

The facilities and space available at Leicester General Hospital are becoming inadequate for the rising numbers of patients attending surgery. We found that the care, welfare and dignity of patients could be improved further by an increase in bed spaces in wards. In August 2013 a new Advanced Recovery Unit opened, with larger than average recovery space in line with the Critical Care Core Standards. There is a need for improved storage capacity and improvements to the overall hospital environment.

Intensive/critical care

Good

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

There was always sufficient equipment available to meet patients' needs. Patients' medications were stored securely and within their expiry date. The intensive care unit was visibly clean and well-maintained, though there was a

Summary of findings

general lack of space, particularly between patients' beds. Patients had either one-to-one nursing, or were supported by one nurse to two patients. Where possible, patients were supported to make decisions about their care and relatives were involved in their family member's care.

Maternity and family planning

Good

Services for women in maternity were generally safe, but we noted that the number of hours for consultants on the delivery unit was not in line with the recommended guidance However, the trust was aware of this and had taken actions to address the deficit. Staff reported that equipment was not always readily available.

There was an effective mechanism to capture incidents, near misses and Never Events. Staff told us they knew how to report these to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to make a complaint was visible to people using the service.

There was also an extensive audit programme. We saw audits had been carried out on such topics as foetal heart rate monitoring, augmentation of labour, missed appointments, antenatal screening and mental health. However, we spoke with a number of staff who told us they did not always report incidents because they were too busy.

A number of staff told us that senior managers and modern matrons were visible in the clinical areas and that communication was good. In particular, the senior midwife was known by all the staff and was very visible. The senior midwife displayed an excellent understanding of the unit and spoke with clarity and passion about the service provided.

End of life care

Good

Patients received safe end of life care. Patients who were nearing end of life were identified early so that they could be supported to make decisions about their care.

Staff were knowledgeable and experienced in providing care that met patients' needs. The hospital had actively listened to feedback from patients and relatives about end of life care and had made changes in response.

The chaplaincy reflected the cultural diversity of the patients and responded to their individual needs.

There was board-level support for the role of the palliative care team and end of life care within the hospital. This ensures that issues are raised at a senior level in the trust.

Summary of findings

Outpatients

Good

In general we found the outpatients department to be safe, with care being provided by an adequate number of staff in a clean environment. We noted though that one of the main clinics did not have immediate access to a resuscitation trolley.

The trust did not meet their targets for 18-weeks referral-to-treatment times and some patients have had clinics cancelled at short notice or may have to wait some time for a follow-up appointment. This is partly due to volume and partly due to the way in which some services were organised. The trust has identified some issues and is taking action to address these. In addition the neurology outpatients building had access problems for people with limited or restricted mobility.

We saw staff caring for people in a compassionate way and maintaining their dignity and privacy and found the service to be well-led by senior clinical staff who had a clear vision for their department and supported their staff.

Summary of findings

What people who use the hospital say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust can be seen to be under the England average for the inpatient average component of the test. At the Leicester General Hospital site only Ward 28, was described by the public as the least likely to be recommended to their friends and family. There are 23 wards at Leicester General Hospital.

Areas for improvement

Action the hospital MUST take to improve

- 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.
- Staff were not supported in their role as they did not receive appropriate training, professional development and supervision.
- Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in that medical and nursing staff were not available to care for patients on some wards.

Action the hospital SHOULD take to improve

- Review of elective surgery cancelled on the day because of pressure for beds to improve the patients' experience.
- The provision for dialysis patients to improve privacy and dignity through having the appropriate number of patients on this ward.
- Resuscitation trollies should be maintained appropriately.
- Reduction in outpatient waiting times through review of the booking procedure.
- Review pharmacy procedures to ensure that patients' medication history is always readily available, that self-medication is in place and that there is access to take-home medicines.
- Arrangements are in place to support staff with a duty manager for out-of-hours cover on site.
- Ensure that feedback and learning from reported incidents are always reported to staff.

Good practice

Our inspection team highlighted the following areas of good practice:

- 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' families were informed of the employment of a security guard to manage a long-term patient's aggressive behaviour. The security guard treated the patient with respect and spoke kindly to them.
- Staff had a good awareness of mental capacity assessments and deprivation of liberty safeguards under the Mental Capacity Act 2005, and appropriate authority was sought in a timely manner. Documents were completed to a very good standard and there was evidence that people and their families were at the centre of decisions made about care.
- Patient falls were recorded and grouped by business unit, incident date and division. There was a reduction seen month by month: April: 240 falls, May: 219 falls, and June: 199 falls. We saw that patients at risk of falling were identified and had risk assessments in place.

Leicester General Hospital

Detailed findings

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

Our inspection team

Our inspection team was led by:

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

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

The team of 29 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 Intelligence healthcare information programme.

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. 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.

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

Leicester General Hospital has been inspected by CQC four times. The most recent inspection was in January 2013, and the location was found to be compliant with the single outcome that was inspected. This was a follow up visit following the issuing of the warning notice. Leicester General Hospital has also had a CQC warning notice served in July 2012. This related to the governance structures in quality of care provided by the trust. The subsequent inspection found that the trust had taken the necessary actions to comply with the warning notice.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- 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: nurses, doctors, physiotherapists, occupational therapists, administrative and clerical staff. We talked with patients and staff from all areas of the hospitals, including the wards, theatre, outpatients departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event on 13 January 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 Leicester Royal Infirmary.

Good

Medical care (including older people's care)

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

Information about the service

Of the 10 medical wards at Leicester General Hospital, we visited six including:

- Wards 2, 3, 10, 15, the brain injury unit, and the younger disabled unit

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

Summary of findings

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

Ward staff assessed patients' risk for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients' conditions were deteriorating. We found that, although staff were busy, they were available to meet people's needs.

Care was planned on evidence-based guidelines, but not always delivered in line with it. A number of areas which had been identified through national and local audits were not fully implemented. The Mental Capacity Act was not fully embedded in all wards.

The wards/departments were generally well-led. However, the lack of medical staff in some areas impacted on the support given to patients and to staff.

Good

Medical care (including older people's care)

Are medical care services safe?

Requires Improvement

Safety and performance

It is mandatory for NHS trusts to report all patient safety incidents. An analysis of the trust's reports revealed that it was reporting patient safety incidents appropriately and in line with other trusts in England. The hospital used the Datix patient safety software system to record incidents. Between July 2012 and June 2013, the trust reported 341 safety alerts in medical specialities which accounted for 46% of all incidents at the trust. Staff knew how to report incidents and the wards collected data on how many incidents of harm had happened on their ward.

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

Learning and improvement

We saw evidence that incidents were reviewed and lessons learned from them. For example, on Ward 10, a male renal ward, there was a dedicated treatment room where procedures were carried out. This had led to a reduction in infection rates. Staff were aware of learning from incidents in their area. Information was shared with staff through emails, bulletins, and staff meetings. Staff received emails about safety data and received bulletins from the Medicines and Healthcare Products Regulatory Agency and could describe what actions they took to implement the recommended actions from this bulletin. However, awareness of the never events (serious mistakes that should never occur) which had happened in the trust was low and learning from incidents across the different hospitals needed developing further, as staff could not always describe what had happened in the other trust hospitals.

Systems, processes and practices

Infection control

The hospital had an infection control policy which detailed the precautions needed to minimise the risk of infection. Generally these procedures were being followed. The wards we visited were clean. We saw staff washing their hands and using hand gel appropriately and wearing personal protection equipment such as aprons and gloves. Hand gel was available in all the wards we visited, with prominent signage to remind visitors to the ward to use it on arrival and departure. Patients who had infections were identified and nursed in side rooms.

Medicines management

Medicines were stored securely and checks of controlled drugs were being carried out appropriately on Ward 3. Medicine fridge temperatures were not being recorded daily. Temperatures had been recorded 15 times since 26 November 2013. If fridges are not at the correct temperatures the efficacy of the medication could be affected.

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

Environment

On the younger disabled unit, we found that there were a number of long standing issues with the building: the roof leaked when it rained; the side room doors were too small which made it difficult to get beds and wheelchairs in and out and access patients; one bathroom was unusable as the bath had been fitted incorrectly and there was only one toilet for six side rooms.

We looked at the emergency trolleys when we visited the wards. In some wards they were overfull which could make it difficult to access equipment in an emergency. On one ward, equipment which should have been on the trolley was missing so although records showed that resuscitation trolleys were checked regularly, this was not effectively

identifying issues. There was no standardisation of trolleys which meant that there were different trolleys across the hospital. This can lead to a delay in being able to find equipment quickly. The resuscitation officer had agreed that cardiac arrest trollies should be standardised across the trust to a 5-drawer cardiac arrest trolley, and this is a forthcoming agenda item to be discussed by the resuscitation committee as part of a programme of work for the coming year. There was a structured cardiac arrest team rota available for the hospital which made it clear to all staff who would be attending in the event of a cardiac arrest.

Monitoring safety and responding to risk

Staffing

There was a high level of vacancies on the wards we visited. The trust had told us that they had recruited 250 staff but needed another 250 staff to fill all the nursing vacancies. This amounts to 5% nursing vacancies remaining to be filled at the trust.

On the day of our visit, there were enough staff on the wards we visited. Staff appeared busy but the atmosphere was calm. Staff were delivering good care, including in pressure area care. The trust had a significant number of locums providing medical cover on both day and night shifts. One ward, Ward 2, had been staffed by a long-term locum consultant. However, this person had now moved to the Leicester Royal Infirmary. A lack of permanent medical staff could lead to lack of consistency of care, and lack of support for doctors in training. There were no records to show that locum staff had been inducted which means they may not have known about trust policies and procedures. The trust told us that it would act on this immediately; and speciality medicine would adapt the emergency department checklist to ensure that temporary medical staff were sufficiently aware of trust policies and procedures.

On Ward 10, a male nephrology ward, there were 18 beds with two allocated dialysis beds. The ward was often filled to 20 patients. Patients were moved around the ward (by dialysis nursing staff) to accommodate those who needed dialysis. This made it difficult to promote privacy and dignity. This also created risks at medicine rounds, as there was no record of where each person was situated. There were not enough staff trained to provide dialysis and staff told us there were not enough porters.

We met with staff from allied health professionals such as physiotherapy, occupational therapy and pharmacy staff who reported that there were also vacancies in these staff groups. They felt that they were not viewed as priorities for recruitment. They commented positively on the improved recruitment processes which resulted in faster appointments.

Mental Health Act and Capacity assessment

Staff had a good awareness of capacity assessments and an understanding of when 'deprivation of liberty' safeguards were in patients' best interests according to the Mental Capacity Act 2005. On the brain injury unit we saw that appropriate requests for authority had been made in a timely manner. Documents were completed to a very good standard and there was evidence that people and their families were at the centre of decisions made about care. This was good practice.

On a nephrology ward, however, we found an example where the Mental Capacity Act code of practice was not being followed. One patient who had a brain injury required one-to-one nursing for behavioural issues. The patient could not speak English. The medical team were trying to arrange for dialysis but the patient's behaviour would mean non-compliance. The medical team spoke of using sedation so that they could carry out treatment. There was no record that a mental capacity assessment or a best interest meeting, or an interpreter had been arranged. This means there is a risk that the patient's rights may not have been safeguarded.

Anticipation and planning

The trust had systems in place to monitor how it performed against a number of key safety performance indicators. These systems were embedded on the ward. Staff told us that changes were communicated by email and important messages were printed off and displayed for staff to see, and shared in staff meetings and at handover.

The trust had plans for emergency situations such as norovirus and flu outbreaks. We did not see these implemented at the time of our inspection however staff were aware of the processes in place.

Safety metrics (information about performance against targets) were displayed, on all wards, to monitor the safety of care. This was generally up to date. Where action was needed we saw that this had been taken.

Good

Medical care (including older people's care)

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

Good

Using evidence-based guidance

We saw that guidance from the National Institute for Clinical Excellence (NICE) was in place at the hospital. National guidance and monitoring was in place in respect of patients having had a stroke being cared for on a designated stroke ward. The percentage of stoke patients spending 90% of their stay on a stroke ward in August was 88.6% against a target of 80%. An action plan is in place to address areas of deficit and this is monitored by the trust board through the Quality and Performance report. These actions include raising awareness through training of nurses and doctors and the secondment of a nurse to ensure that people having had a stroke are moved to the appropriate ward as soon as possible.

Leicester General Hospital provides one of the largest renal services in the UK. The hospital provides treatment for acute and chronic renal problems as well as treatment for end-stage renal failure therapy. This includes haemodialysis, continuous ambulatory peritoneal dialysis (CAPD) and kidney transplants. The outpatient haemodialysis unit at the General Hospital is the largest dialysis unit in Leicestershire. Approximately 160 patients receive dialysis in this unit. Dialysis services are provided and are monitored through national audit programmes. The hospital services perform well in these audits achieving 90% overall.

The Royal College of Physicians' National Audit of Falls and Bone Health in Older People examined the organisation and commissioning of services provided to older people for falls prevention and bone health, the clinical care delivered to people who have fallen and fractured a bone, and patients' experiences of fall services. The trust was performing within expectations for most of the areas assessed; however, four areas out of 19 were tending to worse than average including written documentation, patients attending an exercise programme, and the prescribing of medication for osteoporosis.

The reduction in inpatient falls was an element of the reducing harm component of the trust's Quality Commitment. This programme of work began in in March 2013, initially with 20 wards and extending to the 23 wards with the highest number of falls in the trust. In the first quarter of 2013/14, there was a 12% reduction in the number of falls compared with the same quarter, and a 14% reduction compared to the fourth quarter of the previous year. Patient falls by business unit and incident date grouped by division has seen a reduction month by month. Patients at risk of falling were identified and had risk assessments in place.

Nursing metrics (audits of nursing care) are undertaken by the nursing teams and overall the medical wards perform well in the areas of medicines management, pain management, patient dignity and pressure area care. However further action needs to be taken against the audit on discharge. Risk assessments were generally well completed and updated and care was delivered in line with the assessments. Where action was needed, such as pressure-relieving aids or turning of patients in bed, procedures were in place and being recorded. Where a patient was at risk of falls, they had the bell to call the nurse and were nursed closed to the nurses' station. There was a system for identifying patients who required support with meals. Intentional rounding (round-the-clock or comfort care) took place on the wards every hour which means that staff checked patients every hour to see that their needs were being met.

Performance, monitoring and improvement of outcomes

Every cardiac arrest call in the trust had to be reported via the Datix patient safety software system. The resuscitation officer correlated the Datix reports with the switchboard's records of emergency calls. If an incident report had not been completed at the time of the emergency, a report for 'failure to complete' was done. The resuscitation officer reviewed the incident records weekly and raised any areas of concern with the patient safety team and the matron for the area to cascade to ward teams.

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

Good

Medical care (including older people's care)

Staff, equipment and facilities

Before our visit, there had been concerns raised about support to doctors in training. The trust said that it had taken several steps to address the issue of Foundation doctors (those in the two-year, postgraduate medical training programme) being exposed to situations beyond their competence: There are six rotas in the trust where year 1 and year 2 doctors are on the same rota. All clinical management groups had been written to and asked to make plans to remove year 1 doctors from these rotas by April 2014. A system of colour-coded badges had been introduced for all grades of doctors across the trust to aid clear identification of their grades. Posters were also being used to highlight the level of expectations appropriate to different grades.

Staff told us that, where they used agency staff, they tried to get the same staff to ensure continuity of patient care. Matrons were able to describe how they managed poor performance of their staff.

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

Multidisciplinary working and support

We saw evidence that multidisciplinary teams worked effectively together to provide care for patients. We saw examples where patients' and families' wishes had been respected. Patients were generally looked after on the appropriate ward for their needs.

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

Are medical care services caring?

Good

Compassion, dignity and empathy

We observed the care being provided on the wards we visited. We saw that staff introduced themselves and were kind and caring when looking after patients. Although staff were very busy, they did not rush patients and people looked very well cared for. Patients told us that they sometimes they had to wait for a nurse to respond to a call when there were staff shortages but felt that, "staff went the extra mile" to care for them. Patients were treated with respect and notes were respectfully written. Curtain clips were used throughout the wards to ensure that patient dignity was maintained and we saw that staff always checked before entering. There were policies for respecting patient decisions about their care.

Involvement in care and decision making

The trust has consistently scored below the England average for the Inpatient NHS Friends and Family test from July 2013 onwards. The medical wards at Leicester General Hospital received positive feedback in this survey. When we spoke with patients and families they were all very positive about their stay in the hospital and the care they had received. They told us they felt involved and that doctors had explained to them about their care and treatment.

Trust and communication

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

Patients told us that their pain was well controlled and felt they could say if they were in pain and action would be taken. Patients said that they were kept informed about any new medicines prescribed or any changes to their treatment.

Emotional support

Where there were not enough nurses to provide care for patients who needed one-to-one care because they were confused or aggressive, the trust was employing security guards to sit with patients. On one ward we observed a security guard who was looking after a patient who had been aggressive. The security guard treated the patient with respect and spoke kindly to the patient. The records showed that staff had informed the family that a security

guard was helping to keep the patient safe so they were not surprised when they visited. Trust staff told us that they were hoping to reduce the use of security guards in providing this care for patients.

We observed care being delivered on the brain injury unit and saw staff delivering excellent care on a very busy ward. Staff were assisting a patient into a chair and helping the patient walk. Staff used touch to help calm the patient and treated the patient with great care, respect and warmth. They celebrated with the patient after they walked. The team had been nominated for a trust award.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

In Leicester, 36% of the population belong to minority ethnic groups. Three main languages other than English were identified as being spoken by patients. However, there were no signs in the hospital in other languages.

The trust was planning the introduction of electronic surveys which would be available in a range of languages. There was a 24-hour translation service on all wards which staff knew how to access. Information leaflets were available on all wards. Not all wards stocked leaflets in other languages, but staff knew how to access them if needed. Allied health professionals said that the need for a translator was documented in records so that they were able to pre-book translators for referrals and follow-up appointments.

Vulnerable patients and capacity

We met with trust staff to discuss how they had planned care for patients with dementia. They had met with community groups to find out their experiences and needs. The trust had a dementia strategy in place and there was an active network of staff identified as older people's and dementia champions. These staff wore badges to identify themselves and received extra training to support patients and colleagues throughout the hospital. Champions were from all staff groups: administration, nurses, doctors, porters and allied health professionals. Champions we spoke with were very passionate about their role and helped improve care for these patient groups throughout the hospital.

Ward 3 held meetings for relatives and carers of people who had had a stroke, to help support them, which is good practice. Meetings were currently held during the day, which meant that some people would not be able to attend. The ward team also worked closely with the Stroke Association.

Leaving hospital

The trust had undertaken work to improve the patient flow through the hospital. The patients and families we spoke with were informed and included in their discharge. There were policies 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.

On Ward 2 there was an integrated discharge team which included a social worker and had strong links with commissioners. This was an example of good practice. There had been an audit of discharge documentation recently which showed the ward to be only 29% compliant against a trust standard of 98%. The lack of permanent staff may have impacted on the quality of documentation seen in this audit.

On Ward 3, there was a very effective multidisciplinary approach to discharge. We observed a case and saw there was a systematic, comprehensive discussion of the patient. This was well recorded in case notes and in a handover sheet.

When we met with allied health professionals, they told us that there were difficulties in accessing appropriate care for some patients who required help by two or more staff following discharge. This sometimes led to delays and some staff said there was a lack of flexibility in the time of treatment for patients following a stroke. Staff said that there was pressure to get people home but felt there was a lack of therapy available in the community for some patients.

Good

Medical care (including older people's care)

Learning from experiences, concerns and complaints

The trust had effective systems in place to gather information from service users, and had records about people's experience from more than 4,000 patient surveys. This was being used to improve care, for example, addressing delays in answering call bells.

There were Message to Matron postcards on all the wards we visited where patients could give feedback on areas for praise and concern. These were monitored by the matrons and fed back to ward staff to drive improvement.

Patient complaints were monitored as part of ward metrics. Staff were aware of the complaints and actions taken to address them. Patients knew how to raise concerns and complaints with staff and were confident that they would be dealt with.

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

The trust had held workshops in the autumn of 2013 on 'Improving Experience for Patients and Staff' to examine the different ways people communicated and received information. The chief nurse is currently planning actions to be taken to address the issues raised.

Are medical care services well-led?

Good

Vision, strategy and risks

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

Leadership and culture

The chief executive was very visible. Staff said he sent regular emails and held Breakfast with the Boss meetings which staff of all levels told us they had attended. Staff also spoke positively of the Listening into Action programme. Nursing staff told us that the recently appointed chief nurse was very visible and commented positively on the fact that she was often seen on the wards in uniform. At ward level, staff told us they felt very well supported by matrons. We also saw that wards were very well-led by their managers on a day to day basis as managers talked to staff about issues and assisted them in resolving these. These included individual patient challenges as well as discharge arrangements.

Patient experiences, staff involvement and engagement

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

Requires Improvement

Surgery

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

Information about the service

Leicester General Hospital provides 394 bed spaces for elective and emergency surgery.

Last year, the trust saw 22,000 inpatients and 81,000 day case patients. Surgery admissions include general surgery, orthopaedics and urology.

We visited eight wards, including a pre-operative assessment ward, main theatres, day theatre, anaesthetics and recovery areas to observe care provided both pre- and post-operatively. We also held focus groups and individual discussions with junior doctors, consultants (regarding the Never Events) and heads of services.

Summary of findings

Patients we spoke to in all inspected areas complimented staff on their caring approach and professionalism. At ward and theatre level we found that, overall, the provision of care was well-led but some staff felt pressured by the bed managers.

We found that staffing levels did not always meet the trust's agreed levels. Staffing is an issue on many wards and staff indicated that the trust's levels are insufficient to ensure personalised patient care.

The facilities and space available at the Leicester General Hospital are becoming inadequate for the rising numbers of patients attending for surgery. We found that the care, welfare and dignity of patients could be improved further by an increase in bed spaces available in wards and theatres and improvements to the overall hospital environment. In August 20133 a new Advanced Recovery Unit opened, with larger than average recovery space in line with the Critical Care Core Standards.

Staff felt the culture of the hospital was improving with changes to senior management structures and governance and that communication was improving. Staff thought management was more cohesive. However, significant concerns were identified regarding the lack of an overnight on-call manager, resulting in other staff taking on management responsibilities outside their role. Concerns were also expressed about

Requires Improvement

Surgery

external service providers supplying food, cleaning and environmental services. This led to frustration for ward staff, impaired service provision and poor reviews from patients.

Are surgery services safe?

Requires Improvement

Safety and performance

The trust reported three never events (classified as such because they are so serious that they should never happen) between 1 December 2012 and 31 November 2013. We discussed these with relevant medical staff and reviewed the follow-up investigation reports and findings. New protocols and procedures were put in place to minimise risks as part of lessons learned from the events. The action plan for this event was completed in December 2013.

Data we received before the inspection indicated that there may be a lack of understanding of incident reporting procedure. We discussed reporting including safeguarding with all staff interviewed. All clinical staff we spoke with were aware of the Datix patient safety software reporting system and were confident to report any incidents they deemed necessary. We reviewed documentation, including pre- and post-operative assessments and noted that all relevant measures were being taken to alleviate incidents.

We noted that World Health Organization (WHO) surgical safety checklists were completed as per clinical guidelines in all records we looked at.

Learning and improvement

The Listening into Action initiative and its 'Team work is safe work' theme was rolled out in elective orthopaedic theatres to improve communication and team working. We were informed that never events were discussed at cross-site meetings and were attended by all band 6 and 7 staff to share findings. Some junior nursing staff informed us that did not get feedback about incidents they had reported. We were informed that feedback was given to ward sisters or matrons only. Matrons were then responsible for disseminating as required but this was not always happening.

Staff informed us that they had implemented the 'Best Shot' initiative; this involved a nominated person undertaking visual inspection of all pressure areas and reviewing risk assessments at least twice daily. Staff said they felt this was the reason for an improvement in pressure ulcer management. We were informed that recent

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

Systems, processes and practices

Environment

We found that, overall, ward areas were, safe clean and well maintained. However we found a number of issues relating to the environment and equipment which require addressing. There was not enough equipment, in the pre-assessment centre, available for staff to undertake observations on a large number of patients. We were informed by junior doctors that obstetric theatre 2 was too small which they considered to be unsafe. We noted that on wards and in theatre areas, there was insufficient storage for equipment and supplies. On one ward we saw a range of chairs, hoists, emergency trolleys and equipment, and medicines trolley immediately outside the patient bays. This was a post-operative ward requiring a clear pathway for patients who were being rehabilitated and undertaking exercise. The large amount of equipment stored in this area presented an increased risk to patients and visitors, particularly those with limited mobility. We noted on an orthopaedic ward that there was insufficient area for rehabilitation, for example, walking with frames.

We found that the relationship with the company contracted to supply food, cleaning and environmental services were notably poor. We received many negative comments relating to lack of cleanliness and poor infection control as a result. We were informed that repairs were sometimes taking eight weeks or more. This left clinical and medical staff frustrated due to the inflexibility of the service. Some commented that this resulted in a ward failing cleaning and infection control audits, and the closure of a bay, increasing pressure on the bed capacity.

Medicines

Our CQC pharmacist found a number of medication storage issues at the Leicester General surgical site: a controlled drug used for epidural anaesthetic was out of date (it was removed by pharmacy); and there was no lockable room for storage for intravenous fluids.

We were informed that, on one ward, intravenous fluids were routinely checked by the ward pharmacist. We were told that there was variation in prescribing practice, with some departments using paper-based and others electronic methods. The trust informed the inspection team that there was a process to ensure that medication information was transferred between sites. These processes require review if patients are to receive safe care.

Monitoring safety and responding to risk

We saw evidence of good practice in staffing on a number of wards. Staff were usually moved only within their own skills and experience but, when shortages occurred, could be moved anywhere in the hospital. However, we noted that staffing levels and staff recruitment was a problem for many ward sisters. Staffing ratios varied depending on the size and speciality of the ward. A new electronic rostering system has been implemented to ensure full coverage on shifts. The system had caused some problems, with staff sometimes working five 12-hour shifts in one week and then no shifts the next week. This made staff tired and they often swapped shifts to alleviate this. Staff were very flexible and showed goodwill when filling additional shifts.

Anticipation and planning

An overseas recruitment programme had commenced and a number of qualified nurses had been employed by the trust to increase staffing numbers. Some wards we inspected were aware of this and staff in wards and theatres talked about the difference this would make, as many shifts were currently covered by bank, overtime or agency staff. Staff spoke to us about the international nurses' induction programme which is yet to be implemented.

Are surgery services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

We saw evidence that the trust was using guidance from the National Institute of Care Excellence (NICE) especially in its work in renal services. We reviewed the report from the NHS Blood and Transplant service in respect of survival times for patients undergoing transplants and found that while the trust's performance was in line with the national expectations, Leicester had the lowest relative chance of patients receiving a kidney and a lower than the national rate of survival above five years.

Requires Improvement

Surgery

Early warning of deteriorating patients ensures appropriate and timely intervention to improve the outcome for these patients. The trust monitors the early identification of patients and at Leicester General Hospital the hospital scored 100% in the identification of patients whose condition was deteriorating and action was taken within 30 minutes.

The urology department undertakes renal biopsies of cancerous tumours this ensures that patients receive the appropriate treatment. In an audit undertaken to ensure that biopsies are reliable, accurate and useful the hospital scored 100% in the accurate prediction of malignancy. This ensures that patients receive the appropriate counselling and treatment of this disease.

Performance, monitoring and improvement of outcomes

In order to reduce the number of falls at this site a trust initiative had been introduced called Mark and Move in an attempt to ensure patients were mobilising safely and quickly after operations. Documentation was provided to patients who then record (if practicable) when they have moved away from their bed. This was seen in records we inspected.

A matron informed us that, as part of the auditing system, senior management now conducted a quality and safety walk around the wards monthly where they observed staff and talked to relatives and patients. They said that they believed this was why the NHS Friends and Family Test scores had recently improved.

Staff, equipment and facilities

Staff on wards and in theatres told us about their experiences of training and training availability. Most clinical nursing staff told us they had time to do mandatory training and had been given an e-learning account which they could access from home or while at work during less busy periods. Most staff told us they had completed mandatory training. A number of staff told us they had also completed safeguarding and dementia training. However, it was apparent from discussions with staff that they were responsible for completing the training in their own time. Ward managers told us they can access the e-learning account and analyse training records to ensure staff were completing the required training. Concerns were raised about training for agency nurses. However, we were informed that there was to be new induction training. We heard evidence from senior staff that monthly teaching for band 6 and 7 staff was being provided to improve management skills.

Multidisciplinary working and support

We found evidence of multidisciplinary working in all areas we inspected. We saw records of patients admitted for surgery which demonstrated multidisciplinary team input. We spoke with all staff about the clinical governance framework and were assured that full multidisciplinary meetings were held each weekday with heads of departments.

Are surgery services caring?

Good

Compassion, dignity and empathy

NHS Choices website has 407 reviews for Leicester General Hospital with an overall score of 3.5 out of 5 stars, of which 30 comments rated 5 stars, including excellent care, good communication, staff helpfulness, cleanliness and good food. There were 28 comments in the review about lack of staff, cancelled lists, and staff being unhelpful or rude.

In the October 2013 NHS Friends and Family Test, Ward 28, a Urology/General Surgery ward was below the trust average. We visited this and a number of other wards and found, through talking to patients and relatives that they were mainly all very positive about their own experiences of being on the ward.

We received many comments from patients and relatives regarding both clinical and medical staff over the time of the inspection, and only one was negative. We were told by a number of patients and relatives that staff were responsive to their needs and were kind and caring.

We observed some good practice regarding privacy and dignity – for example, use of red 'privacy pegs' and '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 checking that the call bell was within reach.

Requires Improvement

Surgery

We saw good use of privacy screens during visits to the wards and theatre areas. But we were informed that, on occasions, curtains were left drawn for long periods. We were informed that the flexibility of visiting arrangements meant that sometimes ward rounds took place while visitors were still in the wards. We were informed that, to ensure confidentiality, any sensitive information was discussed away from the bedside.

Involvement in care and decision making

We spoke with a patient awaiting day surgery who told us he had been fully involved in both pre-operative and post-operative discussions with nursing and medical staff. He had been given adequate information to ensure he fully understood the details of his operation before signing the consent form. The patient told us that everything had been discussed with him about the operation, including options should an alternative operation be required during the procedure, post-operative recovery and pain relief. We saw a nurse completing paperwork and risk assessments during the discussions.

Many ward staff told us there had been a review of visiting arrangements which were now more flexible, encouraging relatives to spend time with the patient. Patients found this to be a much better arrangement.

Trust and communication

The trust has developed its Caring at its Best strategy. We found evidence of this on all wards and staff were fully aware of it. Staff were working hard to achieve the targets set by the trust for completion of patient questionnaires and we saw an action plan for Message to Matron comments postcards. Patients we spoke with knew how to make a complaint and had been given information in pre-admission documentation.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires Improvement

Meeting people's needs

One patient who was self-administering their own insulin, in line with hospital policy, said they would like to self-administer all of their medicines but this didn't appear to be something that could be supported. We were also told that the trust was developing a self-medication procedure which would include assessing patients for eligibility and risks. Patients deemed not at risk would be provided with appropriate drug storage box and key with a list of medication. Patients would be required to sign consent forms for self-administration.

Wards we visited had information leaflets on display to orientate patients and visitors to the ward, including information about meals, visiting hours, phone calls, and infection control. The leaflets were available in other languages for those who required them. Staff told us of their concerns regarding a lack of beds in some wards which has resulted in patients being transferred to other, less appropriate wards. This has, on one occasion, led to a complaint.

Access to services

The Department of Health monitor the number of elective surgery cancellations, as an indication of the management, efficiency and quality of care. The trust is performing in line with the statistical average for cancelled operations. We received the trust's analysis of operations cancelled on day of admission/surgery which indicated that 484 had been cancelled in the last quarter (October 2013 to December 2013). The reason for the highest number of cancellations between October and December 2013 was that there was no bed available.

We discussed cancellations with nursing, medical and surgical staff and were informed that elective surgery was often cancelled on the day due to pressure of beds (due to emergency admission), over-running of waiting lists and lack of high dependency unit beds. A matron told us that they had experienced bed managers overriding decisions to not move patients, which they found frustrating and unsafe. Other matrons told us they had overridden bed management decisions where they felt this to be unsafe. We attended the bed management meeting and heard staff discussing patients who were fit for discharge. We did not hear any undue pressure being applied to staff to discharge patients who were not medically fit for discharge.

We found that clinical and medical staff had significant concerns regarding the lack of a duty manager for out-of-hours cover, leaving this responsibility to staff nurses to cover. Other concerns related to the decreases in services they would be providing at this location including physiotherapy, occupational therapy and pharmacy. We were informed that, as part of the Listening into Action

initiative, an event had been organised to feedback concerns, particularly about extended working hours. During discussions with senior clinical staff on wards and in theatres and recovery, we found that staffing and bed management were daily issues. We were informed that locum staff did not receive an induction or passwords to the IT system. Some locums were described as having communication difficulties by people we spoke to at the listening event and on site.

Privacy and dignity

We saw that, where possible, wards and bays were single-sex to provide privacy and dignity. One ward was arranged so that males were accommodated at one end with male toilet facilities and females at the other with separate toilet facilities. This facilitated greater dignity for patients. The facilities in the pre-assessment centre clinic were not fit for purpose and did not afford any privacy or dignity. Patients returning from theatres are taken through the clinic areas; the area has a pre-operative area and ward attached for post-operative recovery. We found that there were no female toilet facilities available, despite this being a mixed ward, and no disabled access toilets. Patients had medical observations while facing the ward with a partial fixed screen to enable privacy and dignity.

Leaving hospital

The CQC Adult inpatient Survey 2012 showed an upward trend in delayed discharge and patients not being involved in decisions about discharge. We were informed that bed meetings were held each day and were attended by matrons or ward managers to discuss the day's discharges A number of wards had designated discharge nurses whose role was to manage complex discharges, including fast track discharges which included management of potential safeguarding. We saw a discharge planning meeting during our visit with a physiotherapist and an occupational therapist who were both involved in patients' rehabilitation post-surgery before discharge.

A ward matron told us that many patients did not understand the implications of discharge planning from day one. We were told that this ward was in the process of developing a discharge information sheet for patients to help them understand the process. Some ward staff commented on the trust's policy which has a target to discharge before 11am. Many nursing staff said they felt under pressure to comply with the policy. However, most senior clinical staff we spoke with was content to escalate anything which might result in an unsafe discharge. Where language issues are identified translators (Language Line) are used to ensure patients understand the discharge procedures.

We were told that, on surgical wards, patients were discharged directly from the wards. Also, a dedicated 'To take out' (TTO) doctor" (a doctor who writes up take-home medication) has been in post since 2013 to write prescriptions, meaning less delayed discharges. The only delays occurred if this doctor had not previously seen the patient's notes or if junior doctors were unavailable to write up prescriptions. We were informed that, on some wards, junior doctors had developed 'outstanding tasks before discharge' stickers to ensure safe discharge. Staff informed our pharmacy inspector that access to take-home medication could be an issue in delaying discharge. Nurses or the pharmacist told patients how to take their medicines at home before they left the hospital. We were informed that, after 5:30pm, take-home medication had to be supplied by the pharmacy at Leicester Royal Infirmary. This is compounded by staff experiencing difficulties in obtaining drug prescriptions after 5pm when cover was provided by maternity doctors, who were not always available.

We were informed that a six-week discharge team had been set up recently for patients living in the county of Leicestershire to facilitate discharge of patients with multiple complex issues to reduce long-stay patients on surgical wards. The team supports patients for up to six weeks post discharge and included the input of GPs and nurse practitioners. This initiative was considered to be innovative and would help to improve bed issues.

Learning from experiences, concerns and complaints

The trust had introduced the Listening into Action strategy to improve the patient experience, evidenced in discussions with senior staff on wards, theatres and in focus group discussions.

The approach to managing complaints varied from ward to ward. We spoke with two patients who told us of their own very poor experiences: one wanted to make a complaint and asked for a copy of the complaints procedure but was not given it; the other patient told us she had been kept waiting for pain relief after transferring from another hospital and only received this after demanding to see a doctor. She also told us of an incident she had witnessed

on the same ward where an elderly patient had required assistance with personal care and had been ignored, resulting in her having an accident. There was no ward sister on the ward, and when the patient asked for information about complaints, was not given any. This had been escalated to the matron but not yet resolved. We found on two other wards that matrons were very proactive in dealing with concerns and complaints.

Patients told us they had been alerted to the NHS Friends and Family Surveys (leaflets and website) and understood the need to monitor the quality of the service. We saw the Caring at its Best questionnaires on a number of wards along with Message to Matron comments postcards for patients' and relatives' comments. We reviewed the last month's matron's comments audit and findings which had addressed the concerns raised. We noted that comment cards did not include a space for the person to add their contact details should they wish to discuss their concerns and to receive feedback.

We saw evidence in all wards and associated areas of how to make a complaint, and we saw a poster listing the contact details of the ward matron, and her availability on the ward. Patients told us they were aware of the complaints procedure and most had received feedback when they had made a complaint.

Are surgery services well-led?

Good

Vision, strategy and risks

The trust's Caring at its Best strategy included having a professional, passionate and valued workforce who are creative in their work. Key objectives include staff training and development, better employment, and encouraging innovation. At this location we received very positive feedback from clinical and medical staff we interviewed about the vision of the new chief executive officer and chief nurse, describing them as "inspiring". 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 new senior staff and was well received. We were also informed that the chief executive officer was open to receiving emails and was very visible, making himself available for staff discussions at Breakfast with the Boss meetings. We were told that monthly briefings now took place for senior staff with all staff expected to attend – they were described by one matron as an "open forum".

The de-layered clinical management system had improved the way issues were escalated and managed. Staff told us that there had been changes to the nurse to bed ratios, increases in nurse posts advertised and that ward managers were now (since December 2013) allocated one day per week for supervision. Further improvements included a strong focus on managing pressure ulcers and falls.

Governance arrangements

During our inspection, we saw information boards containing governance information, informing patients, staff and visitors of results from clinical audits. We found that, on most wards we visited, there was a robust organisational structure lead by a matron, ward sister and nurse in charge. Ward managers told us that supervisions are conducted routinely and appraisals annually.

Staff informed us that the restructure of the clinical management group had improved communication and that "briefings were great". Staff told us that they received at least an annual appraisal but in some areas one-to-one supervision was less formal. We noted on a number of wards that staff training and deployment was highlighted on staff rotas.

Leadership and culture

We found that leadership was mostly good at this location in wards and theatre. A number of nurses reported that morale was low, and little feedback was given from senior managers. One nurse told us she was adopting an extended leadership role due to the lack of clear leadership from ward sister. Staff told us in a specific unit that they felt pressure to work when ill, due to the number of clinics increasing the amounts of documentation to be completed. Some staff said that they were pressured to be at work even if unwell and, if they were off sick, there would be no cover for them.

Requires Improvement

Surgery

Patient experiences, staff involvement and engagement

Stakeholders reported that trainees were either left alone or forced to cope with problems beyond their competence or experience on a regular basis. We were told that handovers were not adequate and that they had concerns about the experience they were getting.

We noted that, in some 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. 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 and that they received clinical education /supervision but that documentation was not always completed to confirm this.

Learning, improvement, innovation and sustainability

We were informed that, over the preceding two weekends, the chief executive officer had instigated the 'Super Weekend' initiative to provide seven-day-week working. We discussed this with clinical and medical staff who informed us that generally it had been a good initiative, but that they could not comment on the outcomes or future intentions.

We saw good evidence of team and multidisciplinary working in most areas we inspected. We were informed and saw that daily consultants' rounds were taking place and, on one orthopaedic ward, a specialist care of the elderly consultant had been employed and was wholly based there.

Good

Intensive/critical care

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

Information about the service

The critical care service at Leicester General Hospital has 12 beds in the intensive care unit (ICU), delivering care to adult patients with life-threatening illness and post-operative patients. In addition to this, there are six high dependency unit (HDU) beds, located on another ward within the hospital for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital and is available 24 hours a day, seven days a week.

We talked with two patients, two relatives and 23 staff, including nurses, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

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

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

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

The service was focused on safety. Each member of staff we spoke with confirmed they knew how to report incidents. Staff told us they reported incidents by using the trust's electronic incident reporting system. The matron confirmed that incidents were analysed by senior clinical staff and appropriate specialists recommended improvements. Staff told us that they received feedback from the incidents they reported, both individually and in ward meetings.

Systems, processes and practices

Equipment/environment

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

During our visit we undertook a tour of the ICU. We saw that there was a general lack of space in the ICU, particularly between each patient's bed. This meant that the department was not meeting the national standards for ICUs. In addition to this, some areas appeared cluttered with equipment and there was a lack of storage facilities for equipment and supplies that were not being currently used.

Medicines management

When we checked the medications in the ICU, we saw that patients' medications were stored securely and within their expiry date. We saw that some medications needed to be stored in a fridge. A thermometer was kept in the fridge, and we were told the temperature of the fridge was checked on a daily basis. We saw the daily recordings of the temperature which confirmed what we had been told. The locked controlled drugs cupboard was inside the locked medication room. Controlled drugs were classified by law based on their benefit when used in medical treatment and their harm if misused. The nurse in charge held the key to the controlled drugs cupboard. The use of controlled drugs was clearly recorded in the controlled drugs register. When we checked the register against the stock in the controlled drugs cupboard, we found these matched.

Infection control

We saw that the ICU was visibly clean and well-maintained. Although we saw there were not sinks between each bed, we found that infection control rates were low. Patients were cared for in a clean environment with clean equipment. Hand hygiene gel was available at the entrance and exit of the units. Staff members were observed wearing uniforms and other appropriate personal protective equipment, including gloves and aprons. We saw staff washing their hands before leaving the units and between assisting patients. Patients were protected against the risk of infection. Pedal bins and sharps bins were available for waste disposal. We saw there were processes in place for the cleaning of the environment. Cleaning schedules included the frequency and detail of the tasks performed. We reviewed the comprehensive infection prevention and control policies. We observed and spoke with staff who were able to demonstrate their awareness and knowledge of these policies, and confirmed they had training in relation to infection control and prevention.

We saw appropriate risk assessments had been completed for intravenous lines and urinary catheters. The latest Intensive Care National Audit & Research Centre (ICNARC) report for 2012/13 showed that the trust was performing below the national average for rates of MRSA. This is a positive indicator of infection control practices within the unit. One patient told us that, "the staff are good and look after me well. I think the ward is clean". Patients had no concerns about the cleanliness or infection control within the ICU.

Monitoring safety and responding to risk

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

Good

Intensive/critical care

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

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

Anticipation and planning

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

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

Good

Using evidence-based guidance

The latest ICNARC report shows that the trust is performing within expectations and below the average (preferable results) for: unit-acquired MRSA, hospital mortality, out-of-hours discharges to wards (not delayed) and unplanned readmissions within 48 hours. However, the trust is performing within expectations but above the average for: out-of-hours discharges to wards and delayed discharges (four-hour delay). We were able to corroborate some of this information at our inspection.

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

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

Performance, monitoring and improvement of outcomes

An effective critical care service ensures prompt, appropriate admissions. Patients were admitted and received care and treatment according to national guidelines and this was monitored. The ICU had clear criteria for patient selection and senior staff said the system was effective.

Staff, equipment and facilities

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

We were informed that consultant cover for the ICU was in line with the national ICU guidance. One senior clinician told us: "Staffing at junior doctor level is currently adequate". At times when there were shortages, consultants would "act down" to cover the shortfall.

Multidisciplinary working and support

Throughout our visit, we saw good communication from the staff working in ICU with other healthcare professionals working in the Leicester Royal Infirmary. A range of professionals were involved in the patients' care, including speech and language therapists, physiotherapists, tissue viability nurses, microbiologists, radiologists and pharmacists. We were told that there was easy access to these professionals. We saw that effective handovers occurred when a patient was discharged from the ICU to a medical or surgical ward within the hospital. We were told

Good

Intensive/critical care

there was effective communication with other hospitals and the ICU was part of the East Midlands Critical Care Network where developments, results and themes were regularly discussed.

It was confirmed by a senior member of staff that relatives were regularly consulted and kept up to date about their family member's care and treatment. The relatives we spoke with were very complimentary of the care, facilities and environment which the ICU offered.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Patients told us they were treated with care, consideration and compassion. We spent some time observing the activity on the ICU. We saw staff having good, appropriate interactions with patients. Such interactions were unhurried and at a pace suitable for the patient's needs. We saw staff introducing themselves to patients. We observed staff treating patients in a kind, calm and respectful manner.

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

Involvement in care and decision making

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

Relatives were involved in patients' care. The ICU had a quiet room for relatives. We were told that staff could access the chaplaincy services for patients and relatives, and all denominations were available.

Trust and communication

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

We reviewed patients' records and saw that the notes were written in a respectful way about the patient. The notes, including assessments and care plans, were very detailed and provided a clear picture of the care the patient required and had received. We saw the adult ICU recording chart at the end of each patient's bed. This chart was developed by the University Hospitals of Leicester NHS Trust's ICU service, and contained important information about patients' physical observations and any intervention given. This chart was designed in such a way that it could be folded over to preserve patient confidentiality. The charts we reviewed were comprehensively completed and gave a clear picture of the patient's condition and the interventions that had been given.

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

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

(for example, to feedback?)

Good

Meeting people's needs

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

We saw information about the University Hospitals of Leicester NHS Trust's Patient Information and Liaison Service (PILS) team displayed in public areas. The PILS team can deal with queries, concerns, and complaints. In

Good

Intensive/critical care

addition to this, we saw that an Adult Intensive Care Patient Survey was available for patients and their family to complete. We saw there was also a Message to Matron postcard system in place for staff to leave comments and questions for the matron. The staff we spoke with were aware of the trust's complaints procedure.

Vulnerable patients and capacity

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

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

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

Leaving hospital

We were told, and saw from data which the trust provided to us, that the issue of delayed discharges was problematic. A delayed discharge occurs when a patient's condition improves and they no longer require an ICU bed. At the time of our visit, we were told that a number of patients experienced a delayed discharge on the ICU due to a lack of suitable beds within the rest of the hospital. The bed management team were actively attempting to find suitable beds, though this took time.

The majority of discharges from the ICU were to a medical or surgical ward. We were told that occasionally a patient was discharged directly to their home, but this only occurred on average twice in the year. We were informed that the ICU did not discharge patients after 6pm, due to the risk of rapid deterioration of the patient's physical health, combined with reduced resources available out of the usual working hours.

Are intensive/critical services well-led?

Good

Governance arrangements

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

Leadership and culture

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

Learning, improvement, innovation and sustainability

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

We saw the ICU had a comprehensive business continuity plan which gave details about how patients' care would continue to be provided in the event of an emergency situation. Such situations included, for example, an electricity power-cut, and disruption to the supply of medical gases. This told us that the trust had risk-assessed vital services and had put in place contingency arrangements if such services failed.

Good

Maternity and family planning

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

Information about the service

The trust provides a full range of maternity services. Maternity services are provided on three sites, the Leicester Royal Infirmary, which has approximately 6,000 births per year, Leicester General Hospital, which has approximately 4,000 births per year and St Mary's Birth Centre, which has approximately 300 births per year. The birth rate has fallen from 10,919 in 2011 to 10,300 births recorded in 2013.

The Leicester Royal Infirmary provides care and treatment for women with low- and high-risk pregnancies and provides care during their antenatal, intrapartum and postnatal period. The Leicester General Hospital provides similar care, but cannot offer prolonged neonatal intensive care and so, where possible, babies expected to need such care are delivered at Leicester Royal Infirmary. However, when necessary, babies will be stabilised and transferred ex-utero if they are delivered pre-term or require intensive care for reasons other than prematurity. St Mary's Birth Centre provides antenatal, intrapartum and postnatal care for healthy, low-risk women and their babies.

In addition to maternity services being delivered in these three locations, there are also 10 teams of community midwives and maternity care assistants (MCAs) who deliver antenatal and postnatal care in women's homes, clinics and children's centres across the city and county of Leicestershire, as well as supporting women to give birth at home. In 2013, approximately just under 2% of women experienced a home birth.

Summary of findings

Services for women in maternity were generally safe, although, we noted that the number of hours for consultants on the delivery unit was not in line with the recommended guidance. However, the trust was aware of this and had taken actions to address the deficit. Staff reported that equipment was not always readily available.

There was an effective mechanism to capture incidents, near misses and Never Events (mistakes so serious they should never happen). Staff told us they knew how to report these issues. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to make complaints was visible to the people using the service. There was also an extensive audit programme, and we saw audits had been carried out on such topics as foetal heart rate monitoring, augmentation of labour, missed appointments, antenatal screening and mental health. However, we spoke with a number of staff who told us they did not always report incidents because they were too busy.

A number of staff told us that senior managers and modern matrons were visible in the clinical areas and that communication was reasonable from the most senior of midwifery staff. In particular, the senior midwife was known by all the staff and was very visible. We spoke with the senior midwife who displayed an excellent understanding of the unit and spoke with clarity and passion about the service provided. However not all staff understood the trends, learning and changes to practice from incidents.

Good

Maternity and family planning

Are maternity and family planning services safe?

Requires Improvement

Safety and performance

It is mandatory for the trust to report serious incidents. Of the incidents reported, only a very small number (less than 3%) were reported in the maternity unit. However, we saw that there was an effective mechanism to capture incidents, near misses and Never Events. Staff told us they knew how to report both electronically and in person to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to make complaints was visible to the people using the service. There was also an extensive audit programme, including for foetal heart rate monitoring, augmentation of labour, missed appointments, antenatal screening and mental health. The results of these audits were available for staff. However, we spoke with a number of staff who told us they did not always report minor incidents because they were too busy.

Learning and improvement

We reviewed three recent, serious untoward incidents and saw that a root cause analysis investigation had taken place. The incidents were well investigated with clear action plans. The action plans referenced national guidance and best practice. The changes were implemented in a timely manner.

We asked staff to explain how learning from incidents and complaints was cascaded to all staff. Their response was mixed. Some staff told us they did not receive feedback unless directly involved in the incident or complaint. Others were able to explain to us what changes to practice had been implemented as a result of learning from incidents. During our visit we saw newsletters, emails and memos with information on incidents, complaints and recent changes to practices. A number of staff said they could not always access a computer and their emails. However, we did see that other methods of communication were used, such as newsletters, in a variety of staff areas, which demonstrated the provider disseminated learning.

Systems, processes and practices

We saw a variety of policies and guidelines for clinical care. We asked a number of staff to demonstrate how they would access policies and guidance. All the staff showed us they could access documentation when required. We randomly selected three policies and saw they were current and had been reviewed and updated as necessary.

Equipment

We saw several pieces of equipment during our inspection of the location and checked to see if it was regularly checked and maintained. We also spoke with a number of staff who told us they sometimes had difficulty locating equipment, for example, large blood pressure cuffs, thermometers and foetal scalp electrodes. When questioned, staff told us they very rarely thought to report lack of equipment using the incident reporting system.

Infection control

During our visit we observed all areas appeared clean and well maintained. The department was in the process of a £2.6 million refurbishment plan. We noted that delivery suite was in the process of the refurbishment and not all rooms were accessible due to the work in progress. None of the staff we spoke with expressed any concern about this temporary disruption to the environment.

Monitoring safety and responding to risk

The acting head of midwifery confirmed that the birth ratio was one midwife to 31 births. We saw that this ratio had improved from one to 37 and a working sub-group was continuing to work towards best practice of one to 28. We also spoke with a number of women and their partners. All told us they felt safe and were happy with the service provided.

There was good consultant presence between the hours of 8am and 8pm Monday to Friday. However, we spoke with a number of staff on the delivery suite, maternity assessment unit and the wards who told us doctors were over-stretched out-of-hours and consultants were much less visible. We spoke with the head of service who told us there was currently 60 hours of consultant presence on the delivery suite. The Royal College of Obstetricians and Gynaecologists safer childbirth recommendations state that, for the number of births, the Leicester General Hospital should have 80 hours of consultant presence.

We saw evidence that the provider had recognised the deficiency in consultant cover and had a robust plan in place. Two consultants had recently been appointed with two more to commence employment by April 2014. The head of service explained to us that they were also

reviewing existing consultant's job roles and plan to complete the process within three months. Once the appointments and changes are implemented, the provider will reassess and consider further appointments if required. This demonstrated to us that the provider had recognised the problem, had an interim solution in place and had initiated a longer-term solution. Monitoring of action implementation was through the clinical management board.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The provider was able to demonstrate to us that policies, protocols and guidance were based on nationally recognised guidelines and standards. We saw the provider had a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research based. The provider had robust systems in place for the ratification of new policies and guidance.

We saw regular review, and updating of policies and guidance. We spoke with staff and asked them if they were engaged in the development of policies and how new guidance was communicated to them. All the staff we spoke with told us they did not see draft reports and were not able to comment prior to the ratification of policies. However, we were able to confirm that all new and updated policies were reviewed by the maternity guidelines group. Once approved, policies were circulated to senior midwives to circulate to all staff. New guidance and policies were also included in newsletters, emails and memos to staff.

All relevant National Institute for Health and Care Excellence (NICE) guidance was reviewed in the maternity guidelines group. The midwife for public health and quality standards explained that, when new NICE or national guidance was published, a multidisciplinary working group was set up to discuss implementation or demonstrate the rationale for why the guidance was not implemented.

Performance, monitoring and improvement of outcomes.

The trust has previously been identified as part of the maternity outlier surveillance programme for significantly high rates of puerperal sepsis. The trust's outcomes for this indicator remain high but are now within expected limits. During our visit we spoke with the clinical director who was the nominated lead for the progress and implementation of actions to improve the rate of puerperal sepsis. We saw an action plan, last updated in December 2013, and noted that eight actions had been completed and the remainder eight actions were on track to be completed by March 2014. The clinical director explained to us that 90 health records were reviewed. The main issue identified was that of incorrect coding. However, further steps have been introduced, such as the introduction of sepsis prompt questions for staff to complete prior to discharge, inclusion of the maternity quality dashboard, and the introduction of the sepsis care bundle.

The provider undertook a variety of daily, weekly, monthly, quarterly and annual internal and national audits. We also saw evidence of progress against national maternity indicators and directorate quality dashboard. The results of the internal audits, such as infection control, safety thermometer and patients' comments were displayed in each ward and department. Staff were able to see on monthly basis how they were performing against each audit standard. We spoke with a number of staff and the majority were able to explain how to access the results from audits and quality monitoring. We also spoke with a number of doctors in training who were involved in carrying out audits. One doctor explained they had just conducted an audit into antibiotic prescribing and course duration.

Staff, equipment and facilities

Women were cared for by suitable qualified and competent staff. Staff were able to access a variety of mandatory training and there were opportunities for further development. This training included formal courses and emergency skill drills. We spoke with maternity support workers who explained they were very supported within their role. We reviewed the women and children's division mandatory training dashboard. We noted that there was an overall poor uptake of some training, in particular, conflict resolution and safeguarding training. This had been recognised and managers had been alerted and staff encouraged to attend the training.

Good

Maternity and family planning

A number of staff explained that they often felt over-stretched and found it difficult to find the time they needed to give good care. Many felt that more staff were required. We noted that there was not a dedicated theatre team to cover the obstetric theatres out of hours. Midwives were adequately trained and competency checked to cover the theatres. However, out-of-hours midwives were taken away from their midwifery duties to work in the theatres. We raised these concerns with the senior midwife, who explained that funding had been identified for a theatre midwife to cover out of hours. However, the trust decided the money was to be used to increase the numbers of midwives in general and the present system for covering theatres was safe.

We discussed staffing with the head of midwifery, who explained that the student midwives who qualified in September 2013 had been recruited and at present there was only four whole-time-equivalent vacancies, which were due to be advertised shortly. The ratio of midwives to births had improved from one to 37 to one in 31.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

We saw evidence that the NHS Friends and Family Test was carried out and the results displayed in the ward areas for staff and patients to view. We saw a variety of cards, throughout the trust, for women and their families to write their comments about their experiences. We also noted that women and their families could use the meridian website. Monthly comments were displayed for staff and people to view. Both the staff and women we spoke with assured us there was a culture of caring.

Involvement in care and decision making

We saw that there was an extensive refurbishment programme in progress. We saw that two high-dependency beds were shortly to be available and that a new birth centre had been established with four rooms, including two birthing pools. We noted the number of births in the birth centre had averaged 50 a week. The staff spoke with great pride about the use of the low-risk birth unit.

Trust and communication

During our visit we also saw good staff interaction which was polite and respectful.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Good

Meeting people's needs

The staff we spoke with had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people who were inpatients.

For patients who spoke languages other than English, some staff spoke different languages and staff had access to interpreters through the Language Line service. When asked how useful these services were, the majority of staff told us it was very useful. We also saw a variety of communication aids in departments. However, all the signage we saw was in English.

Vulnerable patients and capacity

The provider had an extensive team of specialist midwives, who supported midwives to care for the more vulnerable people within the community. We saw specialists for bereavement, safeguarding and female genital mutilation (female circumcision). We spoke with specialist midwives who explained how they supported staff to care for women both in hospital and in the community. We also saw that the number of clinics had been expanded to accommodate increased demand. For example, we noted that a clinic had been developed for women with obesity. We also saw examples of multidisciplinary antenatal clinics, which included obstetricians, physicians and specialist midwives.

Access to services

We found that, at busy times, staff were redeployed to the delivery suite. We discussed this with the senior midwife who explained that when there was a peak in activity, clinical care was prioritised and staff were moved to ensure the safest care possible was delivered. We also spoke with two midwives who felt at times they were unable to respond effectively to women's needs. When questioned, staff explained they had introduced innovative ways of working to assist staff in these busy times, such as

completing paperwork and monitoring antenatal inpatients in the midwifery assessment unit in quieter times. The senior midwife was aware of these innovative ways of working and actively welcomed staff initiatives.

Learning from experiences, concerns and complaints

The provider had a robust complaints process. We saw evidence of divisional learning. We saw newsletters, team meetings and emails which contained changes to practice following learning from a complaint. We saw a newsletter which identified a trend in complaints' themes. The newsletter identified what actions had been taken and that further review of the issues would be undertaken to ensure improvements.

Are maternity and family planning services well-led?

Good

Governance arrangements

We saw a robust governance framework and reporting structure. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the committee structure to the board. However, despite seeing various methods used to communicate the findings and learning to staff, we were repeatedly told that staff did not understand the trends, learning and changes to practice. We also saw a risk register which was populated and reported through to the governance committees and on through the trust governance structure to the board. The top three risks were: capacity, due to the refurbishment programme; not meeting the national standard for ultrasound scanning in maternity; and failure to achieve NHS Litigation Authority maternity risk management standards.

Leadership and culture

A number of staff told us that senior managers and modern matrons were visible in the clinical areas and that communication was good, even from the most senior of midwifery staff. In particular, the senior midwife was known by all the staff and was very visible. We spoke with the senior midwife who displayed an excellent understanding of the unit and spoke with clarity and passion about the service provided. The doctors we spoke with also told us they felt there was good medical management and support.

Learning, improvement, innovation and sustainability

Staff told us they felt supported by the modern matron and ward managers. Supervisors of midwives were available for support and were on call throughout the day and night. The ratio of supervisors to midwives was one to 20 – higher than the recommended national standard of one to 15. Staff did not express any concerns about having access to a supervisor of midwives. The majority of staff we spoke with had received their annual supervision. The Local Supervisors Audit in June 2012 made six recommendations, including reducing the number of midwives to supervisors in line with Nursing and Midwifery Council guidance and that there should be enough midwives to safely deliver women using the service. The trust continues to work to meet these recommendations.

We saw that a variety of training was available for staff to attend and there were two dedicated education and development midwives employed. Staff were able to describe to us what midwifery and obstetric training was required, in particular the skill days. We also spoke with a number of junior midwives who felt they were well supported by more experienced midwives and that their preceptorship training year was structured and enabled them to gain vital experience.

We saw and heard that the consultant cover was being increased and a plan had been developed to appoint consultants and review the present roles of consultants. A further review was planned to ensure the planned changes had improved the consultant presence within the maternity unit. We also saw plans to develop the role of the midwifery support worker to include such tasks as scrubbing in theatre for elective caesarean sections, phlebotomy and discharge documentation.

Good

End of life care

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

Information about the service

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

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

We talked to 13 patients and 21 staff, including a palliative care consultant, palliative care nurse specialists, doctors, chaplains, bereavement coordinators, mortuary technicians and porters. We observed care and treatment and looked at four patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we received performance information from the trust.

Summary of findings

Patients received safe end of life care. Patients who were nearing end of life were identified early so that they could be supported to make decisions about their care.

Staff were knowledgeable and experienced in providing care that met patients' needs. The hospital had actively listened to patients' and relatives' feedback about end of life care and had made changes in response to their feedback.

The chaplaincy reflected the cultural diversity of the patients and responded to patients' individual needs. There was board-level support for the role of the palliative care team and end of life care within the hospital. This ensures that issues are raised at a senior level in the trust.

Good

End of life care

Are end of life care services safe?

Good

Safety and performance

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

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

Learning and improvement

The service was focused on safety. Staff reported incidents and told us they did receive feedback and shared the lessons learned. There had been learning from previous safeguarding incidents within the bereavement service, where procedures are now in place to protect patients who had no next of kin or traceable family. The records of each death had an electronic record that could not be closed until all the procedures had been followed and signed off. When the team had established there was no next of kin, the hospital arranged contract funerals and a referral to the treasury solicitor was made. We spoke with a bereavement officer and their manager; they both demonstrated a good understanding of the procedures and their responsibilities. There had been monitoring of these procedures and staff had been tested during their appraisals to ensure that the procedures were robust.

Are end of life care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The end of life care followed government guidelines. In line with NHS recommendations, the trust had undertaken a review and had decided that the Liverpool Care Pathway for the care of the dying patient was no longer to be used at Leicester General Hospital. In its place, the palliative care team had created guidance for staff to support individualised care. The guidance recommended a multidisciplinary assessment of a patient who is in their last days of life. The guidance covered recognition that the patient is dying, sensitive communication, patient preferences for care, review of treatments and investigations and ongoing assessments of their needs.

Staff, equipment and facilities

Following the death of a patient in the hospital, the team of bereavement officers liaised with medical staff to coordinate the provision of essential documents. They met with families in the bereavement suite. The bereavement officers supported families with practical guidance about the bereavement services and ensured they receive their relative's personal belongings and completed essential documents.

Multidisciplinary working and support

Patient's end of life care was managed effectively. The palliative care team responded promptly to referrals from all members of the multidisciplinary team, patients and their relatives. The team across the trust included three consultants in palliative care medicine who also worked at the local hospice and the trust employs 9.27 WTE specialist palliative care nurses who work across all three sites. Included within this is one clinical nurse specialist who works for 0.6 WTE on research and development activities. The service included spiritual support from the chaplaincy team.

Good

End of life care

Are end of life care services caring?

Good

Compassion, dignity and empathy

Staff were sensitive to the privacy needs of relatives and patients at end of life. Patients were accommodated in quiet areas of the wards where possible.

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

Involvement in care and decision making

The palliative care team had applied and been selected by the chief executive's Listening into Action initiative to improve care. The team had six months up to May 2014, where patients and their carers would provide feedback about their experiences; the palliative care team would then provide solutions to improve care. We spoke with one patient who was receiving end of life care, and they told us that staff had listened to them and had respected their wishes.

Emotional support

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

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

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

(for example, to feedback?)

Good

Meeting people's needs

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

Vulnerable patients and capacity

The chaplaincy responded to people's cultural and religious beliefs. Where people had no specific religious or cultural needs the team provided "a listening friend". The chaplaincy team had the skills to help facilitate family reconciliation and support in end of life care. There were alerts on the electronic records that triggered the chaplaincy to a person's needs, such as long inpatient stays, previous chaplaincy visits, or a referral from staff. The members of the chaplaincy team could speak languages such as English, Urdu, Gujarati, Arabic, Hindi, Kutchi, Punjabi, Marathi and Polish, which reflected the patient population at the hospital.

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

Are end of life care services well-led?

Good

Leadership and culture

The chief nurse of the hospital took an active role in supporting and providing help to the palliative care team to improve services. The chief nurse represented the

Good

End of life care

palliative care team on the trust board. This ensured that end of life care was represented at the trust board and that issues affecting the patients experience were discussed at this level.

Patient experiences, staff involvement and engagement

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

Learning, improvement, innovation and sustainability

The palliative care team were active members of the Leicester, Leicestershire and Rutland working group for end of life care, which included community palliative care groups, the hospice and the clinical commissioning groups. The working group had worked strategically to plan and implement an alternative to the Liverpool Care Pathway, a guide to anticipatory prescribing and a unified DNA CPR policy and procedures.

Good

Outpatients

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

Information about the service

The University Hospitals Leicester NHS Trust provides outpatient services at Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital. Appointments are for a variety of specialties. At Leicester General, 188,153 people had outpatient appointments; 51,591 of these were new patients and 136,562 were follow-up appointments. The trust has had difficulty in meeting the 18-week referral-to-treatment target time.

Summary of findings

In general we found the outpatients department to be safe, with care being provided by an adequate number of staff in a clean environment. We noted though that one of the main clinics did not have immediate access to a resuscitation trolley.

Staff were well trained and some had taken on extra responsibilities to develop their practice and offer flexibility in the services provided.

The trust did not meet their targets for 18-weeks referral-to-treatment times and some patients have had clinics cancelled at short notice or may have to wait some time for a follow-up appointment. This is partly due to volume and partly due to the way in which some services were organised. The trust has identified some issues and is taking action to address these. In addition the neurology outpatients building had access problems for people with limited or restricted mobility.

We saw staff caring for people in a compassionate way and maintaining their dignity and privacy and found the service to be well-led by senior clinical staff who had a clear vision for their department and supported their staff.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

Staff in the main outpatients department were aware of incident reporting procedures and told us that they received feedback about incidents, either at team meetings or via email. Staff in the neurology outpatients told us that they had reported incidents but that they had not received any feedback on the outcome. Incidents were reported via the Datix patient safety software system. This is an electronic reporting system used by many healthcare providers. Following an incident, we saw an action plan formulated, identifying the concerns and actions taken to ensure improvements.

Systems, processes and practices

Equipment/Environment

The environment looked clean and well maintained, although staff raised concerns about the quality and frequency of cleaning. We saw audits for 2013 that showed that cleaning was meeting defined standards. There was one resuscitation trolley kept in Clinic 3 for the main outpatients department. While Clinics 1, 2 and 3 are close to each other, Clinic 4 is some distance away down a public corridor. We asked if managing emergencies in this way had been risk-assessed and were told that there was no risk assessment in place. One member of staff told us that, in the event of an emergency in clinic 4, they would get a 'grab bag' of emergency equipment from Ward 22. A member of staff working in Clinic 4 told us they would go to the orthopaedic ward and use their resuscitation trolley, though the matron for orthopaedics was unaware of this arrangement. We could not be sure that there was a robust process in place for the management of a medical emergency in Clinic 4.

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

Monitoring safety and responding to risk

There were enough staff on duty at the time of our visit. During our inspection there were a number of different clinics within main outpatients and specialty clinics. Some clinics were nurse-led. These were operated by staff with extended skills who had received the appropriate training to undertake that type of care. Staff we spoke with told us that they sometimes worked late because of delays with the patient transport service. The neurology outpatients employed a single healthcare assistant with no cover provided if they were on leave or absent through sickness. If the clinic ran late, then that member of staff worked overtime hours to ensure the clinic was properly staffed and safe. Staff in outpatients had received training in the Mental Capacity Act 2005 and staff could describe their responsibilities under the act.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Patients received care that was planned and delivered in accordance with best practice guidelines and national policy. For example, we saw that the care provided to people requiring treatment for Parkinson's Disease was in line with NICE guidance. People told us they were given sufficient information and time to make a decision about their care.

Performance, monitoring and improvement of outcomes

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

Staff, equipment and facilities

Staff in the department had access to training including mandatory training and also National Vocational Qualifications (NVQs). Senior staff showed us how they determined the staffing needs based on skills required to

Good

Outpatients

effectively manage the clinics. Some staff had received further training which enabled the department to offer additional services, including nurse-led clinics, and allowed for flexibility of staffing across departments.

Multidisciplinary working and support

The outpatients department worked with external professionals to ensure continuity of care for patients. There was information for referring people to community nursing services and referral forms contained the necessary information to communicate patients' needs effectively. In one department, the specialist nurse told us that they were directly involved with commissioners in discussing and developing the Parkinson's Disease service.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients we spoke with told us that they were happy with their care. They were given time and information to make a decision and they weren't rushed. They told us that staff kept them informed about what was happening. If there was a significant delay for patients, then refreshments and snack boxes were made available. For people with reduced mobility, a vehicle was available around the hospital grounds to take them close to their clinic. Due to the age of the building and narrow corridors, the vehicle was unable to be used inside the clinic.

Involvement in care and decision making

Message to Matron postcards with patients' feedback were almost all positive in terms of the care that patients had received. We spoke to 16 patients using the service who were all positive about the care they received at the department.

Trust and communication

We observed staff talking to patients in a respectful and polite way. There was positive engagement with patients and we saw humour used to develop rapport. There were quiet areas for patients who may have received difficult news, and staff told us how they supported people in those circumstances. Staff introduced themselves when talking to patients and took time to check patients' details and inform them if there was a delay in clinic and how long the delay would be. Confidentiality was maintained as notes were kept out of sight and staff were discrete when talking on the telephone. We spoke with one patient who told us that they had not understood all the information initially, but the doctor had been happy to go over the information again until she understood.

Emotional support

In the outpatients waiting area there was information for carers for help available and local support.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires Improvement

Access to services

The trust had been failing to meet its 18-week target for referral-to-treatment for outpatients. This would involve the initial contact with the consultant through the outpatients department. Our information showed that the trust had failed to meet its target in 2012/ 13. According to NHS England, in November 2013, 92.3% people started treatment within 18 weeks against a target of 95%. 94% patients for gastroenterology were seen within 18 weeks compared to the target 95%. Staff we spoke with told us that overbooking and cancellation of clinics was common and rebooking was difficult due to capacity issues.

We spoke with staff about the volume of patients they saw in clinic. The daily average for people seen in clinics across the trust was 3,068. We were aware of a large number of cancellations and delays in rebooking patients for clinic. The matron for general outpatients collected information on the service via the Message to Matron" postcard system. The two most frequent areas of concern for patients were waiting times in the department and issues with booking appointments. We spoke with staff who confirmed that late cancellations occurred and that it might not be possible to contact patients before they arrived in clinic. We saw that up to December 2013, 24.7% of gastroenterology appointments were cancelled by the hospital. A database recorded that some clinics were cancelled within a few days of the date of the clinic. We spoke with a member of staff responsible for booking patient appointments who confirmed that, for some specialities, including gastroenterology, patients may have to wait six months

Good

Outpatients

before being seen in clinic for a follow-up appointment. One person we spoke with complained about the lack of appointments. The NHS Choose and Book national electronic referral service is a way for patients to choose an appointment that suits their needs. However, we were told that, in some specialties, after a patient had booked their appointment, it was triaged and, if they are considered to be lower priority, the appointment may be changed. At the time of our inspection, patients requiring a routine physiotherapy appointment had to wait two months.

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

We visited the neurology outpatients department. Access to the department from outside is through a heavy fire door with a concrete slope leading up to the door. The door opened outwards so visitors would have to step backwards down the slope. Due to the nature of the clinic, many people who use it may have mobility and/or balance problems. A member of the inspection team who uses a wheelchair was unable to open the door and access the clinic. Staff working at the clinic showed us incident forms related to patients using the entrance. Patients, their carers and visitors were not able to safely access the clinic from outside.

Learning from experiences, concerns and complaints

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

We saw that a thematic analysis of responses had been completed each month of the issues raised in the Message to Matron feedback postcards. Most responses received were of a positive nature and the results were displayed prominently in public areas. Where there had been concerns that fell within the matron's responsibilities, we saw that actions had been taken to address them. For example, we saw that the clinics now had bariatric chairs available for people who required them and breastfeeding facilities had been introduced.

Are outpatients services well-led?

Good

Vision, strategy and risks

In the outpatients department, we saw the trust and department visions and values displayed. Staff we spoke with were aware of the vision for the department and future plans. Staff said they saw the executive team around the department on occasion and regularly saw the matron responsible for their department.

Leadership and culture

The matron for the main outpatients department demonstrated a strong, coherent vision for the services they were responsible for. They were passionate and enthusiastic about improving the service for patients and demonstrated this through service changes made in response to feedback. There was clear consistency in leadership across the trust's hospitals at departmental level. The matron's contact number was available in public areas so patients could call them direct with any issues. We spoke with a member of staff in a specialty clinic who told us that they had been unclear about who their manager was. They had taken the initiative and ensured they were line managed by a senior nurse.

Patient experiences, staff involvement and engagement

All staff felt well supported in their roles and understood their responsibilities. They had regular supervision and team meetings and said they felt confident to raise any concerns directly with their manager. All staff told us they had received training and many had undertaken further training such as NVQ to develop their skills.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 'Safety and suitability of premises'. 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. Regulation 15 (1) (a) (c)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 'Safety and suitability of premises'. 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. Regulation 15 (1) (a) (c)

Regulated activity	Regulation
Surgical procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 'Safety and suitability of premises'. 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. Regulation 15 (1) (a) (c)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 'Safety and suitability of premises'.

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Compliance actions

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Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 'Staffing'. Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in that medical and nursing staff were not available to care for patients on some wards including Ward 10 and maternity. Regulation 22

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Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 'Supporting workers'. Staff were not supported in their role as they did not receive appropriate training, professional development and supervision, in that: • Not enough staff had dialysis training on Ward 10. • There was a lack of supervision for the doctor on Ward 2. • Uptake of conflict resolution training and safeguarding training was poor on Maternity. • Training in risk assessment for pressure sores had only recently commenced on Surgery. • Overall training and induction for Agency nurses was unclear. Regulation 23 (1)(a)

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This section is primarily information for the provider

Compliance actions

- Uptake of conflict resolution training and safeguarding training was poor on Maternity.
- Training in risk assessment for pressure sores had only recently commenced on Surgery.
- Overall training and induction for Agency nurses was unclear.

Regulation 23 (1)(a)

Regulated activity

Surgical procedures

Regulation

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Regulation 23 (1)(a)

Regulated activity

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