Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **WEDNESDAY, 12 APRIL 2017**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ.**

Members of the Commission

Councillor Dempster (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Cassidy, Chaplin, Cleaver, Sangster and Unsworth

I unallocated Non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

G. J. Carey

For Monitoring Officer

Officer contacts:
Graham Carey (Democratic Support Officer):
Tel: 0116 454 6356, e-mail: Graham.Carey@leicester.gov.uk
Kalvaran Sandhu (Scrutiny Policy Officer):
Tel: 0116 454 6344, e-mail: Kalvaran.Sandhul@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings & Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

Making meetings accessible to all

Wheelchair access – Public meeting rooms at the City Hall are accessible to wheelchair users. Wheelchair access to City Hall is from the middle entrance door on Charles Street - press the plate on the right hand side of the door to open the door automatically.

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in City Hall meeting rooms. Please speak to the Democratic Support Officer using the details below.

Filming and Recording the Meeting - The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media. In accordance with government regulations and the Council's policy, persons and press attending any meeting of the Council open to the public (except Licensing Sub Committees and where the public have been formally excluded) are allowed to record and/or report all or part of that meeting. Details of the Council's policy are available at www.leicester.gov.uk or from Democratic Support.

If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to the area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETINGS

The minutes of the meetings held on 4 January, 2 March and 29 March 2017 have/will shortly be circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListMeetings.aspx?CId=737&Year=0

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

5. CHAIR'S ANNOUNCEMENTS

The Chair to make any announcements as necessary.

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

Mr David Bradley to submit the following representation:-

"Concerns were raised by myself 12 months ago about the care and treatment of autistic adults in Leicester both in terms of the lack of adequate and appropriate facilities within the NHS and a poorly managed process to return such patients back into the community.

At the time, the previous chair requested a report on the outcome of further discussions on the matter and questioned whether the policy could be changed to improve the care of people diagnosed with Asperger's or autism.

I am aware that a case study has been carried out by Mark Griffiths into particular failings in the CPA process, but I am not aware of any report or policy changes with regard to the care of adults with autism whilst held in hospital where there is a distinct lack of understanding or training in dealing with the complex issues of such cases. I note that the CQC also found deficiencies in providing necessary psychological therapies for such patients.

Similarly I would still like to question the effectiveness of the Care and Treatment Review process in achieving its aims of returning adults with learning disabilities or autism back into the community, where it is painfully obvious that there are not enough specialist residential establishments in Leicester to receive them. The result being that patients are kept in hospital far longer than is beneficial for their health and wellbeing, or they are transferred out of the region again adding additional cost to their care and treatment.

When will this commission hold LPT to account for not providing appropriate care for autistic adults whilst in recovery and hold Social Services to account for not engaging with health services to prepare and provide appropriate care packages in the community?

I refer the Commission to the Statutory Guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (March 2015) – page 31 – Local Authorities, NHS bodies with commissioning responsibility should JOINTLY – Develop and update local JOINT commissioning plans for services for adults with autism, based on effective JOINT strategic needs assessment, and review them annually, for example with the local Health and Wellbeing Board."

7. CQC REVIEW OF HEALTH SERVICES FOR LOOKED AFTER CHILDREN AND SAFEGUARDING

To receive a presentation from the Leicester City Clinical Commissioning Group on the CQC review for Looked After Children and Safeguarding.

8. CQC INSPECTIONS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST 2016

Appendix A (Pages 1 - 130)

To receive a report from the University Hospitals of Leicester NHS Trust (UHL) providing an overview of the outcome of Care Quality Commission (CQC) comprehensive inspection of the Trust.

9. UNIVERSITY HOSPITALS OF LEICESTER QUALITY ACCOUNTS **Appendix B (Pages 131 - 200)**

The University Hospitals of Leicester NHS Trust to submit a report on the Draft Quality Account for 2016/17. The Commission is invited t review the draft Quality Account and provide feedback by Monday 1 May 2017, as part of the statutory Quality Account process.

10. SHARED CARE AGREEMENTS **Appendix C (Pages 201 - 206)**

The Leicester City Clinical Commissioning Group to submit a report on Shared Care Agreements.

11. ORAL HEALTH UPDATE **Appendix D (Pages 207 - 212)**

The Director of Public Health to submit a report providing an update in Oral Health in Leicester.

12. WORK PROGRAMME **Appendix E (Pages 213 - 216)**

The Scrutiny Policy Manager submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2016/17. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

13. ANY OTHER URGENT BUSINESS

Appendix A

University Hospitals of Leicester NHS Trust

LEICESTER HEALTH AND WELLBEING SCRUTINY COMMISSION

12th April 2017

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

CQC INSPECTION

Purpose of report

1. The purpose of this report is to provide the Leicestershire Health and Wellbeing Board with an overview of the outcome of the Care Quality Commission (CQC) comprehensive inspection of University Hospitals of Leicester NHS Trust (June 2016).

Policy framework

2. The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose care.

3. Where they find poor care, they will use their powers to take action.

4. A summary of the CQC's findings is attached as Appendix A. A copy of the CQC's full trust level report is attached as Appendix B.

5. All of the CQC reports from their inspection of UHL's services in June 2016 were published in January 2017 and can be found here:

   http://www.leicestershospitals.nhs.uk/aboutus/performance/care-quality-commission/

Background

6. On the 20th to the 23rd June 2016, the CQC carried out a comprehensive inspection of UHL's services. The aim of a comprehensive inspection is to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led.

7. This inspection covered seven of the eight core services:

   - Urgent and emergency services (A&E)
   - Medical care (including older people's care)
   - Surgery
   - Maternity and gynaecology
   - Services for children and young people
   - End of life care

- Outpatient services and diagnostic imaging (such as x-rays and scans)

8. Due to CQC inspector availability, the eighth core service, critical care, was inspected at a later date, on the 25th to the 27th July 2016.

9. Prior to the inspection, the CQC were provided with over 2,000 items of documentation covering each of the eight core services. This documentation informed a series of CQC Intelligence Packs (one for each core service and one at trust level), which were used by the CQC to help direct their lines of inquiry during their inspection.

10. Before their inspection the CQC also approached other organisations to share what they know about the UHL, this included:

    - The Clinical Commissioning Groups (CCGs);
    - NHS Improvement
    - NHS England
    - Health Education England (HEE)
    - General Medical Council (GMC)
    - Nursing and Midwifery Council (NMC)
    - Royal College of Nursing
    - Leicester Mercury Patients' Panel
    - Healthwatch Leicester

11. The CQC held a number of staff focus group, covering a range of staff disciplines across the three UHL sites, as well as interviewing members of the senior executive team and Trust Board.

12. Throughout the inspection and beyond, the CQC continued to request additional information and documentation, with over 600 separate requests received.

UHLs compliance actions action plan

13. UHL's compliance actions action plan was discussed at a Quality Summit held on the 28th March 2017, attended by UHL, the CQC, NHSI and external stakeholders.

14. Actions to address CQC Compliance Actions which require additional resources have been identified within UHL's comprehensive action plan. Where additional resource requirements have been identified, these will be subject to the Trust's normal financial and business planning/prioritisation process.

Conclusions

15. UHL remains committed to achieving a 'Good' rating across all services.

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

#hello my name is…

CQC Inspection

Julie Smith, Chief Nurse
Sharron Hotson, Director of Clinical Quality

One team shared values

University Hospitals of Leicester NHS Trust

Caring at its best

The CQC Inspection

- The inspection took place on the 20th to the 23rd June 2016 and covered seven of the eight core services:
  - Urgent and emergency services (A&E)
  - Medical care (including older people's care)
  - Surgery
  - Maternity and gynaecology
  - Services for children and young people
  - End of life care
  - Outpatient services and diagnostic imaging

- Due to CQC inspector availability, critical care was inspected on the 25th to the 27th July 2016

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

The CQC Inspection

- Prior to the inspection, the CQC were provided with over 2,000 items of documentation covering each of the eight core services

- This documentation informed a series of CQC Intelligence Packs (one for each core service and one at trust level), which were used by the CQC to help direct their lines of inquiry during their inspection

University Hospitals of Leicester NHS Trust

Caring at its best

The CQC Inspection

- Before their inspection the CQC approached other organisations to share what they know about the UHL, this included:
  - The Clinical Commissioning Groups (CCGs)
  - NHS Improvement
  - NHS England
  - Health Education England (HEE)
  - General Medical Council (GMC)
  - Nursing and Midwifery Council (NMC)
  - Royal College of Nursing
  - Leicester Mercury Patients' Panel
  - Healthwatch Leicester

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

The CQC Inspection

- The CQC held a number of staff focus group, covering a range of staff disciplines across the three UHL sites, as well as interviewing members of the senior executive team and Trust Board

- Throughout the inspection and beyond, the CQC continued to request additional information and documentation, with over 600 separate requests received

University Hospitals of Leicester NHS Trust

Caring at its best

CQC ratings

- On Thursday 26 January, the CQC published their final reports along with their ratings of the care provided
- The CQC rated the Trust overall, as '**Requires Improvement**'
- The Leicester Royal Infirmary, the General and Glenfield Hospitals were all individually as '**Requires Improvement**'
- Of the 100 ratings (for each domain of each core service):
  - 1 is Outstanding (for the effectiveness of our East Midlands Congenital Heart service at Glenfield)
  - 55 are Good
  - 41 are Requires Improvement
  - 1 is Inadequate (the Responsive domain of emergency care at the Royal)
  - Two elements were unrated for technical reasons

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

CQC ratings

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

	Medical Care	Surgery	Intensive / Critical Care	Maternity & Gynaecology	Services for children & Young People	End of Life Care	Outpatients & diagnostic Imaging	Overall
Leicester Royal Infirmary	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

	Medical Care	Surgery	Intensive / Critical Care	Maternity & Gynaecology	End of Life Care	Outpatients & diagnostic Imaging	Overall
Leicester General Hospital	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

	Medical Care	Surgery	Intensive / Critical Care	Services for children & Young People	End of Life Care	Outpatients & diagnostic Imaging	Overall
Glenfield Hospital	Good	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement

One team shared values

University Hospitals of Leicester NHS Trust

Caring at its best

CQC findings

"The rating we gave the trust in this inspection was the same rating as they were awarded in the 2014 comprehensive inspection. However, we did find improvements had been made, particularly in staff engagement. Confidence in the leadership team had been sustained."

University Hospitals of Leicester NHS Trust

Caring at its best

CQC findings

- Many staff commented on the positive culture change in the Trust under the current Chief Executives leadership
- The Trust is led by a respected board
- The Executive staff are much respected and staff had confidence in their leadership
- The Trusts vision and values are generally embedded into practice
- The Trust has a five year plan and a vision and strategy and most of the staff spoken to knew about this

University Hospitals of Leicester NHS Trust

Caring at its best

CQC findings

- Since the inspection in June 2016 a number of improvements have been made and some concluded
- We will be providing evidence of this and ongoing actions to the CQC as required
- At the time of inspection, the Trust had a Section 31 condition in place following the unannounced CQC inspection of the Emergency Department in November 2015
- Sufficient evidence of improvement has been provided to the CQC to enable the lifting of this condition on the 15 November 2016

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Outstanding practice and areas for improvement

- Children & Young People (Glenfield) – Outstanding for effective
- Caring – good throughout all three hospitals
- Challenges around the emergency pathway
- Care of the deteriorating patient – robust plans in place
- Challenges around our Estate

University Hospitals of Leicester NHS Trust

Caring at its best

Quality Summit

- Took place on 28th March 2017
- Attended by representatives from UHL, the CQC and a range of stakeholder organisations
- Comprehensive action plan to address Compliance Actions agreed and will be closely monitored

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Conclusions

- We are an organisation which is:
  - Improving quality systematically
  - Dealing with substantial increases in demand
  - Working better with our partners
  - Tackling longstanding strategic issues
  - Building a more empowered culture
  - Staffed by very committed people

- It is our ambition to achieve ‘Good’ for all services at all three sites

Care Quality Commission

University Hospitals of Leicester NHS Trust

Quality Report

Infirmary Square,
Leicester,
Leicestershire,
LE1 5WW
Tel: 03000 303 1573
Website: www.leicestershirehospitals.nhs.uk

Date of inspection visit: 20 - 23 June
Date of publication: This is auto-populated when the report is published

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

Our key findings were as follows:

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

Summary of findings

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

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

We saw several areas of outstanding practice including:

Leicester Royal Infirmary

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- A range of medicines to manage Parkinson's disease was available on the Clinical Decisions Unit (CDU) at the Glenfield Hospital. These medicines are time

Summary of findings

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

- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.
- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities facilitator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24-hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.
- The trust had introduced a non-religious carer to provide pastoral support in times of crisis to those patients who do not hold a particular religious affiliation .Also to provide non-religious pastoral and spiritual care to family and staff.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The maternity inpatient risk assessment booklet also included a situation, background, assessment, recommendation (SBAR) tool, a sepsis screening tool, a venous thromboembolism (VTE) assessment tool which also had a body mass index chart, a peripheral intravenous cannula care bundle, a urinary catheter care pathway and assessment tools for nutrition, manual handling and a pressure ulcer risk score. This meant that all assessment records were bound together.

- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.
- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24 hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.

Leicester General Hospital

- A new computerised individualised dosing system was in operation on the renal wards.
- New Starters in nephrology had a 12-week supernumerary period within the ward area and a bespoke Professional Development Programme. Included within the development programme was; trust behaviours, early warning score (EWS), infection prevention control, planning / evaluating care, managing pain, care of the dying patient and equipment training. Templates were also included to assist registered nurses in their revalidation process.
- An MDT meeting took place weekly on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals (physiotherapy, occupational therapy and speech and language therapy), medical and nursing staff and a neurological psychologist. The patient and relevant family member would also be present at this meeting where a patient's individual rehabilitation goals would be discussed and reviewed.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- On ward 1, a flexible appointment service was offered for patients. In order to help patients who had other personal commitments, for example work

Summary of findings

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

- The development of a pancreatic cancer application to support patients at home with diagnosis and treatment. This will potentially assist patients and family members face the diagnosis and treatment once they have left the hospital.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified obstetric early warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The risk assessment booklet also included a range of risk assessments. This meant that all assessment records were bound together.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Glenfield Hospital

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- A range of medicines to manage Parkinson's disease was available on the clinical decisions unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.
- A 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, and body language and physical changes to help determine level of patient comfort.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Trust wide

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

Urgent & emergency services

- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department. **This also applies to medical areas.**
- The trust must take action to ensure standards of cleanliness and hygiene are maintained at all times to prevent and protect people from a healthcare-associated infection. **This also applies to medical areas and outpatient and diagnostic areas.**
- The trust must ensure patients requiring admission who wait in the ED for longer that 8 hours have a VTE risk assessment and appropriate thromboprophlaxis prescribed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

Summary of findings

Medicine

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

Surgery

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

Critical Care

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

Maternity and gynaecology

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the maternity and gynaecology service.
- The trust must ensure that midwives have the necessary training in the care of the critically ill woman, anaesthetic recovery and instrument/scrub practitioner line with current recommendations.
- The trust must address the backlog in the gynaecology administration department so that it does not impact patient safety.

Services for children and young people

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

End of life care

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

Outpatients & Diagnostic Imaging

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

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust specialist and acute services to a population of one million patients throughout Leicester, Leicestershire and Rutland. There are three main hospital locations; Leicester Royal Infirmary, Leicester General Hospital and The Glenfield Hospital. Glenfield Hospital has a heart centre which provides specialist heart surgery for patients across the East Midlands. The trust has 1,784 inpatient beds and 175 day-case beds. It is one of the biggest acute NHS trusts in England.

We inspected the trust in 2014 under our new inspection methodology and rated it as "Requiring Improvement". During this inspection we followed up on the identified areas that required improvement from the 2014 inspection. We looked at a wide range of data, including patient and staff surveys, hospital performance information and the views of local partner organisations. The inspection teams visited all three hospital locations.

Leicester, Leicestershire and Rutland have a population of approximately 1.03 million, with 32% of people living in the city, 64% in Leicestershire and 4% living in Rutland. The three areas have significant differences. The city of Leicester has a younger population and the county areas are older. The city of Leicester is an ethnically diverse population with over 37% of people being of Asian origin.

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

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

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

How we carried out this inspection

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

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

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

Summary of findings

Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

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

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

What people who use the trust's services say

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

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

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

o Outpatient services 94% (NHS average 93%)

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

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

Facts and data about this trust

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,771 inpatient beds and 176 day-case beds. 937 inpatient beds and 85 day-case beds are located at Leicester Royal Infirmary.

University Hospitals of Leicester NHS Trust provide specialist and acute services to a population of one million patients throughout Leicester, Leicestershire and Rutland. There were 149,806 inpatient admissions, 993,617 outpatient attendances and 135,111 emergency department attendances between April 2015 and March 2016.

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

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

Summary of findings

Our judgements about each of our five key questions

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

Key findings were:

Duty of Candour

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

Safeguarding

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

Summary of findings

- Arrangements were in place to safeguard women or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. Mandatory safeguarding training for both midwives and doctors covered child sexual exploitation, modern day slavery and honour based violence.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- Without exception we found staff knew how to report incidents through the trusts electronic incident reporting system.
- The trust report approximately 27,000 incidents every year. We were told the patient safety team reviewed all cases graded as moderate or above. A decision on whether the incident qualified as a serious incident was made by the Director of Safety and Risk with input from the Medical Director and Chief Nurse.
- We received a mixed picture regarding staff receiving feedback from incidents. Some areas were able to tell us they received feedback and learning through email, staff meetings, board 'huddles' and, during handovers. Whereas in some areas, staff did not feel they received feedback.
- In some areas we inspected we were able to find evidence of changes that had been introduced as a result of learning from incidents.
- The trust had an array of techniques to communicate and embed learning. These included bulletins and the use of the East Midlands Learning Network to spread and absorb lessons, utilising incidents in clinical education and using clinical simulations.

Staffing

- Nurse staffing levels were displayed in all the clinical areas we visited and information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were 'gaps' in staffing, bank and agency staff had been requested.
- Across UHL since September 2014 all clinical areas had collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for

Summary of findings

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

- The Trust used recognised tools to assess the level of nursing staff and skill mix required. The Chief Nurse was sighted on nursing risks and wards which were alerting as requiring more support. There were some areas where the actual staffing fell below the planned staffing levels. Recruitment to vacancies was in process and staff were able to utilise bank and agency staff to fill the staffing.
- We found differences in staffing levels on the three sites. Generally, staffing levels across the trust were sufficient to deliver safe care. There were some wards where there were more vacancies but recruitment was underway.
- Neonatal staffing at the Leicester Royal Infirmary (LRI) neonatal unit did not fully meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM) because they were unable to provide one nurse to one baby care in the intensive care unit for all babies. Information provided by the trust stated this was due to staff vacancies, sickness and maternity leave. Funding was available to recruit a further 11 WTE staff and there was an active recruitment campaign.
- The maternity department used an acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015.
- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. The UHL maternity service ratio of 1:29.5 births was lower (worse) than this recommendation. The staffing ratio included specialist midwives that held a caseload, of which there were 3.2 WTE trust-wide.
- We held a number of focus groups with staff before the inspection, staffing levels were discussed in these groups. Although staff felt there were gaps in staffing in some areas they generally felt the trust were taking steps to recruit staff. Some staff expressed concern that they perceived there might be cuts to staffing due to the financial position of the trust. Nurses generally felt able to raise concerns if they didn't feel they had enough staff to deliver safe care.

Summary of findings

- The trust had a slightly lower percentage of consultants when compared to the England average. The percentage of junior grade staff was slightly higher than the England average.
- Essential information and guidance was available for all temporary staff including bank, locum and agency staff and there was an induction process in place. We were not always assured that this process had been followed at Leicester Royal Infirmary.

Infection

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

Summary of findings

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

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required.
- Patients with a suspected infection or an EWS of three or more, or those for whom staff or relatives had expressed concern were to be screened for sepsis, a severe infection which spreads in the bloodstream, using an 'Adult Sepsis Screening and Immediate Action Tool'.
- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- During our inspection we reviewed patient observation charts. We found nursing staff did not always adhere to trust guidelines for the completion and escalation of EWS, frequencies of observations were not always appropriately recorded on the observation charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated.
- In the emergency department, he number of patients screened for sepsis throughout June 2016 varied between 86% and 100%, however, the number of patients who received intravenous antibiotics within an hour was variable. Throughout June 2016, there were 13 days where 100% of patients received their intravenous antibiotics within an hour. For the rest of the month between 33% and 78% of patients received their intravenous antibiotics within an hour. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- Following the inspection, we asked the trust to provide more information about their plans to improve performance on the management of deteriorating patients as well as sepsis. The trust had a plan in place to improve their performance and they

Summary of findings

voluntarily offered to report this to us every week. We were satisfied they had adequate plans and governance processes in place to monitor and act on their data and their performance was showing improvement.

- During the week 3-9 October 2016, there were eleven patients with red flag sepsis identified in ED. Of these, 82% of patients received Intra venous antibiotics (IV) antibiotics within an hour, with a mean time of 44 minutes. The trust carried out reviews on patients who did not get their antibiotics within the hour so that any lessons could be identified.

Are services at this trust effective?

Requires improvement

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

Key findings were:

Evidence based care and treatment

- We found patients had their needs assessed and their care was planned and delivered in line with evidence-based, guidance, standards and best practice.
- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection we saw a number of care bundles in place.
- Midwives used a 'fresh eyes' approach for cardio-tocography (CTG) hourly observations. 'Fresh eyes' is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed.
- The trust had a clinical audit and quality improvement plan for 2015 to 2016 which identified 117 audits the service was undertaking and the lead for each audit. In additional to local audits, the trust participated in all the national audits it was eligible to participate in.
- Following the withdrawal of the Liverpool Care Pathway, the trust had introduced individualised care plans for patients on the end of life care pathway. The individualised care plans recognised the five priorities for end of life care according to the Leadership Alliance for the Care of Dying People (2014).

Patient outcomes

Summary of findings

- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) had been below 100 for the past 3 years. Hospital standardised mortality ratios (HSMRs) are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.
- The latest published Summary Hospital-level Mortality Indicator (SHMI) for April 2015 to March 2016 was 99. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The trust rate was as expected.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. From October 2015 to December 2015 SSNAP scored the trust overall at level C, on a scale where level E is the worst possible. The trust varied in performance against individual indicators. The trust's SALT indicator had been rated E from January 2015 to December 2015, while performance against the 'standards by discharge' indicator had been graded A for the same reporting period. Following our inspection we reviewed SSNAP data for the reporting period January to March 2016 which showed the trust's speech and language therapy indicator had improved to a D rating with a trust overall rating maintained at level C.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where medicines are given rapidly to dissolve blood clots in the brain). The trust standard was that all patients admitted following a stroke should be thrombolysed within three hours of admission. For the last 300 patients who had experienced a stroke and were admitted to this trust, 27 were thrombolysed (9%). This was lower than the trust target of 12%. All 27 patients (100%) were thrombolysed within 3 hours.
- The endoscopy unit at Glenfield Hospital was accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. The endoscopy unit at the Leicester Royal Infirmary was "Improvements required," however a further assessment was due in November 2016.
- The trust participated in the Heart Failure Audit. Glenfield Hospital's results in the 2014 Heart Failure Audit were higher than the England and Wales average for five of the 11 standards.

Summary of findings

- The trust performed well in both the 2012/13 and 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audits. MINAP is a national clinical audit of the management of heart attack. In 2013/14, almost 100% of patients who had sustained a non ST elevation myocardial infarction (NSTEMI), also known as a heart attack, were seen by a cardiologist or a member of their team, compared to 94% nationally and 83% were referred for, or had, an angiography, compared to 78% nationally. Angiography is a type of X-ray used to examine blood vessels. In total, 49% of patients experiencing a NSTEMI were admitted to a cardiac unit or ward compared to 56% nationally, this was the only standard to fall below the England national average.
- From January 2016 to May 2016 patients presenting with a NSTEMI waited on average four days to undergo a coronary angiogram, this was in line with NICE guidance CG94: Unstable angina and NSTEMI: early management, who recommend this should occur within 96 hours. A NSTEMI is a type of heart attack caused by a blood clot partly blocking one of the coronary arteries. A coronary angiogram allows the cardiac team to look inside coronary arteries for narrowing or blockage. Special dye is passed into the coronary arteries through a thin flexible tube (catheter) and shows up narrowed areas on an X-ray.
- From August 2015 to May 2016 medical patients at this trust had a higher than expected risk of readmission for non-elective and elective admissions.
- Within the maternity services, the normal birth rate was 61% which was slightly better than the England average of 60%.
- The Leicester Royal Infirmary (LRI) performed worse than the England average for six of the eight measures in the Hip Fracture Audit, 2015. For example, patients admitted to orthopaedic care within four hours was 23.6% compared to the England average of 46.1%. Patients having surgery on the day or day after admission was 60.3% compared to the England average of 72.1%. Following our inspection, we requested the trust's action plan for addressing performance in the hip fracture audit 2015. The plan identified a need for an improvement in the whole hip fracture pathway from admission to discharge. For example to improve patients time to surgery outcomes, (how quickly the patient has their operation), work will concentrate on ensuring patients are optimised (fully prepared and fit) for theatre as soon as possible in the emergency department. Extra theatre lists were planned and a specialist frailty consultant of the day to ensure continuity and access for patients in a timely manner.
- The trust planned to submit details of the implementation plan and the timescale for achieving sustained performance to the

Summary of findings

local clinical commissioning group (CCG) by October 2016. During April/May 2016, the time to theatre target of 72% had been met however, the trust was aware this did not guarantee sustained performance.

- The trust demonstrated good performance in the national bowel cancer audit 2015 and performed better than the England average for three of the six measures. For example, post-operative length of stay 74% compared to the England average of 69% and case ascertainment, (discovery of the disease) 102%% against an England average of 94%.
- The 2014 Lung Cancer Audit found the trust discussed a higher percentage of patients at multidisciplinary team meetings than the England average of 95.6% at 99.6%. The trust also had a higher percentage of patients receiving a CT scan before bronchoscopy at 97.3% compared to the England average of 91.2%. Trust performance therefore met the required 95% standard in both areas.
- On average elective and non-elective patients spent a similar time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from April 2015 to March 2016 was 3.4 days, compared to 3.3 days for England. For non-elective (emergency) patients the average length of stay was 5.1 days, which was equal to the England average.
- The trust was an outlier nationally for the rate of readmissions within 30 days of discharge. This means the trust had more re-admissions within 30 days than the national average. In response, the trust had made a commitment for 2016/17 to reduce readmissions within 30 days to below 8.5%. The trust plans to reduce readmissions included; monitoring readmissions through their governance structure, focussing discharge resources on those patients at a higher risk of readmission and addressing clinical variations in consultant re-admission rates. The new project had been implemented throughout June 2016.
- Results from the patient reported outcome measures (PROMs) between April 2015 and March 2016 for groin hernia, hip replacement, knee replacement and varicose veins were similar to the England average. PROMs are data collected to give a national-level overview of patient improvement after specific operations.
- The Leicester Royal Infirmary (LRI) demonstrated a mixed performance in the national emergency laparotomy audit (2015). The audit rates performance on a red, amber, green

Summary of findings

(RAG) scale, where green is best. A green rating was applied to five out of the eleven indicators. These were for final case ascertainment, documenting risk, arrival to theatre in appropriate timescale, consultant surgeon present in theatre and direct post-operative admission to critical care. The trust scored red against two measures: consultant review within 12 hours of emergency admission and assessment by MCOP (Medicine for Care of the Older Person) specialist.

- At the LRI one surgical site infection had been reported for 2015. A full investigation was carried out however; a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts however, not all categories of surgery are required to be included. The trust reported on surgical site infections where hip and knee replacement surgery had been undertaken.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Within stroke services, MDT meetings took place daily Monday to Friday in addition to a weekly conference call with a local trust that provided rehabilitation services.
- Access to specialist support from for example, diabetes, dietetics, SALT and, learning disability were made through the trust's electronic referral system. Ward nursing staff we spoke with all confirmed this was an easy process and had not experienced any delays in patients being seen.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training were not delivered as part of the mandatory training programme across the trust.
- We found variances in how many staff understood the MCA. Nursing staff we spoke with told us they had not received training on the MCA. Some staff had a basic awareness and understanding of DoLS, but not of the MCA. The MCA is a piece of legislation applying to England and Wales, its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The DoLS is part of the MCA. DoLS aim to make sure that people in care homes,

Summary of findings

hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Anybody under a DoLS application must first have had a mental capacity assessment and be found to lack mental capacity to make a decision with regard to the situation they find themselves in.

- The trust did not audit MCAs or DoLS applications. This meant the trust could not tell us if these assessments were being completed correctly.
- We looked at a number of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. DNACPR orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families, and lack of discussion with the patient.
- The trust routinely reviewed 25 sets of DNACPR records from across the three sites (10 each from the LRI and GGH, 5 from the LGH).This monthly DNACPR audit included compliance with policy and specifically the communication with patients and relatives. Face to face feedback was given to individuals who were found not to have correctly followed policy.

Are services at this trust caring?

Good

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

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

Key findings were:

Compassionate care

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

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

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

o Outpatient services 94% (NHS average 93%)

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

Summary of findings

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

- Across the trust patients privacy and dignity was respected, however there were some areas, particularly at LRI where this was more difficult due to the limitations of the environment. For example, the overcrowding in the Emergency Department meant that staff had no alternative but to care for patients in areas that were not suitable. This was also the case in one of the two ophthalmic outpatient clinics.
- In the maternity service, women and their partners reported they were treated with compassion, dignity and respect.
- Throughout our inspection, we observed members of medical and nursing staff provided compassionate and sensitive care met the needs of babies, children, young people and their parents and carers.

Understanding and involvement of patients and those close to them

- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'University Hospitals of Leicester (UHL) carers charter' was developed in 2015. The carers charter described to carers what they could expect from staff in the trust. This included; identifying carers on the wards, assessing carers needs, ensuring open channels of communication and providing essential information.
- All parents we spoke with felt involved with the decision making of their child's care and felt that everything had been explained to them. However, the view of a parent of a child with a learning disability was they had really motivated play staff but there was no real understanding of complex learning disabilities and how to support parents of those children.

Emotional support

- Chaplaincy services provided spiritual and religious support for patients and relatives and were accessible to staff if required. The chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains.

Summary of findings

- A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss. The bereavement services team produced an information leaflet to assist relatives/carers during the early days of bereavement.
- Patients and staff had access to clinical nurse specialists across many areas. For example, we saw that there were specialist nurses for colorectal, stoma, thoracic, breast care and the acute pain team. Clinical nurse specialists supported patients to manage their own health, care and wellbeing and to maximise their independence.

Are services at this trust responsive?

Requires improvement

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

Key findings were:

Service planning and delivery to meet the needs of local people

- Generally, the services we inspected understood the different needs of the people it served and acted on these to plan, design and deliver services. There was a range of appropriate provision to meet needs and support people to access and receive care as close to their home as possible. For example, the trust provided an outpatient intravenous antibiotic facility for patients receiving long-term antibiotic therapies.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally. For example, Leicester Royal Infirmary (LRI) was the centre for surgery of cancers of the stomach and oesophagus for Leicester, Leicestershire, Northamptonshire and Rutland. It was also one of the two designated NHS centres in the East Midlands providing weight loss surgery.
- Patients aged 17 to 18 years old were offered the choice to see a paediatric or adult consultant. Managers we spoke with were aware that the transition from child to adult services needed developing.

Meeting people's individual needs

- The trust had an interpreting and translation policy. Staff had access to interpreting services for patients who did not speak or

Summary of findings

understand English. The service was provided externally and included the provision of British Sign Language. Staff told us the interpretation service sometimes found it difficult to allocate a translator.

- The trust employed 2.5 full time equivalent acute liaison nurses (ALNs) that provided advice and support to patients admitted to the trust who had a learning disability. In addition to this, a flagging system linked to the Leicestershire Learning disability register alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- During our inspection, we observed a member of staff comforting a patient through the use of pictorial and signing methods. The patient, although unable to communicate, looked upset. The nurse took time to ensure the patient was given appropriate and timely support and information to alleviate their anxieties.
- During our inspection, some patients were fasting for Ramadan. Ward 42 at the Leicester Royal Infirmary was unable to provide hot meals for patients who wished to fast and eat in the evening because they could only heat food during specified meal times. This meant patients who were fasting were unable to have hot food and had to order a snack box. Another patient on Ward 40 had needed to attend an appointment at 5pm; this meant the patient had missed their meal. When they returned to the ward all that could be offered was toast. We discussed this with nursing staff who told us there was no hot food available outside of set meal times and food could not be heated on the ward including that bought in by patients relatives.

Dementia

- The trust had a dementia strategy in place.
- The trust had appointed approximately eight meaningful activity facilitator across the trust. They were able to provide reminisce therapy for patient living with dementia.
- On Ward 23, we met the ward 'meaningful activities co-ordinator'. During our visit a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient, they told us by making it a social event they hoped the patient would eat.
- Monthly monitoring of dementia screening was undertaken as part of the National Dementia Commissioning for Quality and Innovation (CQUIN). The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this means better

Summary of findings

experience, involvement and outcomes. Data for the reporting period January to March 2016 showed 95.8% of patients were screened for dementia. This was better than the 90% target set by the commissioners of the service.

Access and flow

- The outpatient service had a backlog of patients who were waiting for follow-up appointments.
- The trust had a plan in place to address the backlogs and we could see they were reducing.
- Following the inspection the trust told us how this back log was being managed so that the risk to patients was as safe as possible.
- The trust cancelled outpatient appointments more than the England average. Between June 2015 and May 2016, the trust cancelled 30% of ENT appointments, 30% of rheumatology, 25% of eye clinic and 15% of dermatology and gynaecology appointments. Cancelling appointments created patient dissatisfaction, delays and complications with rebooking as well as a need to clinically re-assess the urgency and the patient in some cases.
- Clinics did not always run on time. The trust carried out its own analysis of wait times and the causes of delay and found the eye clinic was particularly prone to delays. The trust developed an action plan to improve waiting times, but when we inspected it was too early to assess its impact.
- Outpatient capacity did not meet demand. ENT, gastroenterology and orthopaedics did not have enough clinic slots to offer to patients. Some specialties did not have enough doctors to offer more clinics. For example, the eye and dermatology specialties were all trying to recruit doctors.
- Diagnostic services helped improve performance on the 62 week cancer pathway target although they acknowledged there was more to be done. They did this by creating extra slots to meet demand and employing two people to take bookings before the patient left the hospital. The gynaecology service offered same day colposcopy appointments if needed. This meant the service could identify cancers and pre-cancers quickly.
- The Department of Health target for emergency departments is to admit, transfer, or discharge 95% of patients within four hours of arrival at accident and emergency. Between July 2014 and February 2015, the department had consistently performed below the standard and was below the England average. The trust had a whole hospital response escalation policy, and gold

Summary of findings

command meetings took place up to four times per day to look at staffing, bed status and escalate any risks that could potentially affect patient safety, such as low staffing and bed capacity issues.

- The emergency department had escalation areas, which were used to provide extra capacity space when the emergency department was crowded. There were five red marked out spaces in the middle of the majors department, an emergency department corridor that could accommodate four trolleys and a bay opposite the EDU, which could hold up to four trolleys or beds. There was an escalation pathway with specific criteria for using the escalation areas.
- A new emergency department was being built on the Leicester Royal Infirmary site. This would significantly increase the capacity of the department. Some staff expressed concern to us that even though they would have more space and modern facilities, the numbers of patients coming through the department would continue to be difficult to manage.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care. Between March 2015 and February 2016 the operational standard of 90% for admitted pathways was met in all but one of the applicable medical specialties (cardiology, dermatology, neurology, rheumatology and thoracic medicine). Gastroenterology was the only specialty to fall below the 90% standard at 89%.
- Diagnostic waiting times are a key part of Referral to Treatment (RTT) waiting times. RTT waiting times measure the patients' full waiting time from GP referral to treatment, which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within six weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks. Since June 2015 the trust had performed worse than the England average, with a higher than average percentage of patients waiting six or more weeks for diagnostics.
- The trust were experiencing an issue with sustainable performance in the 2 week cancer wait. The trust had mitigating actions in place to sustain performance and had improved. Cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.
- During our announced and unannounced visits to this hospital, there was one medical outlier. Medical outliers are where patients are receiving care on a different speciality ward. The

Summary of findings

trust had robust systems in place to monitor medical outliers throughout the trust. There was evidence of a daily medical review and an 'oversight' of the patients' progress including estimated date of discharge, which was held by the senior site manager.

Learning from complaints and concerns

- Leicester Royal Infirmary (LRI). Waiting times and communication were common themes. There were 19 complaints during 2015/16 that were referred to the Parliamentary and Health Service Ombudsman of the 19, four were partially upheld.
- The trust had an independent complaints review panel who reviewed a sample of complaints from a patient's perspective.The panel was held quarterly and provided important external scrutiny on the quality of complaints responses and the complaints handling process.
- Over half of formal complaints to the trust concerned outpatient clinics. We reviewed formal complaints from March 2015 to March 2016, and 58% concerned outpatient clinics across all three hospital sites (457 complaints out of 787).
- Of the outpatient complaints, 56% were about clinics at the Leicester Royal Infirmary. They focused on delays in clinics, cancellations, waiting time and administration of appointments, and communication.

Are services at this trust well-led?

Requires improvement

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

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

Summary of findings

the problems being experienced. The trust saw a constant increase in the number of attendances at A&E. Although there were a number of initiatives in place, there was little evidence that these were having an impact.

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

However:

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

Vision and strategy

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

Summary of findings

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

Governance, risk management and quality measurement

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

Summary of findings

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

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

Summary of findings

expect. Staff told us they felt frustrated that flow through the department affected patient care, as the department was so busy. Medical and nursing staff told us when the department was busy it resulted in patients receiving a poor standard of care, for example medication not being administered, comfort rounds not taking place and patients deteriorating prior to assessment. This suboptimal standard of care had to some extent been normalised and staff did not always report these sorts of harm. Senior leaders told us the problems would be solved once the department moved into its new building where they would have the space and environment to care for the increased numbers of patients they saw. However other staff told us they were concerned that there was too much reliance that this would fix the problems. The challenges faced in the emergency department were not solely because of the numbers of patients and the cramped environment.

- A system wide approach with the whole health and social care community was needed to support the trust to address the increasing attendances in the Emergency Department. Although there were plans in place and different initiatives to address the problems, we saw little evidence that these were making any impact on the numbers of attendances.
- In July 2015, NHS England instructed their regional team to set up A&E Delivery Boards. The board for Leicester, Leicestershire and Rutland was chaired by the trusts Chief Executive. An action plan had been developed and was subject to twice weekly monitoring to ensure the actions were having the desired impact. It was too early to comment what impact this was having on the trusts Emergency Department.
- At our previous unannounced inspection in November 2015, we found patients were at risk of avoidable harm because staff were failing to ensure all patients received adequate care and treatment in accordance with the trust's sepsis pathway. We warned the trust and placed conditions on the trust's registration, which meant the trust had to ensure there was an effective system in place to deliver sepsis management, in line with relevant national clinical guidelines. In addition, there was a requirement for the trust to report to the Care Quality Commission (CQC) describing the actions taken and how the clinical outcomes were being audited, monitored and acted upon on a weekly basis. The weekly reports indicated the trust was making some progress in the management of patients presenting to the emergency department with sepsis. However, at the time of the inspection, not all patients were getting treatment in accordance with national guidance.

Leadership of the trust

Summary of findings

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

Summary of findings

risks of the trust. We were told by several leaders in the organisation that they felt the non-executive directors were very engaged and were taking steps to ensure they were fully informed by attending the different trust Board committees.

- The executives told us that relationships between the trust executive team and other organisations such as the Clinical Commissioning Group and the local authority were said to have improved under the current leadership. We spoke with commissioners before our inspection and they echoed this.

Culture within the trust

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

Fit and Proper Persons

Summary of findings

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

Public engagement

- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations
- The trust had a patient experience committee and a patient and public involvement strategy. All of the clinical management groups had PPI leads (usually the heads of nursing). They reported monthly to the patient experience committee on patient equity, patient experience and patient engagement.
- The patient engagement team told us they felt the executive leaders in the trust were committed to patient engagement.
- The trust had a patient involvement, patient experience and equality assurance committee (PIPEEAC) and a patient and public involvement (PPI) strategy.
- All of the clinical management groups had PPI leads (usually the heads of nursing). They reported monthly to the PIPEEAC on service equality, patient experience and patient involvement.The patient and public engagement team told us they felt the executive leaders in the trust were committed to patient/ public engagement. The trust had "Patient Partners" who are members of the public that provide a lay perspective. Patient Partners were attached to all of the Trust's CMGS and

Summary of findings

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

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

Summary of findings

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

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

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

o Outpatient services 94% (NHS average 93%)

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

Staff engagement

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

Innovation, improvement and sustainability

Summary of findings

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

Summary of findings

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

Overview of ratings

Our ratings for University Hospitals of Leicester NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

Leicester General Hospital

- A new computerised individualised dosing system was in operation on the renal wards.
- New Starters in nephrology had a 12-week supernumerary period within the ward area and a bespoke Professional Development Programme. Included within the development programme was; trust behaviours, early warning score (EWS), infection prevention control, planning / evaluating care, managing pain, care of the dying patient and equipment training. Templates were also included to assist registered nurses in their revalidation process.
- An MDT meeting took place weekly on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals (physiotherapy, occupational therapy and speech and language therapy), medical and nursing staff and a neurological psychologist. The patient and relevant family member would also be present at this meeting where a patient's individual rehabilitation goals would be discussed and reviewed.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- On ward 1, a flexible appointment service was offered for patients. In order to help patients who had other personal commitments, for example work commitments, staff would work flexibly sometimes starting an hour earlier in the day to enable the patient to receive their care at a time and place to meet their needs.
- The development of a pancreatic cancer application to support patients at home with diagnosis and treatment. This will potentially assist patients and family members face the diagnosis and treatment once they have left the hospital.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified obstetric early warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The risk assessment booklet also included a range of risk assessments. This meant that all assessment records were bound together.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Glenfield Hospital

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- A range of medicines to manage Parkinson's disease was available on the clinical decisions unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.
- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.

Outstanding practice and areas for improvement

- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24 hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.
- A 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, and body language and physical changes to help determine level of patient comfort.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015.

Areas for improvement

Action the trust MUST take to improve

Trust wide

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

Urgent & emergency services

- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department. **This also applies to medical areas.**
- The trust must take action to ensure standards of cleanliness and hygiene are maintained at all times to prevent and protect people from a healthcare-associated infection. **This also applies to medical areas and outpatient and diagnostic areas.**
- The trust must ensure that patient in the emergency department who wait in for longer than 8 hours have a VTE risk assessment and appropriate thromboprophlaxis prescribed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

Medicine

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

Surgery

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

Critical Care

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

Maternity and gynaecology

Outstanding practice and areas for improvement

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the maternity and gynaecology service.
- The trust must ensure that midwives have the necessary training in the care of the critically ill woman, anaesthetic recovery and instrument/scrub practitioner line with current recommendations.
- The trust must address the backlog in the gynaecology administration department so that it does not impact patient safety.

Services for children and young people

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

End of life care

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

Outpatients & Diagnostic Imaging

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (2)(a)** Service users must be treated with dignity and respect, ensuring the privacy of the service user. **How the regulation was not being met:** • The trust did not ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department. There were five red bays in the middle of the majors area on which patients requiring a trolley waited until a bay became available. There were no screens to afford the privacy of patients with male and female patients being located in very

This section is primarily information for the provider

Requirement notices

close proximity next to each other. In addition, the way the trolleys were positioned meant these patients were facing the bay opposite them and this compromised the privacy of the patient in the corresponding bay.

- Within the assessment area of the emergency department, we observed overcrowding with patients waiting on marked out red bays whilst they waited for an assessment cubicle to become available. We observed patients being transferred from ambulance trolleys to hospital trolleys. This was done in view of other patients with no screens in place to afford the privacy and dignity of the person being transferred.
- The privacy of patients was not ensured in changing area D at Leicester General Hospital in diagnostic imaging, which was shared between male and female patients.
- The lack of patient gowns at Leicester General Hospital in the computerised tomography (CT) waiting/changing room at Leicester General Hospital compromised patients' privacy and dignity. It was difficult for patients to tie up the backs of their gowns. There were insufficient gowns for patients to be routinely offered one to use as a dressing gown to cover gaps at the back.
- Not all patient tests were carried out in private surroundings, this compromised patients privacy.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1)** When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. **How the regulation was not being met:** • The provider must ensure that appropriate systems and training are in place to ensure that Consent forms are completed appropriately for patients who lacked capacity and were made in line with the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2)(a)** Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. **How the regulation was not being met:** • There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients. Nursing staff did not consistently adhere to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always document a clear plan of treatment if a patient's condition had deteriorated. • Where patients had met the trust criteria for sepsis screening, they were not all screened in accordance with national guidance. • The trust's sepsis protocol was not embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration. • Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments reviewed after 24 hours. patients requiring admission who waited in the ED for longer that 8 hours did not always have a VTE risk assessment and or appropriate thromboprophlaxis prescribed. **Regulation 12 (2)(c)** Care and treatment must be provided in a safe way for service users by ensuring that person providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. **How the regulation was not being met:** • Midwives did not have the necessary training in the care of the critically ill woman and anaesthetic recovery in line with current recommendations.

This section is primarily information for the provider

Requirement notices

- Nursing staff were providing care to high dependency children and young people without having qualified in speciality (QIS) training or having completed a High Dependency Unit training module.
- Staff caring for patients after a never event had no formal training in the use of the documentation designed to reduce the risks to patients suffering delirium.
- Staff had a limited understanding of what was a reportable incident and were not consistently reporting patient safety concerns in a timely manner. There had been a delay in the timely reporting of a recent never event.

Regulation 12 (2)(d)

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

How the regulation was not being met:

- The waiting environment for ophthalmic patients and eye casualty was overcrowded. Patients were standing or sat on the floor because all the seats were occupied. There were six patients sitting in wheelchairs along the corridor which reduced the corridor access.
- Control of substances hazardous to health materials were stored in unlocked cupboards.

Regulation 12 (2)(e) Care and treatment must be provided in a safe way for service users ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way

How the regulation was not being met:

- There were insufficient numbers of suitable syringe drivers with accepted safety features available to ensure patients would receive safe care and treatment.

Regulation 12 (2)(g)

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users by ensuring the proper and safe management of medicines.

How the regulation was not being met:

- Medicines were not always kept securely. They were stored in unlocked cabinets or in fridges with unreliable temperature control.
- Hazardous materials and liquid nitrogen were stored in unlocked cupboards.
- At Glenfield Hospital, one locked cupboard in Clinic B, the asthma clinic, contained FP10 prescriptions but there was no audit trail for their use.

Regulation 12 (2)(h)

Care and treatment must be provided in a safe way for service users by assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

How the regulation was not being met:

- Staff were not consistent in isolating patients at risk of spreading infection to others. On Wards 16, 23, 24, 31, 42 and 43 we saw doors left open to side rooms where it had been identified patients might present an infection control risk to others.
- Hand hygiene audits across 20 clinical areas were worse than the trust's target of 90%.
- Staff were not consistent in adhering to the trust's infection prevention control policy including adhering to the dress code, which was to be 'bare below elbows'.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(1)(2)** Safeguarding service users from abuse and improper treatment **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

- There were no effective systems and processes in place to protect children and young people on Ward 27 from abuse and harm. The admission criterion for Ward 27 allowed children and young people age 13 to 24 years old to share the same social space, unsupervised.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15(1)(a)** Premises and equipment **How the regulation was not being met** • Systems and processes to prevent and control the spread of infection were not operated effectively and in line with trust policies, current legislation and best practice guidance. • There were a number of toilets in the emergency department which were not clean. In the outpatient department clean areas were not always respected and some areas were dusty and not clean. There were no cleaning schedules on display and no evidence to suggest that equipment was clean and ready for use. **Regulation 15 (1) (e)** All premised and equipment used by the service provider must be properly maintained. **How the regulation was not being met:** • At Leicester General Hospital five items had not been safety tested by the required date. In outpatients three, a defibrillator had not been safety tested on its due date in April 2016. A sphygmomanometer, a thermometer and two urilisers (diagnostic apparatus) had not been safety tested by the required date. • At Leicester General Hospital there was a roof leak by the diagnostic imaging reception area. A container was in place to catch the water and stop the floor getting slippery for both patients and staff.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1)(a)** Good governance Systems or processes must be established and operated effectively to ensure the quality and safety of the services provided are assessed, monitored and improved. **How the regulation was not being met:** • The service had failed to prioritise some patients with urgent needs who were waiting for follow-up appointments. The eye speciality had a backlog of 964 patients needing follow up from 2015/2016 and 1706 patients from 2014/2015. • Some outpatient clinics did not treat patients in a timely way. In May 2016 four patients across three specialities waited for treatment for more than 52 weeks. • Patients did not always have timely access to initial assessment, diagnosis or urgent treatment. Diagnostic imaging had backlogs of patients waiting for their scan to be authorised. In May 2016, there were 1012 magnetic resonance imaging patients, 655 computerised tomography scan patients and 139 ultrasound scan patients. In each of these groups, nine patients should have been seen within two weeks. • The service did not consistently prioritise care and treatment for people with the most urgent needs. In April 2016, the trust did not achieve the nationally reported target for a two-week wait for 93% of suspected cancer patients with an urgent GP referral, achieving 91% instead.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1)** **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.** **How the regulation was not being met:** • The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units. • Midwifery staffing ratios did not meet current recommendations or minimum acceptable levels. One to one care in labour was not always provided. • Consultant obstetric cover in the delivery suite was 82 hours a week which did not meet the Royal College of Obstetrics and Gynaecology recommendation of 168 hours a week for a unit of this size. • At Leicester General Hospital in maternity and gynaecology services the lack of junior doctors, especially out of hours, led to delays in patient reviews which could pose a risk to patient safety. • Medical staffing in the children's and young people's service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants. • Neonatal staffing on the neonatal unit did not meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved. • Training shortfalls existed in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance.

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

This section is primarily information for the provider

Requirement notices

Regulation 5 (3) (a)

The individual is of good character,

How the regulation was not being met:

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. On 4 December 2015, following an unannounced inspection to the emergency department at the Leicester Royal Infirmary, we exercised our powers under section 31 of the Health and Social Care Act 2008 to impose conditions on the trust's registration because we believed that patients in receipt of care in the emergency department at the Leicester Royal Infirmary were or may be exposed to the risk of harm if we did not impose these Conditions urgently. The trust failed to demonstrate that it had an effective system in place so to ensure: • An appropriate skill mix to provide a safe standard of care to patients who require care and treatment within the emergency department at the Leicester Royal Infirmary. • Patients received an appropriate clinical assessment by appropriately qualified clinical staff within 15 minutes of presentation to the ED at the Leicester Royal Infirmary in line with best practice, • Patients received care and treatment in accordance with the trust's sepsis clinical pathway. Following our inspection of the Leicester Royal Infirmary, the section 31 HSCA Urgent procedure for suspension, variation etc. remains in place.

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

#hello my name is…

Julie Smith, Chief Nurse
Sharron Hotson, Director of Clinical Quality

CQC Inspection

One team shared values

University Hospitals of Leicester NHS Trust

Caring at its best

The CQC Inspection

- The inspection took place on the 20th to the 23rd June 2016 and covered seven of the eight core services:
  - Urgent and emergency services (A&E)
  - Medical care (including older people's care)
  - Surgery
  - Maternity and gynaecology
  - Services for children and young people
  - End of life care
  - Outpatient services and diagnostic imaging

- Due to CQC inspector availability, critical care was inspected on the 25th to the 27th July 2016

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

The CQC Inspection

- Prior to the inspection, the CQC were provided with over 2,000 items of documentation covering each of the eight core services

- This documentation informed a series of CQC Intelligence Packs (one for each core service and one at trust level), which were used by the CQC to help direct their lines of inquiry during their inspection

University Hospitals of Leicester NHS Trust

Caring at its best

The CQC Inspection

- Before their inspection the CQC approached other organisations to share what they know about the UHL, this included:
  - The Clinical Commissioning Groups (CCGs)
  - NHS Improvement
  - NHS England
  - Health Education England (HEE)
  - General Medical Council (GMC)
  - Nursing and Midwifery Council (NMC)
  - Royal College of Nursing
  - Leicester Mercury Patients' Panel
  - Healthwatch Leicester

University Hospitals of Leicester NHS Trust

Caring at its best

The CQC Inspection

- The CQC held a number of staff focus group, covering a range of staff disciplines across the three UHL sites, as well as interviewing members of the senior executive team and Trust Board

- Throughout the inspection and beyond, the CQC continued to request additional information and documentation, with over 600 separate requests received

University Hospitals of Leicester NHS Trust

Caring at its best

CQC ratings

- On Thursday 26 January, the CQC published their final reports along with their ratings of the care provided
- The CQC rated the Trust overall, as '**Requires Improvement**'
- The Leicester Royal Infirmary, the General and Glenfield Hospitals were all individually as '**Requires Improvement**'
- Of the 100 ratings (for each domain of each core service):
  - 1 is Outstanding (for the effectiveness of our East Midlands Congenital Heart service at Glenfield)
  - 55 are Good
  - 41 are Requires Improvement
  - 1 is Inadequate (the Responsive domain of emergency care at the Royal)
  - Two elements were unrated for technical reasons

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

CQC ratings

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

	Medical Care	Surgery	Intensive / Critical Care	Maternity & Gynaecology	Services for children & Young People	End of Life Care	Outpatients & diagnostic Imaging	Overall
Leicester Royal Infirmary	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

	Medical Care	Surgery	Intensive / Critical Care	Maternity & Gynaecology	End of Life Care	Outpatients & diagnostic Imaging	Overall
Leicester General Hospital	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

	Medical Care	Surgery	Intensive / Critical Care	Services for children & Young People	End of Life Care	Outpatients & diagnostic Imaging	Overall
Glenfield Hospital	Good	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement

One team shared values

University Hospitals of Leicester NHS Trust

Caring at its best

CQC findings

"The rating we gave the trust in this inspection was the same rating as they were awarded in the 2014 comprehensive inspection. However, we did find improvements had been made, particularly in staff engagement. Confidence in the leadership team had been sustained."

University Hospitals of Leicester NHS Trust

Caring at its best

CQC findings

- Many staff commented on the positive culture change in the Trust under the current Chief Executives leadership
- The Trust is led by a respected board
- The Executive staff are much respected and staff had confidence in their leadership
- The Trusts vision and values are generally embedded into practice
- The Trust has a five year plan and a vision and strategy and most of the staff spoken to knew about this

University Hospitals of Leicester NHS Trust

Caring at its best

CQC findings

- Since the inspection in June 2016 a number of improvements have been made and some concluded
- We will be providing evidence of this and ongoing actions to the CQC as required
- At the time of inspection, the Trust had a Section 31 condition in place following the unannounced CQC inspection of the Emergency Department in November 2015
- Sufficient evidence of improvement has been provided to the CQC to enable the lifting of this condition on the 15 November 2016

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Outstanding practice and areas for improvement

- Children & Young People (Glenfield) – Outstanding for effective
- Caring – good throughout all three hospitals
- Challenges around the emergency pathway
- Care of the deteriorating patient – robust plans in place
- Challenges around our Estate

University Hospitals of Leicester NHS Trust

Caring at its best

Quality Summit

- Took place on 28th March 2017
- Attended by representatives from UHL, the CQC and a range of stakeholder organisations
- Comprehensive action plan to address Compliance Actions agreed and will be closely monitored

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Conclusions

- We are an organisation which is:
  - Improving quality systematically
  - Dealing with substantial increases in demand
  - Working better with our partners
  - Tackling longstanding strategic issues
  - Building a more empowered culture
  - Staffed by very committed people

- It is our ambition to achieve ‘Good’ for all services at all three sites

Care Quality Commission

University Hospitals of Leicester NHS Trust

Quality Report

Infirmary Square,
Leicester,
Leicestershire,
LE1 5WW
Tel: 03000 303 1573
Website: www.leicestershirehospitals.nhs.uk

Date of inspection visit: 20 - 23 June
Date of publication: This is auto-populated when the report is published

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

Our key findings were as follows:

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

Summary of findings

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

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

We saw several areas of outstanding practice including:

Leicester Royal Infirmary

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- A range of medicines to manage Parkinson's disease was available on the Clinical Decisions Unit (CDU) at the Glenfield Hospital. These medicines are time

Summary of findings

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

- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.
- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities facilitator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24-hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.
- The trust had introduced a non-religious carer to provide pastoral support in times of crisis to those patients who do not hold a particular religious affiliation .Also to provide non-religious pastoral and spiritual care to family and staff.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The maternity inpatient risk assessment booklet also included a situation, background, assessment, recommendation (SBAR) tool, a sepsis screening tool, a venous thromboembolism (VTE) assessment tool which also had a body mass index chart, a peripheral intravenous cannula care bundle, a urinary catheter care pathway and assessment tools for nutrition, manual handling and a pressure ulcer risk score. This meant that all assessment records were bound together.

- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.
- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24 hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.

Leicester General Hospital

- A new computerised individualised dosing system was in operation on the renal wards.
- New Starters in nephrology had a 12-week supernumerary period within the ward area and a bespoke Professional Development Programme. Included within the development programme was; trust behaviours, early warning score (EWS), infection prevention control, planning / evaluating care, managing pain, care of the dying patient and equipment training. Templates were also included to assist registered nurses in their revalidation process.
- An MDT meeting took place weekly on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals (physiotherapy, occupational therapy and speech and language therapy), medical and nursing staff and a neurological psychologist. The patient and relevant family member would also be present at this meeting where a patient's individual rehabilitation goals would be discussed and reviewed.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- On ward 1, a flexible appointment service was offered for patients. In order to help patients who had other personal commitments, for example work

Summary of findings

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

- The development of a pancreatic cancer application to support patients at home with diagnosis and treatment. This will potentially assist patients and family members face the diagnosis and treatment once they have left the hospital.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified obstetric early warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The risk assessment booklet also included a range of risk assessments. This meant that all assessment records were bound together.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Glenfield Hospital

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- A range of medicines to manage Parkinson's disease was available on the clinical decisions unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.
- A 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, and body language and physical changes to help determine level of patient comfort.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Trust wide

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

Urgent & emergency services

- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department. **This also applies to medical areas.**
- The trust must take action to ensure standards of cleanliness and hygiene are maintained at all times to prevent and protect people from a healthcare-associated infection. **This also applies to medical areas and outpatient and diagnostic areas.**
- The trust must ensure patients requiring admission who wait in the ED for longer that 8 hours have a VTE risk assessment and appropriate thromboprophlaxis prescribed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

Summary of findings

Medicine

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

Surgery

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

Critical Care

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

Maternity and gynaecology

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the maternity and gynaecology service.
- The trust must ensure that midwives have the necessary training in the care of the critically ill woman, anaesthetic recovery and instrument/scrub practitioner line with current recommendations.
- The trust must address the backlog in the gynaecology administration department so that it does not impact patient safety.

Services for children and young people

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

End of life care

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

Outpatients & Diagnostic Imaging

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

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust specialist and acute services to a population of one million patients throughout Leicester, Leicestershire and Rutland. There are three main hospital locations; Leicester Royal Infirmary, Leicester General Hospital and The Glenfield Hospital. Glenfield Hospital has a heart centre which provides specialist heart surgery for patients across the East Midlands. The trust has 1,784 inpatient beds and 175 day-case beds. It is one of the biggest acute NHS trusts in England.

We inspected the trust in 2014 under our new inspection methodology and rated it as "Requiring Improvement". During this inspection we followed up on the identified areas that required improvement from the 2014 inspection. We looked at a wide range of data, including patient and staff surveys, hospital performance information and the views of local partner organisations. The inspection teams visited all three hospital locations.

Leicester, Leicestershire and Rutland have a population of approximately 1.03 million, with 32% of people living in the city, 64% in Leicestershire and 4% living in Rutland. The three areas have significant differences. The city of Leicester has a younger population and the county areas are older. The city of Leicester is an ethnically diverse population with over 37% of people being of Asian origin.

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

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

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

How we carried out this inspection

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

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

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

Summary of findings

Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

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

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

What people who use the trust's services say

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

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

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

o Outpatient services 94% (NHS average 93%)

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

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

Facts and data about this trust

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,771 inpatient beds and 176 day-case beds. 937 inpatient beds and 85 day-case beds are located at Leicester Royal Infirmary.

University Hospitals of Leicester NHS Trust provide specialist and acute services to a population of one million patients throughout Leicester, Leicestershire and Rutland. There were 149,806 inpatient admissions, 993,617 outpatient attendances and 135,111 emergency department attendances between April 2015 and March 2016.

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

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

Summary of findings

Our judgements about each of our five key questions

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

Key findings were:

Duty of Candour

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

Safeguarding

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

Summary of findings

- Arrangements were in place to safeguard women or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. Mandatory safeguarding training for both midwives and doctors covered child sexual exploitation, modern day slavery and honour based violence.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- Without exception we found staff knew how to report incidents through the trusts electronic incident reporting system.
- The trust report approximately 27,000 incidents every year. We were told the patient safety team reviewed all cases graded as moderate or above. A decision on whether the incident qualified as a serious incident was made by the Director of Safety and Risk with input from the Medical Director and Chief Nurse.
- We received a mixed picture regarding staff receiving feedback from incidents. Some areas were able to tell us they received feedback and learning through email, staff meetings, board 'huddles' and, during handovers. Whereas in some areas, staff did not feel they received feedback.
- In some areas we inspected we were able to find evidence of changes that had been introduced as a result of learning from incidents.
- The trust had an array of techniques to communicate and embed learning. These included bulletins and the use of the East Midlands Learning Network to spread and absorb lessons, utilising incidents in clinical education and using clinical simulations.

Staffing

- Nurse staffing levels were displayed in all the clinical areas we visited and information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were 'gaps' in staffing, bank and agency staff had been requested.
- Across UHL since September 2014 all clinical areas had collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for

Summary of findings

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

- The Trust used recognised tools to assess the level of nursing staff and skill mix required. The Chief Nurse was sighted on nursing risks and wards which were alerting as requiring more support. There were some areas where the actual staffing fell below the planned staffing levels. Recruitment to vacancies was in process and staff were able to utilise bank and agency staff to fill the staffing.
- We found differences in staffing levels on the three sites. Generally, staffing levels across the trust were sufficient to deliver safe care. There were some wards where there were more vacancies but recruitment was underway.
- Neonatal staffing at the Leicester Royal Infirmary (LRI) neonatal unit did not fully meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM) because they were unable to provide one nurse to one baby care in the intensive care unit for all babies. Information provided by the trust stated this was due to staff vacancies, sickness and maternity leave. Funding was available to recruit a further 11 WTE staff and there was an active recruitment campaign.
- The maternity department used an acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015.
- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. The UHL maternity service ratio of 1:29.5 births was lower (worse) than this recommendation. The staffing ratio included specialist midwives that held a caseload, of which there were 3.2 WTE trust-wide.
- We held a number of focus groups with staff before the inspection, staffing levels were discussed in these groups. Although staff felt there were gaps in staffing in some areas they generally felt the trust were taking steps to recruit staff. Some staff expressed concern that they perceived there might be cuts to staffing due to the financial position of the trust. Nurses generally felt able to raise concerns if they didn't feel they had enough staff to deliver safe care.

Summary of findings

- The trust had a slightly lower percentage of consultants when compared to the England average. The percentage of junior grade staff was slightly higher than the England average.
- Essential information and guidance was available for all temporary staff including bank, locum and agency staff and there was an induction process in place. We were not always assured that this process had been followed at Leicester Royal Infirmary.

Infection

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

Summary of findings

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

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required.
- Patients with a suspected infection or an EWS of three or more, or those for whom staff or relatives had expressed concern were to be screened for sepsis, a severe infection which spreads in the bloodstream, using an 'Adult Sepsis Screening and Immediate Action Tool'.
- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- During our inspection we reviewed patient observation charts. We found nursing staff did not always adhere to trust guidelines for the completion and escalation of EWS, frequencies of observations were not always appropriately recorded on the observation charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated.
- In the emergency department, he number of patients screened for sepsis throughout June 2016 varied between 86% and 100%, however, the number of patients who received intravenous antibiotics within an hour was variable. Throughout June 2016, there were 13 days where 100% of patients received their intravenous antibiotics within an hour. For the rest of the month between 33% and 78% of patients received their intravenous antibiotics within an hour. This meant there were times when patients did not receive their intravenous antibiotics within an hour and this increased their risk of harm and increased the possibility of death.
- Following the inspection, we asked the trust to provide more information about their plans to improve performance on the management of deteriorating patients as well as sepsis. The trust had a plan in place to improve their performance and they

Summary of findings

voluntarily offered to report this to us every week. We were satisfied they had adequate plans and governance processes in place to monitor and act on their data and their performance was showing improvement.

- During the week 3-9 October 2016, there were eleven patients with red flag sepsis identified in ED. Of these, 82% of patients received Intra venous antibiotics (IV) antibiotics within an hour, with a mean time of 44 minutes. The trust carried out reviews on patients who did not get their antibiotics within the hour so that any lessons could be identified.

Are services at this trust effective?

Requires improvement

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

Key findings were:

Evidence based care and treatment

- We found patients had their needs assessed and their care was planned and delivered in line with evidence-based, guidance, standards and best practice.
- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection we saw a number of care bundles in place.
- Midwives used a 'fresh eyes' approach for cardio-tocography (CTG) hourly observations. 'Fresh eyes' is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed.
- The trust had a clinical audit and quality improvement plan for 2015 to 2016 which identified 117 audits the service was undertaking and the lead for each audit. In additional to local audits, the trust participated in all the national audits it was eligible to participate in.
- Following the withdrawal of the Liverpool Care Pathway, the trust had introduced individualised care plans for patients on the end of life care pathway. The individualised care plans recognised the five priorities for end of life care according to the Leadership Alliance for the Care of Dying People (2014).

Patient outcomes

Summary of findings

- The trust's 'rolling 12 month' Hospital Standardised Mortality Ratio (HSMR) had been below 100 for the past 3 years. Hospital standardised mortality ratios (HSMRs) are intended as an overall measure of deaths in hospital. High ratios of greater than 100 may suggest potential problems with quality of care.
- The latest published Summary Hospital-level Mortality Indicator (SHMI) for April 2015 to March 2016 was 99. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The trust rate was as expected.
- The trust submitted data to the sentinel stroke national audit programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. From October 2015 to December 2015 SSNAP scored the trust overall at level C, on a scale where level E is the worst possible. The trust varied in performance against individual indicators. The trust's SALT indicator had been rated E from January 2015 to December 2015, while performance against the 'standards by discharge' indicator had been graded A for the same reporting period. Following our inspection we reviewed SSNAP data for the reporting period January to March 2016 which showed the trust's speech and language therapy indicator had improved to a D rating with a trust overall rating maintained at level C.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where medicines are given rapidly to dissolve blood clots in the brain). The trust standard was that all patients admitted following a stroke should be thrombolysed within three hours of admission. For the last 300 patients who had experienced a stroke and were admitted to this trust, 27 were thrombolysed (9%). This was lower than the trust target of 12%. All 27 patients (100%) were thrombolysed within 3 hours.
- The endoscopy unit at Glenfield Hospital was accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. The endoscopy unit at the Leicester Royal Infirmary was "Improvements required," however a further assessment was due in November 2016.
- The trust participated in the Heart Failure Audit. Glenfield Hospital's results in the 2014 Heart Failure Audit were higher than the England and Wales average for five of the 11 standards.

Summary of findings

- The trust performed well in both the 2012/13 and 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audits. MINAP is a national clinical audit of the management of heart attack. In 2013/14, almost 100% of patients who had sustained a non ST elevation myocardial infarction (NSTEMI), also known as a heart attack, were seen by a cardiologist or a member of their team, compared to 94% nationally and 83% were referred for, or had, an angiography, compared to 78% nationally. Angiography is a type of X-ray used to examine blood vessels. In total, 49% of patients experiencing a NSTEMI were admitted to a cardiac unit or ward compared to 56% nationally, this was the only standard to fall below the England national average.
- From January 2016 to May 2016 patients presenting with a NSTEMI waited on average four days to undergo a coronary angiogram, this was in line with NICE guidance CG94: Unstable angina and NSTEMI: early management, who recommend this should occur within 96 hours. A NSTEMI is a type of heart attack caused by a blood clot partly blocking one of the coronary arteries. A coronary angiogram allows the cardiac team to look inside coronary arteries for narrowing or blockage. Special dye is passed into the coronary arteries through a thin flexible tube (catheter) and shows up narrowed areas on an X-ray.
- From August 2015 to May 2016 medical patients at this trust had a higher than expected risk of readmission for non-elective and elective admissions.
- Within the maternity services, the normal birth rate was 61% which was slightly better than the England average of 60%.
- The Leicester Royal Infirmary (LRI) performed worse than the England average for six of the eight measures in the Hip Fracture Audit, 2015. For example, patients admitted to orthopaedic care within four hours was 23.6% compared to the England average of 46.1%. Patients having surgery on the day or day after admission was 60.3% compared to the England average of 72.1%. Following our inspection, we requested the trust's action plan for addressing performance in the hip fracture audit 2015. The plan identified a need for an improvement in the whole hip fracture pathway from admission to discharge. For example to improve patients time to surgery outcomes, (how quickly the patient has their operation), work will concentrate on ensuring patients are optimised (fully prepared and fit) for theatre as soon as possible in the emergency department. Extra theatre lists were planned and a specialist frailty consultant of the day to ensure continuity and access for patients in a timely manner.
- The trust planned to submit details of the implementation plan and the timescale for achieving sustained performance to the

Summary of findings

local clinical commissioning group (CCG) by October 2016. During April/May 2016, the time to theatre target of 72% had been met however, the trust was aware this did not guarantee sustained performance.

- The trust demonstrated good performance in the national bowel cancer audit 2015 and performed better than the England average for three of the six measures. For example, post-operative length of stay 74% compared to the England average of 69% and case ascertainment, (discovery of the disease) 102%% against an England average of 94%.
- The 2014 Lung Cancer Audit found the trust discussed a higher percentage of patients at multidisciplinary team meetings than the England average of 95.6% at 99.6%. The trust also had a higher percentage of patients receiving a CT scan before bronchoscopy at 97.3% compared to the England average of 91.2%. Trust performance therefore met the required 95% standard in both areas.
- On average elective and non-elective patients spent a similar time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from April 2015 to March 2016 was 3.4 days, compared to 3.3 days for England. For non-elective (emergency) patients the average length of stay was 5.1 days, which was equal to the England average.
- The trust was an outlier nationally for the rate of readmissions within 30 days of discharge. This means the trust had more re-admissions within 30 days than the national average. In response, the trust had made a commitment for 2016/17 to reduce readmissions within 30 days to below 8.5%. The trust plans to reduce readmissions included; monitoring readmissions through their governance structure, focussing discharge resources on those patients at a higher risk of readmission and addressing clinical variations in consultant re-admission rates. The new project had been implemented throughout June 2016.
- Results from the patient reported outcome measures (PROMs) between April 2015 and March 2016 for groin hernia, hip replacement, knee replacement and varicose veins were similar to the England average. PROMs are data collected to give a national-level overview of patient improvement after specific operations.
- The Leicester Royal Infirmary (LRI) demonstrated a mixed performance in the national emergency laparotomy audit (2015). The audit rates performance on a red, amber, green

Summary of findings

(RAG) scale, where green is best. A green rating was applied to five out of the eleven indicators. These were for final case ascertainment, documenting risk, arrival to theatre in appropriate timescale, consultant surgeon present in theatre and direct post-operative admission to critical care. The trust scored red against two measures: consultant review within 12 hours of emergency admission and assessment by MCOP (Medicine for Care of the Older Person) specialist.

- At the LRI one surgical site infection had been reported for 2015. A full investigation was carried out however; a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts however, not all categories of surgery are required to be included. The trust reported on surgical site infections where hip and knee replacement surgery had been undertaken.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient care and treatment; with involvement from general nurses, medical staff, allied health professionals (AHPs) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Within stroke services, MDT meetings took place daily Monday to Friday in addition to a weekly conference call with a local trust that provided rehabilitation services.
- Access to specialist support from for example, diabetes, dietetics, SALT and, learning disability were made through the trust's electronic referral system. Ward nursing staff we spoke with all confirmed this was an easy process and had not experienced any delays in patients being seen.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training were not delivered as part of the mandatory training programme across the trust.
- We found variances in how many staff understood the MCA. Nursing staff we spoke with told us they had not received training on the MCA. Some staff had a basic awareness and understanding of DoLS, but not of the MCA. The MCA is a piece of legislation applying to England and Wales, its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The DoLS is part of the MCA. DoLS aim to make sure that people in care homes,

Summary of findings

hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Anybody under a DoLS application must first have had a mental capacity assessment and be found to lack mental capacity to make a decision with regard to the situation they find themselves in.

- The trust did not audit MCAs or DoLS applications. This meant the trust could not tell us if these assessments were being completed correctly.
- We looked at a number of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. DNACPR orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families, and lack of discussion with the patient.
- The trust routinely reviewed 25 sets of DNACPR records from across the three sites (10 each from the LRI and GGH, 5 from the LGH).This monthly DNACPR audit included compliance with policy and specifically the communication with patients and relatives. Face to face feedback was given to individuals who were found not to have correctly followed policy.

Are services at this trust caring?

Good

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

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

Key findings were:

Compassionate care

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

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

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

o Outpatient services 94% (NHS average 93%)

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

Summary of findings

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

- Across the trust patients privacy and dignity was respected, however there were some areas, particularly at LRI where this was more difficult due to the limitations of the environment. For example, the overcrowding in the Emergency Department meant that staff had no alternative but to care for patients in areas that were not suitable. This was also the case in one of the two ophthalmic outpatient clinics.
- In the maternity service, women and their partners reported they were treated with compassion, dignity and respect.
- Throughout our inspection, we observed members of medical and nursing staff provided compassionate and sensitive care met the needs of babies, children, young people and their parents and carers.

Understanding and involvement of patients and those close to them

- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'University Hospitals of Leicester (UHL) carers charter' was developed in 2015. The carers charter described to carers what they could expect from staff in the trust. This included; identifying carers on the wards, assessing carers needs, ensuring open channels of communication and providing essential information.
- All parents we spoke with felt involved with the decision making of their child's care and felt that everything had been explained to them. However, the view of a parent of a child with a learning disability was they had really motivated play staff but there was no real understanding of complex learning disabilities and how to support parents of those children.

Emotional support

- Chaplaincy services provided spiritual and religious support for patients and relatives and were accessible to staff if required. The chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains.

Summary of findings

- A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss. The bereavement services team produced an information leaflet to assist relatives/carers during the early days of bereavement.
- Patients and staff had access to clinical nurse specialists across many areas. For example, we saw that there were specialist nurses for colorectal, stoma, thoracic, breast care and the acute pain team. Clinical nurse specialists supported patients to manage their own health, care and wellbeing and to maximise their independence.

Are services at this trust responsive?

Requires improvement

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

Key findings were:

Service planning and delivery to meet the needs of local people

- Generally, the services we inspected understood the different needs of the people it served and acted on these to plan, design and deliver services. There was a range of appropriate provision to meet needs and support people to access and receive care as close to their home as possible. For example, the trust provided an outpatient intravenous antibiotic facility for patients receiving long-term antibiotic therapies.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally. For example, Leicester Royal Infirmary (LRI) was the centre for surgery of cancers of the stomach and oesophagus for Leicester, Leicestershire, Northamptonshire and Rutland. It was also one of the two designated NHS centres in the East Midlands providing weight loss surgery.
- Patients aged 17 to 18 years old were offered the choice to see a paediatric or adult consultant. Managers we spoke with were aware that the transition from child to adult services needed developing.

Meeting people's individual needs

- The trust had an interpreting and translation policy. Staff had access to interpreting services for patients who did not speak or

Summary of findings

understand English. The service was provided externally and included the provision of British Sign Language. Staff told us the interpretation service sometimes found it difficult to allocate a translator.

- The trust employed 2.5 full time equivalent acute liaison nurses (ALNs) that provided advice and support to patients admitted to the trust who had a learning disability. In addition to this, a flagging system linked to the Leicestershire Learning disability register alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- During our inspection, we observed a member of staff comforting a patient through the use of pictorial and signing methods. The patient, although unable to communicate, looked upset. The nurse took time to ensure the patient was given appropriate and timely support and information to alleviate their anxieties.
- During our inspection, some patients were fasting for Ramadan. Ward 42 at the Leicester Royal Infirmary was unable to provide hot meals for patients who wished to fast and eat in the evening because they could only heat food during specified meal times. This meant patients who were fasting were unable to have hot food and had to order a snack box. Another patient on Ward 40 had needed to attend an appointment at 5pm; this meant the patient had missed their meal. When they returned to the ward all that could be offered was toast. We discussed this with nursing staff who told us there was no hot food available outside of set meal times and food could not be heated on the ward including that bought in by patients relatives.

Dementia

- The trust had a dementia strategy in place.
- The trust had appointed approximately eight meaningful activity facilitator across the trust. They were able to provide reminisce therapy for patient living with dementia.
- On Ward 23, we met the ward 'meaningful activities co-ordinator'. During our visit a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient, they told us by making it a social event they hoped the patient would eat.
- Monthly monitoring of dementia screening was undertaken as part of the National Dementia Commissioning for Quality and Innovation (CQUIN). The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this means better

Summary of findings

experience, involvement and outcomes. Data for the reporting period January to March 2016 showed 95.8% of patients were screened for dementia. This was better than the 90% target set by the commissioners of the service.

Access and flow

- The outpatient service had a backlog of patients who were waiting for follow-up appointments.
- The trust had a plan in place to address the backlogs and we could see they were reducing.
- Following the inspection the trust told us how this back log was being managed so that the risk to patients was as safe as possible.
- The trust cancelled outpatient appointments more than the England average. Between June 2015 and May 2016, the trust cancelled 30% of ENT appointments, 30% of rheumatology, 25% of eye clinic and 15% of dermatology and gynaecology appointments. Cancelling appointments created patient dissatisfaction, delays and complications with rebooking as well as a need to clinically re-assess the urgency and the patient in some cases.
- Clinics did not always run on time. The trust carried out its own analysis of wait times and the causes of delay and found the eye clinic was particularly prone to delays. The trust developed an action plan to improve waiting times, but when we inspected it was too early to assess its impact.
- Outpatient capacity did not meet demand. ENT, gastroenterology and orthopaedics did not have enough clinic slots to offer to patients. Some specialties did not have enough doctors to offer more clinics. For example, the eye and dermatology specialties were all trying to recruit doctors.
- Diagnostic services helped improve performance on the 62 week cancer pathway target although they acknowledged there was more to be done. They did this by creating extra slots to meet demand and employing two people to take bookings before the patient left the hospital. The gynaecology service offered same day colposcopy appointments if needed. This meant the service could identify cancers and pre-cancers quickly.
- The Department of Health target for emergency departments is to admit, transfer, or discharge 95% of patients within four hours of arrival at accident and emergency. Between July 2014 and February 2015, the department had consistently performed below the standard and was below the England average. The trust had a whole hospital response escalation policy, and gold

Summary of findings

command meetings took place up to four times per day to look at staffing, bed status and escalate any risks that could potentially affect patient safety, such as low staffing and bed capacity issues.

- The emergency department had escalation areas, which were used to provide extra capacity space when the emergency department was crowded. There were five red marked out spaces in the middle of the majors department, an emergency department corridor that could accommodate four trolleys and a bay opposite the EDU, which could hold up to four trolleys or beds. There was an escalation pathway with specific criteria for using the escalation areas.
- A new emergency department was being built on the Leicester Royal Infirmary site. This would significantly increase the capacity of the department. Some staff expressed concern to us that even though they would have more space and modern facilities, the numbers of patients coming through the department would continue to be difficult to manage.
- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care. Between March 2015 and February 2016 the operational standard of 90% for admitted pathways was met in all but one of the applicable medical specialties (cardiology, dermatology, neurology, rheumatology and thoracic medicine). Gastroenterology was the only specialty to fall below the 90% standard at 89%.
- Diagnostic waiting times are a key part of Referral to Treatment (RTT) waiting times. RTT waiting times measure the patients' full waiting time from GP referral to treatment, which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within six weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks. Since June 2015 the trust had performed worse than the England average, with a higher than average percentage of patients waiting six or more weeks for diagnostics.
- The trust were experiencing an issue with sustainable performance in the 2 week cancer wait. The trust had mitigating actions in place to sustain performance and had improved. Cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.
- During our announced and unannounced visits to this hospital, there was one medical outlier. Medical outliers are where patients are receiving care on a different speciality ward. The

Summary of findings

trust had robust systems in place to monitor medical outliers throughout the trust. There was evidence of a daily medical review and an 'oversight' of the patients' progress including estimated date of discharge, which was held by the senior site manager.

Learning from complaints and concerns

- Leicester Royal Infirmary (LRI). Waiting times and communication were common themes. There were 19 complaints during 2015/16 that were referred to the Parliamentary and Health Service Ombudsman of the 19, four were partially upheld.
- The trust had an independent complaints review panel who reviewed a sample of complaints from a patient's perspective.The panel was held quarterly and provided important external scrutiny on the quality of complaints responses and the complaints handling process.
- Over half of formal complaints to the trust concerned outpatient clinics. We reviewed formal complaints from March 2015 to March 2016, and 58% concerned outpatient clinics across all three hospital sites (457 complaints out of 787).
- Of the outpatient complaints, 56% were about clinics at the Leicester Royal Infirmary. They focused on delays in clinics, cancellations, waiting time and administration of appointments, and communication.

Are services at this trust well-led?

Requires improvement

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

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

Summary of findings

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

However:

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

Vision and strategy

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

Summary of findings

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

Governance, risk management and quality measurement

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

Summary of findings

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

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

Summary of findings

expect. Staff told us they felt frustrated that flow through the department affected patient care, as the department was so busy. Medical and nursing staff told us when the department was busy it resulted in patients receiving a poor standard of care, for example medication not being administered, comfort rounds not taking place and patients deteriorating prior to assessment. This suboptimal standard of care had to some extent been normalised and staff did not always report these sorts of harm. Senior leaders told us the problems would be solved once the department moved into its new building where they would have the space and environment to care for the increased numbers of patients they saw. However other staff told us they were concerned that there was too much reliance that this would fix the problems. The challenges faced in the emergency department were not solely because of the numbers of patients and the cramped environment.

- A system wide approach with the whole health and social care community was needed to support the trust to address the increasing attendances in the Emergency Department. Although there were plans in place and different initiatives to address the problems, we saw little evidence that these were making any impact on the numbers of attendances.
- In July 2015, NHS England instructed their regional team to set up A&E Delivery Boards. The board for Leicester, Leicestershire and Rutland was chaired by the trusts Chief Executive. An action plan had been developed and was subject to twice weekly monitoring to ensure the actions were having the desired impact. It was too early to comment what impact this was having on the trusts Emergency Department.
- At our previous unannounced inspection in November 2015, we found patients were at risk of avoidable harm because staff were failing to ensure all patients received adequate care and treatment in accordance with the trust's sepsis pathway. We warned the trust and placed conditions on the trust's registration, which meant the trust had to ensure there was an effective system in place to deliver sepsis management, in line with relevant national clinical guidelines. In addition, there was a requirement for the trust to report to the Care Quality Commission (CQC) describing the actions taken and how the clinical outcomes were being audited, monitored and acted upon on a weekly basis. The weekly reports indicated the trust was making some progress in the management of patients presenting to the emergency department with sepsis. However, at the time of the inspection, not all patients were getting treatment in accordance with national guidance.

Leadership of the trust

Summary of findings

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

Summary of findings

risks of the trust. We were told by several leaders in the organisation that they felt the non-executive directors were very engaged and were taking steps to ensure they were fully informed by attending the different trust Board committees.

- The executives told us that relationships between the trust executive team and other organisations such as the Clinical Commissioning Group and the local authority were said to have improved under the current leadership. We spoke with commissioners before our inspection and they echoed this.

Culture within the trust

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

Fit and Proper Persons

Summary of findings

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

Public engagement

- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations
- The trust had a patient experience committee and a patient and public involvement strategy. All of the clinical management groups had PPI leads (usually the heads of nursing). They reported monthly to the patient experience committee on patient equity, patient experience and patient engagement.
- The patient engagement team told us they felt the executive leaders in the trust were committed to patient engagement.
- The trust had a patient involvement, patient experience and equality assurance committee (PIPEEAC) and a patient and public involvement (PPI) strategy.
- All of the clinical management groups had PPI leads (usually the heads of nursing). They reported monthly to the PIPEEAC on service equality, patient experience and patient involvement.The patient and public engagement team told us they felt the executive leaders in the trust were committed to patient/ public engagement. The trust had "Patient Partners" who are members of the public that provide a lay perspective. Patient Partners were attached to all of the Trust's CMGS and

Summary of findings

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

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

Summary of findings

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

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

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

o Outpatient services 94% (NHS average 93%)

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

Staff engagement

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

Innovation, improvement and sustainability

Summary of findings

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

Summary of findings

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

Overview of ratings

Our ratings for University Hospitals of Leicester NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

Leicester General Hospital

- A new computerised individualised dosing system was in operation on the renal wards.
- New Starters in nephrology had a 12-week supernumerary period within the ward area and a bespoke Professional Development Programme. Included within the development programme was; trust behaviours, early warning score (EWS), infection prevention control, planning / evaluating care, managing pain, care of the dying patient and equipment training. Templates were also included to assist registered nurses in their revalidation process.
- An MDT meeting took place weekly on ward two; this included all members of staff included in an individual patient's care. For example, allied health professionals (physiotherapy, occupational therapy and speech and language therapy), medical and nursing staff and a neurological psychologist. The patient and relevant family member would also be present at this meeting where a patient's individual rehabilitation goals would be discussed and reviewed.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- On ward 1, a flexible appointment service was offered for patients. In order to help patients who had other personal commitments, for example work commitments, staff would work flexibly sometimes starting an hour earlier in the day to enable the patient to receive their care at a time and place to meet their needs.
- The development of a pancreatic cancer application to support patients at home with diagnosis and treatment. This will potentially assist patients and family members face the diagnosis and treatment once they have left the hospital.
- Midwifery staff used an innovative paper based maternity inpatient risk assessment booklet which included an early warning assessment tool known as the modified obstetric early warning score (MEOWS) to assess the health and wellbeing of all inpatients. This assessment tool enabled staff to identify and respond with additional medical support if required. The risk assessment booklet also included a range of risk assessments. This meant that all assessment records were bound together.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Glenfield Hospital

- Staff in the paediatric emergency department told us about the development of 'greatix', this was to enable staff to celebrate good things in the department. Staff likened it to 'datix', which enabled staff to raise concerns. Staff used greatix to ensure relevant people received positive feedback relating to something they had done. Many staff throughout the emergency department told us of times when they had received feedback though greatix and told us how this made them feel proud and valued.
- A range of medicines to manage Parkinson's disease was available on the clinical decisions unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.
- On Ward 42, we attended a 'posh tea round'. This took place monthly on the ward and provided an opportunity for staff and patients to engage in a social activity whilst enjoying a variety of cakes not provided during set meal times.

Outstanding practice and areas for improvement

- During our visit to Ward 23, a patient was refusing to eat. The meaningful activities co-ordinator sat and had their dinner with the patient. They told us by making it a social event they hoped the patient would eat.
- Within oncology and chemotherapy, a 24 hour telephone service was available for direct patient advice and admission in addition to a follow up telephone service to patients following their chemotherapy at 48 hours, one week and two weeks post treatment.
- A 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, and body language and physical changes to help determine level of patient comfort.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015.

Areas for improvement

Action the trust MUST take to improve

Trust wide

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

Urgent & emergency services

- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department. **This also applies to medical areas.**
- The trust must take action to ensure standards of cleanliness and hygiene are maintained at all times to prevent and protect people from a healthcare-associated infection. **This also applies to medical areas and outpatient and diagnostic areas.**
- The trust must ensure that patient in the emergency department who wait in for longer than 8 hours have a VTE risk assessment and appropriate thromboprophlaxis prescribed.
- The trust must ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department.

Medicine

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

Surgery

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

Critical Care

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

Maternity and gynaecology

Outstanding practice and areas for improvement

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the maternity and gynaecology service.
- The trust must ensure that midwives have the necessary training in the care of the critically ill woman, anaesthetic recovery and instrument/scrub practitioner line with current recommendations.
- The trust must address the backlog in the gynaecology administration department so that it does not impact patient safety.

Services for children and young people

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

End of life care

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

Outpatients & Diagnostic Imaging

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (2)(a)** Service users must be treated with dignity and respect, ensuring the privacy of the service user. **How the regulation was not being met:** • The trust did not ensure the privacy and dignity of patients within the majors area and the assessment area of the emergency department. There were five red bays in the middle of the majors area on which patients requiring a trolley waited until a bay became available. There were no screens to afford the privacy of patients with male and female patients being located in very

This section is primarily information for the provider

Requirement notices

close proximity next to each other. In addition, the way the trolleys were positioned meant these patients were facing the bay opposite them and this compromised the privacy of the patient in the corresponding bay.

- Within the assessment area of the emergency department, we observed overcrowding with patients waiting on marked out red bays whilst they waited for an assessment cubicle to become available. We observed patients being transferred from ambulance trolleys to hospital trolleys. This was done in view of other patients with no screens in place to afford the privacy and dignity of the person being transferred.
- The privacy of patients was not ensured in changing area D at Leicester General Hospital in diagnostic imaging, which was shared between male and female patients.
- The lack of patient gowns at Leicester General Hospital in the computerised tomography (CT) waiting/changing room at Leicester General Hospital compromised patients' privacy and dignity. It was difficult for patients to tie up the backs of their gowns. There were insufficient gowns for patients to be routinely offered one to use as a dressing gown to cover gaps at the back.
- Not all patient tests were carried out in private surroundings, this compromised patients privacy.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1)** When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. **How the regulation was not being met:** • The provider must ensure that appropriate systems and training are in place to ensure that Consent forms are completed appropriately for patients who lacked capacity and were made in line with the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2)(a)** Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment. **How the regulation was not being met:** • There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients. Nursing staff did not consistently adhere to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always document a clear plan of treatment if a patient's condition had deteriorated. • Where patients had met the trust criteria for sepsis screening, they were not all screened in accordance with national guidance. • The trust's sepsis protocol was not embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration. • Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments reviewed after 24 hours. patients requiring admission who waited in the ED for longer that 8 hours did not always have a VTE risk assessment and or appropriate thromboprophlaxis prescribed. **Regulation 12 (2)(c)** Care and treatment must be provided in a safe way for service users by ensuring that person providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. **How the regulation was not being met:** • Midwives did not have the necessary training in the care of the critically ill woman and anaesthetic recovery in line with current recommendations.

This section is primarily information for the provider

Requirement notices

- Nursing staff were providing care to high dependency children and young people without having qualified in speciality (QIS) training or having completed a High Dependency Unit training module.
- Staff caring for patients after a never event had no formal training in the use of the documentation designed to reduce the risks to patients suffering delirium.
- Staff had a limited understanding of what was a reportable incident and were not consistently reporting patient safety concerns in a timely manner. There had been a delay in the timely reporting of a recent never event.

Regulation 12 (2)(d)

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

How the regulation was not being met:

- The waiting environment for ophthalmic patients and eye casualty was overcrowded. Patients were standing or sat on the floor because all the seats were occupied. There were six patients sitting in wheelchairs along the corridor which reduced the corridor access.
- Control of substances hazardous to health materials were stored in unlocked cupboards.

Regulation 12 (2)(e) Care and treatment must be provided in a safe way for service users ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way

How the regulation was not being met:

- There were insufficient numbers of suitable syringe drivers with accepted safety features available to ensure patients would receive safe care and treatment.

Regulation 12 (2)(g)

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users by ensuring the proper and safe management of medicines.

How the regulation was not being met:

- Medicines were not always kept securely. They were stored in unlocked cabinets or in fridges with unreliable temperature control.
- Hazardous materials and liquid nitrogen were stored in unlocked cupboards.
- At Glenfield Hospital, one locked cupboard in Clinic B, the asthma clinic, contained FP10 prescriptions but there was no audit trail for their use.

Regulation 12 (2)(h)

Care and treatment must be provided in a safe way for service users by assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

How the regulation was not being met:

- Staff were not consistent in isolating patients at risk of spreading infection to others. On Wards 16, 23, 24, 31, 42 and 43 we saw doors left open to side rooms where it had been identified patients might present an infection control risk to others.
- Hand hygiene audits across 20 clinical areas were worse than the trust's target of 90%.
- Staff were not consistent in adhering to the trust's infection prevention control policy including adhering to the dress code, which was to be 'bare below elbows'.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(1)(2)** Safeguarding service users from abuse and improper treatment **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

- There were no effective systems and processes in place to protect children and young people on Ward 27 from abuse and harm. The admission criterion for Ward 27 allowed children and young people age 13 to 24 years old to share the same social space, unsupervised.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15(1)(a)** Premises and equipment **How the regulation was not being met** • Systems and processes to prevent and control the spread of infection were not operated effectively and in line with trust policies, current legislation and best practice guidance. • There were a number of toilets in the emergency department which were not clean. In the outpatient department clean areas were not always respected and some areas were dusty and not clean. There were no cleaning schedules on display and no evidence to suggest that equipment was clean and ready for use. **Regulation 15 (1) (e)** All premised and equipment used by the service provider must be properly maintained. **How the regulation was not being met:** • At Leicester General Hospital five items had not been safety tested by the required date. In outpatients three, a defibrillator had not been safety tested on its due date in April 2016. A sphygmomanometer, a thermometer and two urilisers (diagnostic apparatus) had not been safety tested by the required date. • At Leicester General Hospital there was a roof leak by the diagnostic imaging reception area. A container was in place to catch the water and stop the floor getting slippery for both patients and staff.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1)(a)** Good governance Systems or processes must be established and operated effectively to ensure the quality and safety of the services provided are assessed, monitored and improved. **How the regulation was not being met:** • The service had failed to prioritise some patients with urgent needs who were waiting for follow-up appointments. The eye speciality had a backlog of 964 patients needing follow up from 2015/2016 and 1706 patients from 2014/2015. • Some outpatient clinics did not treat patients in a timely way. In May 2016 four patients across three specialities waited for treatment for more than 52 weeks. • Patients did not always have timely access to initial assessment, diagnosis or urgent treatment. Diagnostic imaging had backlogs of patients waiting for their scan to be authorised. In May 2016, there were 1012 magnetic resonance imaging patients, 655 computerised tomography scan patients and 139 ultrasound scan patients. In each of these groups, nine patients should have been seen within two weeks. • The service did not consistently prioritise care and treatment for people with the most urgent needs. In April 2016, the trust did not achieve the nationally reported target for a two-week wait for 93% of suspected cancer patients with an urgent GP referral, achieving 91% instead.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1)** **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.** **How the regulation was not being met:** • The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units. • Midwifery staffing ratios did not meet current recommendations or minimum acceptable levels. One to one care in labour was not always provided. • Consultant obstetric cover in the delivery suite was 82 hours a week which did not meet the Royal College of Obstetrics and Gynaecology recommendation of 168 hours a week for a unit of this size. • At Leicester General Hospital in maternity and gynaecology services the lack of junior doctors, especially out of hours, led to delays in patient reviews which could pose a risk to patient safety. • Medical staffing in the children's and young people's service did not meet the Royal College of Paediatrics and Child Health (RCPCH) standards for sufficient paediatric consultants. • Neonatal staffing on the neonatal unit did not meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM). This was because the ratio of 1:1 and 1:2 nurse to baby care in the neonatal high dependency unit was not achieved. • Training shortfalls existed in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance.

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

This section is primarily information for the provider

Requirement notices

Regulation 5 (3) (a)

The individual is of good character,

How the regulation was not being met:

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. On 4 December 2015, following an unannounced inspection to the emergency department at the Leicester Royal Infirmary, we exercised our powers under section 31 of the Health and Social Care Act 2008 to impose conditions on the trust's registration because we believed that patients in receipt of care in the emergency department at the Leicester Royal Infirmary were or may be exposed to the risk of harm if we did not impose these Conditions urgently. The trust failed to demonstrate that it had an effective system in place so to ensure: • An appropriate skill mix to provide a safe standard of care to patients who require care and treatment within the emergency department at the Leicester Royal Infirmary. • Patients received an appropriate clinical assessment by appropriately qualified clinical staff within 15 minutes of presentation to the ED at the Leicester Royal Infirmary in line with best practice, • Patients received care and treatment in accordance with the trust's sepsis clinical pathway. Following our inspection of the Leicester Royal Infirmary, the section 31 HSCA Urgent procedure for suspension, variation etc. remains in place.

University Hospitals of Leicester NHS Trust

LEICESTER HEALTH AND WELLBEING SCRUTINY COMMISSION

12th April 2017

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

DRAFT QUAILTY ACCOUNT 2016/17

Purpose of report

1. Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. There is a legal requirement under the NHS (Quality Accounts) Regulations 2010 for all bodies who provide, or arrange to provide (sub-contract) NHS services to produce a Quality Account. This is the eighth year that we have been required to produce a Quality Account.

2. The aim of a QA is to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. These reports are for the public and report on the quality of services looking at the three domains of safety, effectiveness and patient experience.

Policy framework

3. The contents of the Quality Account is informed by Department of Health guidance (toolkit) and regulations. The toolkit has not been updated therefore the content remains largely unchanged however a letter to Chief Executives regarding 2016/17 Quality Account resulted in the following additional information being included:

   - How we are implementing the Duty of Candour
   - Our patient safety improvement plan as part of the Sign Up To Safety campaign
   - Our most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard
   - Our CQC ratings grid, alongside how we plan to address any areas that require improvement or are inadequate and by when we expect it to improve

4. The toolkit includes the requirement for further mandatory statements following each of these NHS outcome indicators.

5. Appendix A provides a summary of the Quality Account.

6. The full Quality Account is attached at Appendix B. Although every effort has been made to populate the first draft as much as possible some further (end of year) information is required. This will be updated as soon as the information is available.

Priorities for Improvement 2017/18

7. Each Quality Account must include priorities for improvement for the forthcoming year under each of the following headings; patient safety, patient experience and care. These priorities are those identified in the 2016/17 Quality Commitment and are included in the draft Quality Account.

External Assurance of the Quality Account

8. External audit of Quality Accounts is a national requirement. KPMG will be providing a limited assurance opinion in this respect. External audit colleagues review the Quality Account against a checklist to ensure the format / content follows national guidance and also perform testing against indicators in the NHS outcome framework table (Clostridium Difficile and patient safety incidents).

9. There is a statutory requirement to share the Quality Account with the following; local Healthwatch, CCGs, Local Overview and Scrutiny Committee, who are offered 28 days to provide commentary.

10. These commentaries will be included in the final draft of the Quality Account presented to UHL's Trust Board in June.

Conclusions / recommendations

11. The Health and Wellbeing Board is invited to review the Quality Account and provide feedback by Monday 1st May 2017.

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

#hello my name is…

Julie Smith, Chief Nurse
Sharron Hotson, Director of Clinical Quality

2016/17 Quality Account

One team shared values

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Background

- Eighth year we have been required to produce a Quality Account
- Look back on quality of services in 2016/17
- Balanced picture of successes and challenges
- Follows a prescribed format
- Externally audited

University Hospitals of Leicester NHS Trust

Caring at its best

Quality metrics 2016/17

- Patient safety incidents moderate harm or above: 114 year to date
- Serious incidents: 34 year to date
- Clostridium difficile: 55 year to date
- Avoidable MRSA: Zero year to date
- Avoidable pressure ulcers: 112 year to date
- Inpatient Friends and Family Test: 96% Feb 17
- A&E Friends and Family Test: 94% Feb 17

University Hospitals of Leicester NHS Trust

Caring at its best

Challenges

- ED 4 hour wait
- Referral to treatment (RTT)
  - Continuing rise in referrals (8% increase = approximately 1,000 more new referrals per month)
  - Increase in emergency pressures and admissions resulting in high numbers of operations being cancelled in some specialities
- Cancer targets
  - Increasing demand; (approximately 6% in two week wait urgent cancer referrals on top of the previous year's 11%)

University Hospitals of Leicester NHS Trust

Caring at its best

Priorities for 2017/18

2017 – 18 Quality Commitment

	Clinical Effectiveness Improve Patient Outcomes	Patient Safety Reduce Harm	Patient Experience Care and Compassion
Aim	What are we trying to accomplish?		
KPI	To reduce avoidable deaths	To reduce harm caused by unwarranted clinical variation	To use patient feedback to drive improvements to services an care
2017 / 18 Priorities	What will we do to achieve this? We will:		
	• Focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI	• Further roll-out track and trigger tools (e.g. sepsis care), to improve the management of deteriorating patients • Introduce safer use of high risk drugs (e.g. insulin) • implement processes to improve diagnostic results management	• Provide Individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) • Improve the patient experience in our current outpatients service and begin work to transform outpatient models of care
	How will we know if we have done it?		
	SHMI ≤ 99	Reduce incidents that result in severe / moderate harm by further **9%**	>75% of patients in the last days of life have individualised EoLC plans

Organisation of care – we will:

- Align our bed capacity with expected demand (including by reducing delays through Red2Green, working more effectively to care for step down patients and increasing the medical bed base)
- Optimise processes in our new Emergency Department
- Work to separate emergency and elective work
- Transform the hospital pathway for frail complex patients
- Improve the efficiency of our operating theatres

University Hospitals of Leicester NHS Trust

Caring at its best

Next steps

- Refresh end of year data
- Feedback from stakeholders by 1st May 2017
- Trust Board to sign off Quality Account in public on 1st June 2017
- Quality Account uploaded to NHS Choices by 30th June 2017

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Draft

Quality Account

2016/2017

Contents

		Page
1.	**Introduction from the Chief Executive**	**4**
2.	**Review of quality performance in 2016/17**	**6**
2.1	Our aims for 2016/17	6
2.2	Review of last year's Quality Commitment priorities	7
2.3	Patient Safety Improvement Plan	10
2.4	National Patient Safety Alert compliance	12
2.5	Never Events 2016/17	15
2.6	NHS Outcome Framework Indicators	16
2.7	Performance against national standards	24
2.8	The 'UHL Way'	29
2.9	Staff survey results	30
2.10	Freedom to Speak Up Guardian	31
2.11	How we keep everyone informed	31
2.12	Patient and public perspective	31
2.13	What do our patients tell us	35
3.	**Our Plans for the Future**	**42**
3.1	Quality Commitment 2017/18	42
4.	**Statements of Assurance from the Board**	**44**

4.1	Review of services	44
4.2	Participation in clinical audits	46
		Page
4.3	Participation in clinical research	48
4.4	Use of the CQUIN Payment Framework	49
4.5	Data Quality	49
4.5	NHS Number of General Medical Practice Code Validity	50
4.6	Clinical coding error rate	51
4.7	Information Governance Toolkit attainment level	52
4.8	CQC ratings	52
5.	**Other Statements**	**55**
5.1	Statements from our stakeholders	55
5.2	Statement from our External Auditors	55
5.3	Statements of Director responsibilities in respect to the Quality Account	55
6.	**Appendices**	
6.1	Appendix 1.1: National clinical audits that Leicester's Hospitals were eligible to participate in during 2016/17	56
6.2	Appendix 1.2: National Confidential Enquiries that Leicester's Hospitals were eligible to participate in during 2016/17	58
	Feedback form	59

1. Introduction from the Chief Executive

I am delighted to introduce to you our Quality Account and Quality Report for the University Hospitals of Leicester NHS Trust (Leicester's Hospitals) for 2016/17. Within an exceptionally challenging financial environment, we remain committed to focusing our resources and actions to providing safe services and the very highest of care for our patients and this report is an outline of our achievements and successes against our quality priorities over the past 12 months.

During 2016/17 our quality priorities were:

- To reduce avoidable deaths and reduce avoidable re-admissions
- To reduce harm caused by unwarranted clinical variation
- To use patient feedback to drive improvement to services

In June (20th - 23rd June 2016), the Care Quality Commission carried out a comprehensive inspection of our hospitals services. The aim of this inspection was to check whether our services are safe, caring, effective, well-led and responsive to people's needs.

The inspection team were extremely complementary about the staff they met, saying staff were universally welcoming, open and transparent. They were clearly very impressed by the compassion, professionalism and loyalty of everyone whom they encountered. I am pleased that despite the overall 'Requires Improvement' that the CQC has recognised our caring staff. The reports gave a clear message that we are going in the right direction, but have more to do.

Our focus on quality as the driving force will continue and strengthen through a reworking of our Strategic Objectives and Annual Priorities for 2017/18. An action plan has been being produced to cover the specific compliance actions in the report, but rather than create separate actions most of the improvements we need to make will be within our core improvement programmes.

Overall the CQC report shows that we have progressed or met our targets in the majority of areas however in a few areas we have not and these priorities will continue to be a focus for the coming year as part of our annual priorities and updated Quality Commitment.

During the year we have struggled with continuing operational pressures that have seen our hospitals in and out of critical incident status and bed escalation

for many months. We required a change in the way we delivered services if we were to deliver a safe and quality service that improves the experience of our patients whilst in hospital, at the level of efficiency which our commissioners and the general public demand of us. In December we introduced Red 2 Green which aims to change behaviour and identify where we can work better. We wanted to use this simple methodology to identify patients' needs, identify any problems that are blocking flow and discharge and improve the process of escalation. So far I can advise that this new process has had a positive impact.

This year as part of our Quality Commitment we have launched the country's first dedicated Emergency Department (adult) based Sepsis Team - we are leading the way in this area as no other NHS trust in the UK has a dedicated team for the recognition and management of sepsis for adults in an emergency. We have more to do and the work of this team will be spread across the Trust through 2017/18.

So despite financial challenges, constraints and the increases in patient numbers I have every confidence that during 2017/18 our continued hard work will pay further dividends and our patients, carers and visitors will see concrete improvements as we deliver more of our 5-Year Plan.

I hope this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at Leicester's Hospitals.

To the best of my knowledge and belief the Trust has properly discharged its responsibilities for the quality and safety of care, and that the information presented in this Quality Account is accurate

Electronic signature to be added prior to submission externally (31st March 2017)

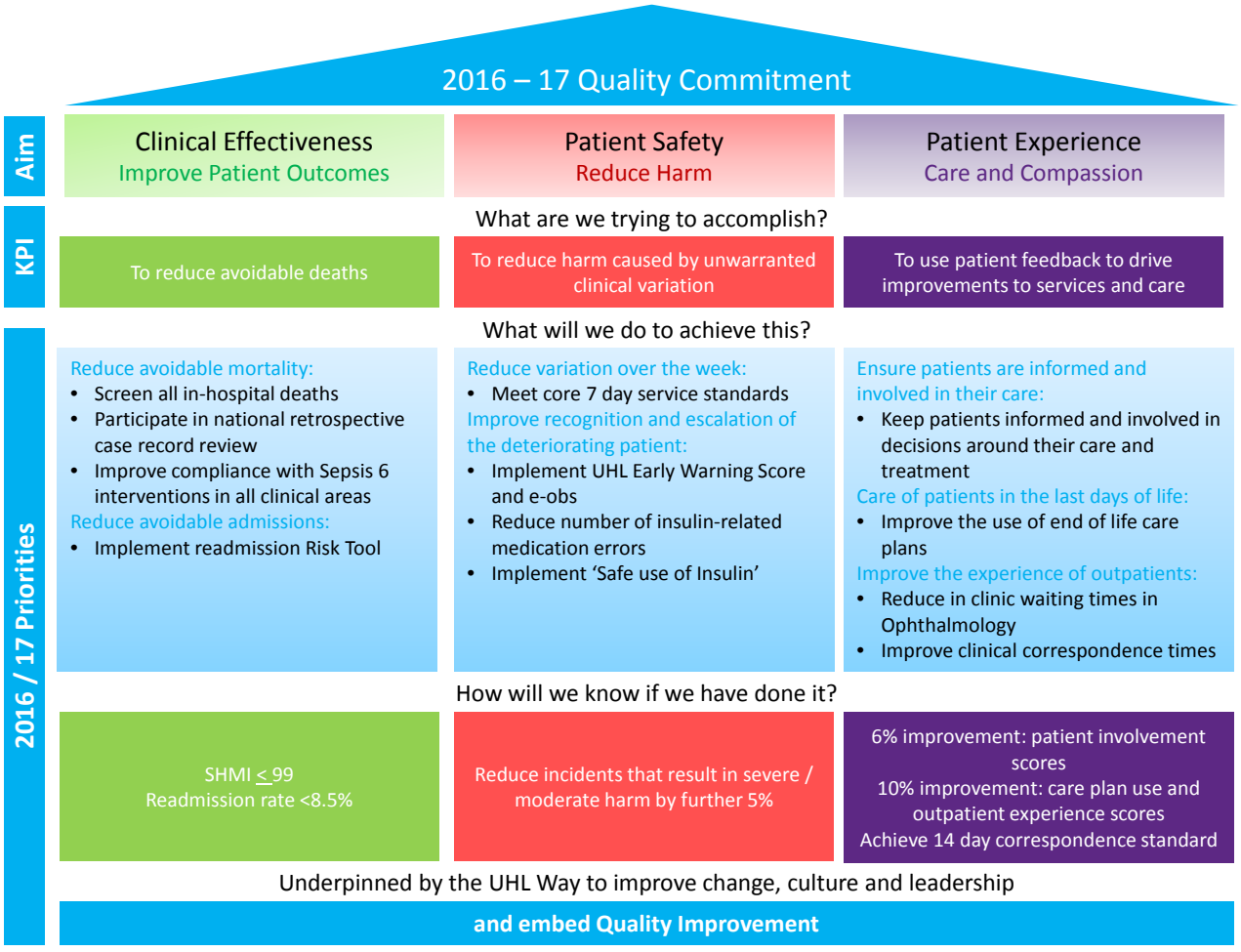
John Adler
Chief Executive

2. Review of quality performance in 2016/17

2.1 Our aims for 2016/17

Last year (2016/17) we set the following three priorities:

- To reduce avoidable deaths
- To reduce harm caused by unwarranted clinical variation
- To use patient feedback to drive improvement to services



2.2 Review of last year's Quality Commitment priorities

We said we would:

Reduce avoidable deaths and reduce avoidable re-admissions

In 2016/17 we:

- Have focussed on the early recognition of sepsis and Acute Kidney Injury (AKI) through the implementation of the Sepsis Care Bundle and the AKI Bundle
- Embedded the screening of all in-hospital deaths by medical examiners. Over 800 patient records have been screened by the medical examiners (over 90% of adult deaths at the Royal Infirmary) with 20% of these being referred for further review by our speciality morbidity and mortality groups
- Have been an early adopter with our participation in the National Retrospective Case Review
- Supported daily use of PARR 30 (Patient's Risk of Re-admission within 30 days) incorporating discharge planning

Further improvements we need to make are:

- Extending the medical examiner process to the General Hospital and Glenfield
- Improving the collation of morbidity and mortality review findings
- Increasing the numbers of cases where death classification is confirmed
- Including PARR30 scores in our electronic patient information systems

Results:

- The latest published figure for Summary Hospital Mortality Index (SHMI) covers the period July 2015 to June 2016. Our SHMI is 101 which is above our Quality Commitment threshold but still within the national expected average
- For the period April 2016 to January 2017 our 30 day emergency re-admission rate was 8.5%, a reduction on the 2015/16 rate of 8.9%

We said we would:

Reduce harm caused by unwarranted clinical variation

In 2016/17 we:

- Have improved compliance with the four core 7 day service standards
- Further rollout of Early Warning Scores (EWS) and e-observations
- Implemented the Safe Use of Insulin Strategy

Further improvements we need to make are:

- Ensuring Cardiology & Respiratory emergency admissions are seen and thoroughly assessed as soon as possible but at the latest within 14 hours from the time of arrival at hospital
- Moving away from manual reporting of EWS and pilot daily electronic reporting within one clinical area
- Developing trigger and track 'clinical rules' to improve the identification of sepsis and AKI
- Increasing the number of medical staff who have completed the 'Six Steps' insulin training
- Implementing the Point of Contact system for monitoring blood glucose levels

Results:

- **At the end of December 2016 we were on track to meet our Quality Commitment target of a 5% reduction in harm by March 2017**

We said we would:

To use patient feedback to drive improvements to services and care

In 2016/17 we:

- Have improved the use of individualised care plans in keeping with the '5 priorities for care'
- Kept patients informed and involved in their care
- Reduced the 'in clinic' waiting times in Ophthalmology
- Improved clinical correspondence turnaround times

Further improvements we need to make are:

- Evaluating the role of End Of Life Facilitators in providing extra support to wards caring for the dying person
- Showing an improvement in patients feeling involved and informed in their care
- Increasing the number of patients seen within 30 minutes of their appointment time, within Ophthalmology from 23.6%
- Ensuring patients receive correspondence within 14 days of their consultation

Results:

- **At the end of December 2016 we were on track to achieve a 6% improvement in patient involvement scores**
- **Met the quarter 3 Quality Commitment target for the 14 day standard for correspondence**
- **Failed to meet the target set for reducing the number of patients wait more than 30 minutes to be seen in Ophthalmology**

2.3 Patient Safety Improvement Plan

'Sign up to Safety' campaign

In September 2014 Leicester's Hospitals signed up to the national 'Sign Up to Safety' campaign. The campaign aims to halve avoidable harm and save an additional 6,000 lives over three years.

As part of the 'Sign Up to Safety' campaign, we have pledged to:

- Put patient safety first
- Focus on continuous learning
- Be honest and transparent
- Collaborate with others to share learning and good practice
- Be supportive and help people understand why things go wrong

In 2015 we were allocated £1,581,587 (one of the largest successful bids in England) from the National Health Service Litigation Authority (NHSLA) to support the delivery of our safety improvement plan.

Our 'Sign up to Safety' safety improvement priorities are aimed at improving the recognition, escalation, response and effective on going management of the deteriorating patient.

In 2016/17, as part of the 'Sign up to Safety' campaign we have:

- Introduced electronic observations for both adults and paediatrics across all three hospitals, through the implementation of Nervecentre
- Provided structured feedback to ward clinicians for all emergency patients admitted to the Royal Infirmary Intensive Care Unit with sepsis. These sessions provide the space for continual learning from peers
- Embedded a sepsis training module into our statutory resuscitation training
- Placed Sepsis Black Boxes in all of our resuscitation trolleys
- Introduced a Red Flag Sepsis Pathway to ensure patients receive the treatment they need within 1 hour

- Developed a Patient Safety Portal to help staff adopt best practice, share information and lessons learnt from incidents and complaints and work with other departments to improve patient safety and reduce avoidable harm

- Developed a partnership with Kettering hospital to implement the Red Flag Sepsis Pathway, Sepsis Black Boxes and training

- Created an obstetric video training package to share best practice and improve patient safety

- Created human factors e-learning modules for staff undertaking investigations and all healthcare staff

Duty of Candour

On 1st April 2015 the statutory Duty of Candour (Regulation 20 Health and Social Care Act 2008) regulated by the Care Quality Commission, came into force for all health care providers.

The intention of the regulation is to ensure that providers are open and transparent in relation to care and treatment provided. It also sets out specific requirements to ensure patients and their families are told about 'notifiable patient safety' incidents that affect them. Patients and their families receive an explanation and apology person to person. This is then followed up in writing and documented in the patient's records. Patients and their carers are kept informed of any further investigations / actions if and as appropriate.

To help staff understand the Duty of Candour requirements we have:

- Developed a short training video available on the hospital's intranet

- Updated our Duty of Candour (Being Open) Policy, with templates and flowcharts

- Held face to face training and briefing sessions for all staff groups

- Created posters and mouse mats displaying key messages for staff

- Adapted our incident management system so that when incidents are reported, a mandatory 'Duty of Candour' prompt encourages staff to record the relevant information and take the appropriate action

2.4 National Patient Safety Alert compliance

The National Patient Safety Alerting System (NPSAS) is a system for highlighting patient safety risks in NHS organisations and monitoring the implementation of actions to reduce these risks.

NHS trusts who fail to comply with the actions contained within patient safety alerts (PSAs) are reported in monthly data produced by NHS Improvement and published on the NHS Improvement website. Compliance rates are monitored by Clinical Commissioning Groups (CCGs). Failure to comply with the actions in a PSA results in a red status report on the NHS Choices website and the overdue alerts remain open.

The publication of this data is designed to provide patients and their carers with greater confidence that the NHS is able to react quickly to identified risks.

Within Leicester's Hospitals there is a robust accountability structure to manage PSAs. Heads of Nursing taking an active role in the local management of alerts and our Executive Quality Board (EQB) and Quality Assurance Committee (QAC) providing oversight of this process. Any alert that fails to complete within the specified deadline is reported to the EQB and QAC with an explanation as to why the deadline was missed and a revised timescale for completion.

The risk and assurance manager for the Leicester's Hospitals ensures the recommended actions from these alerts are locally monitored, working closely with clinicians and managers to ensure these actions are implemented within prescribed timescales wherever possible.

During 2016/17 (data up to and including 20/03/17) we have received 10 alerts and no breaches of due dates.

Table 1: National Patient Safety Alerts received during 2016/17

Title	Due date	Closed date
NHS/PSA/RE/2016/003 - Patient safety incident reporting and responding to Patient Safety Alerts	3 June 2016	1 June 2016
NHS/PSA/W/2016/004 - Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	22 June 2016	22 June 2016
NHS/PSA/RE/2016/005 - Resources to support safer care of the deteriorating patient (adults and children)	31 January 2017	20th January 2017
NHS/PSA/RE/2016/006 - Nasogastric tube misplacement: continuing risk of death and severe harm	21 April 2017	Remains open
NHS/PSA/RE/2016/007 - Resources to support the care of patients with acute kidney injury	17 February 2017	3rd February 2017
NHS/PSA/D/2016/008 - Restricted use of open systems for injectable medication	7 June 2017	Remains open
NHS/PSA/D/2016/009 - Reducing the risk of oxygen tubing being connected to air flowmeters	4 July 2017	Remains open
NHS/PSA/W/2016/010 - Risk of death and severe harm from error with injectable phenytoin	21 December 2016	21 December 2016
NHS/PSA/W/2016/011 - Risk of severe harm and death due to withdrawing insulin from pen devices	11 January 2017	10 January 2017
NHS/PSA/W/2017/001 – Resources to support safer care for full term babies	23rd August 2017	Remains open

2.5 Never Events 2016/17

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

In 2016/17 four incidents were reported which met the definition of a Never Event. Thorough root cause analysis (RCA) is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence.

The following table gives a description of the four Never Events, their primary root cause, the key recommendations to prevent reoccurrence and the level of patient harm. Patients and / or their families were informed of the subsequent investigations and involved throughout the process.

Never Event type	Description of incident and level of harm	Primary root cause	Key recommendations to prevent recurrence
Mis - selection of a strong potassium containing solution July 2015	Patient intravenously received a strong potassium solution rather than an intended different medication **Major patient harm**	Routine non-compliance with the IV administration policy, due to the absence of a workable local IV administration policy.	Medication Safety Lead to continue to share learning from this investigation nationally, to influence guidance and the appearance of the national supply of concentrated potassium ampoules. Consider moving to pre-filled potassium syringes, by analysing the business plan formulated during this investigation. Consider removing stock of 30mls syringes. Develop a standard operating policy (SOP) for IV administration on ITUs.
Retained Swab November 2016	Unintended swab left in situ following procedure in maternity **Minor Patient Harm**	Failure to follow Trust policies and procedures	Management of swabs, instruments, needles & accountable items' and 'Perineal or Genital Trauma following Childbirth – Identification and Repair' Policies to be sent out to all clinical staff within Obstetrics Spot check of compliance with current practice Individualised training programme for key individuals. Introduction of teaching sessions for Specialist trainees to include: 1. Counting

Never Event type	Description of incident and level of harm	Primary root cause	Key recommendations to prevent recurrence
			2. Scrubbing and donning gown and gloves correctly 3. Documentation Formation of a 'task and finish group' to: • Assess feedback regarding change to the use of large gauze swabs • Risk assess the re-introduction of tampons • Evaluate the use of short training videos on theatre etiquette and safety
Wrong site surgery January 2017	Extraction of incorrect tooth **Minor Patient Harm**	RCA still in progress	RCA still in progress
Wrong site surgery February 2017	Extraction of incorrect tooth **Minor Patient Harm**	RCA still in progress	RCA still in progress

2.6 NHS Outcome Framework Indicators

NHS Outcomes Framework domain	Indicator	2015/16	2016/17	National Average	Highest Score Achieved	Lowest Score Achieved
Preventing people from dying prematurely	SHMI value and banding	99 Apr15-Mar16 Band 2	101 Jul15-Jun16 Band 2	100 Jul15-Jun16 Band 2	117 Jul15-Jun16 Band 1	69 Jul15-Jun16 Band 3
	% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (contextual indicator).	21.9% Apr15-Mar16	21.8% Jul15-Jun16	29.2% Jul15-Jun16	54.8% Jul15-Jun16	0.6% Jul15-Jun16
Helping people to recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery	0.084 (150 records) EQ5D Index Apr15 – Mar16	0.110 (64 records) EQ5D Index Apr16 – Sep16	0.089 EQ5D Index Apr16 – Sep16	0.161 EQ5D Index Apr16 – Sep16	0.016 EQ5D Index Apr16 – Sep16
	Patient reported outcome scores for hip replacement surgery (Hip replacement Primary)	0.435 (492 records) EQ5D Index Apr15 – Mar16	0.466 (89 records) EQ5D Index Apr16 – Sep16	0.449 EQ5D Index Apr16 – Sep16	0.525 EQ5D Index Apr16 – Sep16	0.330 EQ5D Index Apr16 – Sep16
	Patient reported outcome scores for knee replacement surgery (Knee replacement Primary)	0.319 (652 records) EQ5D Index Apr15 – Mar16	0.326 (86 records) EQ5D Index Apr16 – Sep1	0.337 EQ5D Index Apr16 – Sep16	0.430 EQ5D Index Apr16 – Sep16	0.260 EQ5D Index Apr16 – Sep16
	Patient reported outcome scores for varicose vein surgery.	(no records) EQ5D Index Apr15 – Mar16	No Score (7 records) EQ5D Index Apr16 – Sep16	0.099 EQ5D Index Apr16 – Sep16	0.152 EQ5D Index Apr16 – Sep16	0.016 EQ5D Index Apr16 – Sep16
	% of patients <16 years old readmitted to hospital within 28 days of discharge	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below
	% of patients <16 years old readmitted to hospital within 30 days of discharge*	8.3% Apr15-Mar16 Source: CHKS Acute Trusts	8.3% Apr16-Dec16 Source: CHKS Acute Trusts	NHS digital data not available	NHS digital data not available	NHS digital data not available
Ensuring that people have a positive experience of care	% of patients 16+ years old readmitted to hospital within 28 days of discharge	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below
	% of patients 16+ years old readmitted to hospital within 30 days of discharge*	9.3% Apr15-Mar16 Source: CHKS	8.8% Apr16-Dec16 Source: CHKS	NHS digital data not available	NHS digital data not available	NHS digital data not available
	Responsiveness to inpatients' personal needs (Patient experience of hospital care)	69.6 Hospital stay: 01/07/2015 to 31/07/2015; Survey collected 01/08/2015 to 31/01/2016 Aug 2016 Publication	Results due Aug 2017	Results due Aug 2017	Results due Aug 2017	Results due Aug 2017

NHS Outcomes Framework domain	Indicator	2015/16	2016/17	National Average	Highest Score Achieved	Lowest Score Achieved
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of staff who would recommend the provider to friends or family needing care	64% Source: National NHS Staff Survey	65% Source: National NHS Staff Survey	NHS digital data not available	NHS digital data not available	NHS digital data not available
	% of admitted patients risk-assessed for Venous Thromboembolism	95.9% Apr15-Mar16 Source: UHL	95.9% Q3 2016-17 (October to December 2016) Source: NHS England	NHS digital data not available	NHS digital data not available	NHS digital data not available
	Rate of C. difficile per 100,000 bed days	11.7 Apr15-Mar16 Source: UHL data	10.6 Apr16 - Jan17 Source: UHL data	National data not published	National data not published	National data not published
	Rate of patient safety incidents per 1000 admissions	41.5 Oct15-Mar16	38.6 Apr16 – Dec16 Source: UHL data	NHS digital data not available	NHS digital data not available	NHS digital data not available
	% of patient safety incidents reported that resulted in severe harm	0.07% Oct15-Mar16	0.18% Apr16 – Dec16 Source: UHL data	NHS digital data not available	NHS digital data not available	NHS digital data not available

*NHS Digital data out of date so alternative national indicator used (30 days readmissions)

Where NHS Digital data as at 22/03/17 is unavailable, alternative data sources (specified) have been used

Preventing people from dying prematurely

Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health. It compares our actual number of deaths with our predicted number of deaths.

For the period July 2015 to June 2016, Leicester's Hospitals SHMI was 101. This is above the national average of 100, but is still within expected average.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reason:

Our patient deaths data is submitted to the Secondary Uses Service and is linked to data from the Office for National Statistics death registrations in order to capture deaths which occur outside of hospital.

The University Hospitals of Leicester NHS Trust intends to taken the following action to reduce mortality and so improve the quality of its services, by:

- The continued implementation of our Quality Commitment
- The continued implementation of the Pneumonia Care Bundle
- Earlier recognition of sepsis and acute kidney injury
- Increased cardiology input at the Royal Infirmary
- Improving pathway for patients admitted with gastro-intestinal haemorrhage

As part of our mortality monitoring and investigations, we will continue to make use of our medical examiners. Since July 2016 our medical examiners have reviewed over 800 patient records (over 90% of all adult deaths at the Royal Infirmary). 20% of these records have been referred for a more detailed review by speciality clinical teams to ensure the appropriate learning and actions.

Helping people to recover from episodes of ill health or following injury

Patient reported outcome scores

Patient reported outcome measure (PROM) is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia, knee replacement, hip replacement and varicose vein surgery patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

Hip and knee replacement surgery, groin hernia repair surgery and varicose vein surgery PROMS outcomes are in line with the national average.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

Leicester's Hospitals will continue to collect PROMs data to help inform future service provision.

The percentage of patients readmitted to hospital within 28 days of discharge

Data for the percentage of patients readmitted to hospital within 28 days of discharge is not available on NHS Digital. Leicester's Hospitals monitors its readmissions within 30 days of discharge.

The data describing the percentage of patients readmitted to hospital within 30 days of discharge are split into two categories: percentage of patients under 16 years old and percentage of patients 16 years and older. This data is collected so that the University Hospitals of Leicester can understand how many patients that are discharged from hospital return within one month. This can highlight areas where discharge planning needs to be improved and also where Leicester's Hospitals need to work more closely with community providers to ensure patients do not need to return to hospital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

We have seen our emergency readmissions rise for a number of years which is why we decided to include it in our Quality Commitment. We have seen an improvement in performance as a result of close working with our partners in the Leicestershire Partnership Trust, Councils and CCGs and focus from the discharge and our site management teams.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

- The introduction of a "stranded patient" dragons' den; a weekly meeting where wards discuss their three patients with the longest length of stay and highest readmission risks with Red2Green leads. This ensures these patients have appropriate support post-discharge

- Make the PARR30 score visible on the NerveCentre patient information system

- Continue to take a case management approach to patients with a high PARR30 score. This has already provided valuable insight into individual patients by visiting them in their home environment to look at factors that might be impacting on their high readmission rate

Ensuring people have a positive experience of care

Responsiveness to inpatients personal needs

Based on the Care Quality Commission national inpatient survey, this indicator provides a measure of quality. A 'composite' score is based on five questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?

- Did you find someone on the hospital staff to talk to about your worries and fears?

- Were you given enough privacy when discussing your condition or treatment?

- Did a member of staff tell you about medication side effects to watch for when you went home?

- Did hospital staff tell you who to contact if you were worried about your condition after you left hospital?

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

Date for 2016/17 is due to be published in August 2017.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

- Continue to focus on the elements of care that matter most to patients

- Encourage clinical areas to review patient feedback and act upon the findings

- Display any changes that we make in response to patient feedback to improve the services we offer on the “You said we did” boards on our wards

- Continue to offer patients, carers and family members the opportunity to give their feedback on the care that they receive and act upon this feedback

Treating and caring for people in a safe environment and protecting them from avoidable harm

Percentage of staff who would recommend the provider to friends or family needing care

The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working within the NHS inform local improvements.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- The survey conducted on behalf of the Care Quality Commission is sent to a random sample of Leicester’s Hospitals staff with the results analysed by an independent contractor and the results published nationally

- Our 2016/17 performance is based on the 2016 staff survey results, This information is presented to Leicester's hospitals Trust Board

The University Hospitals of Leicester NHS Trust intends to take the following actions to improve this and so the quality of its services:

- The continued implementation of the 'UHL Way'
- Through our Quality Commitment

Venous thromboembolism (VTE)

Risk assessing inpatients for VTE is important to help to reduce hospital acquired VTE. We work hard to ensure that not only are our patients risk assessed promptly but that any prophylaxis is given reliably.

The University Hospitals of Leicester considers that this data is as described for the following reasons:

- Matrons and lead nurses undertake a monthly review of VTE occurrence as part of the Safety Thermometer
- VTE risk assessment rates are reviewed by Leicester's Hospitals Thrombosis Prevention Committee. This information is provided twice yearly to our Executive Quality Board

The University Hospitals of Leicester has taken the following actions to improve this and so the quality of its services:

- Provided VTE risk assessment rate data to clinical areas and presented quarterly to the Thrombosis Prevention Committee and Clinical Quality Review Group to encourage changes to clinical practice where required
- Provided pharmacological and / or mechanical thromboprophylaxis to eligible patients
- Carried out Root Cause Analysis for all inpatients who experience a potentially hospital acquired VTE during their admission or up to 90 days following discharge

Clostridium Difficile (CDiff)

CDiff is a bacterial infection which can be identified in patients who are staying in hospital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Clostridium difficile numbers are collected as part of alert organism surveillance. Numbers are reported to and collated by Public Health England on behalf of the NHS

- A weekly data set of alert organism surveillance is produced by the Infection Prevention Team within Leicester's Hospital and disseminated widely throughout the organisation

The University Hospitals of Leicester has taken the following actions to improve this and so the quality of its services:

- The weekly data set is used to inform clinical governance and assurance meetings that take place. Clinical teams are then able to direct the focus of actions and interventions to continue to ensure that infection numbers are as low as possible

Patient safety incidents

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm for one or more receiving NHS care.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Patient safety incidents are captured on Leicester's Hospitals patient safety incident reporting system, Datix and are also reported to through the National Reporting and Learning System (NRLS)

- Themes and trends are reported quarterly to provide a national picture of patient safety incidents

The University Hospitals of Leicester NHS Trust has taken the following action to improve the percentage of harm incidents, by having a clear focus on the issues that have caused the most harm to patients as a key priority within the safety pillar of the Quality Commitment.

- The number of patient safety incidents reported within Leicester's Hospitals this year remains similar compared with the same period of the previous year. The percentage of incidents reported as resulting in severe harm or death data can be found within the NHS Outcomes framework data table. Our top three reported incidents are pressure sores, slips / trips / falls and staffing levels

- Leicester's Hospitals actively encourage a culture of open reporting and widespread sharing and learning from incidents to improve patient safety. The safety of our patients is our principal concern and we are relentless in our focus on reducing avoidable harm. We will be open and transparent about our safety work, our incidents and our actions for improvement. We will strive to make the care in our hospitals harm free

2.7 Performance against national standards

Indicators

ED 4 hour wait

Performance Indicator	Target	2016/17 YTD	2015/16	2014/15	2013/14	2012/13
A&E - Total Time in A&E (4hr wait)	95%	**79.2% (Apr-Feb)**	**86.9%**	**89.1%**	**88.4%**	**91.9%**

Key: **Green = Target Achieved** **Red = Target Failed**

There have been significant challenges all year with providing timely care at the Leicester Hospital's emergency department (ED)

Leicester's Hospitals have not met the target to treat and discharge a minimum of 95% of patients within four hours, with attendances increasing by 5% (30 additional attendances a day) and all emergency admissions rising by less than 1%.

The high number of patients in the department at any one time has inevitably had an effect on the quality of care provided for patients and in particular this has impacted on ambulance handover times. This has been recognised as a very serious concern by both Leicester's Hospitals and East Midlands Ambulance Service NHS Trust. The plan to deliver improvements ahead of the new ED floor opening in 2017/18 is being monitored at the A&E delivery board which is chaired by our chief executive.

The new Emergency Floor due to open in April 2017 will give the Emergency Department the space it needs and enhance patient and staff experience. There is a clear transition plan for Emergency Department services to move into the new space.

During 2016/17 the Urgent Care Centre continued to play a key role in supporting emergency care by utilising GPs to see patients at the start of their care. This coupled with a GP assessment unit which supports patients referred in directly from GPs has helped to reduce the growth in the number of patients requiring admissions to Leicester's Hospitals.

We continue to work with partners across Leicester, Leicestershire and Rutland to improve our emergency performance and the quality of care provided on the emergency care pathway. Our chief executive is the chair of the A&E delivery board which oversees the plan for improvement and contains all of our health system partners including the Leicestershire Partnership NHS Trust and the local councils.

MRSA

Performance Indicator	Target	2016/17 YTD	2015/16	2014/15	2013/14	2012/13
MRSA (All)	0	2 (Apr-Feb)	1	6	3	2
MRSA (Avoidable)	0	0 (Apr-Feb)	0	1	1	2

Key: **Green = Target Achieved** **Red = Target Failed**

For the year 2016/17 we have seen 2 patients with an MRSA bacteraemia against a national target of zero which is a significant achievement for a hospital

of this size. Although reported by Leicester's Hospitals they were attributable to a third party. A formal process to further review these 2 cases is being led by Public Health England.

Referral to treatment (RTT)

Performance Indicator	Target	2016/17 YTD	2015/16	2014/15	2013/14	2012/13
RTT - incomplete 92% in 18 weeks	92%	**91.2% (Apr-Feb)**	**92.6%**	**96.7%**	**92.1%**	**92.6%**

Key: **Green = Target Achieved** **Red = Target Failed**

The RTT incompletes standard measures the percentage of patients actively waiting for treatment.

2016/17 has been a difficult year for the Leicester's Hospitals in terms of maintaining this elective target, the RTT incompletes standard.

Compliance with the standard was maintained from April to August and during November 2016.

The factors that have impacted on our ability to deliver this standard consistently are:

- A continuing rise in referrals (8% increase, this equates to approximately 1,000 more new referrals per month)
- An increase in emergency pressures and admissions resulting in high numbers of operations being cancelled in some specialities

This compound effect has meant that month on month the numbers of patients waiting longer than 18 weeks has increased. The focus for our patients remains treating those most clinically urgent and the longest waiters.

We continue to have capacity constraints within some key services, notably adult and paediatric ear nose and throat and ophthalmology. These are being addressed by additional resource, in particular further investment in clinical staff.

In 2016 the discovery of poor waiting list practices in some areas of ophthalmology has resulted in a thorough review of waiting list management across the Trust, this is being supported by our external auditors KPMG.

The findings and recommendations of this review will result in a comprehensive Trust wide plan. Meanwhile ongoing efforts are being made to raise the profile of the importance of good waiting list management across our hospitals, with the e-learning module for RTT along-side face-to-face training sessions being provided to all relevant staff across all three hospital sites.

Diagnostics

Performance Indicator	Target	2016/17 YTD	2015/16	2014/15	2013/14	2012/13
Diagnostic Test Waiting Times	1.0%	**0.9% (Apr-Feb)**	**1.1%**	**0.9%**	**1.9%**	**0.5%**

Key: **Green = Target Achieved** **Red = Target Failed**

Leicester's Hospitals maintained good performance against the diagnostics tests waiting time standard of no more than 1% of patients waiting for a diagnostic test longer than six weeks, during 2016/17 with the exception of two months.

The two months of failure have been associated with two unforeseen episodes in imaging / radiology, where five machines (CT and MRI) were out of action over a period of three days due to an electrical storm. This was followed the following month by serious disruption to the departments following the implementation of a regional IT system. The service continues to need to run additional sessions and has recruited a significant number of additional consultant radiologists in 2016 to meet the ever rising demand.

Cancer targets

Performance Indicator	Target	2016/17 YTD	2015/16	2014/15	2013/14	2012/13
Cancer: 2 week wait from referral to date first seen - all cancers	93%	93.0% (Apr-Jan)	90.5%	92.2%	94.8%	93.4%
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	94.1% (Apr-Jan)	95.1%	94.1%	94.0%	94.5%
All Cancers: 31-day wait from diagnosis to first treatment	96%	93.5% (Apr-Jan)	94.8%	94.6%	98.1%	97.4%
All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.6% (Apr-Jan)	99.7%	99.4%	100.0%	100%
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	84.9% (Apr-Jan)	85.3%	89.0%	96.0%	95.8%
All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	92.5% (Apr-Jan)	94.9%	96.1%	98.2%	98.5%
All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	77.4% (Apr-Jan)	77.5%	81.4%	86.7%	83.5%
All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	88.8% (Apr-Jan)	89.1%	84.5%	95.6%	94.5%

Key: **Green = Target Achieved** **Red = Target Failed**

As in the previous year, Leicester's Hospitals have struggled with cancer performance during 2016/17 and this area remains one of our highest priorities.

One of the reasons behind this failure to meet key standards is increasing demand; (approximately 6% in two week wait urgent cancer referrals on top of the previous year's 11%). This in turn has increased the number of patients requiring diagnostics and treatment for cancer.

The hospital has an agreed cancer recovery plan with the local CCGs which has resulted in some clear signs of improvement.

The 'Next steps' for cancer patients (which ensures all patients who are on a suspected cancer pathway know what their next step is and they receive the date for that within an agreed timeframe) is being extended to cover all cancer tumour sites. We are starting to see that this has significant benefits for patients primarily but also for our hospitals.

2.8 The 'UHL Way'

The 'UHL Way' is a way of building better teams, improving the things we really care about in a planned and systematic way.

The 'UHL Way' builds on the success of Listening into Action as a way of building better teams.

Better engagement

Listening into Action (LiA) has been used by teams across Leicester's hospitals to engage and empower staff to help transform our hospitals and deliver Caring at its Best. LiA is part of the 'UHL Way' under the Better Engagement strand.

As part of Better Engagement we launched an informal staff recognition scheme to ensure that staff feel recognised and valued for what they do. In the first two months over 200 cards and pin badges were sent out to members that wanted to recognise their hard work and dedication.

Better Change

Better change has been adopted as the 'UHL Way' of managing change projects across Leicester's hospitals. Teams that have that utilised the Better Change Methodology are:

- The Emergency Floor Transformation Programme
- The Next Steps for Cancer patients
- Vascular Services
- Time: Heart, Pacing and Rhythm Team
- The Safer Bundle of Care
- 7 Day Services

Better Teams

Better team working is important to Leicester's Hospitals, as the relationship staff have with their team can make a real difference to their experience at work and patient experience.

Taking part in the Better Teams Programme, gives our staff the opportunity to develop strong team working.

Pulse Check

In addition to the national staff survey, we undertake a more frequent Pulse Check of how staff are feeling, what behaviours they are displaying and how engaged they are. Every quarter, 25% of staff are surveyed using the Pulse Check.

2.9 Staff survey results

Each year Leicester's Hospitals participate in the National Staff Survey. The results of this survey are used to develop human resource, workforce and organisational development strategies aimed at improving staff experience of working at Leicester's Hospitals.

Every organisation that participated in the 2016 Staff Survey receives a report that provides organisation level results with data covering 32 areas known as 'Key Findings'

In 2016 23% of Leicester's Hospitals staff reported that they had experienced harassment, bullying or abuse from staff in the last 12 months (compared to 24.1% nationally). This compares with a score of 28% in 2015.

In 2016 84% of staff reported that they believed that Leicester's Hospitals provides equal opportunities for career progression or promotion (compared to 85.4% nationally). This compares with a score of 93% in 2015.

2.10 Freedom to Speak Up Guardian

In line with national requirement we have appointed a freedom to speak up guardian who took up post in February 2017.

2.11 How we keep everyone informed

Information for staff, public and patients

We produce a bi-monthly magazine called 'Together' for staff, members and the public, in which we share good news, innovations, schemes and initiatives from across our hospitals.

The Communications team manages several social media accounts such as Twitter, Facebook, Vimeo, Instagram and YouTube, which are used to quickly and effectively share information, images and advice. The team respond quickly to issues/ concerns raised by members of the public through these forums. They also respond to comments posted on NHS Choices and Patient Opinion about our services.

Our public website (www.leicestershospitals.nhs.uk) provides patients and visitors with information about our hospitals and services. We regularly issue press releases about good news and interesting developments within our hospitals, along with `news alerts` for those who have signed up to receive notifications.

2.12 Patient and public perspective

Patient partners

Within Leicester's Hospitals the patient voice is represented through our Patient Partners who are attached to the Clinical Management Groups. There are

currently 13 people fulfilling this role which provides a valuable independent and lay perspective on the work within the hospitals. It is anticipated a further eight people will be appointed by April, 2017.

Patient Partners are members of the public who work closely with patients and staff giving advice and feedback on a wide range of issues from changes to service and advising on new developments to examining performance figures and trends and facilitating patient focus events. Patient Partners also sit on key strategic committees, relating to finance, performance, research, safeguarding and the reconfiguration of services.

“Patient and public involvement now has a higher profile in Leicester’s Hospitals than ever before and Patient Partners have an important part to play. Significant progress has been made in relation to embedding the role although there is still work to be done in ensuring it is fully effective across all Clinical Management Groups”, said Martin Caple, chairman of the Patient Partner Group.

“As individuals we provide feedback and work with staff to address patient matters whilst at the same time sharing our collective thoughts and concerns with senior managers”, Martin added.

“Also, following a Leicester’s Hospital’s Trust Board Thinking Day in August 2016, attended by all local patient groups including Patient Partners, initiatives are commencing which hopefully will mean a greater sharing of information and concerns by those groups in future”.

“From a Patient Partner point of view our main concerns in the past year have been centred around the pressures and well publicised difficulties in the Emergency Department, an issue that is replicated throughout the country. We appreciate there are no easy answers to these problems but are hopeful that the new state of the art building for the Emergency Department, with enhanced facilities and systems, and to be opened shortly, will improve the situation”.

“Our other main concerns relate to cancelled operations, discharge planning, some cancer performance targets not being met, signage and way finding needing improvement and delays in outpatient clinics. The future of the Childrens Heart Hospital is of course of great concern to everyone locally and it is hoped that a successful outcome can be achieved urgently so this vital facility remains at Glenfield.”

“There have been some significant improvements in the past year. The new multi-storey car park at the Royal Infirmary has been a great success, alleviating the

long queues and stress for visitors, also, since the contract for catering, cleaning and portering has returned in-house there are encouraging signs of improvement there".

"As Patient Partners we see at first hand many positive and encouraging initiatives to address issues of concern and improve services. In particular we see a hard- working and committed workforce, ably led, who are dedicated to providing high quality patient care; a key point highlighted by the Care Quality Commission following their visit in 2016".

Trust Board engagement

There are a number of ways in which the Trust Board seeks the wider involvement of patients and the public. A quarterly Engagement Forum meeting is chaired by Leicester's Hospitals chairman and attended by the Chief Executive and other Directors. This is an open public forum which considers matters of both topical interest and strategic importance. Invitations are sent to the Trust's public membership Patient Partners put forward an agenda item for each meeting and invite senior staff to the forum to address any concerns. Naturally, the Trust Board holds the bulk of its monthly meetings in public and takes questions from public observers at the end of the public session.

Member engagement

Leicester's Hospitals manages a public membership of over 16,000 people drawn from Leicester, Leicestershire and Rutland. Analysis shows a close demographic match, in terms of ethnicity, to our local population. Members are regularly invited to participate in events, focus groups and surveys. We also ask that our hospital volunteers become members of the hospital. This has helped to attract younger people to our membership and encourages volunteers to feel part of the hospital and to be given opportunities to contribute and participate as members. Members also receive the hospitals bi-monthly magazine "Together".

Every month, the hospital holds a "Leicester's Marvellous Medicine" talk. This provides an opportunity for members to meet some of our medical consultants and engage with them about the services we provide. Each talk concludes with a question and answer session.

We also periodically send out surveys to our members. These may relate to membership itself or support services in the trust to gain a public perspective on their work. In addition to surveys generated by Leicester's Hospitals, we also

send out occasional surveys and invitations on behalf of our partner organisations.

ePartners

In November 2016 the Trust established an ePartner programme in which members of the public sign up to receive surveys online and comment on service developments and patient literature etc. We already have 234 ePartners and hope to increase this number over 2017.

Patient and public involvement (PPI) Strategy

The Trust's Commitment to PPI was strengthened recently through the approval of a new PPI Strategy. The Strategy secured further staff resource to manage the PPI agenda and advocates an expansion of the Patient Partner model and a greater emphasis on community engagement. Progress on the implementation of the strategy is reported to Trust Board on a quarterly basis.

PPI in our Clinical Management Groups (CMGs)

The hospitals services are organised in to Clinical Management Groups (CMGs). As noted above, each of our Patient Partners is attached to a CMG. Most sit on the Boards of their CMGs as well as getting involved in a wide range of activity across the services.

There are also some service specific Patient and Public Involvement groups across the hospitals. For example, some of our Biomedical Research Units have dedicated PPI groups (e.g. Cardiovascular and Respiratory) and two years ago our Cancer Centre established a user group to inform the development of cancer services.

Patient and Public Involvement within the CMGs is monitored through the Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEEAC). The committee meets monthly and is chaired by our deputy chief nurse. It reports quarterly to the Executive Quality Board.

Engagement with Equality Groups

For over ten years the hospital has convened a quarterly meeting to support its engagement with diverse communities. The Equality Advisory Group includes among its members representatives from faith and minority ethnic communities

and from voluntary sector disability groups. The group is managed by the hospital's service equality manager and chaired by the head of chaplaincy

HealthWatch

The hospital has good links with local HealthWatch organisations and a HealthWatch representative sits on all of our Trust Board meetings. Our chief executive meets every three months with HealthWatch representatives to discuss issues that have emerged through their engagement with local communities. These meetings are also attended by the hospital's director of marketing and communications.

A Leicestershire wide review of hospital discharges, commissioned by Healthwatch Leicestershire was published in March 2017. Leicester's Hospitals will be developing an action plan to tackle this important issue.

2.13 What do our patients tell us

Leicester's Hospitals welcomes feedback from patients and/or carers or relatives that have experienced our services. Feedback that is received, both negative and positive is acted upon and displayed in the ward areas on "you said we did" boards.

Feedback is collected in numerous ways including:

- Patient Experience Surveys
- Friends and Family Test
- Message to Matron
- Message through a Volunteer
- Carers survey
- Patient Stories
- NHS Choices / Patient Opinion
- Compliments and complaints provided to the Patient Information and Liaison Service (PILS)
- Online through the hospital website

Friends and Family Test

The Friends and Family Test question "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?", is a nationally set question that is offered to all patients, carers and relatives in all

NHS hospitals. The question is followed by an opportunity for the person to comment as to why they have given the answer that they have. The feedback that is received allows for improvements to be made and measured regarding the experience of care in our hospitals.

During 2015/16, and 2016/17 (to December 2016) Leicester's Hospitals consistently achieved on a monthly basis, 96% of respondents or above who would recommend our ward to friends and family if they needed similar care or treatment. Less than 1% of respondents would not recommend Leicester's Hospitals.

For the last two years the Friends and Family Test has shown that a majority of our patients would recommend Leicester's Hospitals services.

NHS England guidance is that the Friends and Family Test should be available to every patient, allowing them to give their feedback. At Leicester's Hospitals paper versions of the Friends and Family Test is offered in all inpatient and day case areas in the three most popular non-English languages, Polish, Gujarati and Punjabi, any feedback received is translated into English to allow the area to respond.

In the Outpatient areas and the main receptions of the three hospital sites, electronic surveys are used, these devices also allow patients, carers and relatives whose first language is not English the opportunity to give their feedback in one of the three most popular languages.

For patients, carers or relatives with learning disabilities, language or literacy issues, dementia or who are deaf, blind or partially sighted, there is the option of an easy read version of the survey. For children there is a childrens survey, known as rocket feedback.

The electronic devices include the childrens version of the survey where appropriate and in all areas there is the opportunity for the patient to use the easy read version and to make the font bigger for the partially sighted patients.

Patient Information and Liaison Service (PILS)

Feedback from our patients, their families and carers gives us a valuable opportunity to review our services and make improvements. The Patient Information and Liaison Service is an integral part of the corporate patient safety team. The PILS service acts as a single point of contact for members of the public who wish to raise complaints, concerns and compliments.

The service is responsible for coordinating the process and managing the responses once the investigations and updates are received from relevant services or individuals. They are contactable by a free phone telephone number, email, website, in writing or in person.

PILS activity (formal complaints, verbal complaints, requests for information and concerns) by financial year - April 2010 to February 2017

	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017 (to end Feb 2017)
Formal complaints	1531	1723	1513	2030	2110	1553	1307
Verbal complaints	1289	1152	1054	1391	975	1445	1017
Requests for Information	356	434	292	203	234	433	294
Concern (excludes CCG & GP)	0	66	341	343	472	703	1198
Totals:	3176	3375	3200	3967	3791	4134	3816
Percentage change against previous year		6% increase	5 % decrease	24% increase	4% decrease	9% increase	*

*2016/2017 % increase/ decrease unavailable at time of production.

Learning from complaints

Complaints are a vital source of information about the views of our patients, families and carers about the quality of our services and standards of our care. Leicester's Hospitals Patient Information and Liaison service (PILS) administer all formal complaints, concerns, and other provider concerns to include General Practitioner (GP) concerns received from the CCGs.

From April 2016 to February 2017 we received **1,307** formal complaints, **1,198** concerns, and **537** CCG / GP complaints/concerns.

Leicester's Hospitals has achieved good performance in responding to 10, 25 and 45 day formal complaints. We have achieved 87%, 91% and 80% respectively. We are keen to listen, learn and improve using feedback from the public, HealthWatch, feedback from our local GPs and also from national reports published by the Local Government and Parliamentary Health Service Ombudsman.

Most frequent complaints themes are waiting times, medical care and appointment issues. We have continued to work jointly with the CCGs on theming the GP concerns and the most frequent themes have been the management of anticoagulation therapy and incorrect discharge information.

Reopened complaints

Number of formal complaints received and number of those reopened by financial quarter - 2016/17

	Formal complaints received	Formal complaints reopened	% resolved at first response
16/17 Q1	316	36	89%
16/17 Q2	373	28	92%
16/17 Q3	385	30	92%
16/17 Q4	233	5	98%
Totals:	**1307**	**99**	**92%**

Data correct to end of February 2017

Examples of learning from complaints and responding to patient feedback

During 2015/16 a theme of complaints regarding outpatients and in particular ophthalmology services emerged. The complaints related to delay in receiving an appointment, cancelled appointments, waiting times and failure to provide follow up appointments. When this information was triangulated with patient safety incident data this highlighted an issue with overbooking of ophthalmology clinics to meet demand and not routinely rebooking patients when cancelled which was impacting on the services ability to provide safe, high quality care.

In response to this, during 2016/17 UHL have undertaken the following actions:

- A thorough review of the outpatient administration and management of the Ophthalmology department by the deputy head of performance
- An academically-led Hierarchical Task Analysis (HTA) of the service
- Wider organisational; a review of all potentially impacted specialties
- External Audit, review of waiting list governance process and information systems and reports

Further patient feedback told us that patients were telling us that they could not easily find the ophthalmology clinic and that there were never enough chairs to be able to sit down as it was a very busy clinic. As a result, there has been a quality improvement project that has resulted in improved signage to signpost to the clinics, improved signage within the clinics and whole refurbishment of the areas to include new chairs. This has had a very positive effect on the clinic environment for patients.

Example of the actions we have taken in response to patient complaints

Reason for complaint	Action taken
Poor staff attitude of staff and failure to be flexible in approach to support a phobia	Patient given single point of contact for every clinic visit. To attend a specific clinic room at one site each time she visits to allow structure and emotional preparation for phobia.
Lack of communication and information regarding forthcoming surgery	Review and revision of patient information booklet related to that procedure.

Improving complaint handling

Throughout 2016/17 Leicester's Hospitals have continued to participate in the Independent Complaints Review Panel process. The purpose of the panel is to review a sample of complaints from the patient perspective and to report back to the PILS team on what was handled well and what could have been done better. The feedback provided by the Independent Complaints Review Panel is used for reflection, learning and improvement both within the PILS and to the Clinical Management Groups.

Actions for 2016/17 to further improve complaints engagement and learning were:

- GP engagement event – we have worked collaboratively with the CCGs to review the themes of the GP concerns and use this information to prioritise larger scale safety improvement projects within Leicester's Hospitals. Improving the discharge of the patient on warfarin therapy is an example of this collective work

- Two community based Patient Information and Liaison (PILS) clinics – we have been working closely with Healthwatch and endeavour to arrange an initial clinic or be part of a public engagement event during 2017

- Collaboration with the University of Leicester with work on the quality of apology in our complaints response letters – this has been completed and involved a review of the existing literature on apologies and analysing a sample of our written and verbal apologies. Results from this will be used to develop training and other supportive material to support staff in providing good quality apologies both written and face to face

We continue to strive to improve our complaints process and handling of cases. Actions for 2017/18 are:-

- To undertake a new complaints satisfaction survey using new approaches

- To coach and further develop the skills of the Patient Information and Liaison Service team to improve the quality of call handling and drafting of responses using plain English

- To develop further training for staff to enable them to manage and resolve concerns locally and earlier

Parliamentary Health Service Ombudsman

This year we have had less upheld cases by the Parliamentary Health Service Ombudsman, further details are provided below.

Parliamentary Health Service Ombudsman complaints - April 2014 to February 2017

	2014/15	2015/16	2016/17	Total
Enquiry only - no investigation	3	4	4	**11**
Investigated - not upheld	6	10	9	**25**
Investigated - fully upheld	0	0	0	**0**
Investigated - partially upheld	7	4	1	**12**
Complaint withdrawn	0	0	1	**1**
No decision made yet	0	0	4	**4**
Total	**16**	**18**	**19**	**53**

The theme from the upheld case this year was a failure to provide accurate discharge information to a community health care provider.

3. Our Plans for the Future

3.1 Quality Commitment 2017/18

Our draft Quality Commitment for the coming years sets out our quality improvement plan

Through our Quality Commitment we aim to:

- Improve patient outcomes and provide effective care by delivering evidence based care / best practice
- Reduce harm to patients and improve safety by reducing the risk of error and adverse incidents

- Provide care and compassion and improve patient experience by listening to and learning from patient feedback

In developing our plans to improve quality we have taken into account both local and national priorities across the three domains: patient experience, clinical effectiveness and patient safety.

4. Statements of Assurance from the Board

4.1 Review of services

During 2016/17 Leicester's Hospitals provided and / or sub-contracted in excess of 120 NHS services. These include:

- Inpatient - 64 services (specialties)
- Day Case - 62 services (specialties)
- Emergency - 71 services (specialties)
- Outpatient - 88 services (specialties)
- Emergency Department, Eye Casualty and Urgent Care Centre
- Diagnostic Services – including Hearing Services, Imaging, Endoscopy, Sleep Studies and Urodynamics
- Direct access – including Imaging, Pathology, Physiotherapy and Occupational Therapy
- Critical Care Services in Intensive Therapy Unit (ITU), High Dependency Unit (HDU), Post Anaesthesia Care Unit (PACU), Coronary Care Unit (CCU), Paediatric Intensive Care Unit (PICU), Obstetrics HDU, Neonatal Intensive Care Unit (NICU), Extra Corporeal Membrane Oxygenation (ECMO), Special Care Baby Unit (SCBU) and also Paediatric and Neonatal Transport Services
- A number of national screening programmes including Retinal Screening (Diabetes), Breast Screening including age extension (Cancer), Bowel Screening (Cancer) and Abdominal Aortic Aneurism (AAA), Cervical screening, foetal anomalies, infectious diseases of the newborn, newborn infants physical examination, newborn blood spot and sickle cell thalassemia
- A number of services provided in collaboration with other providers with include but are not limited to the LLR Alliance which is a service offering elective, diagnostic and outpatient services and EMPATH, which provides pathology services

Leicester's Hospitals comprises of three acute hospitals; the Royal Infirmary, the Leicester General and Glenfield hospital and the midwifery led birthing unit, St Mary's.

The Royal Infirmary has the only Accident and Emergency Department (A&E), which covers the area of Leicester, Leicestershire and Rutland. The General provides medical services which include a centre for renal and urology patients, and Glenfield provides a range of services which include medical care services for lung cancer, cardiology, cardiac surgery and breast care.

Services are also provided at:

- dialysis units in Leicester, Loughborough, Grantham, Corby, Kettering, Northampton and Peterborough

- through the Alliance partnership at Ashby & District Hospital, Coalville Hospital, Fielding Palmer Hospital, Hinckley & District Hospital, Loughborough Hospital, Melton Mowbray Hospital, Rutland Memorial Hospital and St Luke's Hospital

The University Hospitals of Leicester NHS Trust has reviewed all the data available, on the quality of care in these NHS services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Leicester's Hospitals for 2015/16.

Examples of how we reviewed our services in 2016/17

A variety of performance information is considered when reviewing our services. A few examples include:

- A Quality and Performance report (available at http://www.leicestershospitals.nhs.uk/) is presented at the Quality Assurance Committee and Investment Finance and Performance Committee

- Weekly quality and performance meetings chaired by the chief nurse and medical director with the CMGs

- Service level dashboards (e.g. women's services, children's services and fractured neck of femur)

- Ward performance data at the Nursing Executive Team and Executive Quality Board
- Results from peer reviews and other external accreditations
- Outcome data including mortality is reviewed at the Mortality Review Committee
- Participation in clinical audit programmes
- Outcomes from Commissioner quality visits
- Complaints, safety and patient experience data
- Review of risk registers

4.2 Participation in clinical audits

Leicester's Hospitals are committed to undertaking effective clinical audit within all the clinical services provided and this is a key element for developing and maintaining high quality patient-centred services.

National clinical audits are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP), which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP).

Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health.

During the 2016/17 period Leicester's Hospitals participated in 95% (40 out of 42) of the national clinical audits and national confidential enquiries 100% (14 out of 14) in which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Leicester's Hospitals participated in and for which data collection was completed during the 2016/17 period are listed in appendices 1.1 and 1.2 alongside the number of cases submitted to each audit or enquiry where possible.

The provider has reviewed the reports of 33 national clinical audits and 311 local clinical audits in 2016/17. University Hospitals of Leicester NHS Trust intends to take the following action to improve the quality of healthcare provided:

- All completed audits have an audit summary form which includes details of compliance levels with the audit standards and actions required for improvement including the names of the clinical leads responsible for implementing these actions. The summary forms of every audit undertaken are available to all staff on the intranet.

- There are various examples within this Quality Account of the different types of clinical audits both national and local being undertaken within our hospitals and the improvements to patient care achieved.

- Each year we hold a clinical audit competition for projects that have improved patient care and a summary of the two winners this year are below:-

Management of pain in patients with neck of femur fractures on the integrated care pathway: from the Emergency Department to the Trauma Unit. Reaudit (Orthopaedics #6652)

“Hip fracture is a common injury in the elderly and the commonest cause of accidental death in this age group. In the UK, 1.5 million bed days are used each year to treat patients with hip fractures. 1% of the NHS budget is used for treatment of hip fractures. A Hip fractures service, serves as a marker of health care provision offered to older people.

NICE has provided guidelines for the management of the hip fractures. We performed an audit to evaluate our trust’s compliance with these standards. Our initial audit performed in 2012 showed that the pain was not assessed Nor managed satisfactorily in elderly patients with hip fractures. We introduced an aide-memoire in the form of a checklist for junior doctors to manage pain in hip fracture patients.

This simple measure had a significant impact on patient care, the pain assessment increased from 4% -100%. Likewise, there was a significant improvement in the management of pain and 100% of patients received analgesia.

We observed a significant improvement in the acute care of patients with hip fracture. The checklist served as a tool to ensure compliance with NICE guidelines. In addition, this audit has improved the awareness of junior doctors

and nurses about standards of hip fracture care. Through this audit, we were able to effect a positive change in practice".

Auditing the assessment and management of paediatric burns (Emergency Department (ED) #6639)

"The paediatric burns audit was a joint venture by both the Paediatric ED and burns teams. A trainee in ED with a strong burns interest who recognised that the documentation of burns injuries did not always contain the appropriate information - both from a safeguarding point of view and also from the point of view of what the burns team needed to know. Burns in children are difficult to assess for severity due to the differing sizes of children giving different percentages of burn. An audit was performed that showed that documentation was poor and that antibiotics were still being given to children as a preventable measure.

The team designed a proforma to document all the essential information. It included the necessary body maps and prompts to remember safeguarding and also first aid and analgesia. The form also gives information on follow up and referral pathways.

After implementation our documentation improved markedly and no children were given inappropriate antibiotics. The proformas were recognised by the midlands burn team who externally audit our care, and they are keen to roll them out to other regional hospitals.

The audit findings have been presented locally and internationally.

4.3 Participation in clinical research

The number of patients receiving NHS services provided by or subcontracted by the University Hospitals of Leicester in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 9,914.

The Leicester's Hospitals were involved in conducting 957 clinical research studies. Of these 748(78%) were adopted and 209 (22%) non-adopted. 223 (23%) of the total were commercially sponsored studies. Leicester's Hospitals used national systems to manage the studies in proportion to risk. 54% of the studies given approval were established and managed under national model agreements. In 2016/17 the National Institute for Health Research (NIHR)

supported 748 (78%) of the total number of research studies through its research networks. In the calendar year 2016 there were over 250 full papers published in peer reviewed journals.

In September 2016 Leicester's Hospitals and its main academic partner the University of Leicester together with Loughborough University were awarded Biomedical Research Centre status by the NIHR, building on the success of the previous three Biomedical Research Units hosted by Leicester's Hospitals.

Data refers to 01/04/16 to 28/02/17 except where stated.

4.4 Use of the CQUIN Payment Framework

A proportion of Leicester's Hospitals income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between the hospital and the CCGs and NHSE Specialised Commissioning services. For 2016/17 the baseline value for national, local commissioning and specialised CQUINS was £16,147,504. This means that when the hospital agreed contracts with commissioners and NHSE it was agreed that a % of contract value would be received upon achieving certain quality indicators.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at:
https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

Leicester's Hospitals did not fully meet the targets set for the Next Steps local commissioning CQUIN; this CQUIN aims to ensure that every patient on a cancer two week wait pathway knows what their next step will be, when it will be and where it will be.

Leicester's Hospitals did not fully meet the specialised CQUIN, Hepatitis C Virus Improving Treatment Pathways through Operational Delivery Networks.

Leicester's Hospitals has opted to pursue an 'in house solution' rather than subscribe to one of the 'NHSE framework companies' software' and therefore we did not meet the CQUIN threshold for Clinical Utilisation Review Tool.

As part of the national CQUIN on antimicrobial stewardship we are, as a hospital, required to make a 1% reduction in overall antimicrobial consumption. Consumption of meropenem has increased dramatically over the past 12 months as a result of the treating patients in accordance with the Sepsis 6 Pathway.

4.5 Data quality

University Hospitals of Leicester NHS Trust will be taking the following actions to improve data quality:

- The Data Quality Forum meets monthly to have oversight of the process and gain assurance of the quality of data reported to the Trust Board and to external agencies to ensure by best endeavours that it is of suitably high quality, is timely and accurate. This process uses a locally agreed Data Quality Framework to provide scrutiny and challenge on the quality of data presented. Where such assessments identify shortfalls in data quality, risks are identified together with recommendations for improvements to ensure that the quality is raised to the required standards

- There are quarterly reports on the quality of commissioning data and Clinical Coding presented to the Executive Quality Board. These review the hospital's position compared to peer organisations within the Data Quality Maturity Index (produced by NHS Digital) and benchmarking of Coding completeness

- There is an Information Quality Improvement Group, to establish and agree priorities for improving the quality of commissioning and administrative date. Activities include audit of quality and review of documentation and training guidance

- There is Corporate Data Quality meeting every week where inaccurate and incomplete data collection is challenged. The Data Quality team action reports on a daily basis to maximise coverage of NHS Number, accurate GP registration, and ensure singularity of patient records

NHS Number and General Medical Practice Code Validity

The University Hospitals of Leicester NHS Trust submitted records during 2016/2017 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:

    - 99.8% for admitted patient care
    - 99.8% for out patient care

  - 98.0% for accident and emergency care

- which included the patient's valid General Medical Practice Code was:

  - 100% for admitted patient care
  - 100% for out patient care
  - 100% for accident and emergency care

The patient NHS number is the key identifier for patient records. The National Patient Safety Agency (NPSA) is concerned about the number of patient misidentification incidents reported nationally. Between June 2006 and the end of August 2008, the NPSA received over 1,300 reports of incidents resulting from confusion and errors about patients' identifying numbers. Improving the quality of NHS number data has a direct impact on improving clinical safety. Guidance on the NHS number is available at: www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber

Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a trust to the patient's GP. Information on the validation of the General Medical Practice Code is available at www.datadictionary.nhs.uk/data_dictionary/data_field_notes/g/general_medical_practice_code_(patient_registration)_de.asp

The source for the NHS Number and General Medical Practice Code (Patient Registration) validity percentages is the most recent provider view of the SUS Data Quality Dashboard. The dashboard presents the cumulative percentages of valid NHS numbers and GP Practice Codes in admitted patient care (APC), outpatient care (OP) and accident and emergency care (A&E) records for each acute trust. You can register to receive SUS Data Quality Dashboards at ww.ic.nhs.uk/services/secondary-usesservice-sus/using-this-service/data-quality-dashboards.

Clinical coding error rate

The University Hospitals of Leicester NHS Trust was not subject to the Payment by Results clinical coding audit during 2016/2017 by the Audit Commission.

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient

records. Information about the Payment by Results Data Assurance Framework clinical coding audit is available from the Audit Commission.

4.6 Information Governance Toolkit attainment level

University Hospitals of Leicester NHS Trust's Information Governance Assessment Report score overall score for 2016/17 was 80% and was graded green / satisfactory.

We recognise the importance of robust information governance. During 2015/16, the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Information Governance Toolkit.

This contains 45 standards of good practice, spread across the domains of:

- information governance management
- confidentiality and data protection assurance
- information security assurance
- clinical information assurance
- secondary use assurance
- corporate information assurance

We must achieve level 2 level 2 or above on all 45 requirements to be a satisfactory or trusted organisation

Our information governance improvement plan for 2017/18 is overseen by our Information Governance Steering Group, chaired by the senior information risk owner.

4.7 Care Quality Commission (CQC) ratings

University Hospitals of Leicester NHS Trust is required to register with the CQC and its current registration status is 'Requires Improvement'.

On the 20th to the 23rd June 2016, the CQC carried out a comprehensive inspection of Leicester's Hospitals services. The aim of a comprehensive inspection is to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led.

This inspection covered seven of the eight core services:

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatient services and diagnostic imaging (such as x-rays and scans)

On Thursday 26 January, the CQC published their final reports along with their ratings of the care provided, a summary of which is:

Overall trust ratings

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

Royal Infirmary

Medical Care	Surgery	Intensive / Critical Care	Maternity & Gynaecology	Services for children & Young People	End of Life Care	Outpatients & diagnostic Imaging	Overall
Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

General Hospital

Medical Care	Surgery	Intensive / Critical Care	Maternity & Gynaecology	End of Life Care	Outpatients & diagnostic Imaging	Overall
Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Glenfield

Medical Care	Surgery	Intensive / Critical Care	Services for children & Young People	End of Life Care	Outpatients & diagnostic Imaging	Overall
Good	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement

Of the 100 ratings in total (for each domain of each main service grouping), 1 is Outstanding (for the effectiveness of our East Midlands Congenital Heart service at Glenfield), 55 are Good, 41 are Requires Improvement and 1 is Inadequate (the Responsive domain of emergency care at the Royal). Two elements were unrated for technical reasons.

When the CQC carried out their inspection of our hospitals we told them that our biggest strength was our staff; your strong motivation, commitment and ambition to improve our services for our patients and for each other.

The CQC saw this for themselves and it was echoed in their feedback. They told us that they found our staff to be "*universally welcoming, open and transparent*" and they were clearly very impressed by the compassion, professionalism and loyalty of everyone they encountered. This is reflected in the fact that "Caring" has been rated "Good" across all three hospital sites.

University Hospitals of Leicester NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has taken enforcement action against University Hospitals of Leicester NHS Trust during 2016/17 as follows:

In June 2016 Leicester's Hospitals had a Section 31 condition in place following the unannounced Care Quality Commission inspection of the Emergency Department in November 2015. This Section 31 required weekly reporting to the

Care Quality Commission against staffing in the Emergency Department, sepsis and time to assessment.

Sufficient evidence of improvement has been provided to the CQC to enable the lifting of this condition on the 15 November 2016.

University Hospitals of Leicester NHS Trust has made the following progress by 31st March 2017 in taking such action:

Since the inspection in June 2016 a number of improvements have been made and some concluded. These are captured in an improvement action plan which is monitored through our Trust Board.

5. Other Statements

5.1 Statements from our stakeholders

Statement to be provided by HealthWatch

Statement to be provided by LLR CCGs

Statement to be provided by the Leicestershire Health Overview and Scrutiny Committee

Statement to be provided by the Leicestershire Health and Wellbeing Scrutiny Commission

5.2 Statement from our External Auditors

Statement to be provided by KPMG

5.3 Statements of Director Responsibilities in respect to the Quality Account

6. Appendices

6.1 Appendix 1.1 The national clinical audits that Leicester's Hospitals were eligible to participate in during 2016-17

No	Name of Audit	Did UHL participate?	Stage	UHL Ref number
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Awaiting report	7923
2	Adult Asthma (BTS)	Yes	Awaiting report	7441
3	Adult Cardiac Surgery	Yes	Action Planning	7939
4	Asthma (paediatric and adult) care in emergency departments (CEM)	Yes	Awaiting report	7930
5	Bowel Cancer (NBOCAP)	Yes	Action Planning	8093
6	Cardiac Rhythm Management (CRM)	Yes	Awaiting report	7940
7	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Continuous Data collection	7941
8	Child Health Clinical Outcome Review Programme	N/A	Both studies not applicable to UHL	NA
9	Chronic Kidney Disease in primary care	N/A	Not applicable to UHL	NA
10	Congenital Heart Disease (CHD)	Yes	Action Planning	7943
11	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Awaiting report	7944
12	Diabetes (Paediatric) (NPDA)	Yes	Continuous Data collection	7945
13	Elective Surgery (National PROMs Programme)	Yes	Continuous Data collection	NA
14	Endocrine and Thyroid National Audit	Yes	Awaiting report	8656
15	Falls and Fragility Fractures Audit programme (FFFAP)	Yes	Participated in both relevant	7768, 7473, 8152

No	Name of Audit	Did UHL participate?	Stage	UHL Ref number
16	Head and Neck Cancer Audit	Yes	Continuous Data collection	8659
17	Inflammatory Bowel Disease (IBD) programme	No	No data submitted in 16/17	8208
18	Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	Continuous Data collection	M&M programme
19	Major Trauma Audit (TARN)	Yes	Action Planning	7949
20	National Audit of Dementia	Yes	Awaiting report	6846
21	National Audit of Pulmonary Hypertension	N/A	Not applicable to UHL	
22	National Cardiac Arrest Audit (NCAA)	Yes	Action Planning	7964
23	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes	Continuous Data collection	8339 and 8338
24	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	Yes	Data collection yet to start	7965
25	National Diabetes Audit - Adults	Yes	Action Planning	8183, 7950, 7751
26	National Emergency Laparotomy Audit (NELA)	Yes	Continuous Data collection	7342
27	National Heart Failure Audit	Yes	Awaiting report	7951
28	National Joint Registry (NJR)	Yes	Continuous Data collection	8557
29	National Lung Cancer Audit (NLCA)	Yes	Action Planning	7952
30	National Neurosurgery Audit Programme	N/A	Not applicable to UHL	
31	National Ophthalmology Audit	No	Did not participate	7771
32	National Prostate Cancer Audit	Yes	Continuous Data collection	8655

No	Name of Audit	Did UHL participate?	Stage	UHL Ref number
33	National Vascular Registry	Yes	Continuous Data collection	8657
34	Neonatal Intensive and Special Care (NNAP)	Yes	Continuous Data collection	7999
35	Nephrectomy audit (BAUS)	Yes	Continuous Data collection	6580b
36	Oesophago-gastric Cancer (NAOGC)	Yes	Continuous Data collection	8658
37	Paediatric Intensive Care (PICANet)	Yes	Action Planning	6864
38	Paediatric Pneumonia	Yes	Continuous Data collection	6865
39	Percutaneous Nephrolithotomy (PCNL)	Yes	Continuous Data collection	8562b
40	Prescribing Observatory for Mental Health (POMH-UK)	N/A	Not applicable to UHL	
41	Radical Prostatectomy Audit (BAUS)	Yes	Continuous Data collection	8559b
42	Renal Replacement Therapy (Renal Registry)	Yes	Action Planning	7954
43	Rheumatoid and Early Inflammatory Arthritis	Yes	Completed	6739
44	Sentinel Stroke National Audit programme (SSNAP)	Yes	Continuous Data collection	7953
45	Severe Sepsis and Septic Shock – care in emergency departments	Yes	Awaiting report	7931
46	Specialist rehabilitation for patients with complex needs	Yes	Continuous Data collection	8662
47	Stress Urinary Incontinence Audit (BAUS)	N/A	Not applicable to UHL	
48	UK Cystic Fibrosis Registry	Yes	Awaiting report	7962b and 7962c

6.2 Appendix 1.2 The national confidential enquires that Leicester's Hospitals were eligible to participate in during 2016-17

Enquiry workstream	Enquiry Project Title	Did UHL participate?
Maternal, New-born and Infant Clinical Outcome Review Programme	Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Yes
	National surveillance of perinatal deaths	Yes
	Confidential enquiry into serious maternal morbidity	Yes
	National surveillance and confidential enquiries into maternal deaths	Yes
	Perinatal Mortality Surveillance	Yes
	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes
	Maternal mortality surveillance	Yes
Medical and Surgical Clinical Outcome Review Programme	Perioperative diabetes	Yes
	Cancer in Children, Teens and Young Adults	Yes
	Heart Failure	Yes
	Acute Pancreatitis	Yes
	Physical and mental health care of mental health patients in acute hospitals	Yes
	Non-invasive ventilation	Yes
Mental Health Clinical Outcome Review Programme	Suicide by children and young people in England(CYP)	N/A

6.3 Feedback form

We hope you have found this Quality Account useful. In order to make improvements to our Quality Account we would be grateful if you would take the time to complete this feedback form and return it to:

Director of Clinical Quality
Leicester's Hospitals
The Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Email: sharron.hotson@uhl-tr.nhs.uk

1. How useful did you find this report?
   Very useful □
   Quite useful □
   Not very useful □
   Not useful at all □

2. Did you find the contents?
   Too simplistic □
   About right □
   Too complicated □

4. Is the presentation of data clearly labelled?
   Yes, completely □
   Yes, to some extent □
   No □

5. Is there anything in this report you found particularly useful?

6. Is there anything you would like to see in next year's Quality Account?

If you would like this information in another language or format, please contact the service equality manager on 0116 250 2959

إذا كنت ترغب في الحصول على هذه المعلومات في شكل أو لغة أخرى ، يرجى الاتصال مع مدير الخدمة للمساواة في 0116 250 2959.

আপনি যদি এই লিফলেটের অনুবাদ - লিখিত বা অডিও টেপ'এ চান, তাহলে অনুগ্রহ করে সার্ভিস্ ইকুয়ালিটি ম্যানেজার ডেভ বেকার'এর সাথে 0116 250 2959 নাম্বারে যোগাযোগ করুন।

如果您想用另一种语言或格式来显示本资讯，请致电 0116 250 2959 联系"服务平等化经理" (Service Equality Manager)。

જો તમને આ પત્રઇકાનું લેખિત અથવા ટેઈપ ઉપર ભાષાંતર જોઈતુ હોય તો મહેરબાની કરી સર્વિસ ઈક્વાલિટી મેનેજરનો 0116 250 2959 ઉપર સંપર્ક કરો.

यदि आप को इस लीफलिट का लिखती या टेप पर अनुवाद चाहिए तो कृपया डेब बेकर, सर्विस ईक्वालिटी मेनेजर से 0116 250 2959 पर सम्पर्क कीजिए।

Jeżeli chcieliby Państwo otrzymać niniejsze informacje w tłumaczeniu na inny język lub w innym formacie, prosimy skontaktować się z Menedżerem ds. równości w dostępie do usług (Service Equality Manager) pod numerem telefonu 0116 250 2959.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਲੀਫਲਿਟ ਦਾ ਲਿਖਤੀ ਜਾਂ ਟੇਪ ਕੀਤਾ ਅਨੁਵਾਦ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਡੈਬ ਬੇਕਰ, ਸਰਵਿਸ ਇਕੁਆਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116 250 2959 'ਤੇ ਸੰਪਰਕ ਕਰੋ।

Ak by ste chceli dostat túto informáciu v inom jazyku, alebo formáte, kontaktujte prosím manažéra rovnosti sluzieb na tel. čísle 0116 250 2959.

Haddaad rabto warqadan oo turjuman oo ku duuban cajalad ama qoraal ah fadlan la xiriir, Maamulaha Adeegga Sinaanta 0116 250 2959.

HEALTH AND WELLBEING SCRUTINY COMMISSION

12 APRIL 2017

Report of the Leicester City Clinical Commissioning Group

Shared Care Agreements

Background

1. Shared care arrangements aim to facilitate the seamless transfer of individual patient care from secondary care to general practice. They are intended for use when complex medicines are prescribed for a sometimes complex condition and are initiated in secondary care (i.e., in hospital) and then prescribed by GP in primary care once the patient is considered stable. These medicines and conditions will require ongoing monitoring.

2. Shared care agreements were introduced through NHS Circular No 1992 (GEN) 11 *'Responsibility for Prescribing between Hospitals and GPs'* which states that a consultant should seek the agreement of the GP to share the care of a patient. Information regarding dosage, administration and monitoring should be provided by the consultant for the GP. Decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on convenience or cost of the medicine and associated monitoring or follow-up.
3. EL(91)127 "Responsibility for Prescribing between Hospitals and GPs.", from the Department of Health also states:

4. "When clinical and / or prescribing responsibility for a patient is transferred from secondary to primary care, the primary care prescriber should have the appropriate competence to prescribe the necessary medicines. Therefore, it is essential that a transfer of care involving medicines that a primary care prescriber would not normally be familiar with, should not take place without the sharing of information with the primary care prescriber and their mutual agreement to the transfer of care.

5. Examples of situations where this would apply include medicines:

    - prescribed for a potentially serious condition
    - that are complex [intended use likely to be out with the clinical experience of a GP]
    - that have relatively high adverse effect profile requiring monitoring
    - that may require specific monitoring and dose titration
    - that are new, or rarely prescribed
    -

6. Shared care agreements facilitate the care of patients closer to home for complex conditions and /or complex medicines and new medicines that GPs may not be familiar with. They are for conditions that a GP would not be expected to care for without secondary care input and for drugs that are not wholly appropriate for use without secondary care input to support the GP

7. Since this NHS circular every NHS organisations across the UK has shared care agreements in place. They can also be between other service providers of health, for

example Local Authority commissioned Drug and Alcohol Services and Sexual Health services.

8. Shared Care Agreements have been recognised practice in the NHS since 1992. In Leicestershire, and most other areas, there is a shared care agreement written specifically for each drug and/or condition (or groups of drugs for a condition) deemed suitable for shared care. This is so that all parties are aware of their responsibilities for sharing the care of patients.

9. Clearly defined processes and good communication are essential components to shared care. All prescribers must be aware of their responsibilities when prescribing all medicines and primary care prescribers must receive comprehensive information to allow safe and effective prescribing to take place. Primary care prescribers must feel competent to take on the prescribing, given that these are usually complex medicines for complex conditions, and therefore GP agreement is needed before care is transferred.

What is a shared care agreement?

10. Shared care is an agreement between the patient's GP and Consultant to use a certain medicine, for a given condition, in a predefined manner, where an approved guideline that has been co-authored in primary and secondary care is available.
    For example

11. Without a supporting guideline the full clinical responsibility lies with the person signing the prescription. Where is it not reasonable for the GP to take this responsibility (where the condition is complex or the drug is complex as described above) alone but with the support of a consultant team it is safe to do so, a shared care guideline is written. This is required because the prescriber signing the prescription takes full responsibility for prescribing without the shared care agreement

12. This document provides a clear framework as to what the GP will do and what the consultant will do to support the management of the patient. Therefore the GP has a document that shows that, although outside their normal area of competence, there is a safe plan in place to allow them to take clinical responsibility and sign the prescription. There must always be a quick contact route back to the consultant should there be complications that the GP does not feel competent to manage. A shared care agreement outlines ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and a primary care prescriber. Primary care prescribers are invited to participate.

13. If the GP is unable to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for that diagnosed condition remains with the specialist.

14. Primary care prescribers are advised <u>not</u> to take on prescribing of these medicines unless they have been requested to do so through a shared care agreement request form - which also includes their responsibilities with regards to monitoring, side effects and interactions.

15. Primary care prescribers should inform secondary care of their intentions as soon as possible by returning the completed form. Only then can transfer of care be arranged. This will ensure that there is absolute clarity as to who is taking over the prescribing, and any associated monitoring responsibilities.

16. Sharing of care assumes communication between the specialist, primary care prescriber and patient. The intention to share care is usually explained to the patient by the prescriber initiating treatment (in most cases the specialist clinician). It is important that patients are consulted about treatment and are in agreement with it. Patients should remain under regular follow-up in secondary care, where it is expected that the patients overall response to treatment, and continued need, will be monitored.

17. Prescribers are reminded that the doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

Shared Care in Leicester Leicestershire and Rutland

18. In Leicestershire there are two types of shared care:
    - Full shared care, where a drug requires monitoring of the drug use and condition; or
    - Simple Shared care, where the drug requires no further monitoring but is only initiated by a Specialist consultant because of place in therapy defined by national or local guidance e.g. NICE guidance or Local formulary guidance

19. Before a drug can become a shared care drug there is a robust process to be followed to determine suitability for Shared care (full or simple) which consists of a Medicines information review of the medication to allow the members of the Drugs and Therapeutics Committee (Therapeutic Advisory Service) to complete a critical appraisal of the drug and to recommend to the Joint area prescribing committee (Leicestershire Medicines Strategy Group) whether a drug should be available for shared care.

20. A shared care agreement for each drug and or conditions is written which clearly defines the responsibilities for the specialist, the GP practice and the patient. With this is a shared care request from which must be completed by the specialist for a GP to consider taking on the care. The GP returns this whether they accept the shared care or not.

What conditions are they used for?

21. All areas of medicines use shared care agreements to some extent, although some clinical areas use them more than others e.g. Rheumatology and Mental Health. They are for specific conditions and drugs and provide details of the responsibilities for the consultant the GP and the patient. More details on SCAs can be found on www.lmsg.nhs.uk.

Table 1: Full shared care drugs

Area	Drug
Paediatric physical health	Amiloride (paediatric cardiology)
	Testosterone (paediatric)
	Lisinopril (paediatric cardiology)
	Spironolactone (paediatric cardiology)
	Captopril (paediatric cardiology)
	Furosemide (paediatric cardiology)
	Enalapril(paediatric cardiology)
	Losartan
	Azathioprine (paediatric gastroenterology)
	Mercaptopurine (paediatric gastroenterology)
Paediatric Mental Health ADHD etc	Atomoxetine
	Lisdexamfetamine
	Methylphenidate (paediatric)

	Dexamfetamine
	Guanfacine
Adult Mental Health	Amisulpride
	Antipsychotics (atypical)
	Antipsychotics (atypical) in personality disorder
	Aripiprazole long acting injection
	Aripiprazole oral
	Atomoxetine
	Dexamfetamine
	Donepezil
	Lisdexamfetamine
	Methylphenidate
	Venlafaxine (high dose)
	Zuclopenthixol decanoate
	Lithium
	Flupenthixol decanoate
	Fluphenazine decanoate
	Memantine
	Risperidone long acting injection Agomelatine
	Haloperidol decanoate
	Olanzapine
	Mianserin
	Methylphenidate
	Quetiapine
	Rivastigmine
	Paliperidone palmitate long acting injection
Rheumatology	Methotrexate oral
	Penicillamine
	Gold salts
	Azathioprine
	Hydroxychloroquine
	Sulfasalazine oral
	Leflunomide
Dermatology	Ciclosporin
	Methotrexate oral
	Azathioprine
Gastroenterology	Methotrexate oral (Crohn’s disease)
	Mesalazine oral
	Risperidone oral
	Azathioprine
	Balsalazide
	Mercaptopurine (adult gastroenterology)
	Sulfasalazine oral and rectal
Cardiovascular	Aliskiren
	Apixaban (DVT and PE)
	Dalteparin
	Rivaroxaban (DVT and PE)
	Sacubitril / valsartan
Endocrinology	Cabergoline
	Testosterone
	Cinacalcet
	Denosumab

Neurology	Bromocriptine
	Riluzole
	Modafinil
	Pramipexole
	Rotigotine

Shared care agreement engagement

22. Shared care is an agreement between two clinicians facilitated by the production of shared care agreement. Responsibilities are developed by multidisciplinary teams to support the GP in assessing whether they feel competent to take on the care with the support of the shared care agreement.

23. Most practices across Leicester, Leicestershire and Rutland accept most shared care agreement requests providing:

    - the information they contain is complete
    - the request is in line with the shared care agreement criteria endorsed in Leicester Leicestershire and Rutland
    - the patient is stable
    - the GP feels competent to take on the shared care..

24. Generally, refusal for shared care requests are for the reasons above and are normally resolved by the interface pharmacist, CCG Prescribing Advisors ,the GP and the specialist involved. This means:
    - missing information is provided and the shared care agreement is then normally accepted by the GP.
    - requests outside of the criteria for shared care agreements for the condition and/or medicine are retained by the specialist.
    - shared care is normally accepted once the specialist confirms that patient is stable.
    - where the specialist supports the GP in their competency and knowledge to take on the specific shared care.

    .

25. There are currently two practices in the city refusing most shared care. These are being worked with to address concerns and facilitate acceptance of shared care once their concerns are addressed.

Appendix D

Update on Oral Health in Leicester

Report for : Health & Wellbeing Scrutiny Commission

Report Date: 12th April 2017

Lead Director : Ruth Tennant, Director of Public Health

Useful information

- Ward(s) affected: All
- Report author: Paul Akroyd
- Author contact details: paul.akroyd@leicester.gov.uk, 0116 454 2316
- Report version number plus Code No from Report Tracking Database:

Suggested content

1. Purpose of report

This is the second report to the Health & Wellbeing Scrutiny Commission and provides an update on Oral Health in Leicester.

2. Summary

In September 2013 Leicester City Council established the Oral Health Promotion Partnership Board (OHPPB) to facilitate and coordinate responsibilities and activities for improving oral health. Three months after being established, the Board agreed and endorsed the first Oral Health Promotion Strategy (OHPS) for preschool children (2014-2017).

Poor oral health, as with general health, is more common in individuals from areas of relative deprivation. The wider determinants of health such as poverty, poor housing, access to food, access to services, education and unemployment impact on oral health as they do on general health. Dental decay has been shown to be multigenerational; caregivers with higher decay are more likely to have children with high decay. Therefore improving oral health can have a positive impact on general health and wellbeing across the life course for a wide variety of factors such as diet, nutrition, sleep, social interaction, work, school readiness & confidence. Tooth extraction under general anaesthetic is also one of the key reasons that children are admitted to hospital with associated preventable costs for the NHS.

The ambition of the board is to see a 10% increase in the number of 5 year olds who are decay free by 2019. Dental health survey results for five year olds released by Public Health England in May 2016 already show a significant 8% improvement.

Soon after it was established the board embarked on the establishment of Leicester's early intervention programme Healthy Teeth, Happy Smiles! (HTHS!). A range of leaflets aimed at adults & children have been developed & distributed and are also available to download.

The Council has received an award from the Royal Society of Public Health for its programme of oral health improvement for children. The Chief Dental Officer is also looking into how the Leicester model can be fed into a national programme.

3. Recommendations

Health & Wellbeing Scrutiny Commission are asked to note the contents of this update.

4. Report

Update

Oral Health Promotion Services: Leicester's Oral Health Promotion Service (OHPS) was established in February 2015. This extension to the skills mix has been key in delivering operational aspects of the oral health programme. To date 401 people have attended oral health training, and 758 members of staff in pre-school settings have been trained to deliver Supervised Toothbrushing. The service has been at 83 venues & spoke to 6240 people about oral health during national campaigns like National Smile Month, World Oral Health Day & Mouth Cancer Action Month.

Supervised Toothbrushing Programme : All pre-school settings in the City have been given the opportunity to take part in a supervised toothbrushing programme with free training & free resources provided by the Council.

The numbers of settings currently offering the programme & movement since the last briefing are :

Measure	Previous Briefing	Current Position
STB Programme (Primary Schools) :		
- Proportion of offering STB	20% (n=15)	23% (n=17)
- Number of children involved	1288	1518
STB Programme (Nursery & Playgroups)):		
- Proportion offering STB	45% (n=62)	59% (n=77)
- Number of children involved	3198	4595
STB Programme (Special Schools) :		
- Proportion offering STB	0	13% (n=1)
- Number of children involved	0	16

The supervised toothbrushing in specials schools is being piloted at Ellesmere College and is aimed at all children on the school's roll.

Targets have been set for the Oral Health Promotion Service to ensure the number of settings in the programme continues to increase. The initial focus is nurseries and playgroups followed by schools.

Oral Health Resource Packs: The Universal offer of free toothbrushes and toothpastes to all children in the city at 5 separate points in their lives by age 5 has continued. During December 2016 packs were distributed by city schools to all children in nursery & reception classes. These are in addition to the packs already being distributed by Health Visitors. Over the last 2 years approximately 50,000 packs have been distributed. Targeted packs were distributed by the Family Nurse Partnership & Travelling Families Team.

Dental Epidemiology: As part of the NHS Dental Epidemiology Programme for England, our supplier will soon start collecting information on the oral health of 5 year olds in the city. This data will be an indicator of our progress against our target for a reduction in 5 year olds with decay. The data will also be used by NHS Digital to allow them to link the survey data with a

dataset they hold containing height and weight information from the National Child Measurement Programme

Training: The OHPS held a Continuous Professional Development aimed at dental practice practitioners. The theme of the event was dental prevention. During the event the success of the first Healthy Teeth, Happy Smiles! accredited dental practices was celebrated. The event was attended by 86 dental care practitioners from 14 dental practices across the city.

Accreditation Schemes

Dental: The James Cooil Dental Suite, Fosse Dental Care & Moti Smile Design Centre became the first dental practices in the city to receive the Healthy Teeth, Happy Smiles! accreditation. This quality mark of excellence demonstrates their commitment to improving oral health by supporting and promoting dental prevention.

Nursery: Applications for the pilot of the nursery accreditation were recently opened to nursery settings. The scheme aims to lay solid foundations for good oral health throughout life via regular toothbrushing, health eating & regular visits to the dentist.

Pharmacy: The OHPS is currently working in partnership with the Leicester Pharmaceutical Committee to ensure oral health is incorporated in the Healthy Living Pharmacy Accreditation Scheme.

Adults

A booklet advising on Oral Health in Pregnancy is currently available in all maternity receptions across UHL. Leaflets on tobacco and oral cancer were given out during Stoptober & Mouth Cancer Action Month 2016. A general leaflet on adult oral health is available in front line settings. A leaflet on diabetes and oral health will be available in late February 2017.

During Mouth Cancer Action Month the Oral Health Promotion Service held a number of roadshows across the city raising awareness of mouth cancer and teaching members of the public how to self-check. These sessions were delivered in partnership with NHS Health Education working across the East Midlands.

5. Financial, legal and other implications

5.1 Financial implications

The OHPPB has a ring fenced partnership budget of £631k funded by Leicester City Council & NHS England to cover the years 2014 to 2019. By the end of financial year 2016/2017, the estimated spend over a two year period is £405k. This leaves an estimated £226k to be used to continue delivering the strategy objectives until 2019.

5.2 Legal implications

N/A

5.3 Climate Change and Carbon Reduction implications

N/A

5.4 Equalities Implications

N/A

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

6. Background information and other papers:

None

7. Summary of appendices:

None

8. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

9. Is this a "key decision"?

No

Health and Wellbeing Scrutiny Commission

Work Programme 2016 – 2017

Meeting Date	Topic	Actions arising	Progress
25th May 16	1) Health profile: Overview of the city 2) Better Care Together: overview presentation 3) CAMHS 4) Anchor Recovery Hub Update	1) Health and Wellbeing Survey 2015 to be circulated to new members of the commission. 2) Chair to discuss issues of the delay relating to BCT with the Deputy City Mayor. 3) Information on a permanent site for CAMHS and on the relationship of the service with other agencies and the proposed direction of travel to be provided.	1) Completed
30th Jun 16	1) CQC inspection of University Hospitals of Leicester NHS Trust 2) Sustainability and Transformation Plans 3) Medicines and Self Care 4) Anchor Recovery Hub Update 5) LPT Scrutiny Review Report – Final Draft 6) CAMHS – Scoping document	1) Further information requested. 2) Report back at the next meeting to clarify the position re STPs and BCT including info on the costs of plans, what's being done and when, what's already happened, what do they actually mean in practice and is there any twin-tracking happening. 3) Report back at the next meeting. 4) Deputy CM to update commission members.	
7th Sep 16	1) Medicines and Self Care – verbal update 2) Anchor Recovery Hub – Update by chair 3) Oral Health briefing	2) Anchor hub decision delayed	

Meeting Date	Topic	Actions arising	Progress
9th Nov 16	1) Sustainability and Transformation Plan Update 2) CQC Review of Health Services for LAC and Safeguarding 3) Review of prescribing of paracetamol, other over the counter medicines and Gluten Free Foods 4) Public Health Performance Update	1) That the Commission meet after the STP is published to consider its implications for the health and wellbeing of people in the City. 2) Commission receive a further report in March on the progress made against the action plan shown by a RAG rating. 3) Commission receive a further report on the position statement to be agreed by the 3 CCGs and the details of any health messaging that is issued in relation to this issue.	
4th Jan 17	1) Public Health Budget 2) CQC Inspection of LPT – Update 3) Sustainability and Transformation Plan – Primary Care	1) Future budget reports need to have a summary report specific to the portfolio of the SC and the inter-relationship with spending reviews. 2) CQC second visit report and cover report to come to the next meeting 3) All EIAs relating to the STP need to come to scrutiny.	
2nd Mar 17	1) CQC Inspection of LPT – Follow up visit findings 2) Sustainability and Transformation Plan – Maternity Services 3) Sustainability and Transformation Plan – UHL Acute Hospital Sites		
29th Mar 17	1) Sustainability and Transformation Plan – Mental Health 2) Sustainability and Transformation Plan – Public Representations		

Meeting Date	Topic	Actions arising	Progress
12th Apr 17	1) CQC Review of Health Services for LAC and Safeguarding 2) CQC review of inspection of LRI Emergency Department 3) UHL Quality Account 4) Shared Care Agreements 5) Oral Health Update		

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising	Progress
29th Sep 16	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust 2) UHL NHS Trust's View on NHS England's Proposals for Congenital Heart Disease Services 3) Other Viewpoints on NHS England's Proposals	Contact NHS England to inform them that the committee would like the review process to be stopped but if it is to go ahead then they will need to attend another joint meeting once the consultation is announced.	
14th Dec 16	1) Sustainability and Transformation Plan	All three council scrutiny committees agreed to consider elements of the STP separately based on local concerns. Another joint meeting will convene when each council has had separate consideration.	
14th Mar 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust		
25th May 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	To hear the views of patients and patient's representatives and interested community organisations.	

Forward Plan Items

Topic	Detail	Proposed Date
Anchor recovery hub	Developments of a permanent site	
CCG commissioning plans		
Commissioning of a diabetes structured patient education programme	To be programmed (mins of 21.04.16 refer)	
Dementia, Dental Care, Diabetes, GPs, Obesity, Smoking, COPD and Substance Misuse	Progress to individual strategies/services	
Health and Wellbeing of staff	Monitoring of sick days and support services	
Integrated Lifestyle Services review		
Mental Health and Sexual Health of the LGBT Community	Continue to understand and monitor the issues that impact on LGBT community	
Mental health system / Crisis Concordat	How it works locally and what we get out of it – what is the PH investment?	
Patient experience of the system	Work with Healthwatch to gain an understanding of how patients feel about health services	
Services at St Peters Health Centre		