University Hospitals of Leicester NHS Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

University Hospitals of Leicester NHS Trust was created in April 2000 with the merger of the Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. University Hospitals of Leicester NHS Trust is one of the biggest and busiest NHS trusts in the country, serving the one million residents of Leicester, Leicestershire and Rutland and increasingly specialist services over a much wider area.

The trust has a Children's Hospital and one emergency department on its Leicester Royal Infirmary site and 126 inpatient wards across the trust; 1991 inpatient beds, including 200 day-case beds and 179 children's beds. Each week the trust runs 1224 outpatient clinics.

The trust's nationally and internationally - renowned specialist treatment and services in cardio-respiratory diseases, ECMO, cancer and renal disorders reach a further two to three million patients from the rest of the country.

The trust also provides services from 20 other registered locations including St Mary's Birth Centre.

The trust operates acute hospital services from three main hospital sites:

- Leicester Royal Infirmary
- Leicester General Hospital
- Glenfield Hospital

The trust employs around 17,000 staff and has an income of £1.3bn for the current financial year 2022/23.

Our findings

The trust had set a financial plan to break even in 2022-23. The achievement of this plan was recognised as being a challenge and risks had been identified with system partners committed to develop a collaborative approach to managing any financial risk that emerges throughout the 2022/23 year. There was also a system approach to managing the urgent care pathway.

In April 2022, we conducted an unannounced inspection of urgent emergency care and medical care core services at Leicester Royal Infirmary using our focused methodology as we had concerns about the quality of services in these core services. Following the inspection we served a warning notice to the trust requiring them to make improvements to their urgent and emergency care services, to address safety concerns in respect of staff deployment, flow in, through and out of the emergency department, timely and consistent medical in reach processes, privacy and dignity, clarity in respect of clinical responsibility when patients were referred to speciality services and triage processes.

As part of that inspection, we had an additional focus on the urgent and emergency pathway across Leicester, Leicestershire and Rutland. This was to assess how patients' risks were being managed across health and social care services during increased and extreme capacity pressures.

Between June and September 2022, we conducted a comprehensive inspection of surgery at Glenfield Hospital (28 and 29 June 2022) because we had concerns about the quality of the service provided. These included the number of patients awaiting elective surgery which were breaching 104 weeks. Cancer performance was also a challenge with 31 and 62 day waits continuing on a downward trend, which provided special cause for concern. We also inspected the well-led key question for the trust overall.

We did not inspect any other services at the trust because our monitoring process had not highlighted any concerns. We will re-inspect these services as appropriate.

NHS England System Oversight Framework (SOF) provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes: quality of care, access and outcomes, preventing ill health and reducing inequalities, finance and use of resources, people and leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers requiring the least support. As of April 2022, the trust's SOF score was 4.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level within the trust. Our findings are in the section headed 'is this organisation well-led'. We inspected the well-led key question on 1 and 2 September 2022. NHS England also conducted a financial governance review at the same time as the well-led inspection. A separate 'Use of Resources' assessment was not conducted for this inspection.

Our rating of well-led went down. We rated them as requires improvement because:

- The trust had not always taken effective action to mitigate some risks to patients which were within their ability to improve, with the impact on patient care not yet fully realised in response.
- The trust's vision and strategy did not accurately reflect current priorities.
- Although action was being taken to improve the culture in the trust not all cultural issues had yet been fully addressed.

Our findings

- Not all staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.
- The trust's current governance arrangements resulted in duplication which meant there was duplication in the flow of information through to the executive boards and board committees.
- The audit committee was focused mainly on statutory financial issues with more limited oversight of the other responsibilities.
- The process to identify, escalate and mitigate all current trust risks was not always robust. There were significant delays from referral to treatment for patients waiting for elective care and treatment.

However:

- Leaders had the skills and abilities to run the trust with relevant experience and capability to deliver sustainable care.
- There were the same number of board members from an ethnically diverse background as at the last inspection. There were more women on the board and the senior management team was more diverse.
- The emphasis on the safety and wellbeing of staff within the trust was improving.
- The trust was improving governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.
- The trust now had clear plans and timeframes to implement the new strategy.
- All staff were committed to continually learning and improving services.
- Leaders encouraged innovation and participation in research.

Use of resources

A use of resources assessment was not completed as part of this assessment.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 1 legal requirement. This action related to surgical services at Glenfield Hospital.

Trust wide

- No regulatory breaches

Glenfield Hospital

Surgery

Our findings

- The trust must ensure that medical devices are maintained in line with manufacturer's recommendations. Regulation 12 – safe care and treatment.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that their process for identifying current risks are robust. Regulation 17 – good governance.
- The trust should ensure all documents relating to recruitment practices are retained in line with the trust policy. Regulation 17 – good governance.
- The trust should ensure all Disclosure and Barring Service (DBS) checks are up-to-date and stored correctly in staff employment records. Regulation 17 – good governance.
- The trust should consider increasing the capacity of the Freedom To Speak Up Guardians (FTSUG) to sufficiently support all staff at the trust.
- The trust should consider continuing to improve the promotion of equality and diversity within and beyond the organisation.
- The trust should ensure that patients waiting for elective and cancer care and treatment receive this in a timely manner.
- The trust should continue its work to improve the culture throughout the trust.
- The trust should continue the work to further develop effective governance systems and processes.

Glenfield Hospital

Surgery

- The trust should ensure that they continue to increase staffing levels by improving the recruitment and retention of nursing staff. Regulation 18 – good governance.
- The trust should ensure that staff are trained to monitor fridge temperatures and take appropriate action if medicines have been stored outside of their required parameters. Regulation12– safe care and treatment.
- The trust should ensure that full, partly full, and empty oxygen cylinders are segregated. Regulation12– safe care and treatment.
- The trust should consider improving entertainment and communication facilities for patients.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Our findings

The trust had not always taken effective action to mitigate some risks to patients which were within the trust's ability to improve. However, the trust were developing a full understanding of the priorities and issues the trust faced and how to address them. Leaders had the skills and abilities to run the trust. They had the experience and capability to deliver sustainable care. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust executive and non executive directors had the skills, knowledge and experience to run the trust. There had been a significant number of trust board changes since 2021 which had further extended the skills and abilities of leaders although they recognised they were still developing as a team. The trust chair joined the trust in April 2021. There had been four changes to the remaining non-executive director (NED) posts with the introduction of three new posts of associate NEDs. The NEDs provided a range of skills and experience and the introduction of the associate NEDs had enabled specific skills such as IT to be broadened further. Several experienced executive directors had also recently joined the trust. The chief executive started in October 2021, the chief operating officer and the chief finance officer in January 2022, the chief nursing officer in May 2022 and the deputy chief executive in June 2022.

There had been proactive recruitment into deputy director roles and the teams supporting the executive leadership team. The trust acknowledged that there was further work to do to ensure there was sufficient capacity at executive level. The aim was to ensure they had the capacity and capability to deliver against the current priorities and confidence the current level of progress could be sustained in the long term. They had successfully recruited experienced leaders into existing vacancies and had created new roles to deliver against their 2022-23 trust priorities.

Staff throughout the trust acknowledged positive changes in response to the new chief executive starting in September 2021 and the leadership changes. Feedback regarding the new leadership team recognised they were a cohesive, visible and transparent leadership team who had brought a sense of optimism to the trust and were taking staff with them on the improvement journey of the trust.

Staff we spoke with during the core service inspection confirmed the leadership team were approachable and visible. The chief executive officer (CEO) regularly visited areas across the site. There were mixed views regarding the visibility of the executive team during the COVID-19 pandemic however it is acknowledged that the majority of the team joined the trust in the last six months.

Leaders showed an empathetic and compassionate leadership style where there was a clear emphasis on supporting the wellbeing of staff. We attended the trust's public and private board on 1 September 2022 as part of the well led inspection. Leadership was demonstrated on a highly complex agenda with care, compassion and humility as well as direction and driving for improvements whilst keeping the trust safe and engaging staff, patients and partners.

The trust had a clear operational structure. This consisted of seven clinical management groups; each included a leadership team of a clinical director, head of nursing and head of operations. The team reported to the chief operating officer.

When considering the trusts whole senior leadership team it was now more ethnically diverse than during our last inspection in 2019.

The trust had prioritised making the trust board and overall leadership team more effective particularly since the current CEO had started at the trust in October 2021.

Our findings

The trust board had the same number of members from a black and minority ethnic group as at the previous inspection of the trust in 2019. There was one (8%) director and two (22%) of non-executive directors, including associates from black and minority ethnic groups.

The trust board now had a higher representation of female members than at the previous trust inspection in 2019. Of all the executive members of the trust board, six were female, six were male and a female Director of Communications and Engagement had joined the trust in October 2022.

Leaders were developing a full understanding of the challenges to quality and sustainability the trust faced. The newly formed trust board and executive team were working together collectively to understand these. However, in some areas the trust had not implemented effective actions to address some of the main challenges they faced. For example, the longstanding pressures to its provision of urgent and emergency care were still a concern. Whilst these improvements required a system wide approach, some parts of these issues were within the trusts ability to improve. The trust also had some of the highest backlogs of patients waiting for cancer care and elective procedures in England. They were working with a range of providers to establish additional capacity to address this. The trust's performance against the cancer standards continued to be a concern, with overall trust performance for two weeks, 31 and 62 days still not improving. In addition, the overall waiting list was continuing to grow. As of 26 September 2022, there were a total of 119 admitted elective patients and 48 non-admitted patients waiting between 100 and 109 weeks for procedures at the trust.

A total of 3861 admitted patients were waiting over 10 weeks for their procedure at the trust (892 patients at Glenfield Hospital, 1862 patients at Leicester General Hospital and 1107 patients at Leicester Royal Infirmary. A total of 119 admitted patients had been waiting between 100 and 109 weeks for their elective procedures (8 patients at Glenfield Hospital, 28 patients at Leicester General Hospital and 82 at Leicester Royal Infirmary.) A total of 27980 non-admitted patients were waiting over 10 weeks for their elective procedures to be conducted at the trust (6398 patients at Glenfield Hospital, 7326 patients at Leicester General Hospital and 14526 patients at Leicester Royal Infirmary). A total of 48 day case patients had been waiting between 100 and 109 weeks for their elective procedures (10 patients at Glenfield Hospital, 21 patients at Leicester General Hospital and 17 patients at Leicester Royal Infirmary).

The trust also acknowledged that it would be a challenge to have no patients waiting more than 78 weeks by the end of March 2023 in line with the national guidance.

The trust had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership which included leadership development programmes and leadership succession planning. The trust had a board development programme with external support available to enable the effectiveness of the board to develop further. As a new board they recognised the board development sessions were key to their future as a team, in addition to improving the decision- making structure, governance systems and processes and decluttering diaries. The programme showed a clearly set out schedule planned for up to and including December 2022. There was a correlation between what was set out in this schedule with what was fed back as part of the well-led inspection interviews for the development of the new trust strategy and consideration of risk reviews aligned to the development of the new Board Assurance Framework. The trust had also started their succession planning to strengthen their clinical leadership team. They were working with local educational organisations to further develop their leadership development programmes.

The trust had not ensured all records supported the employment of fit and proper directors. We reviewed six personnel files in line with the Fit and Proper Persons Requirement (FPPR): Directors (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and found most employment checks had been made. However, one non-executive director did not have a disclosure and barring service (DBS) check on file. This was raised with the trust and

they took action to ensure a valid DBS check was carried out following our inspection. A further issue with the FPPR documentation related to documentation in respect of recruitment processes. We reviewed three files for executive directors and found interview notes were not retained in the staff files. However, interview notes had been retained electronically.

The trust was beginning to focus on priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The chief nurse was the trust executive lead for adult and child mental health, learning disability and autism. They were supported by an experienced and specialised team. As a result, systems and processes were implemented to ensure staff could anticipate adjusted care needs. Through liaison with the local NHS mental health trust, patients living with learning disabilities and autism were made known to the trust and recorded and flagged on the trust's electronic patient records system. This enabled the trust to make reasonable adjustments, such as arranging for carers to accompany/stay with patients overnight. Initiatives to help meet the needs of patients had also been implemented, which included the psychiatric liaison service situated within the trust's emergency department. The specialist teams across mental health, learning disability and autism were also working with colleagues and groups across the Integrated Care System to develop a strategy to improve the care and treatment provided to these patients.

Vision and Strategy

The trust's vision and strategy were due a refresh as they did not accurately reflect current priorities. The current strategy did not evidence the trust was focused on sustainability of services and aligned to local plans within the wider health economy. However, the trust now had clear plans and timeframes to implement the new strategy.

The trust's vision and values and strategy did not reflect trust current priorities. The current trust strategy had been developed in 2018 and its implementation had been significantly impacted by the COVID-19 pandemic. The trust had set out their priorities for 2022/23 which were in line with the national priorities. The trust had started their co-production of a new strategy with patients, the local population, stakeholders, and trust colleagues. The trust aimed for this to be in line with the priorities of the Leicester, Leicestershire and Rutland Integrated Care Board who were also redeveloping their strategy for this time period. The trust aimed to complete this by the end of March 2023.

The trust values and vision to 'become the best' had both been developed around ten years ago. At the time of the last CQC well led inspection in 2019, the trust had a newly launched their three-year quality strategy which was for the period 2019 - 2022. In this time period, the trust had faced several significant challenges such as the COVID-19 pandemic in addition to unprecedented pressures on its urgent and emergency services and cancer and elective services. The trust had clear plans and timeframes to take the strategy forward which was due for completion by 31 March 2023. They had plans to coproduce the strategy with their communities, patients, staff and partners for the next financial year. The trust actions document for 2022-2023 clearly identified what actions were needed to deliver this strategy which included priorities aligned to the Leicester, Leicester and Rutland Integrated Care System such as reducing health inequalities and working with system partners to develop an integrated care system across the health and social care sector.

Not all senior staff within the senior leadership team were aware of the current trust strategy and how it aligned to their divisions. However, leaders felt the chief executive and chair had given the executive team a clearer vision and believed the momentum of changes could be maintained. However, there was little evidence of robust monitoring, reviewing or providing evidence of progress against the strategy.

Due to significant financial issues the trust had been placed in financial special measures in July 2020. This had now been replaced by the Recovery Support Programme as a result of a single oversight finance score of 4.

Our findings

The trust had submitted a challenging but realistic financial plan for 2022-23 to set the future financial priorities. The trust's financial forecast was balanced in terms of challenge and support to management in improving patient care.

The executive team understood the importance of addressing challenges in the health and social care system and were working together with the integrated care system (ICS) to ensure all priorities were met. Senior leaders were aware of the benefits of working as part of the system to drive forward future improvements for patients particularly as the trust was the main acute provider for the Leicester, Leicester and Rutland Integrated Care System.

The clinical strategy was being aligned and planned to meet the needs of the relevant population. The trust was part of the East Midlands Provider Network, which had helped to promote partnership working and had strengthened haematology and ear, nose and throat services regionally. The trust was collaborating with a local NHS trust to strengthen and deliver paediatric and rheumatology services. This approach enabled the two trusts to secure funding through specialist commissioning, which had previously been unavailable. The trust had also worked with six other local NHS providers to standardise cardiac surgery pathways to ensure consistency for patients. As part of this work, the trust was also coordinating with other providers to introduce an aortic dissection rota to enable availability of treatment at all six trusts. The trust was heavily involved in a system flow group to look at urgent and emergency care and discharge across the health care system. The group was chaired by the trust's chief executive officer. The group was being used to look at how risk could be shared across the treatment pathways.

Culture

The equality, diversity and inclusion agenda was in its infancy and there was limited strategic direction to comply with legislation and meet the equality standards. Not all staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. Although action was being taken to improve the culture in the trust not all cultural issues had yet been fully addressed. However, the majority of staff felt respected, supported and valued and were focused on the needs of patients receiving care. Staff felt able to raise concerns without fear of retribution

Timely and appropriate action was not always taken to address behaviour and performance that was inconsistent with the trust's vision and values. Some of the management of behaviour and performance had become protracted which had led it to lose some of its effectiveness. The trust was aware that their current policies and practices were not always effective in achieving timely or constructive outcomes. In response, they were implementing an agreed approach based on a 'Just and Restorative culture' which would be supported by appropriate training to improve outcomes. The trust was also working closely with Staff Side colleagues and learning from other partners to address this.

The capacity of the Freedom To Speak Up Guardians (FTSUG) was insufficient to support around 17,000 trust staff, especially as they did not have FTSUG champions to support them. There was only one whole time equivalent Freedom To Speak Up Guardian (FTSUG) for the whole trust which was a job share between two staff members. However, staff had informed us during our core service inspections that they felt able to raise concerns. In addition, staff responses regarding staff not experiencing harassment, bullying or abuse from managers and bullying or abuse from other colleagues were both better than the national average in the latest staff survey. The number of contacts made to the FTSUGs during 2021/22 was relatively low considering the size of the trust at 231. Most contacts to the FTSUGs (170) came directly through the FTSUG route. Whilst there were several ways staff could raise concerns to the FTSUGs, the executive team had already started improvements to ensure Freedom To Speak Up resources were available and used by all groups of staff. The trust had plans to increase the numbers of guardians and champions as part of their planned

restructuring of the trust governance structures and committees. They had recently agreed an interim 12-month plan to support the changes in the FTSUG provision which was due to be discussed at their People Committee in October 2022 before reporting to the trust board. The trust had also gained support from another NHS trust to learn how to further improve their Freedom To Speak Up service.

Leaders had acted on previous concerns that staff within the trust's finance team had felt unable to raise concerns regarding financial governance due to fear of retribution. Significant efforts, including changes in the leadership of the finance team had been made to ensure finance staff now felt comfortable to raise concerns with their leaders.

The trust's equality, diversity and inclusion (EDI) agenda was still in its infancy. The executive team were working to improve the promotion of equality and diversity within and beyond the organisation. The trust had recently appointed a new head for equality, diversity and inclusion to support this promotion who started in May 2022. They were co-ordinating with the current staff networks to develop them further and to strengthen their voice within the trust. However, the governance structures supporting the staff networks was inconsistent which meant escalation of information was variable. The trust had an equality advisory group to help inform decisions about services. It was recognised the membership was not representative of the community members and so work was being carried out to review the make-up of the group, its terms of reference and its direction.

Not all staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. Since being appointed, the head for equality, diversity and inclusion had conducted a gap analysis to assess whether the trust was meeting the requirements under the Equality Act. Gaps had been identified from this process and as a result the trust had engaged with staff to understand their experiences. Action plans were also implemented to address compliance. This process was in its early stages and so further work was required to achieve all the trust's targets. This work had the support of the entire board and included a review of recruitment practices, the trust's sickness absence policy and promotion opportunities. It was acknowledged by members of the executive team there were barriers to creating opportunities for staff from different ethnic backgrounds to lead and for promotion, but they were dedicated to removing them. In some areas of the trust, action had been taken to address this, but progress was slow. Areas of improvement included the emergency department, which had encouraged shared decision making and given those from different ethnic backgrounds opportunities to lead. This had led to an increase in diversity amongst band 6 nurses. It was hoped learning from the emergency department could be shared to promote improvement across the trust. The trust had initiated a leadership programme specifically for those from different ethnic backgrounds, but applications had been low.

During our well led interviews, leaders were open and compassionate. They were passionate about supporting staff wellbeing and the need to be inclusive and compassionate leaders. Staff stated there had been positive changes in culture particularly over the last few months. They felt when the executive team promised to deliver changes to improve staff wellbeing they ensured they were successfully implemented. For example, staff were concerned about the cost of living and a food bank had been set up and food in the canteen was subsidised. In addition, staff had been raising concerns about their safety whilst walking alone to the car park in the evening and during the night and the trust now provided escorts. There had been an improvement in the trust's finance and human resources team responsiveness in both quality and timeliness to pay queries. Staff felt the previous trust sickness policy was excessively harsh and the revised draft policy was much more compassionate. Overall, staff were positive about the changes in the culture across the trust however, some staff were not yet sure it had had changed sufficiently at all levels to yet be truly focused on resolution. It was noted that the joint consultative and negotiation committee was not yet running. Some staff were also anxious about whether these cultural changes would be sustained.

Our findings

The executive team demonstrated their emphasis on the safety and wellbeing of staff within the trust was improving. They were concerned about and recognised that their workforce was exhausted following the COVID-19 pandemic and the current work required for them to re-establish services to pre-pandemic levels. This was reflected in the latest national NHS survey in 2021 for the trust as 'the organisation takes positive action on health and well-being' was included in their most improved survey scores. The leadership team ensured continued wellbeing support packages were available to staff. Actions had been taken to improve medically led occupational health services and counselling for staff. Workshops had also been undertaken to improve education for staff on invisible disabilities. Attempts had been made to deliver initiatives in line with the national people plan and workstreams had been developed, but further work was required to ensure the fundamentals were right. Positive steps had been taken to understand and address support for in work poverty.

The executive team were driving to nurture a culture which centred on the needs and experience of people who use services. However, the trust was at an early stage in developing a strategy to deliver it. The trust had appointed a director of health equality and inclusion to lead on developing and delivering a strategy to address health inequalities.

This addition to the leadership team had the potential to positively impact the trust's culture but work was still in its infancy and there was not yet an infrastructure below director level to support them in the delivery of this work. Positive initiatives to address health inequalities had been implemented and positive outcomes had been achieved. However, the initiatives were not part of a quality improvement programme and the lack of formal processes for supporting, funding and delivering the initiatives meant progress and success could not be guaranteed.

The trust results for the most recent national staff survey conducted in Autumn 2021 were mixed. This was 18 months into the COVID-19 pandemic and the NHS nationally saw declining scores in many of the domains. The trust's response rate had improved from 33% in 2020 to 45% in 2021 and was comparable with the national average. The organisation had a higher than average percentage of respondents from people from a black and minority ethnic group. The scores that had declined the most were: having enough staff to do my job properly; recommending the organisation as a place to work; happy with the standard of care provided if a friend/relative needed treatment satisfied with recognition for good work. These had also declined nationally but the trust was below the national average for all of these. Most improved scores were that the organisation takes positive action on health and well-being; last experience of physical violence reported; not experienced harassment and feeling secure raising concerns about unsafe clinical practice, however these remained slightly worse than the national average. Although there was disparity between white respondents and people from a black and minority ethnic group for all but one of the workforce race equality standards at the trust, the percentages were better than the national average. The results for the disability equality standards were more mixed with half better and half worse than the national standards.

Governance

The trust's current governance arrangements resulted in duplication which meant there was replication of information through to the executive boards and board committees. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust was working to improve governance across the whole trust including reconfiguring processes within the governance framework to ensure reporting provided assurance and meetings ran in a way which meant all agenda items had equal focus.

Our findings

The trust's current governance structure resulted in duplication which meant information was repeated at various meeting in flow through the executive boards and board committees. Work had begun to address this as the director of corporate and legal affairs was taking a paper through to the audit committee to discuss the plans to conduct a review of the trust's existing governance arrangements, to ensure it enables efficient and robust decision making, openness and transparency.

In addition, they were also reviewing the terms of reference and supporting work plans for the board committees and redefining the purpose of the executive board and the work plan to support this. There has been some improvement already by establishing agenda setting meetings with committee chairs and executive leads. These helped to ensure more scrutiny over agenda items and their purpose.

The board assurance framework had recently been revised. The need to revisit this was recognised with the development of the new trust strategy.

The audit committee was focused mainly on statutory financial issues with more limited oversight of the other responsibilities. There was no current work plan made available from the monthly audit committee meetings despite them being established for some time. We were therefore not assured the current board assurance framework (BAF) was representative of the main risks faced by the trust. The BAF did not support leaders to shape the trust's future work plan and the wider issues it needs to secure independent assurance for. The trust had revised its board assurance framework, which was approved at their September 2022 public board meeting, which focused on the main strategic risks to the organisation.

The trust had an unusually high number of outstanding audit recommendations at around 80 in September 2022 from previous audits and years. Approximately half related to audit findings of a financial nature and 10% related to high priority recommendations. Staff from the finance team reported concerns relating to the payroll and purchase to pay systems (accounts payable). These ranged from reliance on manual systems and workarounds to concerns about the way the systems operated. This also correlated with internal audit findings in these areas. The trust had improved the financial management and financial governance arrangements following previous financial concerns which had led them to be put into financial special measures in 2020. Significantly restructuring and investment had taken place for the trust's finance function. However, leaders recognised further improvements were required to ensure current financial issues improved and previous financial issues would not reoccur.

The combination of audit findings, outstanding audit follow up and staff concerns about financial systems, indicated that key components including accounts payable and payroll of the trust's financial systems require further improvement and likely investment in order to remove any control weaknesses and improve workflow.

Observation of trust board meetings and review of minutes of the quality committee demonstrated there was of challenge from all NEDs and ANEDs including on carer, patient and staff experience as well as performance. Equally there was respectful challenge from the CEO and between the executives.

Management of risk, issues and performance

Processes to identify, escalate and mitigate all current trust risks was not always robust. Patients with cancer and patients waiting for elective and non-elective procedures were not always treated in a timely way. The impact of this for patients had not yet been realised. The trust had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Our findings

The trust had full awareness of the risks relating to their backlog in both elective and non – elective procedures. By the end of July 2022, the trust had cleared their 104 -week waiters except those choosing to wait and some of those awaiting complex procedures.

However, the numbers of patients still waiting for elective, non-elective and cancer procedures was increasing and still remained high. As of 26 September 2022, there were a total of 119 admitted elective patients and 48 non-admitted patients including cancer patients waiting between 100 and 109 weeks for procedures at the trust. For these patients, clinical risk assessments were being undertaken to review potential harm and prioritise treatment. It had been identified that action needed to be taken to create long term capacity to reduce the risk of future issues with elective waiting times. As a result, the trust had started the process for building an elective hub which would be used to perform general and musculoskeletal surgery. When completed, this would create two additional theatres and an outpatient theatre. The modular theatres were in development and should be read by the end of the 2022/2023 financial year. The project was anticipated to be complete in two years. The trust had projected 3,000 patients to be treated in the first year of implementation. The plans for the project had been developed with the clinical management groups.

Cancer patients were not always treated in a timely way in line with waiting time standards. The trust had one of the worst backlogs for treating patients with cancer in England. The trust had seen an increase in the numbers of referrals and conversion rates. They were working with other providers in an attempt to reduce the number of patients waiting for treatment. However, the impact of these risks and whether these actions would improve referral to treatment rates for patients was yet to be seen.

The trust also took part in an East Midlands Cancer summit to discuss the safety and harm risks around these patients and to try and find ways to reduce it.

The trust had a risk register which was regularly reviewed but risks were inconsistently scored. Following the trust's implementation of the risk committee, issues had been identified with risk scoring consistency, risk target setting and evidence gaps in respect of mitigating actions. For example, for some risks on the risk register, the actual and target score were the same. The focus of the next round of risk committee meetings was to address the identified issues. The trust recognised the risk register needed further reviewing to ensure this was addressed. The aim of the trust's risk committee was to review high level risks and understand the trust's controls and mitigations. This was to ensure there was sufficient focus on improving the trust's overall oversight and management of risks.

The trust had a backlog of actions following internal audits. This meant risks may not be mitigated in a timely way. The trust had begun to change the approach to responding to internal audit recommendations by ensuring the audit committee was fully sighted and held the executive team to account for responding and implementing the actions. The trust acknowledged that much improvement was still required with this process however, they we confident they will improve over the coming year and track evidence that their internal control has improved from their head of internal audit.

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes, but it was acknowledged improvements could be made. Each of the seven clinical management groups (CMG) produced a monthly performance report which was reviewed at each monthly PRM.

The CMG leadership team, which was the clinical director, head of nursing and head of operations attended the PRMs, were chaired by the chief operating officer and were attended by the executive team. At the PRM, the CMG leadership teams were held to account for their performance but were also supported in developing and implementing plans to make improvements. The PRMs concentrated on the areas of highest risk and empowered CMGs to raise issues and take

ownership of their performance. When actions were identified, owners were allocated and they would be accountable for their progress. It also provided a forum to share performance across the trust, as the performance of some CMGs impacted on others. It was acknowledged that the trust was not where they needed to be in respect of reviewing and improving productivity. The PRM process was welcomed in all CMGs but the shift towards CMG ownership and decision had led to some discomfort. We were assured that when this had been identified, support had been put in place.

There were processes to manage current and future performance. For example, the trust used a live dashboard for monitoring performance with the emergency department and for reviewing flow across each site.

The clinical speciality risk registers were regularly updated and escalated up through the relevant committees in line with the trust's policy. Risks within CMG, which were scored 15 or above, were escalated to the risk committee for further review. Any new or emerging risks were escalated to the risk committee for approval.

There was an alignment between the recorded risks and what staff said was 'on their worry list'. Executives were able to articulate the highest risks related to their portfolios and their descriptions and mitigations matched those on the risk register. There was an acknowledgement that some risks have remained high for a prolonged period and would remain so for the foreseeable future. For example, workforce was scored as a high risk within multiple specialities in each CMG, and across the trust in general, and would remain so but was being mitigated within each specialty with varying degrees of success. To gain assurance CMGs were safe, intelligence reports were produced from multiple data sources. This process was used to identify where the worry areas across the trust were. Following production of the reports, mock inspections within CMGs were carried out to understand the reasons why services might not be performing as well as expected. This process was used to review compliance with regulation and accreditations. Outcomes were reported through the executive quality board.

There was a centralised process to maintain oversight of incidents which were graded moderate or above. This served as a quality assurance process as each serious incident (SI) was reviewed by the patient safety team. This provided challenge and support to clinical management groups (CMG) to produce reports of sufficient quality. The patient safety team also provided each CMG with a report outlining the number of SIs they had outstanding.

We reviewed four serious incidents and found these to be investigated and managed in line with the trust's procedures.

Processes for identifying, disseminating and embedding learning and actions from serious incidents across the trust were improving. The trust had implemented an adverse event committee which reviewed open and closed serious incidents. Leads for each serious incident investigation presented their reports at the committee to share the lessons learnt and the actions identified. The committee maintained an action tracker which was reviewed to identify any overdue actions. This was then fed into clinical management group board reports and escalated to the executive board, dependent upon severity. The overdue actions were also reported through the performance review meetings on a monthly basis to ensure there was consistent and frequent oversight.

Information Management

The trust was improving arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. The information systems were integrated and secure.

Our findings

The trust was in the process of developing and rolling out an electronic patient record system across the organisation. The aim of this was to ensure that all clinical patient information is stored together and made easily accessible to staff across all care settings. In addition, the trust aimed to promote good practice and reduce their reliance on paper records whilst also enabling patients to receive appropriate care and treatment. This is due to be rolled out across the trust by the end of 2023/24 and features integration with the local shared care record in collaboration with system partners.

Processes had been implemented to include relevant data within monthly performance review reports and clinical management group (CMG) board reports, including service performance, complaints and incidents. When there were gaps in this information or actions needed to be taken, clinical management groups were contacted to improve compliance. The performance review reports were produced by the operations team to minimise the amount of administrative time for CMGs.

The trust was beginning to collect and review productivity data within clinical management groups and across the trust to assess whether actions being taken were having the desired improvements. The trust had started to assess the impact on productivity when investment in workforce or changes to how services were delivered were made. This was being done within oncology and cardiology services.

The trust had robust arrangements for cyber security controls in place. The trust had recently experienced a cyber attack on a key system supplier. They had demonstrated appropriate action had been taken to ensure other hospital systems were not compromised and to mitigate against the risk of further impact. This was a combined approach between the trust's IT team and the service provider for technology services at the trust.

Engagement

Leaders had improved engagement with patients, staff, equality groups, the public and local organisations to plan and manage services but recognised there was more work to do. They collaborated with partner organisations to help improve services for patients.

The trust was proactively engaging with staff to drive the future strategies and vision for the trust.

The trust used patient partners to inform their work to give the patient view however, this had reduced due to the COVID-19 pandemic.

The profile of the workforce at a more senior level did not reflect the local community. The trust was aware of this. Staff networks were in place however, the trust had recognised they were not consistently run and had identified plans to refresh them.

The trust was proactively building positive and collaborative relationships with external partners to build a shared understanding of the challenges within the system and the needs of the relevant populations. However, work to deliver services to meet those needs was in its early stages. Patient and community engagement leads were working with colleagues across the Leicester, Leicestershire and Rutland Integrated Care System (ICS). A new system wide strategy was being implemented leads across the system met monthly to progress it.

The trust's engagement with the local integrated care system was in its infancy and a clearer focus on working together as a system to improve care for patients through their whole patient pathway was required. However, the executive team recognised the importance of wider partnership working to ensure patients care across the whole of the patient pathway was improved.

Our findings

The trust generally had a good response rate for the NHS Friends and Family Test (FFT) particularly in inpatients, accident and emergency, maternity and outpatient services. In May 2022, 98% would recommend inpatient services, 79% would recommend emergency services, 97% would recommend maternity services and 94% would recommend outpatient services.

People's views and experiences were starting to be gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. The heads of patient community engagement and patient experience were both working on strategies for both patient experience and public involvement respectively, but they were not going to be signed off until the Director of Communications had taken up their post in October 2022. Work was in progress and therefore, the strategy was not finalised and any processes, for gathering views and experiences of service users, were not yet embedded.

People who used services, those close to them and their representatives were being actively engaged and involved in decision making to shape services and culture. The head of community engagement held nine listening events over the past 12 months with carers, and with organisations that supported carers. The head of community engagement was working with the head patient experience to look at the themes within the feedback to produce an action plan to improve engagement and its effectiveness. This was going to be used to collaborate with carers to co-produce actions which were aligned with system partners. It was envisaged the action plan will be shared in October/November 2022.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research. However, the quality improvement methodology within the trust was not clear as it was not evident if this was consistently used throughout the organization.

Leaders expressed learning, continuous improvement and innovation whilst encouraged was only evident in some areas. There were several quality improvement specialists available to go into clinical areas and work with the teams to drive improvement. Project examples included work in the cardiac catheter laboratory and reducing length of stay in gynaecology. However, quality improvement was not embedded through the trust. The processes for identifying, supporting and funding new ideas and improvements was inconsistent and informal with little governance to support their success.

The approach to quality improvement was discussed at the quality committee in August 2022 and plans were being revised to roll out and embed quality improvement with consideration of engaging with an external partner to support and accelerate this.

The trust had a strong focus on research with an average of 12,000 people taking part in research every year and 500 members of the public have joined the trusts research register to hear about opportunities to take part in research.

The trust's website displayed information for patients and those close to them to access support for them to make a complaint regarding services at the trust in line with the trust's complaint's policy.

Between August 2021 and August 2022, the trust investigated and responded to complaints in accordance with the trust's complaint policy. During this time period, 93% of formal complaints were acknowledged within 3 working days. However, the trust's responses to formal complaints was not always timely enough and in line with the trust's complaints policy. During this period the performance for meeting formal complaint deadlines for 10 working days was 49%, 44% for 25 working days and 38% for 45 working days.

Our findings

The trust did not have a patient advice and liaison service instead it has a patient information and liaison service which filtered and managed all enquires, information requests and complaints and concerns. The demands on this service were therefore quite high and this was under review.

We reviewed complaints files and found some of the responses to be quite clinical and transactional in tone rather than empathetic.

The review of complaint responses did show the trust were discharging their responsibilities appropriately under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of candour. This regulation requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them.

From August 2021 to August 2022, the trust had received a total of 327 compliments across all services and hospital sites. The trust reviewed compliments for themes and for which services the compliments were received. From the data received the following top three themes of the compliments included: compassionate care and kindness, staff thanked for listening to patients and staff going above and beyond to care for patients. The top three specialities that had received compliments in this data period were the emergency department, critical care and maternity.

The trust had a mortality review committee, chaired by the medical director which met monthly and reported quarterly to the board. The trust's latest Summary Hospital Level Mortality Indicator (SHMI) for 2021/22 was 104 and the *Hospital Standardised Mortality Ratio (*HSMR) was 97.9 and both within the expected range. The crude mortality for 2022/23 to date was similar to pre COVID pandemic rates (1.2%).

The mortality review process was in line with what would be expected. Appropriate deaths were being reviewed although there were some delays, this being addressed and improving. There was good working processes which involved the medical examiners and colleagues undertaking structured judgement reviews. The mortality lead had good oversight of the data and information which was being recorded and this was appropriately being reviewed and analysed. Information was used for improvement and earning lessons and shared across the trust.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
St Mary's Birth Centre	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Leicester Royal Infirmary	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022
Glenfield Hospital	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022
Leicester General Hospital	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Overall trust	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for St Mary's Birth Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018

Rating for Leicester Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022

Rating for Glenfield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ➔ Nov 2022
Overall	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022

Rating for Leicester General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020

Glenfield Hospital

Groby Road
Leicester
LE3 9QP
Tel: 03003031573
www.uhl-tr.nhs.uk

Description of this hospital

Our rating of this surgical service went down. We rated it as requires improvement because:

- Many wards did not have enough nursing staff to be able to spend time with their patients and met their individual needs. There was a high reliance on bank and agency nurses.
- There were numerous examples of medical devices that were past their next service date and staff were not checking this themselves before use.
- People could not always access the service when they needed it and sometimes had to wait too long for treatment.
- Staff did not always appropriately monitor room temperatures and take appropriate action if medicines have been stored outside of their required parameters.
- Staff did not always ensure that full, partly full and empty oxygen cylinders are segregated.
- Several patients who spent a long time in hospital complained that there were no entertainment facilities in their rooms.

However:

- The service had enough staff to keep patients safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Across all subjects and staffing groups training completion figures were high and above the trust target with most at 100% or in excess of 95%.

The information senior staff provided on the wards corresponded to this. On ward 37, the transplant ward, senior staff said they were mostly up-to-date, but Basic Life Support (BLS) training had been difficult to conduct with staff throughout the pandemic. However, this training was now being rolled out as face-to-face meetings had been reinstated across the trust. Only three staff on the ward were now required to complete this training. On the cardiac surgery ward, all the staff we spoke to were fully up-to-date with BLS training.

Not all staff were always given enough protected time to complete their mandatory training. We spoke to a foundation year two doctor who said they were up-to-date with their mandatory training. However, they had to complete it in their own time because wards were so busy, and they could not be released to do the training

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered the appropriate subjects including safeguarding, resuscitation, infection prevention and control and moving and handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff could access support from specialist teams and nursing staff when needed. However, staff feedback about some aspects of this training was mixed.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them six weeks warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were knowledgeable about safeguarding and some could give examples of when they had needed to act to safeguard patients.

However, a foundation year two doctor on ward 31 said they had received safeguarding training, but they were not aware of the term Female Genital Mutilation (FGM) and said they had had no training about it. Female genital mutilation/cutting is defined as the partial or the total removal of the female external genitalia for non– medical reasons.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of information on wards to guide them about when and who to contact to make a safeguarding referral and staff knew about this.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They usually kept equipment and the premises visibly clean. However, the service did not currently have local audit systems for surgical site infections.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were recently refurbished wards which had been designed to the latest national standards and included, for example on the transplant ward, positive pressure side rooms which protected occupants from airborne infection.

The older wards were sometimes short of space and this led to clutter which can make cleaning tasks more difficult.

On ward 31 one patient said bathrooms were “superficially clean” but that there was often urine on toilet seats. Another patient on ward 31 commented on the lack of cleanliness in the toilets and that there was food on the walls of their bed space when they arrived. However, the inspection team did not see evidence of a lack of cleaning.

The service generally performed well for cleanliness. On ward 26, a thoracic surgery ward we were shown how thoracic patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) before admission with the exception of patients arriving at the hospital as emergencies from home or as transfers from another hospital. These patients were placed in side rooms and additional measures were taken until their MRSA status was known. There was good signage which indicated the status of the patients and the precautions to be taken.

Staff used records to identify how well the service prevented infections. During the last two years the requirement to complete the Infection Prevention Annual Programme had been suspended as part of the Emergency Preparedness, Resilience and Response (EPRR) arrangements for the trust and COVID-19 management. A reduced programme was delivered but the auditing of wards and departments was suspended. As part of the restoration and recovery programme for infection prevention MSRA screening was due to be reinstated during quarter two of 2022/23 and the next audit would be conducted in July 2022. The MRSA policy was due to be reviewed and this would consider data from the July 2022 audit.

We also understood that antimicrobial audits had also been suspended for the same reasons and were just about to be resumed at the time of the inspection. However, the trust had continued to monitor for any concerns, and none had been noted that required action.

Surgery

Staff followed infection control principles including the use of Personal Protective Equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE.

On the transplant ward where some patients were immunosuppressed there was enhanced Infection Prevention and Control (IPC) including temperature checks, enhanced PPE and entry restrictions. All staff on this ward were face fit tested to ensure patients were as protected as possible form infections.

Theatre areas were noted to be suitably clean and procedures adhered to including those enhanced for COVID-19. However, we noted that some senior staff were wearing jewellery in contravention of the trust's IPC policy. They were wearing scrubs within the theatre suite but were carrying out management tasks and not patient care.

Staff cleaned equipment after each patient contact and labelled equipment with "clean" stickers to show when it was last cleaned.

While staff worked effectively to prevent, identify and treat surgical site infections the trust did not have a current Surgical Site Infection Programme to support reporting to the Surgical Site Infection Surveillance Service other than those mandated for certain surgical procedures which did not form part of the activities carried out at the Glenfield site. Voluntary surveillance had been paused because of COVID- 19 but we understood that a business case to reintroduce a site wide programme had been approved and was being recruited to.

The Board Assurance Framework for Infection Prevention and Control had some recorded gaps in assurance such as reduced capacity to carry out audit, deep cleaning and the ability to ventilate for COVID-19 due to other risks such as fire and security and lack of side rooms. There were no risks that appeared uncontrolled or unmitigated.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, there were significant numbers of medical devices that had gone past their service by date.

All the wards were suitable for their purpose, but some were more crowded than others with limited storage space. On ward 31 a patient told us that they were concerned about tripping over equipment on the ward.

We examined the bathrooms on ward 31. We found damage to a wall in a female bathroom which had been partially mended. We did not see anything of concern in the two male bathrooms.

Three wards, 35, 36 and 37 were newly refurbished and provided a good environment for patients and staff with staff rooms, day rooms, kitchen and changing facilities. Staff told us they were pleased with the improved facilities.

However, aspects of the newbuild that were not yet complete including oxygen storage racks and the provision of patient entertainment including televisions.

On the transplant ward, ward 37 we noted that a fire exit to an adjacent area had been blocked off using a lightweight privacy screen to prevent people using it as a cut through because of infection concerns. The member of staff in charge

of the ward assured us that this had been approved as a temporary measure by the trust's fire officer as part of their fire risk assessment on 6 June 2022. The recommendation from the fire officer was that the ward investigate appropriate door controls so that the screen can be removed. This action was on-going and owned by the ward sister, who was in discussion with the estates department to rectify this.

There was a maintenance backlog across all theatre suites including the one at the Glenfield Hospital site. This posed a risk that if it was not addressed this could result in a failure to meet the required safety standards. It was also of note however that this was also due to increasingly stringent standards since the theatres were built. We also noted that there were plans to develop temporary modular theatres to allow work to take place.

Patients could reach call bells and staff responded quickly when called. Patients on ward 35 said staff responded quickly although there were occasional delays when everyone rang at once. However, on ward 31 patients gave inconsistent feedback about the responsiveness of staff to call bells.

Overall, the design of the environment followed national guidance. However, we noted that ward 31 had multiple entrances and was often used as a thoroughfare between other wards. This was referenced as a security risk on the divisional risk register with plans to introduce door controls. We also saw that the staff room was very small with no windows, tables and sink.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys on wards 31, 34, 36, 37 and in the theatre suite. Daily checks were completed correctly on all wards except for on ward 34 where for five days in the month the records were not fully completed.

We did a full check of one resuscitation trolley on ward 35 and in theatre and the trolleys were secure with all equipment and supplies present and in date.

The service had suitable facilities to meet the needs of patients' families. On ward 31, where adult patients with learning disabilities were often treated patients were given side rooms so relatives could stay with them to offer support

Staff disposed of clinical waste safely. The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them. On ward 26, staff told us that they usually had enough equipment and consumables. However, there was sometimes a problem obtaining chest drains but staff had raised this with senior staff and a solution to allow more people to be able to order these was being put in place to rectify this.

We noted that there was only a single model of infusion device in use on ward 31 and all staff had been signed off as competent to use them However, this ward had a variety of vital signs monitors which had been acquired from other wards when they had closed which may cause confusion to staff using them.

Throughout the wards there were no air outlets present in line with recent guidance in the prevention of inadvertent connection of equipment needing oxygen to air supplies. There was a syringe driver that was in date and labelled as being in a safe modification state in line with recent Medical and Healthcare Products Regulatory Agency (MHRA) alert. This demonstrated that this requirement had been implemented.

During the inspection, we checked samples of medical devices to ensure they had been serviced within the required timescales. We found several examples of where equipment must conform to had not been regularly serviced in line with the trust policy.

On ward 31, there were three out of nine vital signs monitors which beyond their due date for a service. Two were out of date by six months and the other by nine months. Ward 35 had a hoist in a corridor space that was six months beyond its next service date. Staff told us it was out of use but there was no labelling to indicate this and there was a safety risk as staff could still try to use it. On ward 26 there was a transfer chair that was beyond its service date by six months.

Overall, we looked at 24 devices and 5 were out-of-date representing some 20% of the equipment checked. It was also of concern that staff were using out of date devices either without checking or knowing they required maintenance.

On ward 31, we noted that some oxygen cylinders were stored loose adjacent to racked cylinders and one of these was empty. Empty cylinders should not be stored with usable cylinders as they can be selected in error and fail in use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records showed that staff had used the early warning scoring system that the trust used to correctly record, calculate and review patients for signs of deterioration as required. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust's early warning and sepsis scoring protocols.

All patient observations were entered into the trust's Electronic Patient Record (EPR) system and compliance with this was audited. The system automatically screened for patients at risk from sepsis and an alert was sent to the nurse or doctor's mobile device. They then have the authority to deescalate through their clinical judgement or continue on the sepsis pathway. The system then monitored required actions, such as the administration of antibiotics were carried out in a timely way. Patients flagged for sepsis were reported to the nurse in charge and the trust's Deteriorating Adult Response Team.

The above process was regularly audited and data that showed when concerns were noted harm reviews took place.

The emergency and urgent operating theatre provision to fulfil the recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report was provided according to a standard operating procedure. A system provided access to an emergency theatre through the next available elective slot within 30 minutes. There was provision to make a second theatre available should it be needed. This system was under review as the recent move of services to the Glenfield Hospital site had changed the demand for emergency surgery.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked, in detail at sets of records across four wards and theatres which were a combination of paper and digital records on the trust's EPR system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

We observed the World Health Organisation checklist for safe surgery (WHO checklist) being used and noted good practice in that patients were checked in by both the surgeon and anaesthetist. We looked at five records for patients in theatre during our inspection and the WHO checklist was correctly followed and recorded in all cases. The service carried out regular audits of the use of the checklist and for the last three months compliance with the use of the checklist was at 100%.

Staff knew about and dealt with any specific risk issues. A foundation year doctor on ward 31 knew about the sepsis protocols and gave a recent example of when they had followed the appropriate protocol and carried out all steps before their consultant's review.

Patients were risk assessed for venous thromboembolism (VTE) risk on admission and pre-admission and where appropriate suitable prophylaxis was given. The trust audited compliance with this requirement and the most recent overall compliance rate, from March 2022 was 98% with some wards scoring 100% and no ward was below 76% compliance. This excluded those wards that had recently moved.

Patients were risk assessed and reassessed for pressure area concerns using a suitable tool and patient records showed that actions were taken in response.

The service had 24-hour access to mental health liaison teams and specialist mental health support. Records showed a patient with mental health concerns and their notes indicated when and how staff could seek assistance to support them.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. On ward 26, handovers took place at 7am and 7pm with a safety huddle at 11am. We observed a handover and saw that staff identified patients with diabetes, drains, catheters and those at risk of falls. On ward 26 they were trialling new nameboards for patients to flag the need for observations and repositioning, risk of falls, nutritional needs and diabetic status to staff. Handovers were supported using briefing documents to ensure consistent messages across shifts.

Out-of-hours the theatre was staffed from 5:30pm to 3am with an on-call arrangement from 3am to 8am with a specialist registrar designated for each of hepatobiliary, vascular and renal areas. There was a separate on-call team covering cardio thoracic emergencies.

Several staff had expressed concerns about the on-call system, and we noted that a review was underway.

Nurse staffing

The service had staffing vacancies which sometimes compromised the levels of patient care staff could provide to patients. However, the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff.

Overall, there was evidence of high nursing staff vacancy rates, high sickness rates and a reliance on agency and bank staffing to keep the service safe. While this presented a risk, we did not identify avoidable harm to patients. However, patients told us that they had to wait for personal care and that call bells were not always answered quickly because of short staffing.

On ward 35 a patient told us that the staff seemed "stretched" and things that were promised did not happen. They said they had to buzz several times before staff came.

Surgery

Theatres were established to Association for Perioperative Practice (AfPP) guidelines. Senior staff told us that nurse staffing vacancies were an issue across all theatres particularly since additional specialities had been brought over to Glenfield Hospital from other hospitals in the trust. Some specialities were affected more than others, for example there were five whole time equivalent vacancies in the thoracic team.

This was having an effect in that lists were reduced, and operations were cancelled due to lack of staff. The service was addressing its significant staffing challenges by using a specialised staffing agency and we were told that this would be in place and resolving the issue by July 2022.

This meant that there was a high reliance on bank and long-term agency staffing in order to provide a safe service while recruitment was being carried out. However, this was not the case in recovery where only bank staff were used.

Other staff and managers told us that staff were frequently moved between wards to maintain safe staffing levels. Staff told us this could be unsettling but that it was not unsafe.

Many people told us that staff had left or were leaving. The reasons they gave were the stress caused by the pandemic but also that some staff had found the move of wards from other sites to Glenfield inconvenient. Conversely some staff said it suited them better.

Theatre staff told us that the lack of staff on wards 35 and 36 resulted in them having to return patients to the ward themselves as staff could not leave the ward. While this was consistent with safe staffing guidance to spread risk across the site it added pressure to the already stretched theatre teams.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

In theatres staff used a staffing tool to help plan the number of staff required on each shift. There was a staffing board in reception showing who was on duty. On the transplant ward we were told that the tool did not meet their specific needs and was being revised. They also said that they never used agency staff, only bank staff because of the specialist skills needed and the risk of infection.

Managers discussed the varying needs of the different wards at the site bed meeting at 8am and arranged for staff to be redeployed in order to keep the service as safe and effective as possible. They clearly knew the staffing needs of each ward and any shortfalls or extra capacity in ward staffing. This meant they were able to work together to deal with immediate staffing issues such as sickness, emergency admissions and patients who were more acutely unwell than expected. We noted the effectiveness of this process. A “tactical matron” was assigned each day to manage these issues across the site. This ensured there was a single consistent view and freed up other senior nurses for their core duties.

When we attended the ward 31 handover, they discussed that a Registered General Nurse (RGN) had called in sick. We noted that the whole team shared ownership of the risk by discussing whether they would need to request support or could cope.

The number of nurses and healthcare assistants did not always match the planned numbers. During our inspection we noted that on ward 35 the staffing did not meet the planned levels. For all shifts on the 29 and 30 June 2022 the staffing board showed there were two nurses less than the planned number.

Surgery

Shift fill rate data supplied by the trust validated our concerns about the staffing levels on wards 31, 35 and 36. The trust provided a commentary that demonstrated reasons for this which were long term sickness, staff redeployment and staff leaving as a result of the recent site relocation.

On ward 26 staff and managers told us that they were never short of staff but that this was achieved through using agency. Cover for the shifts on the ward confirmed this. There were six high dependency beds in a separate area of the ward, and these were staffed with properly skilled personnel through an agency.

The service had high vacancy and turnover rates

Data supplied by the trust demonstrated high vacancy rates on some wards, primarily the hepatobiliary, transplant wards for which the vacancy rate was 10% and the breast ward for which the rate was 20%. However, the hepatobiliary ward was demonstrating improvement.

The figures also demonstrated significant shortfalls in the theatre establishment with a 20% shortfall in Cardiac and General Surgery and almost 50% in recovery. However, because of the ongoing reconfiguration the figures were not completely accurate, and staff were being deployed across the theatre suite to meet staffing needs in accordance with patient acuity.

In theatres we were told that staff who were working alongside better paid agency staff were leaving to join those agencies and returning as agency staff.

The service had a workforce plan overseen by a project team to address staffing in theatres. This included rolling recruitment, open days and targeted advertising. The plan also considered the staff survey in depth as well as flexible working and professional development to improve staff retention.

Several staff told us that staff had left, often for retirement, because of stresses associated with COVID-19. However, some staff had left as they were not happy frequently moving wards to accommodate staffing pressures.

Some staff told us of travel pressures following the transfer of services to Glenfield Hospital. Conversely other staff found this site it more convenient.

Senior staff told us that there was an expectation that rising community COVID-19 levels would have a further negative impact on staff sickness rates.

The service provided exception reports and a narrative for those wards having sickness over 10% which were wards 31 & 35.

For those wards reporting high levels of sickness these often included staff on long-term sickness. Ward 31 and the transplant ward were particularly affected by this.

The service had high rates of bank and agency nurses.

The trust provided data that demonstrated high use of bank and agency staff on wards 23, 35 and 36. Staff also confirmed this.

Managers requested bank and agency staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

In theatres we were shown how all agency staff were given an induction. All staff new to the surgical wards told us they had a supernumerary induction period and bank staff on ward 31 told us they had received an induction. Managers had no problems accessing the trust and clinical induction for new starters.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep patients safe. The service had a good skill mix of medical staff on each shift and the medical staff matched the planned number. On ward 26 staff told us that there was always a doctor on the ward during the day and that out-of-hours, the junior doctors who were responsible for three wards were "generally responsive" to requests.

Out-of-hours there was a registrar grade medic and consultant anaesthetist on call who resided on site. Consultant surgical cover was available 24 hours a day, seven days a week. Junior medical staff were supported by more senior staff if needed.

On ward 31 we were told that there was sufficient medical support with very good presence on the ward. Foundation year doctors were always available and there were good consultant numbers and consultants conducted pre- and post-operative ward rounds each day.

Nursing staff commented that the computerised system for allocating tasks to junior medical staff worked well.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on-call during evenings and weekends. Cardiothoracic anaesthetic consultants were on site from 8am to 6pm from Monday to Friday while general cover was provided until 8pm. Outside of these times there was a non-resident consultant on call for these specialities.

Consultants were on-site for the cardiac, thoracic, renal transplant and vascular specialities from 8am to 6pm Monday to Friday. They were also present to review patients on weekend mornings from 9am to 12pm, and in the case of cardiac from 5pm to 6pm. Outside of these times there was a non-resident consultant on call for these specialities.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. We reviewed twelve sets of patient records across four wards and theatres which were a combination of paper and digital records on the trust's Electronic Patient Record (EPR) system. We noted that they were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Recommended Summary Plan for Emergency Care and Treatment (RESPECT) and Do not Attempt Cardio Pulmonary Resuscitation DNACPR records were properly recorded for patients who needed them.

Medicines

The service used systems and processes to safely prescribe, administer and medicines. However, some medicines were not always stored correctly.

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date. Staff followed national practice to check patients had the correct medicines when they were admitted. Medicines recorded on both paper and digital systems for the twelve sets of records we looked at were fully completed, accurate and up-to-date.

Staff usually stored and managed all medicines and prescribing documents safely. In theatres, Controlled Drugs (CD) were kept securely and staff checked them twice a day. Similarly, drugs that needed to be kept cool were kept in a locked fridge and were found to be in date. Fridge temperatures were recorded daily, and no concerns were noted by the inspection team.

Temperature records on ward 31 were completed however, we noted that the room temperature on the day of our inspection was 25.7 degrees Celsius which was very slightly above the threshold of 25 degrees. There had been repeated examples of temperatures higher than this over the previous two weeks. We spoke to member of staff who did not know what action to take and another member of staff said they would usually put a fan on to cool the room, but they had been taken away because of COVID-19 precautions. While the use of a fan might even out the temperature in a room it will not cool the room down.

We spoke to the Nurse in Charge who was aware of the correct protocol to contact the pharmacy and took the matter in hand.

The medicines fridge temperatures on ward 31 were accurately completed and within limits.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the trust policy. Staff received feedback from investigation of incidents, both internal and external to the service. On ward 31 we noted a positive incident reporting culture and evidence of learning from incidents through our discussions with staff. We also saw boards and notices in the staff room demonstrating this. On ward 31 we saw recent incidents reviewed and actions shared at handover.

In theatres there was a good awareness of incidents with senior and junior staff able to describe learning following recent events.

Surgery

Examples included late starts for breast surgery being reduced by changing start times and the disruption of late finishes in cardiac surgery being mitigated by the introduction of some long days.

The service had one never event on the wards and theatres that we inspected. Managers shared learning about never events with their staff and across the trust. All senior staff with whom we discussed the matter and most junior staff were aware of the most recent never event and previous never events and the actions being taken to prevent reoccurrence.

Managers shared learning with their staff about never events that happened elsewhere. Nursing and medical staff were aware of a recent never event outside of the inspected activities and told us how it had been discussed and learning disseminated.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff particularly on wards 31 and 35 were very knowledgeable about the duty of candour

There was evidence that changes had been made as a result of feedback. Staff on ward 31 explained and gave examples of additional training implemented following a medication incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. Across theatres matrons reviewed incidents for trends and took action when necessary to ensure patient safety.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

Surgery

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Menus were very varied with a wide choice of meals. They met the specialist nutritional needs of people in hospital as well as cultural and personal dietary preferences well aligned to the local communities. In addition to providing comprehensive nutritional information the menus were very well presented in a restaurant style with appetising descriptions of the food.

Patients on ward 31 told us they were happy with the menu choices and that water was always available.

Patients in recovery in the theatre suite had their nutrition and hydration needs, including mouthcare met.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Housekeeping staff received nutrition training through a dedicated training day and they told us this enabled them to support nursing staff in meeting patient's needs. A patient on ward 31 said they catered for his individual preference for soya milk and another told us that despite being on a low-fat diet they still got plenty of choice. However, a patient on ward 31 said they had seen some patients struggle to eat and that there was not enough staff to support them.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patients' notes showed that patients who needed their fluid intake and nutrition monitored had this done by staff.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' notes showed that all patients had their nutritional needs assessed on admission and further assessments carried out as necessary. This included their weight.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There were pain assessment tools for patients who had difficulty communicating. Learning disability support staff used these to assist patients. Patients received pain relief soon after requesting it. On ward 31 a patient told us staff were responsive to their pain relief needs. The service carried out pain audits and the results from this demonstrated that patients were largely satisfied.

Staff prescribed, administered and recorded pain relief accurately. Patient records showed pain relief needs and medication was recorded correctly.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Surgery

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. This included those audit and monitoring programmes relevant to the specialised surgery carried out at the hospital such as those carried out by National Institute for Cardiovascular Outcomes Research (NICOR)

Outcomes for patients were positive, consistent and met expectations, such as national standards. Mortality meetings took place and we were made aware of how recent meetings had discussed a contentious topic of the allocation of cases to either the unit or individual surgeons.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and made sure staff understood information from the audits. The service conducted several audits including the theatre audit bundle, five moments of hand hygiene, health and safety, surgical site infections, uniform standards and the care of drains and cannulae.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they had sufficient training and support to care for patients.

Band seven staff in theatres were monitored to make sure 50% of their duties were clinical to ensure they kept their clinical skills and experience up-to-date.

However, many staff expressed concern that senior and experienced staff were leaving due to "burn out", COVID-19 and to join agencies. This meant that experience across the hospital was reducing.

Managers gave all new staff a full induction tailored to their role before they started work. When we spoke to recently recruited staff they all told us they had received a full induction.

Across theatres recruitment difficulties meant many staff were newly qualified or new to the NHS and they were given a twelve-week supernumerary period supported by practice development nurses and targeted educational support.

Staff felt supported by managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified poor staff performance promptly and supported staff to improve. All staff and managers told us that they received yearly appraisals.

However, the appraisal data we requested from the trust for surgical services at Glenfield Hospital was difficult to interpret. The data was up to May 2022 and demonstrated a range of values from 100% down to 75% although most were around 90%. It was difficult to draw conclusions as, for example while the data showed ward 37 to have the worst rate of 75% our conversations with the ward manager showed that this was out of date and the current figure was around 90% as the service recovered from COVID-19 and accommodated the staff changes as a result of the recent move.

A newly qualified nurse told us that they received additional support and mentoring including more frequent appraisals. Another member of staff who had recently graduated told us they were still in their induction period and getting the support they needed. They said they had no worries and found more experienced staff approachable and supportive.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Notes were taken at meetings and made available to all staff to ensure they kept up-to-date

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Clinical educators supported the learning and development needs of staff. The service promoted good practice in the use of the Specific Theatre And Recovery Training (START) days. This was an initiative to promote training over and above mandatory training and replaced the previous Essential To Role (ETR) training. The programme was a fresh start to ensure staff were up to date following the disruptions of COVID-19 and allowed them to train as a team in a relaxed and enjoyable environment.

Where theatre lists or individual operations were cancelled the theatre was used for enhanced staff training in order to make teams more flexible and able to staff the specialist theatres.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There were programmes in place across theatres to develop existing nursing and other staff at all levels through development opportunities including apprenticeships and registered associate programmes. Many registered staff to whom we stoke gave examples of how they were in their current job as a result of personal development from other roles. Some staff told us that vacancy rates gave enhanced opportunities for them.

Managers made sure staff received any specialist training for their role. We noted staff who were given specialist “link” roles such as for infection prevention and control (IPC) and transplantation. Staff in both these roles told us they had enough time to fulfil their responsibilities.

However, staff in the theatre suite staff expressed concern that there was not always a fully trained member of staff on duty to operate a “cell saver” device. This is piece of equipment that can recover blood lost by a patient and return it to them. We asked the trust about this and they demonstrated that five members of staff were trained but did not show how these staff were deployed to ensure there was always a staff member able to provide this support.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The complexity of much of the surgery that took place as well as the patient’s illness meant that multidisciplinary work was embedded into the care provided.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff had access to mental health specialists and that there was good consideration of patient’s individual mental health needs and anxieties of patients receiving specialist surgery such as transplantation.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including at weekends. Patients are reviewed by consultants depending on the care pathway. On wards 26 and 31 there were registrar-led ward rounds from 8:30am each day and consultants came around after theatre in the afternoon.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Out-of-hours the theatre was staffed from 5:30pm to 3am with an on-call arrangement from 3am to 8am with a specialist registrar designated for each of hepatobiliary, vascular and renal.

There was a separate on-call team covering cardio thoracic emergencies. Several staff told us they had expressed concerns about the lack of on-site staff between 3am to 8am and we noted that this had been acknowledged by managers and that a review was currently underway.

Diagnostic imaging was readily available and staff said the diagnostic service was responsive to their needs. There was always an on-call pharmacist available.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. The nature of much of the surgery provided by the unit meant patients needed to change aspects of their lifestyle either to prepare for or to take best advantage of the planned treatment. Patients told us that this was discussed in depth pre-operatively and they were given good support and guidance.

Printed material relevant to healthier living generally as well as specific to surgery was available on the unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Where appropriate patients were given pre-operative physiotherapy and exercise programmes to ensure they were fit for surgery and better able to carry out their post-operative rehabilitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Overall, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Overall, staff gained consent from patients for their care and treatment in line with legislation and guidance. Most patients consistently told us that the risks and benefits of surgery were explained well and that they gave their explicit consent for surgery and any emergency procedure that might be needed. We were also told how relatives were invited into the discussions if desired.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Theatre staff demonstrated good knowledge of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and consent. A member of staff told us about their training and they confidently discussed how capacity was affected under the influence of anaesthesia and sedation. Another member of staff gave a recent account of when DoLS had been implemented within the theatre suite.

Patient's notes showed all patients had a record of their capacity and psychological welfare on admission and where an assessment was needed this had been completed.

Surgery

Staff clearly recorded consent in the patients' records. The recording of consent in patient's notes was to a high standard.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients and treated them in a respectful and considerate way.

Staff interactions with patients was good. Staff maintained unconscious patients' dignity in theatres.

Patient feedback demonstrated high levels of satisfaction for the compassion received from staff and almost all responses were good or very good. There were high scores in the Friends and Family Test survey for patients being treated with dignity and respect and individual comments often made reference to staff being friendly.

Patients said staff treated them well and with kindness. Almost all the eight patients reported that they were treated with kindness. However, one patient on ward 35 told us that the attitude of staff was variable with some needing a better "bedside manner".

Staff followed policy to keep patient care and treatment confidential. Throughout our visit we observed staff being suitably discreet when caring for patients. During the handover on ward 31, patients were allocated to nurses in the handover by the nurses' station then they moved to the day room to discuss individual patients to maintain patient confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient feedback demonstrated high levels of satisfaction for the emotional support received from staff and almost all responses were good or very good. A patient on ward 35 said that they had been "down", but staff had been supportive and helpful.

Staff were encouraged to spend time with patients through the a "compliments" system but again this was compromised in some areas by low staffing levels.

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, patient feedback regarding the emotional support they had received was mixed. A patient on ward 31 said that their pre-op visit was very helpful. Another patient on that ward said the surgeon was quite matter of fact in explaining their operation and that they would have wished for more emotional support.

There was a relative's room in the theatre reception area which had been setup by a member of staff under their own initiative after they had seen worried relatives did not have a dedicated waiting area and had to wait in the corridor area outside the theatre suite. It was also used as an occasional quiet space for staff.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff consistently made sure patients and their families understood their care and treatment. On ward 31 a patient told us that there was very good communication with their spouse by staff on the ward. The patient notes included information about patients' relatives and evidence of when the hospital had communicated with them on the patient's behalf. Another patient said staff had explained their care and treatment well. Their spouse confirmed they had been involved in the conversations and that this had put their mind at rest.

Transplant coordinators provided specialist support for those patients having transplants and their organ donors.

Visiting times on the surgical wards were later than on other wards across the trust to allow patients who had had surgery to, where possible, receive visitors on the same day.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The department had a specialist team who supported adult patients with learning disabilities who were undergoing surgery for congenital heart disease

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had surveys including "Friends and Family Test" and "message to matron" to collate patient, their families and staff feedback.

Patients gave positive feedback about the service. Feedback was generally positive. The latest Friends and Family Test report for the previous three months showed positive comments about support staff provided to families and the transplant ward scored 100% for positive feedback.

Is the service responsive?

Requires Improvement ↓

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Surgery

Managers planned and organised services, so they met the needs of the local population. The specialised surgical services provided by the hospital served patients across a wide geographical area. The trust provided remote clinics to patients from further away to reduce the burden of travelling for people whose illness made that difficult. Systems were also being trialled to conduct post discharge reviews remotely to further support patients who had difficulty travelling.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Because the surgical wards knew which patients would be admitted to the wards or coming through from critical care or surgery they were able to plan bed spaces and manage those patients that arrived as emergencies so there had been no mixed sex breaches during the year before our inspection. We noted that there was a mixed sex bay on ward 26 but as a level two area this was permitted.

There was provision on ward 34 for male breast cancer patients and it was well managed and no mixed sex breaches had occurred.

Facilities and premises were usually appropriate for the services being delivered. No wards were unsuitable but there was a notable contrast between those wards that had been recently refurbished and those that had not. They were in the process of reconfiguring and improving the surgical services estate.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health needs and learning disabilities. The service had systems to help care for patients in need of additional support or specialist intervention. There were specialised outreach services to help manage deteriorating patients as well as a specialist team to support cardiac patients with learning disabilities.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments. During the “tactical meeting” that we attended during the inspection specialities were aware of patients who might be moved to the surgical wards from the Emergency Department (ED). They took the initiative to admit these patients which improved safety, the patient’s experience and reduced pressure on the ED.

Meeting people’s individual needs

Due to the nursing staffing vacancies, there were sometimes not enough staff for them to be able to spend time with their patients and met their individual needs. Many patients expressed dissatisfaction with a lack of entertainment and communication facilities

However, the service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However,

Staff often did not have enough time to interact with patients and those close to them which impacted on the care patients received. Almost all patients reported positive experiences of care from staff often giving examples, but on ward 35 staff commented that they did not have enough time and some reported that they felt guilty when patients made specific requests they could not accommodate due to staffing pressures. This was confirmed by some staff who were frustrated by this. However other wards, such as the transplant ward were well staffed and could therefore meet patients individual need more effectively.

Surgery

The provider was working towards better meeting the accessible information standards through a programme of work under the direction of the trust's Equality, Diversity and Inclusion Board.

Staff made sure patients living with mental health problems and learning disabilities received the necessary care to meet all their needs. Staff supported patients living with learning disabilities by using 'This is me' documents and patient passports. Examples of these were used in transplantation and surgery for congenital heart conditions. Staff on the specialist wards were complimentary of the team that supported patients with a learning disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community which included Punjabi in addition to leaflets available in an easy read format. We understood other languages were also available relevant to the local population.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was provision for face-to-face interpreters and these translators were booked in advance for elective patients. British Sign Language interpreters could also be booked. Staff had access to clear visors and masks with clear panels so patients could lip read while staff still adhered to COVID-19 PPE requirements.

In an emergency staff had access to a telephone translation service and there was a list of staff with fluency in other languages who had agreed to act as translators.

Relatives could translate for day-to-day matters such as meal choices, but professional interpreters were used for all clinical decisions in line with good practice.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus were very varied with a wide choice of meals. They met a variety of cultural and personal dietary preferences and were well aligned to meet the needs of local communities.

Staff had access to communication aids to help patients become partners in their care and treatment. The cardiac surgery service worked with the specialist congenital heart disease service that supported both children and adults. Some of the patients of this service were adults with learning disabilities associated with their underlying conditions and staff on ward 31 spoke highly of the cross-site admission coordination service for these patients.

This service provided person centred admission support to people living with learning disabilities. Staff appropriately conducted best interest decision making and mental capacity assessments.

However, all the patients we spoke with on the refurbished wards were disappointed that television sets had not yet been installed and that internet and phone signals were poor. They told us that they were often bored.

On ward 31 a patient said a mobile telephone signal was only available in some areas meaning communication with family and friends was difficult. On ward 31 a patient told us that their television did not work despite them having paid for it. On ward 35 a patient told us, that their television had not been fitted which we confirmed. Another patient on ward 35 patient told us the phone and wi-fi very poor and they could not contact home.

Surgery

Access and flow

Despite the service working innovatively in an attempt to treat as many people as possible, people could not always access the service when they needed it and receive the right care promptly. Patients had to wait long periods of time to receive treatment. Waiting times from referral to treatment were not in line with national performance.

Managers monitored waiting times. However, patients could not always access services when needed and not all patients received treatment within agreed timeframes and current national targets. As of 26 September 2022, the largest group of patients were those waiting for elective cardiology surgery at Glenfield Hospital at 1686 patients.

With 13 admitted patients waiting over 100 weeks, 100 patients waiting over 70 weeks and 379 over 50 weeks (as at 26 September 2022) the service knew it would be very challenged to meet the 78 weeks target by 31 March 2023. In line with national trend waiting lists were continuing to increase.

Providing timely cancer services was also challenging whist the two week wait for breast and lung was meeting the target, the 62 day target was not met and was lower than the England average.

We understood that the COVID-19 pandemic had had significant effects on the service's ability to carry out surgery. For example, some cardiac operations had not gone ahead because the intensive care beds needed by patients after their operations were occupied by very ill COVID-19 patients.

The service was using other providers to support its recovery of activity with, for example two cardiac surgeons doing a full day of lists every other week for NHS patients at a local private hospital. Managers told us that the recovery of their activity levels was going well.

During the pandemic, transplant services had been paused on several occasions due to staffing and due to the particularly vulnerable nature of the patients whose surgery required that their immune systems be suppressed which made them vulnerable to COVID-19. The renal services were catching up post COVID-19 with a waiting list for procedures such as hernias, access including access to veins for dialysis and removal of the thyroid gland.

Vascular surgery activity was also very low during the pandemic and this had resulted in a large backlog of patients needing surgery. Again, theatre sessions in the independent health sector were being used to address the waiting lists.

The service held mortality reviews and serious incident reviews where patients had died whilst waiting for their surgery or their condition had significantly deteriorated due to the delays.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service participated in national monitoring and audit of which the length of stay for specific types of surgery was measured.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers worked to minimise the number of surgical patients on non-surgical wards. Few patients from the surgical specialities we looked at were cared for outside of the surgical speciality. At the time of inspection, five patients from ward 31, a cardiac surgical ward were being cared for on the adjacent ward 32. This was a cardiology ward and they were nursed by cardiac nurses and overseen by a surgical consultant.

The trust had a standard operating procedure that prescribed when and how patients could be accommodated on wards of a different speciality whilst waiting for an available bed on the admitting speciality ward.

Surgery

Managers worked to keep the number of cancelled operations to a minimum however the number of operations cancelled on the day of surgery was 1.5% against a target of 1% (year to date).

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. When we discussed the management of theatre lists with senior staff we learned that elective lists were locked down two weeks in advance and those that were urgent 72 hours beforehand. Bookings were arranged via the individual consultant's secretaries as there was no central booking team but there was a surgical flow coordinator who monitored ward capacity.

Non-clinical cancellations were all reviewed and reported as incidents. These were mostly due to emergencies, staffing and theatre availability.

We heard several patient stories about cancelled operations. On one of our inspection days there had been an emergency surgical admission that was taking a lot of resources in theatre as well as surgeon's time resulting in several cancellations. A patient on ward 26 told us their operation was cancelled three times because of emergencies. They were understanding but they had experienced a week in hospital waiting to be operated on. A patient on ward 31 told us their operation had been cancelled once because of an emergency and a second on that ward said their operation too had been cancelled.

During our inspection, staff and managers told us that they were seeing a rise in patients admitted both for and with COVID-19. The trust was starting to put in place arrangements to cope with this increase. These measures, such as opening "Covid wards", would have a negative impact on the activity levels the service would be able to provide.

The service based its view on previous experiences in September 2021 when a surge of COVID-19 resulted in cancelled operations due to a lack of staff.

We were also told that lack of access to the hybrid theatre facilities were sometimes a barrier to the number of operations that could be performed. This was due to the need to access specialist equipment in that operating suite but also due to staffing challenges among nursing and anaesthetic staff. This was, to some extent, because it was early in the services reconfiguration programme and there was competition for theatre resources. Senior managers recognised that this was stressful for staff.

Thoracic surgery had low staffing levels which was affecting the service's ability to meet the targets for treatment carried out by 21 and 62 days after diagnosis of lung cancer.

Managers and staff started planning each patient's discharge as early as possible. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Because of the nature of the specialist surgery at Glenfield patients were usually able to be discharged to their own homes once they were well enough. As a result, discharge was not dependent on access to adult social care resources and the most usual external factor to preventing discharge was slight delays in patient transport.

The ward 31 handover meeting that we attended discussed discharge arrangements for the following day and the trust tactical meeting asked leaders to ensure that patient transport was booked well in advance.

Staff supported patients when they were referred or transferred between services. We noted that the specialist surgical services worked to identify patients waiting in A&E or other emergency portals that should be transferred to their unit.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were advice leaflets and posters on how to complain displayed prominently throughout the wards.

There was also material encouraging patients to share positive and negative comments through other routes such as the Patient Information and Liaison Service (PILS) and initiatives such as “Message to Matron”.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The trust carried out analysis of complaints and had put in measures to address the most common or significant. An overview of complaints data showed that the majority of complaints were about standards of care, staff interactions and cancelled or delayed treatment.

There was work taking place to address staffing which was a common reason for delay or cancellation of operations as described elsewhere in this report. We also saw that there was an initiative to keep patients on waiting lists better up-to-date to reduce anxiety and therefore complaints.

Board meeting notes showed the trust was not meeting its performance targets for complaints investigations. However, this information was not specific to surgery at Glenfield Hospital and we could therefore not determine the individual performance for this service as a result.

Managers shared feedback from complaints with staff and learning was used to improve the service. Amongst some of the specialities work was in progress to ensure that individual wards considered complaints and feedback to better improve patients’ experience.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

While some staff reported lack of visibility from the executive team during the pandemic, they were positive about the presence of leaders at a divisional level or below. There was a “matron of the day” initiative across the Glenfield Hospital site which meant there was someone available to respond to events without having clinical or other managerial responsibilities.

Surgery

The trust had introduced a system to support staff who had undergone traumatic experiences known as Trauma Risk Management (TRiM). This was a response, in part to the stresses imposed on staff due to their work during the COVID-19 pandemic.

Staff whose wards had recently moved across from other hospitals told us that they had had good support from their departments, managers and matron.

Staff were positive about their leaders and co-workers and leaders spoke highly of their staff. For example, a new nurse on ward 31 told us very well supported by manager and colleagues and a staff member on ward 26 said they had a very supportive matron including for personal issues and COVID-19. Senior managers told us they were proud of how staff were working to recover surgical services.

Senior staff in theatres told us that the recent transfer of services continued to be a challenge including the maintenance of a safe emergency theatre service. There were options being looked at and staff were being consulted as to their views.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

There was a clear three-year plan at trust level that identified quality strategies and priorities across the whole organisation.

The provision of surgical services at the Glenfield site formed a key part of this strategy as it was recognised that following the bringing together of three hospitals to form the trust the configuration of the services was a matter of accident not planning.

As part of the reconfiguration some specialist surgical services were being consolidated on the Glenfield site. At the time of our inspection a new base for cardiovascular surgery was being established with the recent move of vascular surgery to join the established cardiac service and transplantation had also recently moved.

There were ambitious plans to create a treatment centre and provide additional level two and three intensive care capacity to support the additional surgery.

Established regional and national services for Lung Volume Reduction Surgery (LVRS) and Laser Metastasectomy were to be retained and innovation such as robotic thoracic surgery introduced.

This was to be underpinned by changes to staffing including additional consultants as well as staff development and education initiatives.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff survey results across the management groups which included surgery at Glenfield Hospital indicated some dissatisfaction with staff reporting “burnout”, work related stress, low health and wellbeing and emotional exhaustion. There was also a desire to get back to normal after the stressful and distressing times during COVID-19.

The notes of divisional board meetings showed the organisation took these concerns very seriously and were working to understand the root causes and respond. They also clearly recognised the impact on staffing and ultimately performance and the quality of patient care.

Feedback about the attitude of medical staff in the department was mixed. A senior nurse in one of the theatre specialities told us that medical staff were sometimes "sharp" with staff who were new to the trust. However, instances were recorded as incidents and dealt with by the management team. Other nursing staff reported medical staff to be "approachable" and an assistant practitioner on ward 26 said they felt confident approaching surgeons for advice.

Senior staff in theatres told us that they ran an open-door policy and that the most recent staff survey demonstrated an improvement in staff engagement. Junior staff said that the culture was good and that they were able to approach management and escalate concerns.

They said that there had been a lot of disruption and apprehension as a result of the service moves but issues were discussed and there was support.

Staff and managers told us that because staff were frequently moved from their usual ward to cover on other wards some of them found this stressful.

Some nurse managers said that while they were supportive of their staff, they thought that there could be better provision for nurses who had joined the trust from overseas outside of their line management structures.

We discussed how any conflict and behaviours that did not meet the values of the trust within teams was addressed and were given an example of how this could be done with external support to discuss individual staff behaviours and communication.

A foundation year doctor on ward 31 told us they felt very supported as a junior by seniors and also the nursing staff and physiotherapists. They contrasted this with experiences in other areas and hospitals. They also said they were supported to progress to their desired speciality.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a complex but clear and rational management structure in place across the surgical specialties that we inspected. There were four management groups which had responsibilities over and above the location and the services we inspected across the rest of the trust. These management groups were The Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS), Intensive care, Theatres, Anaesthesia, Pain and Sleep (ITAPS), Musculoskeletal and Specialist Surgery (MSS) and the Renal Respiratory and Cardiovascular (RRCV) groups.

The notes of recent management group meetings showed that for the Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS) board they were trialling the integration of quality and safety boards which were currently separate for each management group to avoid repetition and save time.

The various groups used differing approaches to their governance which was evidenced through their meeting agendas. However, they all demonstrated an open discussion of matters with responsibilities allocated to named individuals or groups and reporting of progress.

Across the theatre suite there were daily briefings at 8am and outside of this there were noticeboards and all staff emails. The matrons met monthly and liaised with the head and deputy head of nursing.

The trust carried out a programme of monthly nursing metrics covering observations, nutrition and hydration, infection prevention and control (IPC), hand hygiene and the prevention of falls and pressure ulcers. We were provided with the figures for the previous three months. Through the trust's colour coding mechanism 62% of the audits were green indicating these metrics were in line with performance targets, 32% where amber denotes some metrics are being met but not all and 6% were red as they were below the targets set. There were associated action plans when shortfalls were noted.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

We discussed systems that the service had in place for assuring safety during operations. We were told that the service had recognised that these needed improving as a result of never events that had taken place. Senior managers were familiar with these incidents and spoke authoritatively about their causes and the measures taken to prevent a repeat.

These included a strengthening of Local Safety Standards for Invasive Procedures (LocSSIPs) that are local implementations of national safety standards. Staff in theatres confirmed this.

Managers discussed the varying needs of the different wards at the site bed meeting at 8am and arranged for staff to be redeployed in order to keep the service as safe and effective as possible. This meant they were able to work together to deal with immediate issues such as sickness, emergency admissions and patients who were more acute than expected. These conversations covered the acuity of individual patients, staff absence, emergency admissions and theatre throughput. A further meeting took place at 1pm.

The meeting which was chaired by the deputy chief nurse allowed staff to raise safety concerns which could be dealt with.

There was a site matron of the day who was responsible for troubleshooting and had both the individual authority and access to senior staff to deal with issues.

During our inspection, the trust was becoming increasingly pressured from an emerging COVID-19 wave as well as other respiratory viruses and flu. There was a coordinated response across the site as managers worked to reintroduce measures such as the enhanced wearing of masks and the reintroduction of COVID-19 wards. Although the measures were not yet enforced staff were tasked to make sure their areas, staff and patients were prepared. Managers were also reminded to ensure that COVID-19 screening of patients took place according to the trust protocols as a dip in performance it had been noted.

A further tactical meeting covered the whole trust and as well as the issues in the trust discussed external factors such as available ambulance resources. We noted that the specialist surgical services worked to identify patients waiting in the emergency department or other emergency portals that should be transferred to their unit.

Teams shared responsibilities for decision making. For example, at a handover on ward 31 there was a team discussion on whether they would need to request additional staffing support or could cope in response to a member of the nursing team being off sick

The service held risk registers at a divisional level which were aligned with the issues staff and managers raised with us on the inspection. They were in a suitable format and clearly described the issue, risk, mitigations, remedies and the current status of action plans.

In theatres, senior staff told us the greatest risks on their register were the theatre environment and staffing and this was well documented in the associated risk register which was annotated with mitigation and resolution plans.

Mortality meetings took place and we were made aware of how recent meetings had discussed a contentious topic of the allocation of cases to either the unit or individual surgeons.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Information technology systems were used to monitor and improve patient care. The service had suitable clinical and managerial information systems to provide information for patient care, and both day to day and strategic management.

Service performance measures were reported and monitored. Managers and senior staff had access to these reports and relevant and appropriate service performance information.

Returns were made to the relevant bodies as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The plans for the development of specialist surgical services that demonstrated that they were prepared in collaboration with local and national commissioners as well as charities, other providers and academic institutes. This was clearly done in the context of many of the surgical services provided being centres of excellence for research, innovation, specialist training and care of the sickest patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Staff within the CHUGGS management group used a project management methodology to set up projects to improve quality and experiences for patients and staff. This ensured that such work was properly scoped and managed and prospective benefits were balanced against risks and costs.

Staff helped to alleviate patient's anxiety by holding pre-operative visits with the surgical recovery team and ensuring they woke up to a staff member they were familiar with.

Surgery

There was an ongoing trial of remote post discharge clinics. The service had a newly introduced database to analyse mortality data and ensure the correct management of complex and unit cases in cardiac surgery.

Staff participated in local, national and international research.

There was a longstanding tradition of innovation and tradition involving the surgical provision at the Glenfield site including the development of ground-breaking innovations. This continues through the involvement of staff as authors of papers in world class peer reviewed journals.