Care Quality Commission

Leeds Teaching Hospitals NHS Trust

St James's University Hospital

Quality Report

Becket Street
Leeds LS9 7TF
and
Seacroft Hospital Outpatients Department
York Road
Leeds LS14 6UH
Tel: 011324327799
www.leedsth.nhs.uk/home/

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

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Good
Medical care	Requires improvement
Surgery	Requires improvement
Intensive/critical care	Requires improvement
Maternity and family planning	Good
End of life care	Good
Outpatients	Good

Summary of findings

Contents

Summary of findings

Overall summary

St James's University Hospital is one of seven hospitals forming the Leeds Teaching Hospitals NHS Trust, which is one of the largest in the United Kingdom. St James's University Hospital is one of the largest teaching hospitals in Europe. The trust serves a population of 751, 485 in Leeds and surrounding areas. In total, the trust employs around 15,000 staff. St James's University Hospital has 1113 inpatient beds.

The hospital provides accident and emergency services for adults as well as surgical, critical care, maternity and family planning services. The hospital also provides general and acute medical services. Cardiology, neurology and stroke services are concentrated at Leeds General Infirmary.

Many new initiatives were in the process of development or introduction in the hospital, including the new management and governance structure, which has created 19 Clinical Service Units across the hospital sites. It is acknowledged that these have yet to have time to become fully established, and some services had adapted more quickly than others.

Staff reported that there had been a positive change in the leadership at trust level and that the executive team were more visible, especially the Chief Executive. Staff felt much more positive and better informed over what was happening within the hospital and the trust as a whole. Staff across the hospital reported a much more open and honest culture, with patient care a priority.

A safety culture was not yet fully embedded in the hospital. We found that not all staff groups were consistently reporting incidents, although this was more fully embraced by the nursing staff. Although there were several formal processes in place for sharing learning, such as a trust-wide Learning Points Bulletin we still found that lessons were not being learnt from investigations across clinical service units and other hospitals in the trust, which was a missed opportunity to improve the quality and safety of services.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. However, more work was needed with auditing, particularly of the implementation of trust policies, guidelines and clinical audit. Generally, there was good access to services and the hospital was able to respond to patient's needs.

Patients were positive about their experience in the hospital and reported that staff were kind, kept them informed and they were involved in decisions over their treatment. Patients felt treated with dignity and respect. On the whole feedback from patient surveys was good, although some concerns had been raised about communication with some clinicians, staffing levels and some staff attitudes. We did, however have concerns about the assessment of mental capacity and patient involvement in end of life decisions.

Staffing

Nurses worked hard to meet the needs of patients and took pride in working in the hospital. However, there were nursing and medical staff shortages across a number of areas, which meant that the necessary experience and skills mix, did not always meet Royal College and national recommendations for best practice. Medical cover out of hours was a particular concern, particularly on elderly care and surgical wards.

There was a training programme in place, but not all staff had completed their mandatory training. Staff, particularly junior doctors reported that access to training could at times be problematic due to staff shortages. Staff reported that they felt supported locally, although some staff had not had an appraisal.

Cleanliness and infection control.

There were arrangements in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found all areas visited clean. The trust's infection rates were within a statistically acceptable range, but there was an elevated risk for Clostridium difficile infections and there been a number of cases, although investigations had failed to identify any common cause.

Summary of findings

Medicines Management

There were good arrangements in place to ensure the safe storage, administration, handling and recording of medication. Generally medication was managed appropriately; however, oxygen was not always prescribed according to trust policy.

Complaints Management

When we carried out this inspection we worked with colleagues from the Patients Association and looked at how complaints were managed in the trust. In January 2014, a revised Complaints Policy was implemented across the trust with the strategic intention of improving the management of complaints, attitude to complainants and to provide all those involved in the complaint handling with training. A new team had been established and this was impacting positively on the receipt and handling of complaints. The executive team was found to be committed to a cultural change in the handling of complaints and an improved response to patients concerns. Work was progressing, but further areas for improvement included the increased capacity of the Patient Advice and Liaison Service, embedding the monitoring and auditing of complaints including performance information and better sharing of lessons learnt.

Seacroft Hospital

As part of this inspection we visited the outpatient clinics at Seacroft Hospital where 51,000 patients attended outpatient clinics in 2012-2013. During the week of our inspection there were 16 speciality services providing outpatient clinics at Seacroft Hospital. We found that the services at Seacroft Hospital were safe, responsive and patients were highly satisfied with their care. The services formed part of the outpatients' clinical service unit. Staff reported that they felt well informed and part of the trust as a whole with good local support and leadership. The findings of this inspection can be found in the outpatients service section of this report.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There were clear arrangements to assess, monitor and report risk with new governance and reporting structures in place, which was still to become established. A safety culture was not yet fully embedded in the hospital. We found good reporting of incidents among the nursing staff, but this was not seen as a priority for all clinical staff. Although there were several formal processes in place for sharing learning, such as a trust-wide Learning Points Bulletin we still found that lessons were not being learnt from investigations across clinical service units and other hospitals in the trust, which was a missed opportunity to improve the quality and safety of services.

Nursing and medical staff shortages were experienced across a number of areas of the hospital and meant that the necessary experience and skills mix did not always meet Royal College and national recommendations for best practice. Medical cover out of hours was a particular concern on the medical elderly care and surgical wards.

The trust had taken a number of steps to address the shortfalls including increasing consultant cover, developing advanced practitioner roles, using agency staff and recruitment was taking place.

There were systems to manage and monitor the prevention and control of infection. All areas visited were clean. The trust was working to locally agreed targets for infection control and had action plans in place to address any shortfalls in identified practice.

Attendance at mandatory training was low in some areas and staff did not always have access to the necessary training to maintain their skills or gain new ones.

We found that mental capacity was not always being assessed in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards; where these were being undertaken, they were not consistently being recorded appropriately.

Are services effective?

Good

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. We observed commonly used care tools such as care bundles for the care and treatment of specific medical conditions.

Work was required on auditing the implementation of trust policy and guidance. Clinical audits were taking place, but there lacked clarity over what was being audited, the outcomes and how this information was captured.

Summary of findings

Further work was required to monitor and audit the implementation of trust policies, guidelines and best practice recommendations. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Are services caring?

Good

We observed that staff were kind, caring and ensured that the patients' privacy and dignity were respected when attending to individuals' personal needs.

Patients told us they had been involved in decisions about their care and treatment. Nurses introduced themselves to their patients at all times. Doctors explained to patients their diagnosis and made them aware of what was happening with their care. We did however, have concerns over patients' and their families involvement in end of life decisions, as records did not consistently demonstrate that discussions had taken place.

Analysis of patient feedback information showed that generally patients were positive about their experience, particularly in the accident and emergency department. End of life support was reported to be good and a specialist team was available to advise and ensure that patients were given, were possible the opportunity to be cared for in their place of preference.

Are services responsive to people's needs?

Requires improvement

We observed that staff were kind, caring and ensured that the patients' privacy and dignity were respected when attending to individuals' personal needs.

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Are services well-led?

Requires improvement

The trust had recently introduced a new leadership and governance structure. Services were arranged within 19 clinical service units (CSUs) led by a senior doctor, nurse and manager. The clinical service unit structure crossed the different hospital sites and was yet to be fully established. There had been a

Summary of findings

change of leadership at trust level in 2013 and staff reported that there had been a shift in culture since this change. The Chief Executive in particular was visible and staff reported a positive lift in confidence within the hospital and trust as a whole.

At a local level, staff reported that they felt supported by their managers and seniors. However, there were still areas that had not embraced the cross site ethos and different cultures were reported in some areas. Opportunities to improve the safety and quality of services were missed as good practice and learning from incidents was not consistently shared across clinical service units and reporting was not fully embedded across different staff groups, meaning further work was required to develop an effective safety culture in the organisation. Access to and completion of mandatory training was not consistent.

New systems and processes were still in their infancy and although improvements were being felt and reported by staff, there was still a need to embed these at local service level and within staff practices.

Summary of findings

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

Accident and emergency

Good

The A&E department delivered services safely. There was sufficient nursing and medical staff to provide a safe service and the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practitioners. The department was clean with arrangements in place to manage and monitor the prevention and control of infection. Monitoring systems ensured the effective assessment, monitoring and addressing of risk. Learning took place following incidents and complaints. However, we found that not all staff had completed mandatory training.

The A&E used nationally recognised best practice guidelines and quality standards to monitor performance. There was good multidisciplinary working with a full range of trauma specialists available 24 hours a day. There was telephone access to mental health services, through the acute liaison psychiatry service (ALPS).

Patients and relatives were positive about the treatment and care they had received. Children's accident and emergency services were provided by Leeds General Infirmary, but there were facilities available should a child arrive at St James's Hospital, once deemed fit to travel, the child would be transferred.

The trust had been performing better than the A&E national targets since July 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged.

The department was well led, and staff felt engaged and supported. There was good team working.

Medical care (including older people's care)

Requires improvement

We found the medical wards to be generally safe. Wards were clean and well maintained, with systems in place for the prevention and control of infection. However, nurse staffing numbers were low in some areas, which meant that safe care could not always be delivered. We found a good culture of reporting incidents among the nursing staff; however, this was not seen as a priority for all clinical staff.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Improvement was needed on the clinical audit system, including the implementation of trust policies and guidelines. Multidisciplinary working was widespread and significant progress had been made towards seven-day working.

Patients were treated with dignity and respect and we saw that staff were kind and caring. Patients spoke positively about the care they received and felt

Summary of findings

informed and supported. However, there had been a concentration on improving the acute care pathway, which meant that the elderly care services had not developed as it should, particularly the care of patients living with dementia.

Staff were positive about the recent changes in their divisional structure, which enabled frontline clinicians to be more involved. The culture of the medical wards was felt to be positive and patient centred.

Surgery

Requires improvement

We were concerned, that at times there were insufficient staff to ensure the safe delivery of care, particularly junior doctor cover out of hours. There were also problems with the availability of anaesthetists. In response to this the trust had increased the use of locums to minimise risk, and junior doctors reported that consultants were easily contactable.

The theatres used the World Health Organisation safety checklist but had not embraced all the list as debriefing sessions were not taking place. Wards and theatres were clean and had systems in place to prevent and control infection.

Trust policies were available, which incorporated best practice guidelines and quality standards to monitor performance. However, there was insufficient audit evidence and systematic monitoring to demonstrate these were implemented and effective.

Patients spoke positively about their care and treatment. There were systems in place to manage the flow of patients through the hospital and discharges dates and plans were discussed for most patients. Staff were aware of how to support vulnerable patients. However, mental capacity assessments were not always documented in accordance with the Mental Capacity Act (2005).

Staff reported good leadership at all levels of the organisation. They reported a positive significant shift in culture since the new trust management had been appointed. Staff understood the managerial arrangements and reported this was working well. The analysis and use of performance data to ensure the services were well-led was developing and was identified by the CSUs as a 'work in progress'. Risk registers across the surgical clinical service units were of variable quality.

Intensive/critical care

Requires improvement

We had concerns over the potential risk to the operation of a safe service in the critical care units. Substantive nurse staffing levels were consistently below the required levels. We found a reliance on nursing staff to work additional hours and a high use of agency staff, which was considered a risk by the permanent nursing team. The critical care units were found to be clean with appropriate arrangements in place to prevent and manage infection, although there was some confusion over the use of some personal protective equipment.

Summary of findings

We found that mental capacity assessments and the deprivation of liberty safeguards were not part of the critical care process. Mandatory training completion was low and although mandatory training was co-ordinated by the Organisational Development department the mechanism in place for ensuring staff were up-to-date with their training appeared ad-hoc.

The critical care units followed a variety of national guidelines to determine best practice and we observed commonly used care tools such as care bundles.

Staff were caring and respected patient's privacy and dignity. Patient's families and carers were kept informed and involved and felt able to discuss concerns with staff. Patient's families and carers were very positive about the support and care given on the units.

Generally, staff felt the changes brought about by the new leadership team had improved communication and there was a greater focus on quality, but staff were concerned about the increasing pressure and demand on critical care beds. We had concerns about the apparent 'us and them' culture between the two main hospital sites and the lack of engagement between senior medical staff within the critical care clinical service unit. There was limited planned cross-site working and staff remarked that the culture across the two main hospital sites was different; this didn't encourage joined-up working.

Maternity and family planning

Good

Maternity and family planning services were safe, although there was a shortfall in relation to midwifery and medical staffing. Action had been taken to recruit midwifery staff and medical rotas were in place to cover the maternity services. Although this was not ideal, staff told us that the unit was well managed and they had no concerns about patient safety.

Maternity service areas were clean and effective procedures were in place to monitor infection control. Where incidents had been identified, staff had been made aware and action taken.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure that staff were following recognised national guidance.

Women were pleased with the quality and continuity of service and felt staff had treated them with dignity and respect. Women felt involved in their care; this had included the development of their birth plan and aftercare.

The maternity service had several midwives who had specialist areas of expertise to meet the diverse needs of women in their care.

We found that that there was consistency across the maternity clinical service unit, regardless of the location. Staff were aware of the trust's vision and told

Summary of findings

us the ethos in the organisation was now about quality, caring and also looking after staff. They were aware of the financial challenges, and said this would not be resolved at the cost of quality. Staff worked well together and there was obvious respect between all grades of staff.

End of life care

Good

Overall, people were protected from abuse and avoidable harm and received safe end of life care. However, we saw some inconsistencies when assessing a patient's capacity when making decisions about attempting resuscitation. We found that patients who lacked capacity were not always having this assessed and documented.

People's care and treatment promoted a good quality of life and were evidence-based. The trust had recently introduced new 'care of the dying patient' care plans to replace the Liverpool Care Pathway (LCP). We were told that a future audit of the use of these was planned to assess their effectiveness.

Staff involved people in their care and treated them with compassion, kindness, dignity and respect. Staff showed a real commitment to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of death.

All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service. Staff were positive about the management and support given with end of life.

Outpatients

Good

Outpatient areas at both St James's University Hospital and Seacroft Hospital were appropriately maintained and fit for purpose. We found consistency in leadership and governance from the clinical service unit at both sites. Staff at all levels told us they felt encouraged to raise concerns and problems. Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learned and improvements were shared across the departments and hospitals. The infection control procedures were adhered to in clinical areas, which appeared clean and reviewed regularly. Staffing levels were adequate to meet patients' needs.

The trust completed audits and had implemented changes to improve the effectiveness and outcomes of care and treatment.

Patients told us they felt involved in their care and treatment and that staff supported them in making difficult decisions. The hospitals provided interpretation services and patients' privacy and dignity were respected. However, a common theme from the analysis of patient feedback was that waiting times in clinics could be improved in terms of length of wait and patients being informed of why and how long they were expected to wait.

Summary of findings

The outpatients were focused on patient care and this was reflected at all levels within the departments. Staff understood the vision and values of the organisation and felt encouraged to achieve continuous improvement.

Summary of findings

What people who use the hospital say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to offer feedback on the quality of care they had received. In October 2013, the trust scored about the same as the England average for inpatient tests, and significantly above for accident and emergency services, with a higher response rate for inpatient data.

Analysis of data from the Care Quality Commission's (CQC) Adult Inpatient Survey (2012) showed that the trust scored about the same as other trusts in nine out of 10 areas of questioning.

St James's University Hospital scored 3.5 out of 5 stars on the NHS Choices website, with 79 people expressing views. Negative themes were staffing levels, poor attitude of staff, late and omitted medications. The hospital scored 4 stars for cleanliness, 3.5 stars for co-operation, 3.5 stars for dignity and respect, 3.5 stars for involvement in decisions and 4.5 stars for the same sex accommodation.

Seacroft Hospital scored 2.5 stars on the NHS Choices website, with 12 reviews, which reported that patients found staff friendly, welcoming and informative. However, negative comments reported patients experienced phones not being answered, cancelled appointments sometimes, the day before or even on the same day, delayed appointments and found some staff rude.

The 2013 Patient-led assessments of the care environment (PLACE) focuses on the environment in which care is provided and looks at cleanliness, food, hydration and the extent to which the provision of care with privacy and dignity is supported. The hospital scored 99% for cleanliness, 87% for food, 91% for privacy and dignity and 923% for facilities.

Seacroft Hospital scored 97% for cleanliness, 79% for food, 84% for privacy and dignity and 76% for facilities.

Healthwatch shared their 2014 survey, where 183 people shared their views and experiences of services across all of the five hospitals at the trust. At trust level, approximately 44% rated the service outstanding, 24% were rated as good, 7% were rated as satisfactory and 26% were rated as requiring improvement. Some areas received positive responses with comments raging from good to outstanding for the accident and emergency services and the ophthalmic clinic. However, negative comments were received over the experience of waiting for care on the surgical assessment unit, some staff's attitude and lack of communication. People at the Speak Out Focus Group raised concerns about the reception area in surgical services at St James's University Hospital being poor, the attitude of some reception staff and a lack of information on medical conditions and what to expect prior to surgery being undertaken.

Areas for improvement

Action the hospital MUST take to improve

- Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical elderly care wards, surgical wards, including anaesthetist availability and medical cover out of hours and weekends.
- Ensure that staff attend and complete mandatory training, particularly for safeguarding and maintaining their clinical skills.
- Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.
- Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.
- Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff act in the best interests of the patient and this is recorded appropriately.
- Ensure staff were aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.

Summary of findings

- Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.
- Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.
- Review the nursing and medical handover to ensure that the appropriate information is passed to the next shift of staff and recorded.
- Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.
- Review the clinical audit and auditing of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.
- Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.
- Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.

Action the hospital SHOULD take to improve

- Review the effectiveness of the recruitment of staff processes to ensure delays to recruitment are kept to a minimum.
- Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.
- Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.
- Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.
- Review the information available for people who have English as a second language and make written information more accessible including clinical decisions and end of life care.
- Ensure that the provision of oxygen is appropriately prescribed.
- Ensure that all staff involved in patient care are aware of the needs of people living with dementia and that the documentation used reflects these needs.
- Ensure that all early warning score documentation is fully completed on each occasion used.
- Consider displaying trend data over a period of time as part of the ward dashboards and that information is disseminated to staff.
- Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.
- Review the support and provision of the medical elderly care services with consideration of providing a seven day service and contribution to the monthly clinical service unit governance meetings.
- Review the use of the World Health Organisation safety checklist for theatres to ensure that it includes all elements such as the team debrief.
- Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.
- Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.
- Review the security of the hospital in general, but specifically with regard to access to theatre departments.
- Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.
- Review the use of personal protective equipment on the critical care units to ensure consistent practice.
- Review the frequency and effectiveness of the surgical morbidity and mortality meetings so that there is a more effective use of lessons learnt to improve patient outcomes.
- Introduce a robust patient tracking system for surgical patients so that there is continuity of care at all times.
- Review the effectiveness and care of patients following surgery on Bexley Wing in relation to the transfer post operation to Geoffrey Giles Theatres in Lincoln Wing, and potential multiple moves to fit in with service operating times.
- Implement a seven day a week critical care outreach team.
- Consistently apply patient feedback processes across clinical support services.
- Review the waiting times in the outpatient clinics and information given to patients to ensure these are kept to a minimum length and patients understand what to expect.

Summary of findings

- Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.

Good practice

- Use of 'Ward Healthcheck' with corporate escalation if an area was shown to be poorly performing in a set number of indicators.
- Information boards in both the A&E departments clearly informed patients of their pathway through the department and what they could expect from each area.
- In response to pregnant women who were travellers and asylum seekers, the trust set up a community midwife led service (Haamla) to assist in meeting their needs.
- The hospital had received a Parliamentary Service Award for the multi-disciplinary team of the year for their diabetes in pregnancy service.
- The women's service had received a runner up award for services for antenatal screening of women with HIV.
- The Respiratory Unit – the "RAG" white board system on the respiratory admission ward ensures patients are seen quickly by admitting doctors and the consultant on the day. These are identified to the bed manager when well enough to move to main wards. The unit holds multidisciplinary handover meetings that include the bed manager and community respiratory nurses. There is a dedicated band 7 bed manager/senior nurse for the unit, meaning all respiratory patients are known, whether they are located in A&E, Leeds General Infirmary or on outlying wards. The result was very rare outliers and a seamless throughput with patients in the right place for their medical needs.
- The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.
- Services provided on the respiratory and gastroenterology wards were considered by the team to be outstanding.
- The Medical Care ambulatory care unit ran 24 hours a day seven days a week and helped to prevent unnecessary admissions.
- The Primary Care Advice Line (PCAL) gave GP's a single point of access to the hospital and ensured that patients were directed to the appropriate department the first time.
- Use of volunteers working in A&E with easy identifiable 'Can I help you?' green t-shirts.
- Outpatient staff at Seacroft Hospital had developed a Quality Manual and Care and Compassion Standards, which included competencies for staff to achieve and this was being shared across all the outpatient departments.
- The Macular Degeneration Clinic at SJUH and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.
- The Disablement Service Centre at Seacroft had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.
- Patients using the car park for all outpatient appointments are charged a set fee irrespective of the length of time of their appointment.

St James's University Hospital

Detailed Findings

Services we looked at:
St James's University Hospital: Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; End of life care and Outpatients.; Seacroft Hospital: Outpatient departments.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett Consultant Radiologist

Head of Hospital Inspections: Julie Walton, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: The team of 80 included CQC senior managers, inspectors and analysts, senior and junior doctors, nurses, midwives, a student nurse, a pharmacist, a paramedic, a theatre specialist, patients and public representatives, experts by experience and senior NHS managers.

Background to St James's University Hospital

There are approximately 86,000 attendances a year in the A & E department at St James University Hospital (SJUH). The resuscitation room had 5 bays and was equipped for five adults. One bay was also equipped for children in case a child attended this A & E and not the children's A & E at Leeds General Infirmary (LGI).

The hospital provides acute and general medical care spread over 20 wards. These included care of the elderly, respiratory, endocrine, infectious diseases, gastroenterology and acute medical wards. It also provides specialist oncology and renal wards, which were not inspected at this time.

There are a range of surgical services including general surgery, urological and gynaecological surgery, organ transplantation and day surgery. There are 16 wards, which provide surgical services spread across several Clinical Service Units (CSUs), with approximately 350 surgical inpatient beds. There is also a surgical admissions unit and a pre-assessment ward. A total of 19 operating theatres are provided across four theatre suites including day surgery theatres.

Adult Critical Care Clinical Service Unit (CSU) has 131 beds across Leeds Teaching Hospitals NHS Trust. The beds are split across two sites with three units at Leeds General Infirmary for general, cardiac and neuro-surgery and two units at St James's University Hospital for general intensive care and high dependency care. Critical care at SJUH comprise of 34 high dependency beds and 15 intensive care beds. There are 14 additional high dependency beds at SJUH and six at LGI, which sit outside the management of the CSU.

Detailed Findings

The trust provided obstetric/midwifery care at the St James's University Hospital and Leeds General Infirmary site, along with community midwifery care. It is a tertiary centre and therefore provides care for and advice to clinicians caring for women with complex needs. The service included pre conceptual care, early pregnancy care, antenatal, intra partum and postnatal care. The trust also had a tertiary Neonatal Intensive Care Unit (NICU) at both sites, which provided medical neonatal care. At LGI the service was for babies under 27 weeks gestation and high risk pregnancies, and they had a total of 31 neonatal cots. At SJUH the service was for babies above 27 weeks gestation and with a total of 34 neonatal cots.

End of life care services are provided throughout the trust. The Specialist Palliative Care Team (SPCT) is located at the Robert Ogden Centre at St James's University Hospital. The team comprises of consultant medical staff, speciality doctors, nurse team leaders, specialist palliative care nurses, a palliative care discharge facilitator, end of life care facilitators, a social worker and a pharmacist.

The trust provided a range of outpatient clinics with just under one million patients attending each year. At St James University Hospital over 390,000 patients attended outpatient clinics in 2012-2013. During the week of our inspection there were 33 speciality services providing outpatient clinics at the SJUH. The trust had dedicated outpatient departments with dedicated outpatient staff. The trust employed 220 nursing staff (Registered and Unregistered) who are supported by approximately 350 administrative and reception staff to provide and support outpatient services.

Seacroft Hospital

As part of this inspection we visited the outpatient clinics at Seacroft Hospital where approximately 51,000 patients attended outpatient clinics in 2012-2013. During the week of our inspection there were 16 speciality services providing outpatient clinics at Seacroft Hospital. The findings of this inspection can be found in the outpatients' service section of this report.

Why we carried out this inspection

We carried out this comprehensive inspection because the Leeds Teaching Hospitals NHS Trust was initially placed in a high risk band 1 in CQC's intelligent monitoring system. Immediately prior to the inspection the intelligent monitoring bandings were updated and the trust was then placed in a lower risk band 4, this was in the main due to an improved staff survey result.

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people – These were not provided.
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits on 17, 19 and 20 March and an unannounced visit to St James's University Hospital on 30 March 2014.

During the visits we held focus groups with a range of hospital staff, including support workers, nurses, midwives, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the

Detailed Findings

wards, theatres, critical care unit, outpatients, and A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held two listening events on 11 March 2014 to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment we looked at as part of the inspection. We also held a community focus group with the support of Regional Voices (through Involve Yorkshire and Humber) who was working with Voluntary Action Leeds so that we could hear the views of harder to reach members of public.

Good

Accident and emergency

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

Information about the service

There are approximately 86,000 attendances a year in the A & E department at St James University Hospital (SJUH). The resuscitation room had 5 bays and was equipped for five adults. One bay was also equipped for children in case a child attended this A & E and not the children's A & E at Leeds General Infirmary (LGI). The conversion rate (percentage of those patients attending who were subsequently admitted) to a hospital ward at this site was 43%.

There were eight trolley bays allocated for the initial assessment of patients who arrived by ambulance, which was approximately 42% of patients. Following initial assessment patients were then moved to bays in the blue or the green area. There were 11 bays in the blue area, including three side rooms, and this area was open 24 hours a day. There were eight bays in the green area, plus a side room used for isolation, which was staffed to open at lunchtime and usually closed about 2am.

For patients that walked into the department there was a minor injuries or illness service, which operated from 9am to 10pm, 7 days a week, and 365 days a year.

There was also a clinical decision unit (CDU). This was a short stay unit, which accepted patients mainly from the A & E, who fulfilled the criteria of one of 19 clinical protocols used. There were six male beds and five female beds; these met the national criteria for mixed sex accommodation. There were also two cubicles. There was an observation area, which was a seated area for seven patients who were awaiting results or transport home.

The trust, across both LGI and SJUH, employed 24 A & E consultants, middle grade doctors and over 200 qualified nurses who were supported by 70 clinical support workers and nursery nurses and 45 administrative and reception staff.

Good

Accident and emergency

Summary of findings

Summary and justification for rating

A & E services were safe. The department appeared clean and tidy throughout our inspection. Nursing and medical staffing levels were safe as the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practitioners and overseas emergency medicine training programmes. Nursing handovers were comprehensive and thorough covering elements of general safety as well as patient specific. There was good ownership of risk and learning from incidents within the department.

We do not currently rate A & E departments on how effective they are. It used nationally recognised best practice guidelines and quality standards to monitor performance such as from the College of Emergency Medicine. There were standard operating procedures in place for both the A & E and Clinical Decisions Unit (CDU) that were used effectively by staff. There was good multidisciplinary working with a full range of specialists available or on-call 24 hours a day. Access to mental health services, through the acute liaison psychiatry (ALP) service based in the A & E was good.

Patients were easily identifiable if they were at risk of falls or in need of pressure care by the use of coloured wrist bands. Staff told us this had reduced the number of falls in the department. Pain management was good on initial assessment. However recording of further pain assessments could be improved.

Patients felt involved in their care and through the use of patient journey wall boards, they were able to keep track of where they were on their journey through the department and what would happen next. We observed that patients were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department. The implementation of dignity rounds helped ensure that patients were as comfortable as possible and that their privacy and dignity was maintained.

The trust had been performing better than the national targets since June 2013 for 95% of patients waiting less than four hours to be admitted, transferred or discharged. Patient flow was maintained through the department and was better than the English average. There was a clear escalation policy in place, which we saw in operation throughout our inspection. There were a number of systems and services in place to ensure that A & E responded to patients needs appropriately and in a timely manner. Overall there was good communication with GPs, other providers and departments within the trust to enable this to happen.

Staff told us there was usually a visible presence of senior leaders, for example, the matron. Staff were aware of the new executive team and the consultation on the 5 year vision and strategy for the trust. At departmental level there were effective procedures in place to ensure that the service was well led for example the nursing handovers. Staff told us they felt engaged and involved in service improvement and redesign work. Staff were supportive of each other. Staff in the CDU were aware of the ward healthcheck and what it meant in terms of quality and performance.

An area for improvement was the development and promotion of localised performance data for the A & E department, which senior staff were aware of. Staff we spoke with did not fully understand the performance data that was displayed on a public notice board.

Good

Accident and emergency

Are accident and emergency services safe?

Good

Cleanliness, infection control and hygiene

- We found that there were arrangements in place to prevent and control infection, including the provision of personal protective equipment such as gloves and aprons. Systems were in place to ensure cleaning was carried out appropriately of the environment and equipment.
- The department appeared clean and we saw staff regularly wash their hands and use hand gel between patients.
- The bare below the elbow policies were adhered to.
- There were weekly hand hygiene audits taking place within the department (a sample of 5 staff were observed and reported on). We saw a hand hygiene audit in progress.
- We saw hand hygiene audits for April to December 2013, the majority of which achieved 100% for both compliance and technique.
- There were audits for peripheral intravenous cannula insertion, which achieved 100%.
- The hand gel dispensers were full and paper towels were available at all sinks and toilet areas.
- Patients were positive about the cleanliness of the department. Patients commented that it appeared clean and one person said, “The cleaners seem to be doing a good job”.
- There were cleaning staff available 24 hours a day. A visible cleaning system was in place whereby large red and green circles (signs) were displayed to denote when a trolley bay or room required cleaning or was clean.
- Sluice areas were clean and there were, “I am clean stickers” on commodes to indicate they had been cleaned and were ready for the next person to use.
- There was a “Diarrhoea and Vomiting in the Emergency Department Pathway,” which included screening for Clostridium-difficile. Meticillin Resistant Staphylococcus Aureas (MRSA) screening was undertaken.

Nursing staffing

- Nursing numbers were currently assessed using data from the Symphony IT system, which indicated peaks and troughs in patient numbers through the department and the work of the service improvement team. We saw copies of the “Demand and Capacity Model for Medical & Nursing Staffing,” which was then generated and measured planned against actual levels.
- Senior staff were aware of the Royal College of Nursing acuity tool for assessing staffing levels that had been used in other parts of the trust. We were told it would soon be implemented in A & E.
- Ideal and actual staffing numbers were displayed for each shift in the department and discussed at every handover.
- Staff vacancies were higher at SJUH than LGI, but staff were able to work across both departments.
- Where there were shortfalls in staffing numbers the department used the NHS agency “NHS professionals” to fill the shifts.
- The rotas for adult A & E from December 2013 to March 2014 indicated that almost every day there were temporary staff on duty; usually ranging from one to four over any 24 hour period.
- Staff reported that they were on occasion understaffed and that vacancies were filled with agency staff. There were no concerns raised regarding the staff coverage of vacancies, these were well managed.
- The head of nursing for urgent care told us about a recent recruitment drive and of the eight new appointments to the nursing team at SJUH.
- Overall the trusts spend on agency staff was the same as other trusts in the same region (Yorkshire and Humber area).

Medical staffing

- There were 24 consultants employed by the trust to cover both the children’s and adult’s A & E at LGI and SJUH. The trust was proactively managing the shortage of middle grade doctors by increased consultant cover and by developing advanced practitioners as well as providing overseas emergency medicine training programmes.
- At SJUH there was consultant cover 24 hours a day. There were usually three consultants on the department floor during the day and two until midnight. There was then a consultant in the department overnight from 11pm to 8am.
- Additionally, overnight there were also two on call (from their home) A & E consultants, one to cover for major trauma at the LGI site and one for any other requirements.

- Junior doctors told us that consultants were contactable by phone if they needed any support.
- The junior/middle grade doctor rota had several vacancies, which were usually filled by using long term locums. One locum specialist registrar (SpR) commented, "I feel valued as a team member despite being temporary staff".
- We were told that only six out of 19 SpR posts were filled on a permanent basis.
- Due to medical staff shortages study leave was very hard to organise. Doctors commented that they felt training was not a priority.
- The trust was developing alternate staffing models to compensate for the local and national shortage of emergency medicine doctors. This included the development of a training programme for advanced practitioners and overseas emergency medicine training programmes. Across both sites there were currently 3 trained and 4 trainee advanced practitioners and 4 doctors on the overseas training programme.

Initial assessment of patients

- Patients who walked into the service were streamed by a receptionist on arrival. This meant that the receptionist took a very brief history and entered this onto the computer. The computer system indicated where the patient needed to be seen within the department, for example, in the majors or minors area. The system also flagged if a person had a history of violence, aggression and if they were children under 16 years of age.
- Patients who came by ambulance were assessed by a senior experienced nurse who had specific training as part of the handover.
- On average patients who came by ambulance had their initial assessment within 4 minutes of arriving. At the end of February 2014 records showed that for SJUH the A&E department 95% of patients received an initial full assessment in less than 14 minutes from their time of arrival, which is better than the contractual requirement of 15 minutes.
- The A & E service used the Rapid Assessment and Treat (RAT) guidelines to stream patients appropriately. This was consultant led for the majority of the time. Those with higher risk then underwent more formal triage (using the Manchester Triage guidance), which included a brief history and observations. Pain relief, X-rays and blood tests were organised if required.
- Patients with chest pain were highlighted by a heart symbol on the computer and transferred immediately to the major's area for tests, including an electrocardiogram (ECG). All notes we looked at demonstrated that these assessments were being completed appropriately and pain relief was given promptly (within 30 minutes).

Management of the deteriorating patient

- Patients who attended the department had their observations undertaken during their initial assessment. These were entered onto their computerised record (Symphony), which automatically calculated their National Early Warning Score (NEWS – a tool to identify when a patient's condition was deteriorating) and prompted action, such as moving the patient to resuscitation if required.
- We saw that where required these observations were repeated and recorded while the patient was in the department.
- The department used a 6 point tool for identifying a patient who might have sepsis.
- Patients were easily identifiable if they were at risk of falls or in need of pressure care by the use of coloured wrist bands: green for falls and blue for pressure care. Staff told us this had reduced the number of falls in the department. It was recorded in staff meeting minutes that falls had been reduced by 80%.
- There were posters up in each cubicle called Preventing pressure ulcers. These contained simple steps for how patients can help prevent pressure ulcers, for example, -change position regularly. Some patients told us they had read the advice and were following it.

Nursing and medical handover

- We observed both medical and nursing handovers.
- Nursing handovers occurred twice a day. Each commenced with a handover of information about the current patients to the incoming staff. Handover also included information on performance, dignity rounds, team brief and staff training. All staff were then allocated areas. This was followed by a debrief for the staff finishing their shift, which included checking the controlled drugs, if there were any safeguarding issues, or any incidents. We observed a handover and noted that the senior nurse thanked the staff and offered positive praise.

- Medical handover occurred twice a day and was led by the consultant on the department floor. We observed the consultant prioritise and allocate the medical team to specific areas.

Handover process to wards

- There was a clear protocol in place for the transfer of patients to wards. Patients with a NEWS score of 5 or above were transferred with a nurse escort. For other patients there was a checklist, which was completed by A & E staff and given to the ward. We looked at 9 checklists and they all had NEWS scores documented. The staff on the receiving wards told us this system worked well for patients with a low NEWS score.
- Nursing staff phoned the ward in advance as part of the handover process.
- Some concerns were raised by nursing staff on one ward that there was limited information and time to prepare before patients arrived from A & E.

Incidents

- There had been three serious incidents reported across the urgent care clinical service unit. We saw that these incidents had been investigated and learning shared with staff.
- One incident had also concerned another department. A doctor commented that, “The information was only accessible to clinicians within their own clinical services unit” and “This did not help trust-wide learning from incidents”. Datix reports and incident notifications were not routinely shared across departments.
- From reviewing incidents and talking with doctors there appeared to be a lack of clear medical ownership of patients who had been seen by another speciality, but were still in the emergency department. This might have led to delays in treatment. Doctors were aware of this issue.
- There was good ownership of risk and learning from incidents within the department. The department used the incident alert SBARR (Situation, Background, Assessment, Recommendation, Read-back) tool. We saw copies of when the tool had been used and circulated to staff. Examples included: reducing error from mislabelled request cards and ensuring a senior doctor reviewed patients re-attending A & E with the same problem and within 72 hours.
- Staff were able to give us examples of where practice had changed as a result of incident reporting.
- There was a bi-annual newsletter called “Errors in ED,” which was widely circulated and contained many examples and the learning gained from them.

Environment and equipment

- The environment on the unit was safe for the number of patients attending the unit.
- Equipment was appropriately checked and cleaned regularly.
- There was adequate equipment on the CDU.

Medicines

- Medicines were well stocked and in date.
- The controlled drugs (CD) were checked twice a day.
- There was a computerised cabinet system in place for the administration and management of medicines. This required a fingerprint scan to access the cupboard.
- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked to ensure that they were maintained at the correct level.
- We observed the administration of medication and found no concerns.
- Allergies were flagged on the patient’s record and patients were wearing red wrist bands to indicate they had allergies.

Records

- The department stored information electronically using an IT system called Symphony.
- There was also printed documentation for nursing and medical staff to jointly input to one record as well as specific proforma to follow for certain conditions, for example - acute asthma.
- The quality of documentation was audited as part of the monthly “Ward Healthcheck”. The CDU scored 100% in February 2014.
- In the minor injuries area we noted that patient information was displayed on 3 of 4 computers in the treatment rooms and in some instances potentially accessible to the public. This could cause a breach of patient confidentiality.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Overall patients were consented appropriately and correctly.
- We were told that for patients who did not appear to have capacity to consent to stay in A & E or to consent to tests, due to the influence of alcohol or other

substances, there was a missing person's assessment tool and capacity was recorded on Symphony. The tool took account of the requirements of the Mental Capacity Act 2005. We saw the tool used with two patients and it was applied correctly to check the person's capacity.
- For patients who were confused and / or living with dementia the procedures were less clear. Staff were able to tell us which patients did not have capacity but this was not formally assessed or recorded. Staff stated that in such cases they would do what was thought best for the patient's recovery. Patients were receiving treatment and tests that they may not have consented to.
- We saw that for patients who had capacity consent was gained appropriately, procedures were explained and all questions answered.

Mandatory training

- We looked at nursing staff mandatory training records. There were set targets for each speciality and staff group to achieve compliance with the training.
- Records confirmed that across the urgent care clinical service unit there was 78% of staff up to date with their mandatory training. Areas that were below target were safeguarding, personal safety and competency assessments. The education practitioner for the department showed us the records for staff training and informed us about the plans in place to address the areas that were below target. We saw forthcoming courses advertised and some staff were booked onto these.

Safeguarding

- Adult and child safeguarding training was part of staff induction and mandatory training. 86% of all staff had up to date training for Level 1 child and adult safeguarding: 90% of medical staff and 92% of nursing staff were Level 1 trained.
- 51% of medical and nursing staff that required Level 2 child safeguarding training had received it.
- 42% of nursing staff that required Level 2 adult safeguarding training had received it.
- Some doctors were unsure about the level of safeguarding training they had received and what they were required to have.
- Staff were aware of how to make a referral if they had any safeguarding concerns.

Major incident awareness and training

- Staff were aware that the A & E at the LGI was the designated major trauma centre for West Yorkshire. This meant ambulances would divert trauma to that unit rather than St James.
- There were also procedures and protocols in place should a major incident occur.
- There was compulsory classroom based major incident training for all nursing and care support workers.

Security

- There was a police office in reception with security staff available.
- On admission to the A & E, certain patients who were known to the staff as requiring security support were flagged on the system.
- We observed a rapid response when A & E staff requested support from both the police and security.
- Security staff told us they had training on how to manage violent or aggressive patients, which included the use of restraint and was scenario based. This training also included information about the Mental Capacity Act 2005. There were panic buttons available for reception staff should they have any concerns.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Use of national guidelines

- The A&E department used a combination of NICE and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with this and were updated.
- The department ensured that the A&E was managed in accordance with the principles in 'Clinical Standards for Emergency Departments' (CEM).
- The department provided us with a list of all completed audits during their past year and the dates. For example a sepsis audit indicated that if people required antibiotics while in the resuscitation area they received them quickly. However, people in the major treatment bays who required antibiotics often had a delay of 2-3 hours before antibiotics were given.

Good

Accident and emergency

- There were clear action plans indicating what improvements needed to be made as a result of the audits.

Outcomes for the department

- The unit contributed to the College of Emergency Medicine (CEM) audits – including consultant sign off, renal colic, vital signs in majors, fractured neck of femur, severe sepsis and septic shock. For example, the renal colic audit indicated that the department was working to the required standards although some actions to further improve patient care were required.
- Unplanned re-attendances for the trust were similar to the England average of between 7 – 8%. However, at the SJUH A & E department the percentage for the year to the end of February 2014 was 9.9%, which was higher than the England average.

Care plans and pathways

- There were single documents and computer records that all staff used for each patient.
- There were specific pathways for certain conditions, for example, sepsis and acute anaphylaxis.
- The CDU had 19 clinical protocols, which formed the admission criteria to the unit.
- Pain management was good on initial assessment. However recording of further pain assessments could be improved.
- Patients made positive comments about pain management, for example, “I was asked about whether I was in pain”, “I haven’t needed to ask for a doctor everything has been taken care of I’ve been checked up on and offered pain killers” and “I have had more pain killers, I was told what it was, but I can’t remember”.

Multidisciplinary team working and working with others

- There was an early discharge and assessment team (EDAT) that operated within the department. Patients on the appropriate pathway were assessed for discharge by the team. This might have involved mobility assessments, referral to geriatricians or the falls team. Referrals were also made to community services as required, for example, the intermediate care team or occupational therapist.
- The unit was involved in a regional network for A&Es and actively learnt from other departments to improve their services.
- There were close links to radiology department with open appointments for patients and easy access to scanning.
- The radiology department was situated next door to the unit and was easily accessible. There was 24 hours a day cover.
- A Primary Care Advice Line (PCAL) enabled GPs to discuss concerns they may have about patients. It was run by qualified nursing staff and could refer patients directly to specialist units within the hospitals or offer outpatient appointments within 48hrs in speciality ‘hot clinics `.
- The ALP service was available 24 hours a day. The service was based at the SJUH A & E department and was available for telephone consultations and/or referrals for face to face consultations with patients at LGI.
- There was a Section 136 suite available 24 hours a day at the Becklin Centre at SJUH hospital. This provided a “Place of safety” for the police to take patients who met certain criteria in accordance with the Mental Health Act 1983 to be assessed by a doctor.

Seven-day services

- A consultant was present in the department 24 hours a day and seven days a week. In addition, there was an on call consultant available.
- Each day the consultants were supported by a team of at least five middle grade doctors, including a specialist registrar. There was also an advanced practitioner on duty each day and two to three clinical assistants.
- Access to mental health services through the ALP nursing team was available 24 hours a day by their SJUH A & E office. Out of Hours access to psychiatrists was by an on-call service.
- Pharmacy services were available 24 hours a day.
- Other services such as radiology and pathology were also available seven days a week.

Are accident and emergency services caring?

Good

Compassionate care

- The A&E Friends and Family test results were above the national average for recommending A & E to friends and

family for the 4 months September to December 2013. Comments included, "Excellent service at St James, excellent staff. The service couldn't be better" and "Very attentive and polite. Everything explained in great detail".

- Additional comments from the Friends and Family test in January and February 2014 included, "You had all my correct details and I was fully informed as to what was happening at all times from seeing one doctor to another. When assessed I was listened to and was given clarification of my injuries and what to do about them. The waiting time was not long and staff showed empathy towards me" and "X was really comforting and talked me through it while giving me stiches". We noted some negative comments from the test but these were in the minority, for example, "Toilet facilities poor" and "Been told I have to stay in pain because they won't give me morphine or anything."
- Comments about A & E from the listening event held as part of the inspection included concerns about a shortage of doctors and that overall the care was good in the CDU, but there was no access to call bells. Other comments included, "A&E was perfect", "At 9pm midweek it looked like a battlefield, the care was excellent" and "Poor environment".
- We saw access to and use of call bells during our inspection. We observed staff responding promptly to the bells.
- The Care Quality Commission Inpatient Survey 2013 questions that related to A&E showed the department performed the same as other trusts nationally.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Patients told us, "It has been wonderful so far, I can't fault the care", "I've no concerns, it's been a good experience" and "The staff have been nice".
- We looked at patient records and found they were completed sensitively and discussions had been had with patients and relatives.
- We saw that patients were routinely checked as part of a dignity round. This included checking if patients required any food or drink, whether they needed the toilet, were in pain, whether the call bell was in reach and whether they were covered to maintain their dignity. These checks were recorded on the patient's computerised notes.
- The department used members of the trust's volunteer service. Volunteers wore a green T-shirt with "Can I help you "written on the back. They told us they helped support patients with basic queries and offered food and drink.

Patient involvement in care

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- We heard staff explaining and seeking consent from patients for tests and treatments.

Emotional support

- We witnessed staff supporting patients and relatives throughout their stay in the department. Patients commented, "The staff are good; very nice and friendly I would say" and "I've been in a few times as I've COPD, the staff tell me not to rush and take my time. They always ask if I'm warm enough, they even gave me an extra blanket today".
- We observed that relatives of patients in the resuscitation area were appropriately supported and cared for by staff.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Access

- The trust had been performing consistently better than the national target since June 2013 for 95% of patients waiting less than four hours to be admitted, transferred or discharged. However, at the end of February 2014 the year to date performance figure at SJUH hospital had dipped to 94.2%. The trust-wide figure (including LGI and Wharfedale minor injuries service – Wharfedale Hospital's minor injuries service was provided by external contract and so was not inspected as part of this review) for the year to the end of February was 96.4%. The performance figure for February 2014 was 89.2% at SJUH hospital and 93.9% trust-wide.

Good

Accident and emergency

- There were no A & E trolley waits greater than 12 hours at the SJUH hospital for the year to the end of February 2014. Since May 2013, for patients who were admitted, 96 -98% were transferred to a ward within four hours.
- Less than 2% waited 4-12 hours for admittance from the decision to admit except in January 2014 when this peaked at 4%.
- The total length of time spent in the A&E department was better than the England average.
- The number of patients waiting in A & E for 1 – 3.5 hours was slightly above average, but then fell in line with the England average after 3.5 hours.
- Patients began to leave the department before the 2 hour mark, after 4 hours this dropped to come in line with the England average.
- The percentage of patients that left the SJUH A & E before being seen for treatment was 4.1% at the end of February 2014, which was higher than the national average. This was still within the standard set by the College of Emergency medicine of less than 5%.

Maintaining flow through the department

- The trust had done extensive work at investigating the 'pressure times' in their A&E department, and had adjusted their staffing rota to try to alleviate the peaks of attendances.
- A business case had been developed to appoint a flow manager role that operated within the department each day from 1 December 2013 to 31 March 2014 to help manage winter pressures. A sister was allocated to the role each day. The role included ensuring patients were seen in a timely manner, test results were fed back promptly, where required referrals to other specialities occurred and beds were secured for admission.
- There was a clinical decision unit to which patients could be admitted for up to 24 hours. There were clear protocols for admission to the unit in place.
- The department was proactive in working with commissioners and local GPs to introduce admission avoidance measures. For example they had established direct admission care pathways to the CDU for patients with suspected DVTs (Deep vein thrombosis), pulmonary embolism (PE) and cellulitis.
- The department had a clear escalation policy, which was based on good practice from the College of Emergency Medicine. We saw this in operation during our inspection.
- The department worked with other departments in the trust so that there was joined up working at busy times.

Meeting the needs of all people

- There were large patient journey boards displayed in all areas including the waiting area, X-ray and each of the treatment cubicles/bays. They clearly stated the journey through A & E. Patients were able to tell us where they were on their journey and what would be happening next, examples included, "I was aware of what I was waiting for in A & E: the boards on the walls helped me" and "They have kept me up to date on my X rays and blood test, everything is fine".
- There were adequate disabled toilet facilities within the department.
- A hearing loop was advertised at the reception desk.
- Within the department there was information for staff on how to request a translator.
- However, we found there was very limited visible information about the PALS (Patient advice and liaison service).
- Information for patients who had English as a second language was very limited. There was almost no visible patient information in languages other than English. When asked most staff were unable to provide leaflets and information in other languages, including the main languages spoken in the community.

Communication with GPs, other providers and other departments within the trust

- A discharge summary was sent to GPs by email automatically on discharge from A & E. This detailed the reason for admission and any investigation results and treatment undertaken.
- In the CDU paper copies of discharge letters were given to the patient and the GP. Plans were in place to make all CDU discharge summaries electronic using a system called EDAN (Electronic discharge advice note).
- There was a Primary Care Advice Line (PCAL), which was a dedicated telephone number or 'hotline' that GPs and other health professionals, for example physiotherapists, could use to speak with a senior nurse directly between the hours of 7am and midnight. PCAL received about 200 calls a day. The staff triaged the calls and used a proforma to determine whether a patient needed an admission to A & E or whether other care

pathways could be activated. The PCAL could refer to out-patient clinics if required. Three way calls could also be set up with on-call acute consultants, for example medical.

- There was an Early Discharge Assessment Team (EDAT) that undertook a number of assessments within the A & E and CDU to enable a safe discharge. The team was available until 6pm. Assessments included reviewing mobility and if required arranging for falls clinic follow ups or referral to the intermediate care team.
- The urgent care clinical service worked as one unit across both sites. We saw this in operation as consultants moved between sites dependent on needs and priorities at each site.
- There was also liaison and movement of patients if required between the 2 CDUs. If a patient could be effectively managed within the emergency department's CDU protocols, rather than admitting to a medical bed, then they would be transferred to the other site if no CDU beds were available.
- There was an acute liaison psychiatry service (ALPS,) which was available 24 hours a day. The service was based at SJUH A&E department and was available for telephone consultations and/or referrals for face to face consultations with patients.
- Ambulance staff commented that the system worked well and they were rarely left waiting in the corridor with a patient.
- Ambulance staff understood what specialities were based at this site and at LGI. They told us they worked to shared protocols and usually brought patients to SJUH for acute medicine, care of the elderly and overdoses.

Complaints handling (for this service) and learning from feedback

- There were some leaflets about how to complain in the reception area. They were written in English.
- There were no posters or prominent information visible about PALS or complaints procedures in the department.
- There was no visible signage or leaflets as to how to access the complaints information in other languages, although inside the complaints leaflet there was a telephone number to ring to receive the leaflet in other formats and languages.
- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift coordinator. If this was not able to deal with their concern satisfactorily they would be directed to the PALS. If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in the complaints leaflets.
- The head of nursing for urgent care and the matron for the A&E department received all of the complaints relevant for their service. A person was then allocated to investigate the concern. The department had an initial response turnaround time of 3 days. All responses to complaints were reviewed by both the urgent care general manager and the head of nursing. Action plans were developed if required.
- Themes from both formal and informal complaints were collected on a quarterly basis and fed back to staff, which we saw recorded in minutes from a staff meeting in February 2014. The minutes recorded 23 complaints for quarter three in 2013.

Are accident and emergency services well-led?

Good

Leadership of service

- The urgent care clinical service unit was led by a clinical director, a head of nursing and a general manager. On each site there was a lead clinician, matron and business manager.
- Staff were aware of the departmental leadership team and of the executive team, especially the Chief Executive and Chief Nurse. Staff told us the new senior leadership of the trust were visible and engaged more effectively with staff.
- Staff told us that the matron and senior staff were hands on and supportive.
- There was a good level of consultant cover and other doctors felt supported.

Culture within the service

- All Doctors and nurses we spoke with said they would bring their family here and staff within the CSU spoke positively about the service they provided for patients.
- Quality and patient experience was seen as a priority and everyone's responsibility.
- Openness and honesty was the expectation for the department and was encouraged at all levels.

- The 2013 NHS staff survey indicated that staff engagement within the trust had improved from the previous year however the trust was in the lowest (worst) 20% when compared with trusts of a similar type. Within the urgent care clinical services unit the staff engagement was higher for this trust and other similar trusts.
- Staff worked well together and there was obvious respect between not only the specialities but across disciplines.
- The unit was well engaged with the rest of the hospital and did not operate in isolation.
- The paramedics we spoke with felt included within the department.

Vision and strategy for this service

- Staff, including student nurses were aware of the 5 year consultation that was ongoing within the trust about its strategy and vision.
- Staff were aware of mechanisms to feedback about concerns, suggestions and comments including the Wayfinder system – a computer system to capture and record staff comments.
- Staff told us about the service redesign work that had happened in A&E at SJUH and was happening across both hospitals now.
- Staff felt engaged and involved in the service redesign work.

Governance, risk management and quality measurement

- We were told monthly governance meetings were held at each site and overall for urgent care; the Urgent Care Clinical Governance Forum. We saw from minutes that topics discussed included patient care and safety; clinical effectiveness and outcomes; risk management; patient involvement, experience and public engagement. Actions required and completion dates were clearly indicated and followed through.
- We saw evidence of audits being undertaken and learning documented and shared, for example, monthly infection control audits, audits of patient records and a consent audit had been done in 2013.
- We saw hand hygiene audits for April to December 2013, the majority of which achieved 100% for both compliance and technique.
- There were audits for peripheral intravenous cannula insertion, which achieved 100%.
- Audits of patient records were for January and February 2014 and almost all were completed correctly.
- The consent audit was part of a trust-wide audit and for the A&E it indicated that improvements had been made and the requirement to target the availability and distribution of the "About Consent" leaflets for patients.
- We saw evidence of audits including clinical audits being undertaken and learning documented and shared, for example, an investigation of suspected renal colic in 2013.
- A quality dashboard for the CDU known as the ward healthcheck was displayed so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to be able to provide.
- A similar performance monitoring system was in development for the A&E department. Nursing staff we spoke with did not fully understand the performance data that was displayed on a public notice board. Senior staff noted that this could be improved.
- There were trust-wide nursing audits, which included the A&E departments and the CDUs. Audits covered positive identification of patients, medication errors, intentional rounding, records, and cleaning and high impact interventions. We saw copies of some of these for A & E. For example, a mandatory nursing audit of records found good standards of legible handwritten entries, accuracy and compliance with dates but a poor standard in the use of abbreviations. Information was to be shared with staff and taken to the next governance meeting for action.
- There were nursing staff meetings that were well attended. We saw minutes for the last one in February 2014. Staff told us over the last year the meetings had been rostered into staff's working time so they could attend. Topics included mandatory training, feedback from complaints and feedback from audits.
- The end of nursing shift handover helped assess risk and quality on a daily basis. Prompts on the handover included noting any: safeguarding incidents, saving lives data, controlled drug checks, teaching points, official missing persons, and significant events.
- The sister's handover checklist included staffing issues, sick and resuscitation patients, any bereavements, staff accidents and new operational information.

Good

Accident and emergency

Innovation, learning and improvement

- Innovation was encouraged from all staff members across all disciplines. Staff were involved in quality improvement projects and were able to give examples of practice that had changed as a result.
- A service improvement team had been working within the urgent care clinical services unit for some months and has redesigned patient flows at SJUH's A & E. Further redesign work was ongoing within minor injuries at SJUH. The learning from this was been used in the LGI A & E.
- We observed the service improvement team auditing the RAT process. This included monitoring time to assessment, time to be seen by a clinician, turnaround times for pathology and pharmacy requests, dependency scoring and impact on capacity.
- A consultant has led the development of CEM Books (Clinical Emergency Medicine), which is an interactive system available on the department's IT system and as an application for the smart phones used by staff. It enabled real-time information to be shared with all doctors, nurses and management staff and across both sites. It included live situation reporting which was red, amber and green rated. It also allowed teams to effectively communicate with each other highlighting key issues.
- Paramedics commented on how well the department was working with the ambulance service to improve pathways.
- We were told of various groups that were set up to manage and improve urgent care services. These included an operational board, a strategic urgent care board and a non-elective working group.
- There were areas where improvements were needed, access to training could be problematic, particularly for study leave. Staff's attendance at some courses such as safeguarding Level 2 and 3 was in need of prioritisation.
- Consent was generally dealt with appropriately. However, further work was required to ensure that patients with diminished capacity were identified and where needed formal mental capacity assessments were not only undertaken but appropriately recorded.

Requires improvement

Medical care (including older people's care)

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

Information about the service

St James's University Hospital provides acute and general medical care spread over 20 wards. These included care of the elderly, respiratory, endocrine, infectious diseases, gastroenterology and acute medical wards, all of which our team inspected. It also provides specialist oncology and renal wards which were not inspected at this time.

Patients were admitted via the Accident and Emergency (A&E) department or direct to the acute medical admissions wards by a GP referral. Patients who called 999 and found to have a suspected cardiological or neurological complaint were transferred directly to the Leeds General Infirmary. Patients who walked into the A&E department and were subsequently found to require cardiology or neurology attention would be first stabilised and then transferred by ambulance to the other site.

Summary of findings

Summary and justification for rating

Medical Care at SJUH has been rated as requires improvement as there were not always sufficient nursing staff on all wards, there were concerns over the level of medical cover for the elderly care wards at night and at weekends and mandatory training was in some cases, undertaken by only 56% of staff. In addition, one of the medical wards had had a significant number of Clostridium difficile diarrhoea cases. Ward areas otherwise were clean and equipped. Equipment was found to be well checked and safe to use. The team had no concerns regarding the safety of care provided on the specialist respiratory or gastroenterology wards.

Effective care was provided at SJUH. The majority of care was consultant led and delivered and national guidelines were used. There was good multidisciplinary working and allied health professionals were available seven days a week. Acute admission proformas were utilised and completion audited.

Overall we witnessed good examples of staff treating patients with kindness and respect. On some of the busier (especially elderly care) wards both staff and patients commented that staff were sometimes too busy to attend to them quickly. Of note, the trust was aware of the nursing shortages and recruitment was ongoing.

Medical Care at SJUH was responsive and the trust had worked hard to reduce unnecessary admissions. Their ambulatory care unit (known as their JAMA) was open 24 hours a day and their interface geriatricians had received national recognition for their early senior

Requires improvement

Medical care (including older people's care)

multidisciplinary assessment of elderly patients presenting to hospital. However, there was evidence that patients were being transferred to wards prior to their bed being ready and thus spending prolonged time on a trolley in corridors. In addition, further work was required for patients living with dementia once they had been admitted.

The trust had recently made significant changes to their divisional structure, which resulted in five divisions devolving into 19 smaller leadership divisions. This was largely seen as a positive move, allowing more frontline clinicians to feel ownership and responsibility for their service. Local ward leadership was also praised, and the culture of the medical wards was felt to be positive and patient centred.

However, it was acknowledged at both local and trust level that these changes were still very much in their infancy, and ensuring that the governance processes were suitably robust would take time. It was also acknowledged at clinical service unit level, that improving the acute care pathway had occurred to a certain extent to the detriment of elderly care on the wards and this now needed to be addressed as a priority.

Are medical care services safe?

Requires improvement

Cleanliness, infection control and hygiene

- Ward areas were clean and we saw staff adhering to the bare below the elbow policy and using hand gel in between attending to patients.
- Weekly hand hygiene audits were undertaken by staff on the wards every Monday, and the results displayed on the ward notice board. From a total of 61 audits, they achieved 99% compliance. In addition, comprehensive cleaning audits were undertaken monthly. Responsibility for the cleaning of specific areas was identified (nursing (commodes), hotel services (doors), estates (ventilation grills), and contracts (external glazing). There was a breakdown of scores for each area and an overall percentage score given.
- The incidence of Methicillin Resistant Staphylococcus Aureus (MRSA) for the trust was within expected limits and there were no cases of MRSA in the past month on the medical wards at this site.
- The trust had a higher than expected number of cases of Clostridium difficile infections (this was a Tier 1 indicator alert). This was largely attributed to one of the medical wards (J19), which had had 12 cases prior to our inspection including two in the previous month. The trust and ward had undergone a significant amount of work to attempt to understand the underlying cause of the problem and the ward had been deep cleaned twice. Antibiotic prescribing audits had been undertaken and prescription of antibiotics was very closely supervised by the pharmacy department. Any prescription of antibiotics that was not in line with trust guidelines had to be discussed with a consultant microbiologist. There were posters explaining Clostridium difficile and what were the increased risk of transmission. A trust wide summit regarding the ward and the number of infections was due to be held at the end of the month.

Nursing staffing

- Nursing numbers were assessed annually using a patient acuity tool. Ideal and actual staffing numbers were displayed on every ward. The process for escalation at times of shortages was displayed next to the staffing numbers.

Medical care (including older people's care)

- The ward healthcheck for February included registered skill mix and post vacancies whole time equivalents. Although most of the medical wards had a good skill mix, three wards were under skilled. Aside from the Gastroenterology and Respiratory wards all other medical wards had post vacancies. This was as high as 10.6 whole time equivalents for J29 (one of the acute admissions ward).
- Wards that we visited and noted to be short staffed were consistent with those highlighted on the ward healthcheck from February as requiring 'escalation'. This meant that they received corporate support and this was corroborated by nursing staff working on those wards. However, there were times when gaps could not be covered. Active recruitment was underway both locally and abroad.

Medical staffing

- There were twice daily consultant led ward rounds on the acute medical admissions wards and the elderly care medical admissions wards. Overnight there were two separate teams of junior doctors (including a SpR, SHO grade and FY1) with the consultant on call from home. They were responsible for admitting patients either via A&E or their GP. In addition, overnight the SpR on the medical admission wards provided senior support to the medical ward (J19-21).
- There were daily consultant ward rounds on the elderly care, gastroenterology, infectious diseases and respiratory wards and both the respiratory and gastroenterology wards had designated SpR's covering the ward overnight. The elderly care wards had just an SHO grade covering six wards, with senior input if required from the respiratory SpR. Concerns had been raised both internally with the trust and with the educational deanery (now the Local Education and Training Board (LETB)) regarding the level of support required for that number of wards, and the junior doctors we spoke with told us that they did not always feel safe covering that number of patients.
- On the other two medical wards consultants undertake ward rounds twice a week. In between the consultant ward rounds SHO undertook rounds daily.

Management of the deteriorating patient

- There was a trust wide early warning score in use and guidelines for escalation were printed on the reverse of the observation chart. The charts we observed had all been correctly completed and escalated as appropriate.
- An issue on the respiratory ward had been raised as patients on oxygen often were scored highly even when they were stable and at their baseline. Staff were aware that this was a problem and it was noted on the patient safety board.
- On the acute medical admissions units patients four hourly early warning score was displayed on the white board. During the morning board round patients were prioritised for review according to this score.
- The respiratory wards used a Red Amber Green (RAG) system to indicate the status of patients on the ward. Red if the patient had just arrived, yellow if they had been reviewed by a doctor and green if they were able to step down to a less acute ward.

Nursing and medical handover

- We observed both medical and nursing handovers, in and out of hours.
- The nursing handovers we attended took place in front of patients, allowing for the nurses ending their shift to introduce the nurse taking over from them to their patients.
- There were several separate handovers for the doctors in the evening depending on what wards they were covering. In response to concerns raised by junior doctors covering the elderly care wards at night (who would be supported by the respiratory registrar), the handover location had been moved so that they could join the respiratory handover. This allowed for any unwell patients to be discussed with the senior doctor face to face.

Safety Thermometer

- Every medical ward we visited had a 'Safety board' clearly displayed. This had been a relatively new initiative but staff spoke positively about it. It included the number of days since a fall, a pressure ulcer, MRSA and Clostridium difficile infection rates. It also showed their recent performance on the Friends and Family test. A 'Ward Barometer' summarised the overall safety performance as well as the percentage of patients receiving harm free care in the past month.
- The data comprised of the previous months performance only and there was no trend data on display. However since July the trust published the Ward Healthcheck on a three monthly basis. The Ward Healthcheck was a very comprehensive summary of

individual wards performance, which included data on healthcare acquired infections, falls, pressure ulcers, VTE and UTI rates, complaints, friends and family tests and nursing staffing.
- Three of the medical wards had achieved under 80% harm free care in the past three months, all of which were elderly care wards. This meant that patients were at risk as the processes in place to keep them safe had not always been effective.
- Comprehensive risk assessments for falls and pressure ulcers were completed on admission and updated throughout patients stay.

Incidents

- Incidents were reported via an electronic Datix form. A copy was sent to the appropriate manager responsible for the area in which the incident occurred. In addition, the trust reported patient safety incidents to the NRLS (National Reporting and Learning System) and all serious incidents and Never Events to STEIS (Strategic Executive Information System).
- According to data collected prior to our inspection, the trust reported an expected number of incidents in total, but when these were examined more closely, the trust had a significantly lower number of incidents resulting in death and severe harm.
- There was a mixed response to how well local incidents were reported and learnt from. Nursing staff were well versed in how to report an incident and all said that they reported incidents frequently. Although staff commented that they did not always get individual feedback on incidents they had reported, we were given minutes of ward meetings, which were held monthly which demonstrated themes of incidents were fed back to staff. Nurses who were not in attendance had to sign the minutes to demonstrate that they had read them.
- There was less of an incident reporting culture among the medical staff. Both junior and more senior doctors told us that they rarely reported incidents and that it was more of a 'nurse's job'. Although incident themes were discussed at the monthly governance meeting this was attended by senior staff only. We saw no evidence of how themes were disseminated to junior staff and staff spoken to were unaware of any recent incidents.
- One Never Event had occurred between December 2012 and October 2013 that was attributed to the Critical Care Unit rather than medicine, but we saw goo evidence that learning had occurred within the medical wards. A nasogastric (NG) tube was inserted into the lungs rather than the stomach, and the wrong chest x-ray was assessed leading to the patient receiving feed down the tube. As a result of this and the subsequent investigation, practice surrounding NG placement and confirmation had completely changed. There were signs up on the wards indicating the change and junior doctors we spoke with on both sites were all aware of the change to practice.

Environment and equipment

- We had no concerns with regards to the safety of the environment or equipment on the medical wards. Resuscitation equipment was checked regularly.

Medicines

- We found that medicines were stored correctly including in locked cupboards or fridges where necessary.
- The hospital had recently (January 2014) introduced a new comprehensive prescribing chart that we saw in use throughout the medical wards. Although in the main we found that these were well completed, we noted that oxygen was not routinely prescribed except on the respiratory wards. This was raised as an issue by one of the junior doctors on the acute admissions ward who told us that they were planning on undertaking an audit to assess current practice.
- Antibiotics were prescribed according to the trust guidelines, and we were informed that there was very active pharmacy input to ensure that clear stop dates and reasons for prescribing were documented. Any antibiotics deemed to be high risk (i.e. side effects or an increased risk of clostridium difficile infection) had to be cleared with microbiology or pharmacy prior to prescribing, whatever time of day or night.

Records

- Records were in paper format (except on J6, which had electronic records) and in general were found to be in good order and well maintained. On some wards (elderly care wards) it was noted that the notes were not always put away correctly.

Requires improvement

Medical care (including older people's care)

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding (DOLS)

- There had been two recent deprivation of liberty safeguarding (DoLS) applications on the medical wards. We examined these in more detail and found them to have been implemented appropriately. The nursing staff on the wards were aware of the implication of the DoLS.

Mandatory training

- We were provided with a comprehensive overview of mandatory training completion by the trust. According to this, only 56.2% of the Acute medical directorate were up to date with their mandatory training. Overall for the trust, mandatory training rates were 56.3% for medical staff and 64.7% for nursing and midwifery.
- Junior doctors told us that the mandatory training was difficult to access and they were unclear what specific training they were required to undergo.

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

Good

Use of national guidelines

- According to the trust's audit annual report, 49 of the 1114 audits undertaken were related to National guidance, and a further 88 to trust guidelines. We were not able to see which guidelines in particular were audited and whether these related to medical services, though junior doctors spoken to told us that they had been encouraged to audit practice against national standards.

Outcomes for the department

- There were no outliers for mortality associated with medical conditions. According to the Dr Foster Intelligence 2012 Hospital Guide, the comparison of observed to expected number of in-hospital deaths during admission with a Hospital Standardised Mortality Ratio (HSMR) was much better than expected.
- A trust wide Clinical Audit Forum was established in December 2012 in order to influence the type and choice of audit undertaken by clinical teams and improve clinical engagement with the audit process. From May 2013 a new Clinical Audit Database was implemented.
- The annual audit report for clinical audit 2012/13 stated that 1114 completed clinical audits were recorded on the database. Results and learning from clinical audits were shared locally through speciality governance or audit meetings. Medical audits were now also shared at the Clinical Audit Forum.

Care plans and pathway

- The acute admissions unit and respiratory wards used a daily ward round proforma, completion of which was audited quarterly.
- There was evidence of a recent change to the documentation as a result of assessments for deep vein thrombosis not being completed consistently.
- Nursing documentation was kept at the end of the bed and was completed appropriately.

Multidisciplinary team working and working with others

- There was evidence of good multidisciplinary team working, including occupational therapists, physiotherapists and dieticians on all of the wards we visited. Multidisciplinary board rounds took place daily (during the week).
- Pharmacy support was seen to be visible, and there was evidence of medication reconciliation in all of the drug charts we looked at.

Seven-day services

- Seven day working was well established at this hospital.
- Consultant ward rounds took place seven days a week on all wards except for J19 and J21 and elderly care wards. An on call consultant was assigned to cover these wards and would see any new patients transferred from the acute admission wards as well as any unwell patients.
- Radiology services (including an urgent ultrasound list) was available on both Saturday and Sunday.
- Physiotherapists and occupational therapists offered a reduced service on the acute admission wards
- There was a pharmacist on site 24 hours a day seven days a week. Discharge medications could be obtained throughout the weekend and there were no reports of delayed discharges due to lack of availability of medications.

Are medical care services caring?

Requires improvement

Medical care (including older people's care)

Good

- Friends and Family test results were displayed at the entrance to every ward as part of the safety board. Posters were displayed encouraging patients and relatives to complete the feedback.
- Comments (both complimentary and critical) made by previous respondents were also shown.
- The results showed significant variation between wards. The respiratory and gastroenterology wards net promotor scores were all 70 and above (the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent). However, on the elderly care and general medical wards the scores were much lower, in some cases in the twenties.

Compassionate care and emotional support

- During our inspection we witnessed good patient and staff interactions. Nursing staff spoke empathetically towards patients and explained what they were doing. Clinical support workers were observed talking to patients while helping them wash and dress.
- Patients praised staff, stating that 'even when they are busy they are kind'. Patients told us staff responded quickly to their 'buzzers' and took time to talk to them and listen to their concerns.
- On the wards already identified as having a shortage of staff by the Ward Healthcheck some patients commentated that the staff where not always able to respond to their needs as quickly as they would like. Staff confirmed that they felt that they were sometimes too busy to be able to spend as much time with patients as they would like.

Patient involvement in care

- Patients and relatives stated they felt involved in their care.
- On one ward (J8) we noted that relatives had been invited in to support their loved ones during lunchtime. This was well received by relatives, patients and staff, with relatives in particular commenting to us that they appreciated being allowed to help.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

- Patients were admitted either via A&E, their GP or by a referral from another hospital. All external referrals were triaged through the Primary Care Advice Line (PCAL), which could refer patients directly to the ambulatory care unit (known as the JAMA) or an appropriate ward.
- Patients over 80 would be referred to the elderly care admissions unit, whereas patients requiring specialist gastroenterology or respiratory input would be referred to the relevant registrar.
- Although the trust performed well in their A&E four hour target, we were told and observed that sometimes patients were transferred to wards prior to their bed space being ready. Many of the ward white boards had 'corridor beds' with nurses allocated to them implying this was not an unusual occurrence. We were provided with one wards list of trolley waits. During the month of March, 24 patients waited on their trolley in the corridor for their bed to be prepared. Although for 5 patients this was an hour or less, 5 patients waited for over 4 hours, one of whom had to wait over 8 hours.

Maintaining flow through the hospital and discharge planning

- The trust had worked hard to reduce unnecessary admissions.
- The JAMA (ambulatory care unit) was well established, open 24 hours a day and saw in the realms of 50 patients a day. One medical registrar told us it was, "The best (ambulatory) unit I've ever worked on". There were multiple proformas and care pathways for specific conditions which were suitable to be treated in the outpatient setting. It was primarily run by advanced practitioners with consultant support during the day. There were plans for the consultant cover to be increased to 8am to 12 midnight by winter 2015. In addition, there was a JAMA clinic which allowed early or next day follow up for patients discharged.
- The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly

reduced the number of admissions. They also provided telephone advice to GPs via the PCAL. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.
- Ward rounds on the admissions units started at 8am and would prioritise unwell patients first, after which they would see potential discharges. All of the other medical wards held a multidisciplinary team ward round every morning.
- During the winter the trust had employed an extra pharmacy support worker to assist the junior doctors with patients discharge medication. This was spoken of positively by both senior and junior staff.
- Patients who were medically fit but required increased support in the community were seen by the early discharge assessment team.
- The speciality wards had facilities to admit patients as day cases (for example ascitic drains) to avoid unnecessary admissions overnight.
- During the winter a so called 'winter pressures ward' opened (J8). This was due to be closed at the end of March, and when we returned for the unannounced visit it was no longer open. When it was open it was led by a permanent ward sister. Although not all of the nurses worked full time on the ward they were primarily members of staff who had worked at the trust for a period of time. Only medically fit patients awaiting discharge would be transferred to the ward and when we examined the notes we found this to be the case. The ward was staffed 9-5pm by a SHO level doctor who worked on the ward for a week at a time.

Meeting the needs of people

- The trust had a locally agreed dementia CQUIN (Commission for Quality Innovation – a payment reward scheme agreed by local commissions aimed at encouraging innovation), for which it was required to ensure that patients were identified and assessed on admission with regards to dementia . Although we found that the trust had achieved this well, we found that once admitted patients living with dementia were not supported as consistently.
- The trust participated in the 'forget me not' system (which alerted staff to patients living with dementia). However we found varied consistency in which it was used. Staff who had undergone their Level 3 dementia training were given a 'forget-me-not' badge to wear on their uniform, but we did not see these being worn. Nursing staff and care support workers spoken to were aware that they were expected to undergo specialist dementia training, but stated that in the main they had not yet had time to undertake this.
- If required, face to face interpreters could be booked in advance for patients. There was also access to a telephone translation service.

Communication with GPs and other specialities

- An electronic discharge summary (known as an EDAN) was emailed to the patients GP on discharge. This included the reason for their admission and any investigations and treatment undertaken as well as medication the patient had been discharged with.
- Respiratory, gastroenterology and general surgery were all provided on this site and would review patients on other medical wards if required.
- Cardiology and neurology advice was provided 24 hours a day by the on call registrar at the Leeds General Infirmary and if the patient was accepted for transfer then this would be arranged.
- An orthopaedic registrar (usually based at the other site) would undertake a daily ward round of any patients requiring orthopaedic input. If then deemed to need an operation they would be transferred across.

Complaints handling (for this service)

- Informal complaints would either be handled by the nurse in charge or the Patient Advice Liaison service. Although they would not record these as formal complaints the PALS team logged every concern so that themes could be identified.
- Formal complaints once logged would be referred to the relevant CSU who were responsible for responding.
- The trust provided us with a list of all complaints received between July and December 2013. 26 of these were specific to the acute medicine, elderly care, respiratory or gastroenterology wards. 17 were regarding care on the elderly care wards. Common themes were both medical and nursing care and communication with relatives.

Requires improvement

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

Leadership of service

- There had recently been a significant change to the leadership structure across the trust. The previous five divisions had been split into 19 smaller divisions known as Clinical Service Units (CSUs)
- Each CSU was led by a triumvirate, of a nursing, medical and managerial lead.
- It was evident from interviews and discussions during our inspection that this structure was still in its developmental infancy and that the benefits of a more devolved structure had yet to be fully realised.
- At ward level nurses and support workers spoke positively about their ward leadership. The matrons were reported to be visible (though Monday to Friday only).

Culture within the service

- In general the inspection team felt that there was a good culture within the medical areas. Staff were open when speaking to us and we saw good examples of staff working together to provide a good standard of care for their patients.
- Staff were prepared to move across wards if one was short staffed for a particular shift and we witnessed physiotherapists supporting nursing staff.
- Consultants reported that the new structure resulted in them feeling more empowered and in control of their service, and that now, when problems were identified they were able to find and enact a solution more quickly than previously.
- There was a mixed response from junior doctors, some of whom felt that they were valued members of the team, while others commented that they did not always receive as much teaching as they would like. FY2 teaching had not been arranged by the hospital. However they had been able to organise their own teaching timetable.

Vision and strategy for this service

- A weekly email from the Chief Executive Officer informed staff and updated them on what was happening on the wards, this was well received.
- The trust vision was visible throughout the wards and corridors. In addition it was printed on staff identification badges.
- Staff were able to repeat the vision to us at focus groups and during individual conversations.

Governance, risk management and quality measurement

- The trust had recently developed the 'Ward Healthcheck,' which gave a 3 monthly oversight of individual ward performance against a multitude of performance metrics. These included staffing, the Family and Friends Test and safety metrics (such as falls, pressure ulcers and healthcare acquired infections). If a particular ward was identified as scoring high in certain areas then it was 'escalated' and corporate support was offered. Of note, all of the wards that the team felt were in need of greater support had also been identified by the trust. This part of the healthcheck had only been in place for a month prior to our inspection.
- Monthly CSU governance meetings were held where performance and safety metrics were discussed, alongside recent incidents and complaints. Any significant concerns were fed upwards to the appropriate trust wide board or sub-committee. Outputs from these were disseminated to the acute medical team via their individual team meetings and the respiratory division produced a regular email update. It was not clear how the elderly care division were updated.
- We attended the acute medicine (which includes elderly care) CSU governance meeting during our inspection and we reviewed minutes from previous meetings. Elderly care was not always represented at these meetings, and it was acknowledged by the clinical lead for the CSU that they had concentrated recently on improving their acute medicine processes (and admission avoidance) and that efforts now needed to be concentrated on the elderly care wards.
- The governance structure was acknowledged both at local and trust wide to be in its infancy and as such it was not possible for our team to assess the long term robustness of the process. This was highlighted on the corporate risk register and extra support was being provided to the CSU to mitigate this risk.

Innovation, learning and improvement

- In recognition of the decreased number of Core Medical Trainees (CMT) that the trust received from the deanery

they had started to train Advanced Nurse Practitioners (ANPs). It was expected that they would have the same competencies as CMTs and also undertake a prescribing course. There were currently four posts funded which was due for review in May 2014.

- There had been recognition of some the problems regarding medical services such as staff shortages, patients waiting on trollies and the need to give attention to the needs of the elderly service. However, there was still work to do to address the issues and ensure that risk was minimalized and that there was improvement in the quality of experience for the patient as a result.

Requires improvement

Surgery

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

Information about the service

The hospital provides a range of surgical services including general surgery, urological and gynaecological surgery, organ transplantation and day surgery. There are 16 wards which provide surgical services at SJU, spread across several Clinical Service Units, with approximately 350 surgical inpatient beds. There is also a surgical admissions unit and a pre-assessment ward. A total of 19 operating theatres are provided across four theatre suites including day surgery theatres.

We visited nine surgical wards including five surgical wards, two urology wards, a gynaecology ward and a breast surgery ward. We also visited all the general operating theatres suites and day case theatres.

We talked with 27 patients and 30 members of staff including matrons, ward managers, nursing staff (qualified and unqualified), medical staff both senior and junior grades and managers. We observed care and treatment and looked at care records for 18 people. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall surgical services required improvement. Surgical wards and theatres were clean and there was evidence of learning from incidents in most areas. There was not however, adequate levels of nursing staff all of the time. In addition, there was insufficient out of hours medical cover and anaesthetic availability.

The operating theatres used the World Health Organisation's safety checklist, although the debriefing element was not embedded. Boards were in use outside each theatre. Comments or issues were written on these and reviewed weekly by team leaders and business managers. This led to improved understanding of working practices and was working to reduce future potential problems.

Completion of mandatory training was low in some areas with less than 70%, for instance staff on the gynaecology short stay surgery unit had 69% compliance.

Trust policies were available, which incorporated best practice guidelines and quality standards to monitor performance. However, there was insufficient audit evidence and systematic monitoring to demonstrate these were implemented and effective.

There was good multidisciplinary working with coordination of care between different staff groups, such as physiotherapists, nurses and medical staff. Pain assessments were carried out and patients overall reported good pain management.

Requires improvement

Surgery

The services provided were caring. Most patients we spoke with and the results of patient surveys including the Friends and Family test, indicated that patients experienced compassionate care.

The surgical services required improvement to be responsive to the needs of the patients. There were systems in place to manage the flow of patients through the hospital and discharges dates and plans were discussed for most patients. However, some improvements could potentially be made regarding access to services, for example, the number of last minute cancelled operations. The portering service had been centralised and this limited their responsiveness to meet the needs of patients.

Medical staff reported there was no clear patient tracking system for patients who were moved temporarily to other wards. Patients requiring ongoing care in Bexley Wing theatre recovery area after 8pm had to be moved to Geoffrey Giles Theatres, but they could be moved back dependent on whether they needed high dependency care. The service was not run to respond to the needs of the patients.

Staff reported good leadership at all levels of the organisation. They reported a positive and significant shift in culture since the new trust management had been appointed. Staff understood the managerial arrangements and reported this was working well.

The analysis and use of performance data to ensure the services were well-led was developing and was identified by the clinical service unit as 'work in progress'. Risk registers were of variable quality. Some had assurances in place, while others had not tested the effectiveness of the some of the measures put in place.

Are surgery services safe?

Requires improvement

Cleanliness, infection control and hygiene

- Ward areas appeared clean and we saw staff regularly wash their hands and use hand gel between patients. Bare below the elbow policies were adhered to.
- Clostridium difficile rates for the trust were higher than expected. Root cause analysis was undertaken of new cases of Clostridium difficile and reviewed by the corporate team. Higher than expected rates for the year to date were found in a number of surgical CSUs including digestive diseases. No trends on particular wards were found. There were two cases of Clostridium difficile for surgical wards at SJUH during February.
- Patients were isolated in accordance with infection control policies. Information was available for patients, visitors and staff.

Nursing staffing

- Nursing numbers were assessed annually using a recognised staffing tool. This had identified a need to increase staffing levels in some areas. The trust was currently recruiting to these additional posts.
- Ideal and actual staffing numbers were displayed on every ward visited. Staff reported that they were sometimes understaffed with gaps on rotas, which put patients at risk but said in most areas this was improving. Bank staff were used to fill most shortfalls.
- Where additional staffing was required to meet the specific safety needs of patients, systems were in place to request additional staffing, although this could not be achieved in all cases. Staff reported that patient safety was the priority; this had not previously been the case.

Medical staffing

- Junior doctors told us there were not enough junior doctors on the wards out of hours. Some doctors reported providing on call cover for up to 250 patients. However they reported senior staff and consultants were easily contactable.
- Managers were aware of the shortage of junior doctors. Within general surgery, rotas were being reviewed and other support roles were being considered, such as pharmacy transcribers.

- The recruitment process was lengthy; managerial staff reported it taking up to 12 months to process the recruitment of some staff groups. The executive team had recently worked to reduce this and this was having some impact at a local level.
- There was a lack of anaesthetic staff. There had been a recent reduction in trainee posts. Locums had been employed and concerns were raised regarding their induction and support. In response to the increased use of locums and to minimise risk, guidance on the use of locums had been recently drafted and circulated but was not yet fully implemented.

Nursing and medical handover

- Nursing handovers occurred at least twice a day, depending on shift rotas and usually included a safety briefing. Staffing for the shift was discussed as well as any high risk patients or potential issues. There was no guidance to ensure handovers were carried out consistently.
- Medical handover took the form of an informal handover between the day and night surgical teams. The handover was neither structured, nor documented and attendance was not recorded.

Management of the deteriorating patient

- The surgical wards used a recognised early warning tool. There were clear directions for escalation printed on the observation charts and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.

World Health Organisation Safety Checklist

- Use of the checklist was embedded in surgical practice throughout the theatre suites. We observed it being used in each of the theatres visited.
- A trust wide audit was performed quarterly and demonstrated over 95% compliance with the exception of the use of team debriefs. One outlying specialty (not named) recorded a compliance figure of around 80% and data issues were being addressed. A qualitative audit tool had been piloted.

Safety Thermometer

- A ward healthcheck was undertaken on a monthly basis on each inpatient ward. This included the national safety thermometer information. The information was clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers. Individual areas had developed improvement plans. There was no consistent dissemination or action planning.
- The healthcheck display was formatted so wards had to score above 70% before this was registered on the dial display. This 'set the bar' regarding the achievements expected and promoted a positive use of the data to promote safety.
- The trust had identified pressure ulcer prevention as a key area to improve.

Incidents

- There have been five Never Events reported at the trust. Four of these related to surgical areas. We saw a serious incident investigation had been undertaken, task and finish groups were established involving clinical staff and action had been taken to ensure learning from the incidents. We reviewed the action plans for surgical-related incidents and found the majority of the actions to minimise recurrence had been implemented.
- The investigation identified the arrangements to share the lessons learned. We found staff within the surgical areas were aware of the never events and were aware of safety priorities and that the affected patients had been fed back to.
- The 'speak out safely' campaign was being promoted particularly in theatres. This is a national campaign to encourage staff to raise concerns about poor care.
- We found the reporting of patient safety incidents was in line with that expected for the size of the trust. (NB all trust level data)
- We saw examples of how information was shared with staff. This included ward specific 'newsletters' and a trust-wide 'Quality and Safety Matters' newsletter.
- Staff we spoke with said they felt confident to report incidents. A few staff reported they did not get feedback regarding incidents they had reported.
- Staff were able to give us examples of where practice had changed as a result of incident reporting.
- Themes from incidents were discussed at weekly meetings.

Requires improvement

Surgery

Environment and equipment

- Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards or available by request to ensure safe care.
- Systems were in place to obtain equipment and handle repairs. Most ward staff said this was done in a way that met patient need.
- Theatre staff told us that they received a poor service from the contractor for surgical sterile trays. They reported slow turnaround times and damaged and incomplete trays being provided.
- Breast theatres reported unresolved issues with the blood fridge, which was not linked to hospital tracking system.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked and audited.
- Medicines charts were completed. Where medicines had not been administered as prescribed, codes and an explanation were completed to indicate the reasons why.
- Recent audits showed that the prescribing of antibiotics was in accordance with trust policy.

Records

- All records were in paper format. Medical, nursing and health care professionals maintained separate documentation.
- Most areas had locked trolleys used to store medical records when not in use.
- Medical health records keeping standards were audited at least annually. Actions to address issues had been identified. The most recent trust-wide audit supplied showed the recording of date and time for each entry in the health records, recording of the author's name designation and contact details and inclusion of the patient's name and NHS number (where available), or case note number, on each page of the clinical health record were areas for improvement. It was not possible to break the information down to identify any specific results across the surgical CSUs.
- A ward assurance audit was completed monthly. This included auditing nursing care records. The results showed levels of compliance of over 90% in most ward areas at SJUH.
- There was no protocol in place for determining frequency of turns so we observed practice to be variable. We saw an example of a patient with a grade 2 pressure sore being prescribed 8 hourly turns, though these were being done 4-8 hourly.
- On ward J82 fluid balance charts for 7 patients who were at risk of dehydration were not completed and pressure area care was poorly documented for 4 patients checked (no risk assessment recorded for one patient, one patient had a grade 2 pressure ulcer with no skin assessment or repositioning recorded and two patients risk assessments were not up to date). There was a lack of dietician involvement for a patient with gastrointestinal disorders.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Staff were aware of the Mental Capacity Act. The trust employs a mental capacity act coordinator and resources were available to support staff.
- A trust-wide audit of consent had been undertaken in December 2013. It was unclear if all surgical specialties had submitted data (overall 61% participation rate). Patients were consented appropriately in most cases. Where audit had identified that consent was not always taken in accordance with policy, actions were being taken to address this, for example feedback provided at monthly audit meetings (Women's CSU risk register). However, the effectiveness of these actions had not been tested.

Mandatory training

- We looked at staff mandatory training records. Overall trust information showed that medical staff and nursing staff were compliant with mandatory training in 56.3 and 64.7% of cases respectively at December 2013. This varied and some surgical areas showed less than 20% compliance.
- Staff said that mandatory training was accessible, but reported that more dates for attendance were required.

Learning culture

- Boards were in use outside each theatre (Geoffrey Giles Theatres). Comments or issues were written on these and reviewed weekly by team leaders and business managers. This led to improved understanding of working practices and was working to reduce future potential problems.

Requires improvement

Surgery

- Staff reported that mortality and morbidity meetings were not consistently held. We reviewed notes of mortality and morbidity meetings and the identification of lessons learned was variable.

Are surgery services effective?
(for example, treatment is effective)

Good

Use of national guidelines

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery. Surgery out of hours is consultant led and delivered.
- The trust provided us with some examples of completed audits at our request. These were not comprehensive and did not demonstrate actions taken to address any identified issues.

Patient outcomes

- Patient Reported Outcome Measures for groin hernia surgery were all within expected limits.
- A review showed there were no mortality outliers for relevant surgical specialties. This indicated that there had been no more deaths than expected for patients undergoing surgery at St. James's University Hospital.
- Emergency readmissions following elective (planned) or emergency admissions compared favourably with national comparators.
- Day case surgery is performed below national expectations at 76.8% of cases in 2013. The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.
- The trust contributed to all national surgical audits that it is eligible for.

Care plans and pathway

- Care pathways were in use, for example, for robotic prostatectomies.
- Enhanced recovery pathways were not in use.
- Nursing documentation was kept at the end of the bed and was mostly completed appropriately.

Multidisciplinary team working and working with others

- Daily 'board rounds' were carried out with members of the multidisciplinary team. Physiotherapists and occupational therapists were available and were regularly on the wards.
- Ward pharmacists and technicians were available. They supported patient-focused initiatives such as the nurse-led discharge and anticoagulant bridging clinic.
- We saw examples of the team learning from other providers. For example, the learning from the surgical never events had included visiting another large teaching hospital.

Equipment and facilities

- There was appropriate equipment to ensure effective care could be delivered

Pain relief

- Pain assessments were routinely carried out for patients and recorded.
- Patients reported their pain was well-controlled.

Seven-day services

- Medical staff reported 7 days a week, 24 hour access to radiological scans.
- Pharmacy was open 7 days a week but for shortened hours on both Saturday and Sunday. Out of those hours there was an on-site on-call pharmacist to dispense urgent medications.
- Over the weekend, Consultant ward rounds took place to see new patients and review any patients where concerns had been raised by junior doctors or nursing staff.

Are surgery services caring?

Good

Compassionate care and emotional support

- We reviewed the Friends and Family test results for the trust and found these did not indicate any areas of risk. We also sampled the information for surgical wards we visited and found the Net Promoter score (proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent) indicated patients were overall satisfied with the level of care received.

Requires improvement

Surgery

- The CQC inpatient survey did not identify any evidence of risk.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly and, with the exception of one ward, patients told us, "You're well looked after" and "The staff are really good."
- On one ward, J82, three patients spoken with raised issues with care provided at night including delay in answering call bells, not being offered a wash, overhearing conversations about other patients and not felt treated with dignity and respect. We revisited this ward as part of our unannounced visit; patients did not raise the same issues and we observed care at that time to be provided with dignity and compassion. Patients on another ward, J44, said they felt there were not enough staff on duty.
- We saw in some areas that comfort rounds (intentional rounding) was undertaken.
- We observed staff introducing themselves to patients and speaking with them in a professional manner.
- We saw curtains were drawn around bed spaces to maintain patient dignity.
- We looked at patient records and found they were completed sensitively.

Patient involvement in care

- Patients and relatives we spoke to stated they felt involved in their care. Where they had raised concerns most patients felt these had been dealt with in a caring manner.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

- Referral to treatment times in less than 18 weeks were below target at 85% against a target of 90% for the admitted pathway.
- The number of patients waiting over 6 weeks for a diagnostic test was less than expected.
- Waiting times for patients with cancer awaiting first treatment was as expected.
- Between July 2013 and September 2013 the bed occupancy rate for general and acute beds (which would include beds for surgical patients) was 85%. The national target is below 85% as high bed occupancy rates can affect the quality of care provided.
- The proportion of patients whose operations were cancelled was higher, but similar, to expected.
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason was higher but similar, to expected.
- The trust reported 855 last minute cancelled operations during the course of 2013.
- There was a dedicated separate team for emergency theatre.

Maintaining flow through the hospital and discharge planning

- There was a dedicated pre-assessment unit at the hospital. It operated 5 days a week. This was nurse-led and supported by an anaesthetist. Patients referred to the pre-assessment from outpatients were seen on the day in 80% of cases. For those not seen on the day, they were seen within 5 days. This need was assessed according to distance they lived from the hospital and urgency of the appointment.
- The trust had established a Surgical Assessment Unit. This unit accepted patients by direct referral from the GP, from the Emergency Department or Clinical Decision Units at both SJUH and LGI. There was weekly rotation of the consultant and medical cover provided by a senior doctor from 8am- 8pm and a junior doctor. Patients were assessed and admitted to a surgical ward or discharged home following review and/or investigations.
- There was also a Same Day Admissions Unit (similar to elective admissions unit) for patients who required planned surgery. The service operated Monday to Saturday and aimed to keep patients stay as short as possible. Discharge was planned and was nurse-led, supported by an onsite prescribing pharmacist.
- Activity and patient flow coordination meetings are held 3 times a day in the main theatres. This was done using a 'bunker' system. This was supported by theatre staff, medical staff and the bed management team.
- Bed managers worked closely with wards to ensure patient flow.

- Daily board rounds were undertaken and involved members of the multidisciplinary team, for example physiotherapists and occupational therapists.
- The trust had a policy on the transfer of patients to reduce the number of bed moves experienced by each patient. The transfer of patients was based on clinical need and should not occur between 10pm and 7am without a documented risk assessment. The clinical site manager was responsible for out of hour's transfers. There was no further escalation within the trust for transfers between ward areas.
- All wards had an estimated date of discharge for patients. Discharge planning documentation was available but was not consistently used.
- Electronic discharge summary is in use within surgical ward areas. Shortage of junior doctors out of hours led to reported delays in prescribing and discharge of patients.
- Staff reported that portering services had been centralised. There were no longer dedicated theatre porters and each 'job' required a separate request. This had resulted in porters no longer combining jobs, for example, when a patient was returned to the ward and another patient was due to be taken to theatre, this was now a separate request. Staff reported this had caused delays. Managers were aware of this issue and monitoring the impact to enable the issue to be addressed.
- Bexley theatre recovery unit ran until 8pm. Patients often require complex all day surgery. Patients requiring ongoing care after 8pm have to be moved to Geoffrey Giles Theatres. Staff said that if it is decided the patient needs HDU care they are then transferred back to Bexley Wing. The service was not run to respond to the needs of the patients.
- Medical staff reported there was no clear patient tracking system. This had resulted in a surgical patient who was outlying on another ward not being seen for 4 days. No harm had resulted.

Meeting the needs of people

- Staff said they had an increasing awareness about dementia. However, nurses on two surgical wards reported they did not have the appropriate training in dementia care to enable them to meet the needs of patients, particularly medical outliers. A trust-wide programme of dementia awareness training had been implemented. Data was not available at CSU level.
- The Same Day Admissions Unit identified that patients with learning disabilities often attended the ward. Arrangements were made so carers could stay throughout the patient's stay.
- An interpreter service was available. The need for an interpreter was included as part of the pre-admission assessment.
- A pharmacy-led clinic had been established as part of the pre-assessment team to organise bridging anticoagulation for patients. This was to improve the patients experience and minimise hospital length of stay.
- The hospital had dedicated faith rooms and a chaplaincy service to meet the religious and spiritual needs of patients.

Environment and equipment

- The Surgical Assessment Unit was cramped and the flooring was planned to be replaced within a few weeks of the visit. There was no bath or shower in use available for patients and staff reported that patients frequently (at least weekly) stayed on the ward overnight. Storage was limited and supplies and equipment was not all stored securely.
- In Geoffrey Giles theatres, patients were checked in with very limited space between them making privacy & dignity difficult.
- Bexley wing theatre staff said theatre lists comprising of like surgical specialities could often not be scheduled in adjacent theatres and this resulted in delays due to equipment having to be transferred across the department.

Communication with GP's and other departments within the trust

- Electronic discharge summaries (eDANs) had been introduced.

Complaints handling (for this service)

- Improvements to the handling of complaints were in progress. The Heads of Nursing reviewed all of the complaints relevant for their CSU. The trust was supporting Clinical Service Units to improve complaint responses, for example a 'complaints buddy' had been identified from the corporate team; they had attended a local CSU governance meeting to discuss complaint responses and expectations.
- If a patient or relative wanted to make an informal complaint then they would speak to the shift

coordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint
- Themes from both formal and informal complaints were communicated to staff. Staff we spoke with demonstrated an awareness of complaints raised and lessons learned. These were shared at handover, ward and unit meetings.

Are surgery services well-led?

Requires improvement

Leadership of service

- The trust was organised into 19 Clinical Service Units (CSUs). This structure had been implemented in July 2013. Six of the CSUs were surgical or contained services that were surgically based. Each CSU had a triumvirate management arrangement with a Head of Nursing, Clinical Director and Business/General Manager. Staff reported that the management arrangements worked well.
- Each ward had a band 7 ward manager. Most ward managers confirmed that they had at least 2 days per week when they were supernumerary.
- A matron oversaw a group of wards. The number of wards they oversaw was manageable. We were told the matrons were visible, coming to each of the wards at least once a day. We saw that matrons were accessible to all staff, for example having dedicated 'drop-in' sessions.
- Clinicians in senior leadership posts could access clinical leadership and management courses and some staff were currently on these courses.

Culture within the service

- Staff at all levels reported a significant shift in culture since the new trust management had been appointed. They reported increased engagement and visibility of the Chief Executive and the board of directors, particularly the Chief Nurse. They viewed this change as very positive. Staff said that it felt like a completely different organisation.
- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff felt encouraged to speak up if they saw something they were unhappy with regarding patient care. They reported they now felt listened to.
- Staff reported and appeared to work well together.
- Staff felt engaged with the trust; staff within the surgical areas were aware of what was happening elsewhere in the trust.
- The staff survey data showed the trust scored as expected in most areas.
- Staff felt supported by the management team

Vision and strategy for this service

- Staff were clear about the provision of high quality care, but could not articulate the trust vision.
- Staff were able to repeat the vision to us at focus groups and during individual conversations. (to edit based on focus group info).

Governance and measurement of quality

- Governance meetings were held within the Clinical Service Units.
- Complaints, incidents, audits and quality improvement projects were discussed.
- Although data was collected, the analysis of the performance data was identified as a 'work in progress'. Additional resource was being considered to enable more detailed analysis of the data collected at CSU level. Each CSU had a performance dashboard produced corporately but were not aware of this. Data at individual surgeon level was not systematically analysed.
- Managers could provide examples of where they had identified issues and taken action to address these. Qualitative as well as quantitative information was used.
- Managers showed an understanding of the issues identified by staff providing 'hands on' care. Risk registers reviewed reflected these concerns. Actions to address issues were planned but their effectiveness had not yet been reviewed in many cases.
- Risk registers across the CSUs were of variable quality. Some had assurances in place, while other CSUs had not tested the effectiveness of the some of the measures put in place. For example, on the Hepatorenal CSU risk register, the impact of reduced numbers of doctors in anaesthesia had been identified in January 2014; none of the proposed control measures had been tested.

Requires improvement

Surgery

- Staffing levels remained a risk although work was progressing to address these.

Innovation, learning and improvement

- Staff reported there had been a significant positive shift in culture. However, innovation was not yet systemically evident.
- Further work was required to embed the use of performance data results such as that provided by the ward dashboards so it could be used to drive improvement.

Requires improvement

Intensive/critical care

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

Information about the service

Adult Critical Care Clinical Service Unit (CSU) has 74 beds across Leeds Teaching Hospitals NHS Trust (LTHT). The beds are split across two sites with three units at Leeds General Infirmary (LGI) including general, cardiac and neuro-surgical and two units at St James's University Hospital (SJUH) including general intensive care and high dependency care. There are 14 additional high dependency beds at SJUH and six at LGI, which sat outside the management of the CSU.

Critical Care on the SJUH site consists of three wards; J81 a 16 bed surgical high dependency unit, J54 a 15 bed intensive care unit and adjacent J53, which has six beds designated L3 or L2 beds as required; J54/J53 are seen as one unit. There are two additional areas providing augmented care including a respiratory care unit (J10H) and a thoracics unit (J84H); these sat outside of the Critical Care CSU.

The Adult Critical Care CSU has seen a rise in activity of 8% over the course of 2013/14 and is forecast to deliver around 33,000 bed days of critical care. LGI activity has risen particularly as a result of Major Trauma Centre designation from April 2013 increasing neurological and general trauma activity.

The Adult Critical Care CSU has in the region of 450 staff, the majority of which are registered nurses to provide the high ratio of nurses per patient required in the delivery of critical care. The Adult Critical Care CSU has a budget of £23m.

LTHT's Outreach service is managed via the Adult Critical Care CSU and is currently a day-time only service but plans are being developed for seven days a week outreach service provision.

Requires improvement

Intensive/critical care

Summary of findings

Summary and justification for rating

The critical care units at SJUH required improvement. They varied in terms of environment; some wards were not suitable for purpose such as J53/54; which was recognised by the trust and plans were in place to upgrade the unit. Whereas, J81 had an excellent environment. It was light and spacious and co-located to a suite of theatres. The critical care units were clean and staff generally adhered to trust policy in relation to the prevention and control of infection. However, some equipment, mainly ventilators and humidifiers, were dated and required upgrading.

Substantive nurse staffing levels were consistently below the required levels and there was a reliance on nursing staff working additional shifts and external agency staff; the latter was seen by staff as a potential risk to patient safety.

We had concerns in relation to mental capacity assessments and deprivation of liberty safeguards; such safeguards were often not part of the critical care processes.

The critical care units were effective and followed a variety of national guidelines to determine best practice and we observed commonly used care tools such as care bundles. Mandatory audits were completed as necessary, but clinical audits could be improved and better aligned to the overall priorities and goals of the adult critical care clinical service unit.

Services were caring and emotional support was offered to patients and relatives; there was a bereavement service where relatives could talk through their emotions with a trained person.

Nurses described how the medical team were open with people about their care and any procedures that needed to be performed.

Improvements were required in the responsiveness of the units to patients' needs. Many staff were concerned about the skill-set of staff on non-critical wards, which was affecting discharge of patients from critical care beds. There were issues in terms of patient flow and capacity and this was a particular challenge for the units. Key performance indicator information provided by the trust showed signs of the pressures being placed on funded beds and the challenges faced by wards in coping with critical care discharge patients.

Staff were positive about the relatively new leadership team of the critical care clinical service unit and felt communication had improved. We had concern about the apparent 'us and them' culture between the two main hospital sites and the lack of engagement between senior staff, including medical staff, within the critical care CSU. There was limited planned cross-site working and staff remarked that the ethos across the two main hospital sites was different; this didn't encourage joined-up working.

Requires improvement

Intensive/critical care

Are intensive/critical services safe?

Requires improvement

Cleanliness, infection control and hygiene

- The Intensive care unit estate in the Lincoln Wing at SJUH was 19 years old.
- The unit had been altered over the years to respond to demand and the layout was not ideal; some bays were too small to easily accommodate critical care equipment and the position of some walls affected lines of sight to some beds; pendants (outlets for medical gases) were also fixed in awkward positions.
- In relation to infection control risk, bed spaces were relatively close together, which made access to areas directly around the bed and the equipment awkward; this made cleaning / disinfection tasks more difficult.
- The close bed proximity and limited space around the beds did not support best practice guidance for a minimum bed space of 25.5 m2 in order to accommodate the amount of equipment needed, for staff access to the patient from all sides of the bed, staff to manoeuvre the patient, themselves and equipment safely, five members of staff to attend to the patient in an emergency situation and the presence of visitors at the bedside.
- There was inadequate side-room provision leading to unfavourable numbers of failure to isolate instances and unnecessary movement of critically unwell patients around the unit.
- The equipment and general environment of the critical care wards we visited were visibly clean including horizontal surfaces and high-contact surfaces / equipment touched by staff and patients
- We observed staff, particularly nurses and doctors, clean their hands appropriately using either soap and water or alcohol hand-rub; this was usually before and after contact with a patient and/or their immediate environment.
- During ward rounds we observed the process whereby a doctor was designated as the alcohol hand rub dispenser lead and they ensured everyone used the alcohol hand rub when necessary.
- All staff followed the trust uniform policy in clinical areas and had rolled up sleeves or wore a short sleeve top; staff did not wear wrist watches.
- Staff were observed wearing apron and gloves for all direct patient contact in most instances.
- There was varying practices across the hospital sites in relation to apron use and colour-coding. The understanding of staff on some units was to use light red coloured aprons during patient contact and yellow aprons for those patients with a known infection. The units at SJUH did not have a strict apron colour-code system and any coloured apron could be worn for any task; this was a potential source of confusion when caring for isolated patients
- We observed staff, including nurses and designated cleaning staff, clean areas of the wards including bed bay areas. A chlorine-based product was consistently used for general cleaning / disinfection and staff understood the trust policy on using chlorine.
- According to information presented to the Trust Board in January 2014 Methicillin-resistant Staphylococcus aureus (MRSA) blood infection rates for critical care were zero.
- Intensive Care National Audit & Research (ICNARC) data (July, 2013) and a related Quality Key Indicator (QKI) report (November 2013) shows above national average figures for unit acquired infections in blood (presence of an infection in any blood sample) and the trust were closely monitoring this.
- The data above highlights the fact that there were no MRSA blood infections for the period described but higher than average infected blood samples not associated with MRSA.
- The number of unit acquired Clostridium difficile infection (CDI) was rising towards the end of 2013 for the Critical Care CSU and there were 2 cases in December 2013. Ward Healthcheck data for all CSU's shows no cases of CDI in critical care for February 2014 and no cases of MRSA blood steam infection for the same month.

Nursing Staffing

- Senior nursing staff on J54/53 had concerns about nurse staffing.
- A senior band 7 charge nurse had been seconded from LGI to J54 at SJUH to mitigate some of the concerns.
- There were concerns about staffing skill-mix, staff retention, high use of agency staff, consistency and the impact all these factors had on patient safety and continuity of care.

Requires improvement

Intensive/critical care

- An overarching theme from data presented by the trust was that nursing staffing levels were below the required level and staff from external agencies were regularly required to maintain safe staffing levels. Staff from LGI were used to support nursing shortages at the SJUH site.
- Intensive care (with Level 3 patients) is synonymous with a 1:1 nurse-patient ratio. The Intensive Care Society (ICS) Core Standards (2014) identify a minimum ratio of 1:1 registered nurse / patient ratio to deliver direct patient care, with recognition that at times to safely meet the needs of some critically ill patients this may need to be higher. An additional supernumerary nurse in charge is required and an additional supernumerary registered nurse as bed numbers increase above 11 beds (these numbers do not take into consideration maternity leave, sickness rates, the skills and competencies of the staff or the design and layout of a Unit).
- The ICS states that a more realistic figure to provide a nurse at the bedside at all times and run a full complement of beds is 7wte per bed. Nursing establishments had been reviewed by the CSU, but with ongoing recruitment and retention issues the units were not currently operating at this level.
- The Critical Care CSU management team (clinical director, head of nursing and general manager) confirmed that nursing staffing levels were a key concern and risk and a high priority to tackle.
- Several issues were identified across all the Critical Care units in relation to staffing including problems with retention, recruitment, maternity leave, sickness, skill-mix and morale.
- Staff on a number of units felt nurse staffing levels were a potential safety concern because the agency staff used to achieve safe staffing levels required extra support from permanent staff which impacted on their work-load. There were inconsistencies in the local induction of agency staff across all the units.
- Senior nursing staff at SJUH commented on how it wasn't always clear what competencies agency staff had which, again, impacted on the work-load of permanent staff because they needed to partially over-see the work of agency nurses as well as manage their own patients.
- Insufficient staffing levels is on the adult critical care risk register and is described as being attributed to high levels of sickness/absence which may result in a failure to protect patients and staff from serious harm; the risk rating was marked as amber.
- Staff rotas, sickness, annual leave and study leave was managed through electronic-rostering (e-rostering), by each unit Band 7 sister / charge nurses.
- The CSU's risk register stated that the measures taken by the adult critical care management team had been deemed effective including ensuring staff request leave in advance and closer monitoring of non-attendance. Use of bank and agency staff is a key control mechanism but there are potential gaps because bank / agency are stated as not being reliable, particularly during day shifts.
- Advanced Trainee Practitioners had been introduced on J54/53 and one on J81, which had a positive impact on patient care.
- In addition, band 4 assistant practitioners supported registered nursing staff on J81.
- Senior nursing staff said some nurses had left the unit because of its dated and impractical design.
- Ward J84 was for post-surgical thoracic patients; the ward was not staffed by nurses trained in high dependency care and during our visit there was one registered nurse and one healthcare assistant caring for four patients.
- Nurses on J84 described how the ward was difficult to staff.
- Staff skill-mix on ward J81 was also discussed; many of the nurses were only trained to manage Level 2 patients. However, senior nurse leadership on the unit was seen to be strong and team building had been good.
- On a positive note, staff from J81 were moved to J54/53 to maintain safe staffing levels as witnessed during our visit.

Management of the deteriorating patient

- We spoke with the head of nursing for the adult critical care; the trust had implemented an early warning score system to assist staff in assessing whether a patient was deteriorating.
- We spoke with nursing staff on the units at SJUH and there was a good overall understanding of the early warning score tool and how it's used across the trust.
- There was an outreach team that provided critical care support to patients on the general wards and cover was provided on the SJUH site between 8am – 8pm seven days a week.
- The middle grade outreach nurse described the team set-up; there were four senior band 7 nurses and eight

band 6 nurses; there was also one senior physiotherapist. There were six nurses working at any one time across both main hospital sites with three to four nurses usually at SJUH.

- There was a consensus that the outreach team needed to extend its support to a seven day a week service and this was seen as essential to ensure safe and effective continuity of care when patients were handed back to the ward staff to manage at 6pm.
- A service review was undertaken in January 2013 and the business case was on-going in terms of extending the service to run seven days a week.
- There was concern raised by outreach staff that ward-based nurses, over a relatively long period, had become de-skilled which has led to a disproportionate and unsustainable reliance on the outreach team which in turn has reduced opportunities for ward-based nursing staff to develop their skills, for example, managing a tracheostomy or chest drain.
- An example was given where a ward nurse at SJUH was close to requesting the use of a critical care bed in order for a patient to have some blood passed into a patient via a drip.
- The outreach team was set up to provide education and training to ward staff to manage the more complex patient but its focus has changed.
- A senior nurse in the outreach team felt that there was potential for improved cross-site working.

Nursing and Medical Handover within the unit

- We observed a ward round at SJUH, which involved several members of the multidisciplinary team including doctors, nurses and physiotherapy.
- There were two nursing handovers per day and a new critical care chart was started every 24 hours; the critical care charts themselves referred to three shift change-overs and this related to when there were shorter nursing shifts and one more handover per day. This created inaccuracies in documentation when patient risk assessments, planned care and safety checks were recorded
- We observed several medical handovers and they were detailed and comprehensive.
- We found there was good dialogue between consultants and junior members of the medical team.
- We observed the early morning multi-professional huddle / staff briefing before the start of the ward round where headline issues were discussed and medical staff allocation occurred using a designated format.

Safety Thermometer

- Safety thermometer information was clearly displayed at the entrances to the critical care wards at SJUH and included information such as, but not limited to, the number of days without an MRSA bloodstream infection, pressure ulcer data and falls information.
- The Ward Healthcheck document (2014) incorporated safety thermometer data and this provided an overview of core key performance indicators (KPI's) and additional indicators for all CSU's.
- The measures that were indicating the highest risk during February 2014 related to pressure sores and staff sickness.

Incidents

- LTHT had five Never Events between December 2012 and November 2013 one of which related to an incorrect chest x-ray being reviewed for a patient requiring a nasal feeding tube. The incident had been fully investigated and learning shared across the CSU and trust.
- Between July 2013 and February 2014 there were seven incidents specific to critical care that were deemed serious enough to require specific investigations, two of which were classed as serious untoward incidents (SUI's). One SUI related to the occurrence of a grade 3 pressure sore and the other SUI was the Never Event as described above (the incorrect chest x-ray being reviewed for a patient requiring nasal feeding tube).
- National Reporting Learning System (NRLS) data for the speciality Anaesthesia Pain Management and Critical Care shows a comparatively low level of incidents compared with other specialities. For example, between July 2012 – July 2013, for a total of seven specific specialities there were 296 patient incidents; 154 (52%) related to medical specialities. For critical care across the trust, there were only 3 NRLS reported incidents which seemed particularly low.
- We spoke with the critical care head of nursing about the NRLS reporting and it was felt the data was incorrect or there had been some issues with underreporting.
- We spoke with numerous members of staff at SJUH about the SUI's and they were aware of the incidents and the learning which had taken place to avoid such incidents occurring again.

Intensive/critical care

- The trust's incident reporting system (Datix) for the adult critical care CSU showed a range of issues that had been reported. There were 20 categories and by far the most reported concern related to the inability to isolate a patient within two hours followed by the number of category 2 pressure sores received into the hospital. The other reports included lack of suitably trained staff, administration, out of hours transfer and lack of, delayed availability of HDU/ITU beds.
- Staff were aware of how to report incidents via the Datix system. Staff described some relatively new initiatives to share learning from incidents including the critical care blog and the monthly adult critical care 'bite size' letter demonstrating learning from incidents.

Environment and Equipment

- We spoke with senior staff on the wards at SJUH about equipment and it was commonly stated that some essential equipment was dated and due for replacement; staff said the equipment was well maintained but some equipment had reached the end of its ideal working life.
- Staff described some equipment as being dated and due for an upgrade, particularly ventilators and humidifiers.
- From reviewing the equipment log specific to the critical wards at SJUH, we noted that some ventilator systems were over 10 years old and some humidifiers were over 15 years old.
- The data showed that the instances of ventilator breakdown did not seem to relate to the age of the machine but for humidifiers older than 13 years, the number of breakdowns did increase.
- We spoke with the senior staff at unit level about equipment and no reference was made to a rolling programme of equipment replacement / upgrades and it wasn't clear how the process was managed.
- We did observe two proposals on how to address the dating equipment and it included rotating equipment between the critical care units and putting in bids to upgrade equipment. We weren't clear how well the proposals were progressing or whether new equipment was due in the near future.

Medicines

- We checked clean utility rooms on the wards and found medicines were stored tidily in locked cupboards and controlled drugs were secure.
- We checked fridge temperatures and these were within the expected ranges.
- We noted a number of controlled drug incident reporting on the Datix system and all had been investigated.

Discharge and handover to other wards

- Discharges from the critical care unit were discouraged after 10pm, but did regularly occur due to bed pressures.
- Prior to discharge the critical care registrar would verbally hand the patient over to the accepting team's registrar. Nursing staff would perform face to face handover on the unit.
- There was a standardised discharge document that was completed by the critical care staff prior to discharge to the ward.
- The discharge document outlined the treatment received while on the unit as well as a decision regarding whether readmission to the unit would be appropriate.

Records

- Critical care standardised nursing documentation was kept at the end of the patients bed.
- We reviewed two critical care charts at SJUH and overall, observations and assessments were consistently recorded and appropriate risk judgements were made in terms of the frequency of some observations.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- We spoke with staff, particularly on J81, about patient restraint and use of mittens to prevent patients from dislodging medical devices that were providing life-saving treatments or nutrition. While this was undertaken in the patient's best interests this was not documented within the nursing or medical records.
- The staff were not clear about the legalities of the Mental Capacity Act (2005) and related Deprivation of Liberty safeguards.
- There were no evidence of the use of the two stage test to assess mental capacity or any evidence that deprivation of liberty was considered within critical care Staff acknowledged that using mittens was in the best interest of the patient because of the harm that can

occur if devices are pulled out but there was no documentation to support why and how staff were making decisions involving restraint or how it might affect liberty.

Mandatory Training

- We reviewed staff mandatory training records for two critical care wards at SJUH and the proportion of staff whose training was in date for the first unit was 65% and the second unit was 55%. Compliance was the highest for corporate induction but relatively low for training for Mental Capacity Act, safeguarding, infection control, nutrition Level 1 and 2 and naso-gastric feeding.
- Overall, mandatory training compliance was low and staff often stated how they did not have time to attend training sessions or work through e-learning on a computer. Staff also commented on the IT system and said it wasn't easy to access the online learning and there were often problems with passwords and logging in; this put them off accessing the training.
- Senior staff on the wards at SJUH said ensuring staff received their necessary mandatory training was a challenge particularly in terms of freeing staff to complete training; this was because of staffing levels not being ideal and relatively high use of agency.
- Staff annual appraisal for the adult critical care CSU was also low; in the region of 50%.
- We noted that National guidance on mental capacity assessments and deprivation of liberty safeguards were not being fully adhered to.

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

Good

Use of National Guidelines

- We noted that the critical care units at SJUH followed a variety of guidelines to determine best practice including that provided by Intensive Care Society, Intensive Care Society Framework and NICE. Others included Intensive Care Medicine Guidelines and use of specific care bundles, for example, ventilator care bundles.
- Other guidelines being followed included assessments for delirium and pressure sore assessments.
- We discussed the use of clinical audits with the clinical director and there were two audit leads; one at LGI and the other at SJUH. Their role was to conduct mandatory and local clinical audits. It was stated that mandatory audits were consistently completed but local clinical audits were more hit-and-miss.
- Cross-city audit meetings had been set up to improve clinical audits and work was on-going. Clinical audits that have been conducted include hospital arrests, ventilator associated pneumonia and central line complications.
- Clinical audit could be improved and better aligned to the overall priorities and goals of the adult critical care CSU.

Outcomes for the unit

- The adult critical care CSU does contribute to the Intensive Care National Audit and Research Centre (ICNARC) database.
- ICU length of stay, mortality and hospital mortality were comparable to case mix programme averages from January 2013 – July 2013.
- The clinical director acknowledged that the lead time on the ICNARC reports for SJUH had been over nine months.
- A summary of the SJUH (Ward 54) case mix programme (1 January 2013 – 31 March 2013) showed that intensive care mortality and hospital mortality had increased compared to other case mix averages; the reason for this was unclear.

Care Plans and Pathway

- The SJUH adult critical care units used standardised nursing critical assessment charts placed at the bottom of patient's beds; these were used to monitor and record data about patients' progress.
- Other documentation included specific critical care nursing record booklets for Level 2 and Level 3 patients; these were three day care records. The nursing record booklets were clearly set out and we observed nursing staff completing these as necessary.
- Key headings within the booklets included isolation, escalation measures, infection control, daily events, ward round decisions, acute incidents, respiratory system, evaluation of care, cardiovascular, renal, nutrition, pain, wounds and communication.
- Care bundles were in place for certain situations including if a patient was ventilated or had a central line.

Requires improvement

Intensive/critical care

Consultant Input

- Consultants conducted ward rounds twice a day including weekends.
- All potential admissions had to be discussed with a consultant and all new admissions were reviewed by a consultant within 12 hours of admission.

Multidisciplinary team working

- There was a daily ward round which had input from members of the multidisciplinary team including nursing, microbiology, pharmacy and physiotherapy.
- There was a critical care pharmacist who worked across the units.
- There was appropriate input from allied healthcare professionals including speech and language, physiotherapy and dietetics.

Seven day services

- There was good consultant presence on the critical care units including at weekends; the consultants were supported by a speciality registrar and a foundation doctor.

Are intensive/critical services caring?

Good

Compassionate Care

- Throughout the inspection we observed how staff, mainly nurses and doctors, engaged with patients and/or their families and relatives. We observed that staff treated people with compassion and in a dignified and respectful way.
- There was one exception to this: we observed a ward round on J53 and the consultant and team did not communicate / engage with the patients they reviewed; it was impersonal and not respectful.
- Clearly, some of the patients we observed were critically ill and were on ventilators. Staff were equally caring and respectful to those patients that would not have been aware of people being around them. Staff would inform patients of what they were doing even when it unlikely the person would be able to hear and/or understand what they were saying.
- We spoke with two critical care patients at SJUH and one patient said “They quite liked it here but it was a bit noisy.” The other patient said, “You can’t fault the staff” and they gave a non-verbal ‘thumbs up’ to the care provided.
- Patients looked comfortable and where appropriate were sat out of bed.
- Curtains were drawn around bed areas while care was delivered and privacy and dignity maintained.

Patient involvement in care

- Due to the nature of the care provided on the critical care units we visited, patients could not always be directly involved in their care. However, we did speak with patients who were ready to be moved off the critical care unit and they said, where possible, elements of their care were discussed and explained to them.

Emotional Support

- During the inspection at SJUH we spoke with staff about the emotional support offered to patients and relatives in particular. There was a bereavement service where relatives could talk through their emotions with a trained person.
- We spoke with consultants on the unit about the support they provided to families; they stated that they would often meet the families when requested and updated them on the progress of the patient on critical care.
- The nursing staff said the nursing and medical team were very open with relatives about the care being provided and the severity of people’s illness / injury.
- Following admission to the unit, the consultant covering the unit would arrange to meet with relatives to update them on their progress; one of the nursing staff would also attend this meeting. When necessary, further face to face meetings were organised and all relatives we spoke with stated that they had been kept fully updated.

Requires improvement

Intensive/critical care

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

(for example, to feedback?)

Requires improvement

Maintaining flow through the department

- The information presented by the Department of Health for critical care bed capacity showed that the available beds for LTHT critical care was 89 with a percentage occupancy figure of 80.9% with the England average being 83.4%.
- The critical care bed spaces available at SJUH were 38 and the number of funded beds was 35.
- We spoke with the clinical lead about the 80.9% occupancy figure and it was likely this was determined using the available beds figure; the clinical lead stated that the actual percentage occupancy figure was much higher and well over 85%.
- Activity across the adult critical care CSU has seen a rise of 8% over the course of 2013/14 and is forecast to deliver around 33,000 bed days of critical care.
- We reviewed ICNARC data and related quality reports and they show the adult critical care units at LTHT are above the threshold for delayed discharges, out of hours discharges to ward, unplanned re-admissions within 48 hours and non-clinical transfers out.
- The above data is an indication that the service is under significant pressure whereby patients may be being discharged from critical care beds too early and / or staff on some wards were not able to manage the patients as well as the critical care team may have hoped. In addition, re-admission rates may have been affected by the lack of seven days a week cover provided by the out-reach team.
- Key performance indicator information provided by the trust showed signs of the pressures being placed on funded beds and the challenges faced by wards in coping with critical care discharge patients.
- We spoke with senior nurses on the critical care units and staff working for the out-reach team; there was agreement that patients were being held in critical care beds because of some wards being unable to manage the more complex patient.
- For the second half of 2013 there had been a steady increase in patient operations being cancelled because of a lack of critical care beds; the number of discharges delayed beyond four hours had remained at similar levels throughout 2013 numbers have not been dropping, this is also the case for out of hours discharges.
- Readmissions within 48 hours dropped significantly during October and November 2013 and have since increased from those levels; there were 25 re-admissions last year (2013) out of 1500 patients.
- We reviewed specific funded bed capacity graphs and noted the occupied bed days were not frequently at full capacity; we spoke with the general manager and this was partly due to staff shortages.

Meeting the needs of all people

- Staff were able to explain how they could access support for staff with physical and learning disabilities if needed.
- Interpretation services were available and staff were aware of how to access the service.
- Staff did comment that the interpretation service was not responsive enough, which had a negative impact on the patient experience and their understanding of the care being provided.
- Some written information was available in different languages.

Complaints handling

- The adult critical care CSU had received four recent complaints between February 2014 and March 2014 and they were in the process of being investigated in-line with trust policy.
- Patients / relatives could complain formally by writing to the trust or discuss concerns more informally with senior nursing staff.
- Patients / relatives could also liaise with the trust's Patient Advice and Liaison Service (PALS); the PALS service was outlined in leaflets and on posters available throughout the hospital.
- The head of nursing was aware of the recent complaints about critical care and a theme from complaints was often about communication short-falls and they were trying to address the issues.
- We reviewed complaints that had involved the PALS team and there had been four between October 2012 and February 2013 for the critical care CSU.
- Complaints, and learning from complaints, were discussed with staff at ward meetings and information was also presented at clinical governance meetings.

Requires improvement

Intensive/critical care

- We saw evidence from the PALS log that complaints were managed in a timely way and learning widely disseminated.

Are intensive/critical services well-led?

Requires improvement

Leadership of service

- The adult critical care staff structure included the clinical lead, general manager and head of nursing who were charged with overseeing both main hospital locations; LGI and SJUH. There was a designated medical lead at each main hospital site and a nurse matron.
- The structure beneath matron level consisted of a tier of band 7 sister/charge nurses, band 6 deputy sister/ charge nurses, band 5 staff nurses and then non-registered staff band 2-4, who assisted the registered nurse in care delivery. Ward receptionists were present and administration and clerical staff were available in limited numbers.

Culture within the service

- We spoke with a number of staff at SJUH about the leadership of the adult critical care service and there was a theme; staff felt there had been an improvement since the formation of the CSUs and the appointment of the current managers / leads nine months ago and staff felt more direction was being provided.
- A senior ward nurse felt the service leads were approachable and in-touch with the challenges being faced by the service including staffing.
- Staff felt communication had improved and learning from incidents and the critical care blog and bite size learning magazine had all been positive.
- Staff appeared concerned about the critical care service and the increased pressures.
- Staff were concerned about the number of agency staff used, dated equipment and the regular movement of staff between hospital sites.
- We spoke with the clinical lead, general manager and head of nursing about their perceptions of their impact on staff and the service. They felt the new structure was still embedding and there was a way to go before significant changes were felt.
- The senior team were confident about the direction of travel and acknowledged the difficulties ahead especially in terms of staff recruitment and working 'as one' between the two main hospital sites where critical care is delivered.
- The clinical lead acknowledged the work that needs to be done to engage staff at all levels between the two main hospital sites.
- Staff felt there was an 'us and them' culture across the two sites, which was an historical mind-set at the trust.
- There was very limited planned cross-site working and there was only one senior doctor that worked regularly at both sites.
- There was a sense from speaking with some doctors that the ethos between the main hospital sites differed which affected working relationships.
- There was a sense of willingness from the majority of staff to ensure the success of the service but senior medical level engagement between the two hospital sites needed to improve sooner rather than later.

Governance, risk assessment and quality measurement

- From speaking with the clinical lead, general manager and head of nursing, they were clear where the challenges for the service were and priority areas.
- Discussions around risk and service improvement were held at monthly clinical governance meetings.
- The challenge with the clinical governance meetings had been engaging with a broader range of staff and cross-site clinical engagement.
- Complaints, incidents, audits and quality improvement projects were discussed.
- Information was cascaded to staff through ward team meetings and performance figures were placed in ward areas.

Vision and strategy for this service

- Staff commented that the trust vision had been communicated well in several ways including via the intranet, newsletters and team meetings.
- Staff were able to repeat the vision to us at focus groups and during individual conversations.

Good

Maternity and family planning

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

Information about the service

Leeds Teaching Hospitals Trust provided obstetric/ midwifery care at the St James's University Hospital (SJUH) and Leeds General Infirmary (LGI) site, along with community midwifery care. It is a tertiary unit and therefore provides care for and advice to clinicians caring for women with complex needs. The service included pre conceptual care, early pregnancy care, antenatal, intra partum and postnatal care. The trust also had a tertiary Neonatal Intensive Care Unit (NICU) at both sites which provided medical neonatal care. At LGI the service was for babies under 27 weeks gestation and high risk pregnancies, and they had a total of 31 neonatal cots. At SJUH the service was for babies above 27 weeks gestation and they had a total of 34 neonatal cots.

Separate reports have been written for each site. However, the locations share the same service information relating to governance and management arrangements. Where information relates to an individual site, reference to that information will be made in the location report.

During 2012/2013 the total number of deliveries at SJUH maternity service was 4510.

Inspection of this location included, the gynaecology assessment and treatment unit (GATU), early pregnancy unit (EPU), antenatal clinic, antenatal day unit, maternity assessment centre (MAC), the antenatal ward and postnatal ward, delivery suite and obstetric theatres. We spoke with 15 women who used the service and 27 staff, including midwives, doctors, consultants and senior managers. In addition to this we also held meetings with midwives, doctors and consultants to hear their views of the service they provide. We observed care and treatment, inspected several patients care records in each area we visited and reviewed the trust's audits and performance data.

Good

Maternity and family planning

Summary of findings

Maternity and family planning services were rated as good, the services were safe, effective, caring and responded to women's and their partner's needs.

The trust had taken action to ensure that ward areas and the delivery suite had sufficient staff to maintain safety. It was recognised that there were insufficient midwives or consultant hours to meet national best practice guidance. However, arrangements had been made to ensure appropriate nursing and medical cover was in place and staff reported that staffing levels were safe. Recruitment was actively taking place and junior doctors reported that there was good access to senior medical staff.

Ward and delivery suite areas were clean, with good infection prevention and control practices used. There were safety dashboards in each patient area and these were used to drive improvement. Maternity outlier alerts for the trust were within expected limits for the majority of indicators and the normal delivery rate was higher than reported nationally.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure consistency of practice. The service had a weekly newsletter and team briefs, which informed staff about new guidance and updates to ensure they were up to date with best practice. Care pathways were in use and the record keeping seen on the day of inspection was of a high standard. Multidisciplinary teams worked closely together and there was evidence women attended joint clinics for those who had medical problems.

Women told us they were pleased with the continuity of service they had received. They were allocated a named midwife from the onset of their care and could contact them with their concerns. Women and their partners spoke positively about the care they had received across the service. They were treated with dignity and respect and they felt involved.

There was a lead nurse for bereavement and midwives received bereavement training. Written information about bereavement services and support was available to women and the information could be provided in different languages on request. A translation services was also available when needed.

The maternity service had several midwives who had specialist areas of expertise to meet the diverse needs of women in their care. For example, safeguarding, substance misuse and bereavement support.

Maternity and family planning services were well led. Staff reported that there had been positive changes in the culture of the organisation and a focus on quality and standards of care. The trust executive leadership team was reported to be visible and that communication had dramatically improved. Staff felt well supported locally.

Good

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

Cleanliness, Infection control and hygiene

- The maternity unit was visibly clean and all staff reported they had infection control training. Policies were adhered to in relation to infection control; these included staff washing their hands, use of hand gel between patients and 'bare below the elbow' dress code.
- Each clinical area displayed an infection prevention notice board and the latest monthly audits. For example, the postnatal ward had scored 98% on the cleanliness of the ward and 96% on hand washing for the previous month.
- Each clinical area had a patient safety board ('Safety thermometer') displaying infection control and safety information. For example, the postnatal ward had 800 days without a Clostridium difficile infection, had not had any pressure sores or falls and had 100% score for patient safety.

Midwifery Staffing

- The births to midwife ratio was 1:30, slightly above the national guidance of 1:28. Staff were aware midwife appointments had been made and there were further plans to address shortfalls.
- Ideal and actual staffing numbers were displayed on every ward and in some instances the actual staff working exceeded the required amount. In other areas although there were sufficient staff on duty, staff experience of working there was dependant on how busy the area was at the time. There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster. Staff reported cross department/ site team working and use of agency staff when needed to address shortfalls.
- The maternity service weekly news 10 March 2014 – advertised for midwives to become supervisors of midwives and informed staff about the course commencing in January 2015.
- Women told us they had received continuity of care and one to one support from a midwife during labour.

Medical Staffing

- Consultants were present on the labour ward between 8.30am to 6pm and on-call outside of these hours. Information we received from the trust specified they operated a rota for the consultants, which identified a dedicated 60 hours a week on both delivery suites; and not 98 hours in line with national guidance.
- Junior doctors told us out of hours consultants were contactable. The service was difficult to be delivered across two sites. However, they also told us staff were managing the unit well and they had no concerns with patient safety. One doctor told us they would be happy to have their wife deliver a baby here at the unit.
- We were told the consultant workforce was in need of expansion and this had been an ongoing problem impacting on the out of hours service. However, we were also told the service remained safe.
- Management plans were in place to address the shortfall in the long term however, there is a national shortfall of staff in this area. Information provided by the trust showed although there were 18 consultants in post, the deficit against the 98 hours over LGI and SJU combined sites were 6 consultants.
- There was 24 hours dedicated anaesthetic cover.

Nursing and Medical Handover

- On the delivery suite nursing handovers occurred twice a day. Staffing for the shift was discussed as well as any high risk patients. This would include updates on women at home who had a potential to impact on the unit's workload. For example, those with ruptured membranes awaiting induction of labour.
- There were consultant led ward rounds every four hours.
- A Situation, Background, Assessment, Recommendation (SBAR) transfer record was used when handing over care between clinical areas. The documentation was signed by both transferring and receiving midwives. The tool is used in maternity services where there may be multiple handovers between staff and it assists in improving communication. (Information detailed date and reason for transfer, obstetric/labour history, current observations/findings and plan of action.)

Management of the deteriorating patient

- The unit used the Modified Obstetric Early Warning Scoring (MOEWS) system. We saw the service had carried out audits in different areas and the MOEWS audit had been collated in April 2013. The results

showed although postnatal data had been completed 100% the initial observations from admission to delivery, could be improved. As a result recommendations were made and we saw the use of the tool was one of the topics regularly discussed at the weekly staff meetings. We also saw in the maternity service weekly news, a baby MOEWS scoring pilot was to take place in April 2014. In relation to the use of the tool, staff were aware of the appropriate action to take and within the necessary time frame if patients scored higher than expected. Appropriately completed documentation was seen in patient records.

Safety Thermometer

- Safety thermometer information was clearly displayed at the entrance to each ward. This included information about falls, venous thromboembolism (VTE), catheter use with urinary tract infections and pressure ulcers. For example, on the antenatal ward there had not been any falls for the last 365 days, no one had experienced a pressure sore and the ward had been a 'harm free' place for the previous month. Where issues throughout the service had been identified, staff had been made aware through briefing sessions and newsletter. This included any learning from the event and where appropriate preventative measures.

Incidents

- Between December 2012 and January 2014 there were four reported serious incidents and one maternal death. The incidents were investigated using root cause analysis and lessons shared with staff.
- We saw across the service the data relating to pressure sores was displayed for people to see. We saw health education literature was available to inform people on the prevention of pressure sores and staff told us they had been informed they needed tissue viability training (in the prevention of pressure sores).
- Staff stated they were encouraged to report incidents. Themes from incidents were discussed at weekly meetings and we saw staff received incident bulletin updates. Staff were also able to give examples where practice had changed as a result of incident reporting. For example, there was an incident where a vaginal swab had been left inside the patient following procedure in theatre. We saw documentation showing audits of swabs now take place following each theatre procedure to ensure that none have been left in place.

Environment and Equipment

- The environment in the maternity unit was safe. Equipment was checked and cleaned regularly. For example through discussion with staff and checking audit records, we saw resuscitation equipment had been audited between January and March 2014. Staff said when the audits first started a number of staff had forgotten to complete them and for that reason they had not been compliant in all areas. The records showed the scores each month were improving.

Medicines

- Medicines were stored correctly and appropriate checks carried out. For example in the delivery suite the controlled drugs and medicines, which required refrigeration were stored correctly and appropriate records kept. We also saw audit checks carried out in January to March 2014 for the resuscitation medication and equipment scored 100% compliant.

Records

- Records were in paper format, comprehensive, up to date and of a good standard of record keeping. When not in use they were kept safe in line with data protection legislation.
- Staff told us documentation audits had recently started and were undertaken monthly; the results were then fed back to the matron whose area had been audited.
- The 'fresh eyes' approach was used, where two staff reviewed foetal heart tracings to reduce misinterpretation, improving patient safety.

Safeguarding

- Staff knew the procedure for reporting allegations or suspected incidents of abuse, including adults and children; they confirmed they had training. They were also aware of the trusts' whistle blowing procedures and the action to take.
- The trusts weekly newsletter dated 10 March 2014, reminded staff of the whistleblowing policy and encouraged them to report and discuss concerns at an early stage before they became potential serious incidents.

Mandatory Training

- Ward and department managers told us they had access to their staff training records and ensured they were up to date with mandatory training. For example in delivery suite we saw the training matrix and confirmed with staff they were up to date with their training.

Good

Maternity and family planning

- Staff confirmed their training included attending annual cardiac and pulmonary resuscitation training and training specific to their role.
- Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and support.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Use of National Guidelines

- The maternity unit used a combination of NICE and RCOG guidelines (e.g. Safer Childbirth: minimum standards for the organisation and delivery of care in labour). CNST Level one guidelines were seen available, neonatal guidelines were available on the intranet and displayed on labour ward; in line with national guidance and recommendations.
- Medical students were encouraged to undertake clinical audits to assess how well guidelines were adhered to. The trust provided us with examples of completed audits during the year, these included the use of MOEWS in relation to 'Recognising ill women,' Standards set out in the trust's policy; employing Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards. The outcome showed 100% compliance on admission to post natal wards across the maternity services, 100% of ill patients had the correct action taken, admission to delivery could be improved and actions suggested were recorded.

Outcomes for the unit

- Maternity outlier alerts for the trust were within expected limits for the majority of indicators: Maternal readmissions, emergency caesarean sections, elective caesarean sections, and neonatal readmissions were lower than expected.
- Normal delivery rate was higher than reported nationally.
- Perinatal mortality indicators were within expected limits; expected number 82.8, observed number 98.
- Staff were aware of the trust's dashboard and areas in which they needed to improve.

Care Plans and Pathway

- Care pathways were used for example, 'Enhanced Midwifery Care Pathway for the Management of Pregnant Women with a Body Max Index score higher than 40 kg/m2.'
- Care plans were of a high standard, comprehensive and clear records kept. Patients had individual hand held records and on the wards, documentation was kept at the end of the bed.

Multidisciplinary Team working and working with others included:

- Where possible, women in Leeds are offered a choice of midwife led care or consultant led care dependant on need. The majority of antenatal care is carried out in the community setting with input from appropriate professionals as required. This may include community midwives, GPs, consultant obstetricians and other specialists.
- Specialist clinics also took place where multidisciplinary teams worked together. For example, clinics covering twin pregnancy, Diabetic/endocrine disorders, Female Genital Mutilation, and Joint clinics with Leeds Addiction Unit and Sexual Health.

Pain relief

- Pain relief was available for birthing mums and women on the post natal ward confirmed they had been offered a choice of pain relief while in labour.
- Epidurals were available 24/7 with a dedicated anaesthetist.

Seven day services

- A consultant was present from 8am to 6pm and on call out of hours. A seven day service was available across the site supported by suitable qualified doctors, registrars and anaesthetists.
- Access to pharmacy and radiology was available.

Are maternity and family planning services caring?

Good

Compassionate Care

- Maternity service survey 2013, the trust scored the same as other trusts for care by staff during labour and birth. Care in hospital after birth was reported as worse than

other trusts. Staff were aware of this information. We were told by a matron on one ward, they ensured there were no handovers taking place when women were transferred from delivery, ensuring they had the time to provide the care needed for the new admission.

- The maternity Friends and Family test is still relatively new; Information about this was seen in clinical areas and women encouraged to complete feedback forms. The weekly staff news letter dated 17 March 2014 reminded staff to ensure women were encouraged to complete the form. The target for completing the data in February 2014 was 20% and the trust completed 23.7%.
- Throughout our inspection we witnessed women being treated with compassion, dignity and respect. We saw call bells were answered promptly. Women confirmed the staff were helpful and caring and treated them with dignity and respect.
- We looked at patient records and found they were completed sensitively and detailed discussions had been had with women and their partners.
- Partners were encouraged to visit and visiting times were waived for mothers in labour.
- On Ward J24, the patient waiting area had a mix of patients, so patients with a non-viable pregnancy were sitting with patients with viable pregnancies. Patients reported this as distressing.

Patient involvement in their care

- Women stated they had been involved in decisions regarding their choice of birth location and were informed of the risks and benefits of each. They told us they felt involved in their care and supported by staff.
- Women were aware of their named midwife, and the cover should that person be on leave and they told us the information and contact number had been recorded in their hand held records.
- Women who chose to have their birth in the hospital were offered a tour of the unit with their partner prior to the birth.

Emotional Support

- There was a lead nurse for bereavement and we were told all midwives received bereavement training.

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

Good

Access

- Bed occupancy was below 75%. (Royal College of Midwives recommends the bed occupancy rate for maternity should be below 75 %.)
- Women spoken with confirmed they were seen throughout their pregnancy when expected and when visiting the service, they told us they did not have to wait to be seen.

Equipment and facilities

- Equipment was available for birthing mums, including a birthing pool, mats and cushions.

Maintaining flow through the department and discharge planning

- Women laboured in designated areas.
- The trust had an escalation policy to deal with busy times and shortages of staff.
- With the exception of the senior ward and unit staff, staff rotated between areas every six months. This ensured they had the knowledge and skills to work in different areas/locations should they be needed. Staff also worked flexibly between units for example between the antenatal ward and delivery.
- Staff told us they followed the escalation procedure re staffing levels in relation to the antenatal wards. The unit would not close as they would continue to care for patients already on the ward. However new patients would be diverted to the other maternity site at the trust.

Meeting the needs of all people

- The needs of people with complex medical needs received co-ordinated shared care between consultants where needed.
- We saw specialised clinics were available for women who had medical conditions such as diabetes. The trust had received a Parliamentary Service Award; for the multi-disciplinary team of the year for their diabetes in pregnancy service.
- They had also received a runner up award for services for women with HIV, antenatal screening.
- Translation facilities were available and several information leaflets seen were available in different languages.

- In response to the needs of people such as travellers, and asylum seekers the trust set up a community midwife led service (Haamla) to assist in meeting their needs. Three part time midwives having a caseload of 10 to 12 patients. One of the aims of the service was to reduce mortality and morbidity rates within this vulnerable group. Leaflets were available in the antenatal clinics advising of the Haamla antenatal group for women, offering support, information and advice. Interpreters were also available in meeting these women's needs.
- A monthly TLC clinic and subsequent pregnancy support service was set up for women in their next pregnancy who had experienced, a miscarriage, stillbirth, termination of pregnancy for foetal abnormality or neonatal death. The clinic was supported by the SJUH and LGI bereavement support midwives.
- Ward noticeboards had information about meeting patient's cultural and religious needs. For example, circumcision.
- Women who requested a home birth were supported and cover provided by the midwives from delivery suites on both sites across the trust. This had proven positive as although there has not been an increase in home births, it has allowed people to have their labour and delivery in their chosen place.
- We found in the antenatal clinic a number of the chairs were damaged; replacement chairs had been ordered and the department waited their delivery.
- Staff reported a lack of storage in the GATU area.

Communication with GP's, other providers and other departments within the trust

- A discharge summary was sent to the GP by email and also by post on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken. This information was also recorded in the patient's take home records and communicated to the midwife and health visitor. This ensured the woman's GP was aware of their care and follow up care where needed.
- Communication was maintained between specialist services where patients had complex care and/or medical needs.
- Examples of partnership working included work to reduce infant mortality rates. The trust, Local Authority, NHS and VCSF sectors were involved in working together over the last six years which saw a reduction in these mortality rates.
- Written information about bereavement services and support was available. The information could be provided in different languages on request. We were also told translation services would be arranged where needed.

Complaints handling (for this service) and learning from feedback

- Data returns for 2013 showed no written complaints were upheld, and there had been no change from 2011/2012.
- Complaints were handled in line with the trust policy. If a patient or relative wanted to make a complaint there was information on how to do this; including, emailing, phoning, and face to face meetings. If the trust was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. Information relating to complaints was seen on ward notice boards, patient areas throughout the service and available in different languages.
- Patients were aware of how to complain and told us in the first instance they would speak with the staff on the ward. They also said they had confidence their concerns would be taken seriously and responded to.
- We also saw information on ward notice boards about the supervisor of midwives role and how they could be contacted should someone have a concern.
- The trust maternity services, monthly clinical governance risk management report for February 2014, detailed incidents reported in the last month. The service across both maternity units had received one new formal letter of complaint and six PALS concerns with a description of the action taken place to date.
- The Maternity Service, Clinical Governance Report, October to December 2013, stated there had been 12 formal complaints received. They also stated the service had responded to 22 informal PALS complaints this quarter. In both instances the information stated there had been a reduction in the complaints received from the previous month.

Good

Maternity and family planning

- Clinical areas were seen to have staff communication notice boards with details of new information and lessons learned from concerns, incidents, new guidelines and performance figures. We saw copies of the staff weekly newsletter, which included information relating to complaints and incidents. Staff confirmed they all received the information and attended weekly team briefs to keep them informed.

Are maternity and family planning services well-led?

Good

Leadership of service

- Openness and honesty was the expectation for the service and was encouraged at all levels.
- Staff told us they supported the new Chief Executive in his openness. One member of staff said in the last 6 months they had found out more about the trust than they had done in their previous 27 years of employment.

Culture within the service

- Staff within the service spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff told us the "Ethos in the organisation is about caring not standards." They told us this shift had recently occurred.
- Staff repeatedly spoke of the new executive team and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care.
- Staff told us they were made aware of 'Never Events' across the service, which had not happened previously.
- Staff worked well together and there was obvious respect between all grades of staff.
- Staff sickness levels were within expected numbers.

Vision and strategy for this service

- The trust vision was visible in in-patient areas and staff were aware of the vision when discussed at the focus groups we attended.

Governance and measurement of quality

- Governance meetings and forum minutes were seen and attendees included clinicians, senior management, team leaders and junior staff. Information discussed included updates and amendments to guidelines, new guidance, risk management, training and updates. Staff were kept up to date with this information through weekly briefs and newsletters.
- Complaints, incidents, audits and quality improvement projects were discussed.
- A quality dashboard was seen in clinical areas.
- Staff in all areas were aware of the issues faced by the service.

Innovation, learning and improvement

- Innovation was encouraged from all staff members across all disciplines. We saw examples of projects junior doctors and student midwives had been involved in which had resulted in a change in practice. For example, the use of MOEWS in relation to 'Recognising ill women.'

Good

End of life care

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

Information about the service

The Specialist Palliative Care Team (SPCT) was located at the Robert Ogden Centre at St James's University Hospital, but provided support and advice trust-wide. The team comprised of consultant medical staff, speciality doctors, nurse team leaders, specialist palliative care nurses, a palliative care discharge facilitator, end of life care facilitators, a social worker and a pharmacist. Currently the service was available Monday-Friday, with consultant on-call advice available out of hours.

Summary of findings

The specialist palliative care team was highly valued by staff and patients, ensuring that patients' needs were responded to appropriately and that the appropriate support was given, particularly with pain relief, symptom control and helping people choose their preferred place of care. Following bereavement there was sensitive support available to families and carers.

However, there was a lack of clarity within patients' records as to whether they or their relatives had been involved in decisions about whether a 'do not attempt cardiopulmonary resuscitation' (DNACPR) was appropriate. We also had concerns that patients who lacked capacity, with confusion for example were not consistently having their capacity formally assessed and taken into account as part of the DNACPR decision process.

Good

End of life care

Are end of life care services safe?

Requires improvement

Cleanliness, infection control and hygiene

- Overall, ward areas appeared clean and clutter free. We saw good practice with hand hygiene from staff. There were systems in place in the Mortuary to ensure good hygiene practices and the prevention of the spread of infection. Staff were qualified in public health and hygiene.

Incidents

- Staff did not recall any incidents they had reported with reference to end of life care issues.
- Mortuary staff said they would complete an incident form if they had any concerns regarding the presentation of the deceased patient or issues over correct identification procedures.
- Staff said they were encouraged to report incidents. They said they usually received feedback and were alerted to any themes from incidents or concerns.

Medicines

- Overall, anticipatory end of life care medication was prescribed appropriately. We reviewed Medication Administration Record (MAR) charts in a number of areas we visited and saw appropriate prescribing.
- However, on one ward we visited we saw anticipatory medication had not been prescribed in a timely manner, leading to a patient experiencing pain and discomfort. We saw that the patient and their relative had complained about this matter and the ward sister was addressing the concerns.
- A patient said staff were, “Very quick to respond with pain killers.” Another said their pain control was discussed and explained well to them.
- A nursing staff member said anticipatory medicines were readily available and prescribed as patients were identified to be nearing the end of their lives. They said they worked as a team with the medical staff to ensure this. Comments included; “The doctors are generally very good at anticipatory medicines.”

Records

- Deceased patient’s records and property were not locked and kept confidential in the bereavement office. The cupboard they were stored in was in a corridor, adjacent to the public waiting area. Bereavement office staff said they would make arrangements to discuss this with their manager.
- We reviewed 12 do not attempt cardio pulmonary resuscitation (DNACPR) forms.
- We saw that the forms had been signed appropriately by a senior member of staff and in the main showed evidence of valid discussion with the patient or their family if the patient lacked capacity. Medical staff were able to describe the procedures for DNACPR forms.
- On one ward a patient had been identified as nearing the end of life and did not have a DNACPR in place, despite medical staff saying this was needed. We also saw there was no evidence in the patient’s notes to show any discussion had taken place about this or their rapid discharge, which was clearly underway. Staff involved agreed this had been an oversight.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- We saw evidence of best interest meetings when discussions about DNACPR and end of life care took place. These included documented discussions of conversations with people’s families or the involvement of Independent Mental Capacity Advocates. (IMCA’s).
- We did not see documentary evidence of mental capacity assessments for patients identified as not having capacity to discuss or consent to DNACPR decisions, in any of the 12 that we looked at. This would be best practice and the trust had procedures and documentation for use in these circumstances. Some medical staff said they assessed capacity by considering CUIRB principles. (Conversation, Understanding, Information, Retention and Balance). However, they agreed they did not always document this to show it had been done. A ward sister said capacity assessments ‘must be done’. However, they could not recall ever having seen one.
- A number of staff could not recall having undertaken training in the Mental Capacity Act. One staff member was completely unaware of it.

Mandatory Training

- The SPC Team had produced an education and training programme to deliver all aspects of palliative and end of life care training.

Good

End of life care

- We saw this included Introduction to the palliative care team, end of life care, communication skills, symptom management and end of life care and discharge.
- Despite this extensive training programme, not all staff were aware of it or knew how to access it. It was not seen as mandatory training by the trust. We were told on one ward that it was up to individual staff if they wished to do this training, that there wasn't enough of a 'push' to encourage staff to do the training.
- We asked for the percentage of staff who had completed training in aspects of end of life care. The trust were not able to provide this information as a percentage. They did however provide us with a record of numbers of staff who had completed training in the last year.
- We were told that the SPCT were promoting the development of end of life care champions through ward based link nurses for palliative care and a senior clinicians development programme. A member of the SPCT said, "Some clinicians and teams have really embedded end of life care."
- A ward sister told us there had been a patient care and safety day where the new documentation for care of the dying patient had been introduced and discussed.
- A junior doctor said they received training on end of life care at the start of their placement and this included symptom control.
- A nurse spoke of the palliative care link nurse on their ward, saying they regularly attended training from the SPC Team and cascaded this to the ward staff.

Are end of life care services effective?
(for example, treatment is effective)

Good

Use of National Guidelines

- The SPCT based the care they provided on the NICE Quality Standard 13- End of Life Care for Adults.
- We saw there was information displayed on wards or available via the trust's intranet on the 10 Key Steps- Caring for patients in the last hours of life. This is also based on the above mentioned NICE quality standard.

We saw the trust had acted on the Department of Health's National End of Life Strategy recommendations. They had introduced the AMBER care bundle. This is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place should end of life care be planned.

Outcomes for the unit

- The hospital contributed to the National Care of the Dying audit. The audit includes an organisational set of 7 key performance indicators and also a set of 10 clinical key performance indicators. The clinical KPIs are derived from a case note review of a minimum of 50 notes, which assess how far the trust is meeting national guidance. The case note review is for patients with an expected death. The trust has achieved 5 out of the 7 indicators. The trust had a higher rate of case notes achieving the standards when compared to the national rates.
- The trust had recently (in the last month) introduced new Care of the Dying Patient care plans to replace the Liverpool Care Pathway. We were told that a future audit of the use of these was planned to assess their effectiveness.

Care Plans and Pathway

- The trust had responded to the national withdrawal of the Liverpool Care Pathway (LCP) by developing their own guidance and care plan documentation on end of life care. Our review of this showed it was a good tool to promote partnership working and all aspects of effective planning and discharge to enable death in the preferred place.
- Staff were aware of the guidance and documentation and how to access support from the SPC Team regarding its use. Most staff felt positive and confident to use this new documentation. One ward sister was unaware of the documentation as they had not yet used it.
- Discussions with the Chief Medical Officer and palliative care consultant indicated that the SPCT had taken responsibility for the introduction and development of the new guidance and care plans for end of life care. There was no evidence of engagement with the Trust Board.

Multidisciplinary Team working

- The SPCT included a full time social worker and a part time pharmacist.

Good

End of life care

- The SPCT met twice weekly with the multi- disciplinary team caring for patients on end of life care. This could include consultants, pain consultants, chaplains and liaison psychologists.
- The palliative care consultant told us that they worked alongside district nursing and hospice staff to ensure rapid discharge and people's preferred place of death was achieved. We were given information which indicated there was an increasing proportion of people dying at home rather than in hospital. (2007- 34%; 2012 39%).
- Ward staff told us they felt well supported by the SPCT and could gain useful advice and information.

Seven day services

- The SPCT were available 9-5pm Monday to Friday with consultant on-call advice available out of hours.
- The Palliative Care Consultant told us they were now looking to extend availability of face to face support to seven days per week and were currently assessing the support networks they needed to put in place to facilitate this. For example, lone working of a cancer nurse specialist.

Are end of life care services caring?

Good

Compassionate Care

- Throughout our inspection we saw patients were overall treated with compassion, dignity and respect. However, one patient told us they had been very upset at being given some bad news about their prognosis when alone without the support of their family.
- We looked at patient's records and found they were completed sensitively and detailed discussions that had been held with patients and their families. We saw that people were given time to come to terms with the situation they were in.
- Patient's records showed care plans were in place to ensure comfort and symptom management and control. Staff described the care they delivered with confidence and compassion.
- Normal visiting times were waived and car parking permits were provided for relatives of patients who were at the end of their lives.
- A patient said, "I'm amazed at how well I have been treated, really have been very pleased." They said staff were prompt in responding to any requests for assistance and that on the whole there were enough staff but some days could be busier than others. On the day of our visit they said they were just having a 'quick wash' as the staff were busy.
- Another patient said, "Care was excellent, staff were enthusiastic and always went that extra mile."
- Staff demonstrated commitment and compassion to enabling good end of life care and dignified after death care.
- We spoke with a specialist consent nurse for requested post mortems. They demonstrated their passion and commitment to ensuring a duty of care to the deceased as well as the relatives. Memory boxes were provided for those that wanted them. The items included locks of hair from their loved ones, plaster cast hand prints and remembrance candles. The nurse offered reassurance, support and explanations to the bereaved and said that they would remain present for the post mortem of their loved one.
- Staff continued to treat patients with dignity and respect after their death. We saw that mortuary staff referred to the deceased people by their name at all times.
- The chaplain staff demonstrated a caring and compassionate approach towards patients, relatives and staff who may be distressed. The Chaplaincy Annual Report of 2012 showed that 16,273 visits had been made throughout the trust of which 122 hours of pastoral counsel was provided to staff.
- Bereavement office staff spoke of the new property bags that had been introduced for the collection of the deceased property. These were more suitable and dignified than the previously used plastic carrier bags.
- We observed a bereavement officer speaking on the telephone with a bereaved relative regarding the possibility of a post mortem and explaining why. Discussion was compassionate, informative and frequently sought whether they had any questions.
- We saw a large number of thank you cards displayed on a notice board on one of the oncology wards. There were positive comments received from families whose loved ones had been cared for on this ward. Comments included; 'Thank you for all the support you gave our

Good

End of life care

mum and made her last days as comfortable as you could.' And 'Thank you for looking after (name of person) with such care and compassion. It made all the difference in her final days.'

Patient Involvement in Care

- Patients said they felt involved in their care. Comments we received included, "See doctors more or less every day" and "Always informed of care."
- We saw from patient's notes that full discussions took place with patients and their families regarding care, treatment, prognosis, discharge and preferred place of death.

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

(for example, to feedback?)

Good

Access

- Staff reported that patients were usually seen within 24 hours of referral to the SPCT. They spoke highly of the responsiveness of the team. Some staff said the team were often there within 20 minutes of being called.
- We saw from a patient's notes on one ward that a referral to the SPCT had been overlooked, causing a delay and the need for a re-referral.
- Records we looked at showed that the SPCT received over 1,000 in-patient referrals per year.
- Figures showed that in 2013/14 the vast majority of the referrals were for cancer patients (915 out of 1063).
- Where possible, side rooms were prioritised for people who were at the end of their life.
- The bereavement office had procedures in place to try to ensure timely issue of death certificates. However, they said the only complaints they ever received were about delays in this due to waiting for medical staff to complete the death certificates. They said they fed this back to staff teams to try and improve matters and make sure they had more time to spend with families rather than 'chasing up' medical staff.

Discharge arrangements

- Most staff showed a real commitment to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of death. However, on one ward a patient told us they wished to go home to die but arrangements were not suitable. Staff seemed unaware of the support mechanisms that could be put in place to enable this wish to be realised.
- On another ward we were told that rapid discharge can be facilitated within at least 48 hours; with equipment, care, symptom control drugs package and district nurse response in place.
- A social worker told us they followed up patients in the community once they were home to make sure all the arrangements were in place and working.
- We noted in one patient's notes that they had been identified for a fast track rapid discharge due to having been identified as nearing the end of their life. However, while in the hospital waiting for this to be arranged they had been moved from a medical admissions ward at 11-30pm. We saw their relative had complained and a meeting had been arranged with the relative and an apology given.
- A palliative care ambulance was available to enable rapid discharge. This could be booked outside of normal transport arrangements.
- There was a dedicated palliative care discharge facilitator who facilitated discharge for all patients whose preferred place of death was home. They worked alongside community nursing staff to enable this.

Meeting the needs of all people

- Interpreters were available when necessary. However, information leaflets from the bereavement office on what to do after a death were not available in any alternative languages or formats. Staff said they may ask the interpreters to translate information if needed but said they had not done this as yet and usually relied on families.
- Multi faith chaplaincy was available 24 hours a day seven days a week. Arrangements had been made with the mortuary and local coroners to ensure where necessary, for religious and cultural reasons, bodies could be released promptly.
- When looking at the way patients and their families were involved in decisions whether a DNACPR was appropriate, we saw that in one patient's record there had not been a discussion with their family despite the family being involved with the patient.

Good

End of life care

- A staff member said the Chapel of Rest had been redecorated, and updated to present as more homely and less funereal in response to suggestions made. They also said that bariatric fridges had been installed in the mortuary in response to the increasing need for this.
- There was a range of viewing rooms and a Chapel of Rest to enable relatives to spend time with their deceased loved one. There was a separate Chapel of Rest for babies and small children. The Chapel of Rests were multi-cultural, private and suitably furnished and decorated.

Facilities for relatives

- Rooms were available on site for relatives of patients at the end of their lives. Pull out beds were also available if relatives wished to stay in the room with their loved one.
- There was also a hotel facility at this hospital for relatives to use.
- We noted there was a lack of literature/leaflets on end of life care available on the wards we visited.
- The A&E department did not have a separate viewing area for relatives to spend time with their deceased relative. We were told that they sometimes use the paediatric resuscitation bays for a viewing area as no other options were available. This was not a pleasant environment for relatives.

Communication with GPs and other departments within the trust

- On discharge a letter was sent to the GP detailing the events of the admission. This system was an electronic discharge letter and included details of all medications.
- A telephone advice service for the SPCT was available 24 hours a day seven days a week. GPs could gain access to advice from a palliative care consultant via this service.

Complaints handling (for this service) and feedback mechanisms

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint then they would speak to whoever was in charge of the ward or department. If their concern was not able to be addressed to their satisfaction in this way they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the hospital and was displayed on multiple posters in several languages.
- Staff were able to describe the above procedures for the handling of complaints. They confirmed that the findings from complaints were shared with them in order to improve the service delivery.
- No-one we spoke with could recall any complaints related to end of life care.
- A member of the chaplaincy service spoke about a complaint received and how this had been investigated and resolved. It was clear from the discussion that lessons had been learned and actions taken to prevent re-occurrence.

Are end of life care services well-led?

Good

Leadership of service

- The trust told us their executive lead for end of life care was the Chief Medical Officer. However, none of the staff we spoke with had any awareness of this. They knew who the palliative care link nurse was on their ward and generally thought the lead must be someone in the SPCT.
- We received a report showing there had been a development programme for senior clinicians in end of life care, October 2011- April 2013. We were told that the programme had been designed to promote learning and changes in practice in end of life care issues such as communication, delivering bad news and issues such as DNACPR. Participants in this training now acted as an expert reference group for the implementation of the End of Life Care Strategy (2008) and NICE Quality Standards (2011).
- All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service.
- Staff said that they felt well supported by managers who worked alongside them. A staff member said they were, “Impressed by the engagement of the senior management team.”

Culture within the service

- The Chief Medical Officer told us, “The most important part of the job for me is to lead and support the nineteen Clinical Service Units, helping doctors and lead nurses to believe in themselves.”

Good

End of life care

- Staff said they felt they were kept updated by the new Chief Executive on what the trust was doing and how they could be involved.

Vision and strategy for this service

- The trust was rolling out "The Route to Success-Achieving Quality in Acute Hospitals" (from the National End of Life care Programme), which sets out clear guidance for hospital teams on how to improve end of life care. The SPCT had secured funding to implement this.
- This guidance included; use of holistic assessment to include spiritual and psychological support, multi-disciplinary and partnership working, monitoring and acting on complaints, advanced care planning, carer's assessments and adequate palliative care consultant cover.

Governance, risk management and quality measurement

Staff showed a commitment to improving quality and the patient experience. Information on wards, known as the 'Safety thermometer information' showed that patient care and experience were monitored and acted on when not up to the standard required. For example, falls and pressure ulcer prevention.

- However, work was still required to ensure that mental capacity assessments were taking place and that systems ensured that patients and their families were appropriately involved in end of life decisions such as DNACPR.

Innovation, learning and improvement

- A palliative care team consultant spoke of how they wanted to improve palliative care within the city. They were currently looking at an initiative of a 'managed clinical network' to assist in the management and complexity of joint working in end of life care. They also spoke of an initiative they were supporting to introduce nurse led beds in care homes, working alongside a local hospice to facilitate this.
- They also said they were aiming to have discharge teams within the trust to be able to facilitate and improve rapid discharge. They said they were doing this as a response to an audit they undertook which recognised the need for this specialised role.
- One of the wards we visited had a display board with the 10 steps of end of life care displayed and written in 'patient friendly' terms. There was also a large display board for with information for patient's relatives and patients who were approaching the end of life. The board had leaflets from the SPCT, information from the multi-faith chaplaincy service, information on advanced care planning and contact points for once at home in the community.

Good

Outpatients

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

Information about the service

Leeds Teaching Hospital NHS Trust provided a range of outpatient clinics with just under one million patients attending each year. At St James University Hospital (SJUH) approximately 390,000 patients attended outpatient clinics in 2012-2013. During the week of our inspection there were 33 speciality services providing outpatient clinics at the SJUH.

At Seacroft Hospital around 51,000 patients attended outpatient clinics in 2012-2013. During the week of our inspection there were 16 speciality services providing outpatient clinics at Seacroft Hospital. The trust had a dedicated outpatient department with dedicated outpatient staff.

The trust employed 220 nursing staff (Registered and Unregistered) who are supported by approximately 350 administrative and reception staff to provide and support outpatient services.

We inspected Elderly Medicine, Oncology, Cardiology, Opthalmology, Endcrinology, Rheumatology, Sleep clinic, Breast Unit, Gynaecology and Dermatology outpatient clinics at SJUH. We spoke with 23 patients and carers, 14 staff and looked at seven sets of patient notes. We looked at the patient environment, the availability of equipment, cleanliness and we looked at information provided to patients.

At Seacroft Hospital we inspected Neurology and Cardiology outpatient clinics and the Disablement Service Centre. We spoke with 14 patients and carers, six staff and looked at four set of patient notes. We looked at the patient environment, the availability of equipment, cleanliness and information provided to patients.

Summary of findings

Outpatients' services at both St James's University Hospital and Seacroft Hospital were rated as good. Staff at all levels told us they felt encouraged to raise concerns and problems. Patient outpatient areas were appropriately maintained and fit for purpose. Incidents were investigated using root cause analysis methodology. Staff and patients and their relatives were kept informed about the progress of the investigation. Actions were taken following incidents to ensure lessons are learned, improvements were shared across the departments and hospitals. The infection control procedures were adhered to in the clinical areas and they appeared clean and regularly reviewed. Staffing levels were adequate to meet patient need.

The hospital completed surveys and took part in audits to improve the quality of the service. Performance information was monitored and was readily available to staff and patients. There was multidisciplinary team working that met patient needs and delivered positive outcomes.

Patients told us they felt involved in their care and treatment. Patients felt staff supported them with making difficult decisions. The hospital provided interpretation services to ensure where there was a barrier for patients to communicate effectively these were overcome using different approaches. Patients told us they felt their privacy and dignity was respected. Analysis of patient feedback was generally good at both St James's University Hospital and Seacroft Hospital, although cancelled appointments the day before or on the day and delays in appointments were reported.

Good

Outpatients

Staff understood the vision and values of the organisation. Staff and patient engagement was encouraged to achieve continuous improvement. Staff felt supported by the local management team.

Are outpatients services safe?

Good

Cleanliness, Infection control and hygiene

- NHS Choice received 21 responses between June 2013 and February 2014 from patients who attended Seacroft Hospital and rated the hospital 3.5 stars out of 5 stars for cleanliness. Three patients told us the hospital was very clean and they saw staff wash their hands.
- At both hospitals we saw that bare below the elbow policies were adhered to by staff. Clinical areas were clean. We saw staff regularly wash their hands and use hand gel between patients. Toilet facilities were clean.
- There were weekly cleaning audits within the departments that showed the clinics were cleaned and any issues were identified and improvements to the cleaning schedule were implemented
- The service completed infection control audits. An infection control audit had been completed 6 months ago and improvements had been implemented. For example the outpatient department at SJUH and Seacroft Hospital changed practice and introduced single-use tourniquet for phlebotomy

Staffing

- There were adequate numbers of staff available to meet patient's needs. Staff and patients told us there was always enough staff. We looked at the numbers for staffing agreed by the trust and these matched the number of staff working on staff rotas.
- We looked at the bank shifts for the SJUH and 80 % of bank shifts were filled to cover outpatient clinics with 10% of bank shifts partially filled and 10% of banks shifts left unfilled between October 2013 and December 2013.
- We looked at the bank shifts for Seacroft Hospital outpatient clinics between October 2013 and December 2013 and found 100% of bank shifts were filled.
- Staff told us staff were transferred from other outpatient departments to cover the unfilled bank shifts.

Incidents

- We looked at 49 incidents reported between October 2013 and February 2014 by the outpatient department at the SJUH. We looked at seven incidents reported between October 2013 and February 2014 at Seacroft Hospital.

Good

Outpatients

- Incidents reported included patient falls, documentation issues, and medication incidents.
- Staff told us they did not always report missing notes as an incident, but the medical records department did record the number of temporary notes for each clinic. Missing notes were escalated to the senior clinician.
- The most recent serious untoward incident led to a full root cause analysis. The results of learning from this had been disseminated by face to face meetings and emailed weekly newsletter.
- Staff stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at weekly meetings and staff were able to give us examples of where practice had changed as a result of incident reporting. A serious incident reported in ophthalmology resulted in a patient identification checklist being developed and used within the outpatient department.

Environment and Equipment

- The environment in the outpatient areas was safe and fit for purpose.
- Staff had worked with the estates department to create clinical areas to facilitate confidentiality and more consulting rooms.
- We looked at equipment and found it was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas. Staff confirmed they had enough equipment.
- Resuscitation trolleys in outpatients were centrally located and checked regularly.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- In a clinic area at SJUH we found that daily fridge temperatures for medications had not been completed since January 2014. We raised this with the sister for the outpatient area. We checked the next day and found the fridge temperature had been checked.
- Patients were adequately counselled for new medication and written information was given.
- FP10s prescription pads were securely locked away.

Records

- Staff told us it was very rare for them to not have the full set of patient's notes in front of them. However, we did find temporary patient notes were only available for some outpatient appointments.
- Some patient notes were difficult to navigate and find the latest information relating to the outpatient appointment.
- Regular audits were undertaken to monitor availability of records and demonstrated only 2% of records were not available for the previous quarter of outpatient appointments. Availability of records was discussed at monthly team meetings attended by clinic and administration staff.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Staff told us they had completed Mental Capacity Act (2005) training. However, we found outpatient staff in most areas did not understand the Mental Capacity Act (2005) and how this related to outpatients in terms of best interest decisions and the vulnerable adult. Staff told us they had not had to use the mental capacity assessment because they felt it did not need to be used in outpatients.

Mandatory Training

- We looked at staff mandatory training records. The trust had a target of each directorate achieving 80% compliance. Records confirmed that 81% of staff were up to date with their mandatory training.

Are outpatients services effective?
(for example, treatment is effective)
Not sufficient evidence to rate

One stop clinics

- The Breast Unit ran a one stop clinic so patients could access the treatment required at the time of a visit and within the department.
- The Endocrinology service had access to the day unit for patient tests to enable patients to access tests and treatment when attending an outpatient appointment.

Multidisciplinary or Specialist nurse clinics

- There was access to multidisciplinary teams and specialists within outpatient clinics.

Good

Outpatients

- The trust provided care and treatment for prosthetics and orthotics as part of the Specialist Rehabilitation Service. The service had also been developing links with the armed forces at Catterick, Europe's largest military garrison to provide care and support to the armed forces.
- The trust provided a nurse led clinic for neurology patients for follow up appointments at the neurology clinic.

Use of National Guidelines

- The outpatients department followed best practice and trust guidelines in the care and treatment of patients.
- The trust had completed audits and surveys in the outpatient clinics. These included audits to understand why patients did not attend (DNA) clinic. The hospital had implemented a system to text message or phone people in advance to remind them about appointments.

Availability of urgent / next day clinics

- Staff told us they would be able to offer urgent appointments. We spoke with a patient who had attended the clinic on the day of our inspection without an appointment and it was arranged for them to see the consultant in the afternoon.

Are outpatients services caring?

Good

Compassionate Care

- The trust had participated in the outpatient survey in 2011 and patients scored the trust 9.6/10 for being given enough privacy when discussing their condition or treatment.
- We looked at the Friends and Family response for endocrinology and dermatology clinics. Comments from patients included: "I always get extremely good care and more," "The care I have had from medical and all the staff has been excellent, and the cleanliness of this hospital is very good" and "care was very good, cured in 6 months."
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- We looked at patient records and found they were completed sensitively and detailed discussions that had been had with patients and their relatives.
- The environment in the outpatient department allowed for confidential conversations.
- Chaperones were provided where required.
- Patients who were kept waiting for appointments or transport were offered drinks and had their needs assessed

Patient involvement in care

- Patients stated they felt that they had been involved in decisions regarding their care.
- In the outpatient survey the trust scored: 9.1/10 for feeling the doctor listened to what they had to say. 8.6 /10 for being involved as much as they wanted to be in decisions about their care and treatment. 9.3 /10 for not being told one thing by a member of staff and something quite different from another.
- The Family and Friends responses for the endocrinology and dermatology clinics collected between October 2013 and January 2014. Comments included: "Doctor told me in detail and explained things that I didn't understand," "Specialist knowledge explained fully, given me confidence," and "Doctor explains things so I understand and answers any questions that I may have."

Emotional Support

- Patients and relatives told us they had been supported when they had been told a difficult diagnosis and had been given sufficient support. Patients were given the contact name and details of a named member of staff who would be available to answer questions and provide information about other organisations who may be able to provide information and advice.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Key responsiveness facts and figures

- Analysis of data showed that there was no evidence of risk for referral to treatment under 18 weeks, non-admitted pathway, diagnostic waiting times for patients waiting over 6 weeks for a diagnostic test or for all cancers the 62 day wait for first treatment from an urgent GP referral.

Good

Outpatients

- We observed that cancellations, delays in clinics and waiting times were displayed in the clinic areas. These were reviewed monthly and changes made to the management of clinics to reduce waiting times for follow-up appointments. We looked at the outpatient matron minutes, which showed discussions and changes were made to clinics. For example a project had been implemented to monitor the need for ad hoc clinics in October 2013.
- There was a mixed response regarding waiting times at SJUH some patients told us they were allocated enough time with staff when they attended outpatient clinics. However, others told us that they were not told clinics were running late and why there was a delay in their appointment times.
- We looked at responses by patients in the Dermatology and Endocrinology clinic Family and Friends test. Positive comments included, “Service was prompt and very efficient and usually the appointment times were very good, with not long to wait,” “Seen to promptly,” and “not kept waiting for very long.” However, some comments included: “excellent care, improve waiting time,” “Waiting times could be improved by texting patients if there is an hour + delay” and ”A long wait - 1 hour.”
- Some patients told us they were informed about how long they would have to wait. However, two patients told us they did not know why their appointments were delayed and how long the wait would be.

Ensuring attendance

- At Seacroft Hospital patients told us they were allocated enough time with staff when they attended outpatient clinics. Patients told us the following comments, “Fantastic service”, “Nurses explained everything thoroughly” and “Seacroft is a smashing little hospital, should be used more, better than St James.”
- Patients were sent an initial letter with a map of the hospital, information about where the clinic was in the hospital, what to expect, the contact number for cancellations or postponing an appointment.
- The trust had improved their DNA rate by using text messaging and automatic telephone messaging. We spoke with the director for informatics who showed us the outpatient dashboard, which showed in the areas where text messaging had been introduced DNA rates had fallen.
- There was good signage on the main corridors directing people to clinic areas.
- Lifts had audio notices next to them and signage information was also written in Braille.

Access for all patients

- Clinics for bariatric patients were based at SJUH. The term bariatric refers to a branch of medicine which deals with the causes, prevention as well as treatment of obesity. The clinic was well equipped and organised.
- There was support for patients living with dementia and learning disabilities. Information was available for patients and their carers. Outpatient clinics were wheelchair accessible.
- There was visually and hearing impaired support. There was a hearing loop for hearing impaired patients
- Signers were available to attend clinics to support patients with a hearing impairment.
- Clinics had access to interpreters and also access to a translation telephone service.
- Written information was available in several languages and large print on request.

Communication with patients and GPs

- Letters were sent to the GP and the patient within one week of the outpatient clinic.
- The hospital audited GP referrals and appropriateness of referrals and fed back to the GP.

Environment

- At both SJUH and Seacroft Hospital car parking was easily available. At Seacroft Hospital there was a set fee for parking for a single outpatient appointment irrespective of the length of time patients waited for their appointments. There were coffee shops in reception areas of the hospital with a wide range of snacks and hot and cold drinks
- There were drinks and snacks available for patients attending the outpatient clinics.
- At Seacroft Hospital the waiting areas had been re-designed into separate specialist areas for example patients living with dementia and information about dementia was available in the area. The waiting areas were spacious and well laid out with a good patient flow between waiting, consultation and treatment areas.
- Patient transport was provided by Yorkshire Ambulance Service NHS Trust (YAS) through a region wide contract.

Good

Outpatients

We looked at the regional contract minutes for YAS and they were achieving the performance indicator that 75% of patients did not have to wait longer than one hour once they were ready to go.

- The trust transport department completed a patient experience survey in August 2013. The trust received 37 responses from patients attending outpatients at the SJUH. Transport for 32 patients had arrived on time, transport for two patients arrived between 15 and 30 minutes late and transport for one patient arrived between 30-60 minutes late. Following their appointments 33 patients waited between 0 minutes to 60 minutes and three patients had to wait between one to two hours for transport home. 31 patients scored the service as being extremely satisfied with the service. Concerns are shared with YAS via the regional Clinical Commissioning Group contract monitoring meeting.

Complaints handling (for this service)

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the outpatient matron, but if this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was depicted on multiple posters in several languages.
- Complaints were discussed at department meetings and themes and trends were fed back to staff. We looked at 111 complaints received by the trust between July 2013 and January 2014. Some complaints had identified concerns about waiting times and we saw these had been discussed in nursing meeting minutes.

Are outpatients services well-led?

Good

Leadership of service

- There was a leadership structure for the department and staff understood the structure, who their line manager was and who they reported to on the structure.
- The executive directors and senior staff undertook regular 'walkarounds' in outpatient areas to 'go and see' the service and talk to patients.
- Junior doctors felt supported. We looked at the Yorkshire and Humber Trainee survey 2013, comments for endocrinology, ophthalmology and genito-urinary medicine included: "St James is a busy eye department with access to fantastic pathology. It has very supportive and willing consultants. My clinical and educational supervisors have been excellent," "very well supported, useful variation between ward work and clinics," and " Very friendly, organised department, gained a lot of clinic experience."

Culture within the service

- Staff within the service spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff repeatedly spoke of a flattened hierarchy and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care. Staff told us they felt well supported. One member of staff told us they were, "Very proud of the team and how they supported each other." Staff told us they felt supported by the matrons for outpatients and felt they could raise concerns.
- Staff felt that the department focused on the importance of a positive experience for patient care.
- Openness and honesty was the expectation within the department and was encouraged at all levels.
- Staff worked well together and there was obvious respect, not only between the specialities, but across disciplines.

Vision and strategy for this service

- The trust vision was visible throughout the wards and corridors. Staff were able to repeat the vision to us at focus groups and during individual conversations.
- Staff were aware the trust had implemented an outpatient transformation project to improve the quality of the outpatient services, which was reviewing:
- DNA Rates
- Text & Voice Reminders
- Hospital Cancellations
- Repeat Hospital Cancellations
- Appointments cancelled by patients
- Late Additions (Clinics booked within less than 24 hours to start)
- % patients seen within 30 minutes
- Patient insight
- Clinic utilisation

Good

Outpatients

Governance, risk assessments and quality measurement

- Quarterly governance meetings and weekly team meetings were held within the CSU and all staff were encouraged to attend, including junior members of staff. We looked at the minutes for October 2013, November2013 and December 2013 and March 2014 and found complaints, incidents, audits and quality improvement projects were discussed.
- A quality dashboard for outpatients was presented so that senior staff understood what 'good looks like' for the service and what they were aspiring to be able to provide.
- Staff on the frontline had the same 'worries' as those at the top of the CSU.

Innovation, learning and improvement

- The trust had begun to use text messaging and automatic telephoning to remind people about appointments. This had reduced the DNA rates for appointments. In addition, appointments were now not booked until six weeks before they were required, which had also reduced the DNA rates for services using the scheme.
- Innovation was encouraged from all staff members across all disciplines. Every junior doctor and student nurse was involved in a quality improvement project and staff were able to give examples of practice that had changed as a result. The ward manager at Seacroft Hospital had involved staff in the development of the care and compassion standards. We looked at minutes for staff meetings which included discussions about the care and compassion standards. Doctors told us they were involved in quality improvement projects.
- Outpatient staff at Seacroft Hospital had developed a Quality Manual and Care and Compassion Standards which included competencies for staff to achieve and this was being shared across all the outpatient departments.
- The Macular Degeneration Clinic at SJUH and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.
- The Disablement Service Centre at Seacroft had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.
- The Specialist Rehabilitation Centre at Seacroft Hospital had produced a DVD for current and future users of the service. It covered a general introduction to the service and information on the services the team provides. These include prosthetics, orthotics, wheelchairs, occupational therapy and physiotherapy.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder and injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 9: Care and welfare of service users (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to – (i) meet the service user's individual needs, (ii) Ensure the welfare and safety of the service user Nursing and medical handovers were not consistently ensuring that the appropriate information was passed to the next shift of staff and recorded, which put service users at risk. There was no oversight of the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors. Systems to ensure that risk assessments were appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices were not effective. There was a risk to patients due to a lack of anaesthetic staff, which had resulted in unsupervised trainees anesthetising patients. There was no peripatetic anaesthetist available to oversee trainees or provide emergency cover.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder and injury	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Staff were not always assessing the mental capacity of service users to ensure that the ability to consent was appropriately ascertained.

Regulated activity	Regulation
Treatment of disease, disorder and injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI, particularly on medical elderly care and surgical wards, including the availability of anaesthetists and medical cover out of hours and at weekends in order to safeguard the health, safety and welfare of service users.

Regulated activity	Regulation
Treatment of disease, disorder and injury	Regulation 23 (1) (a) & (b) HAS 2008 (Regulated Activities) Regulations 2010 Supporting workers. There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had completed their mandatory training or had the opportunity to attend training to enhance or maintain their skills. Not all staff had received an appraisal or had appropriate supervision.