

Leeds Teaching Hospitals NHS Trust

St James's University Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Good



Medical care (including older people's care)

Good



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Good



End of life care

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Leeds Teaching Hospitals NHS Trust is one of the largest trusts in the United Kingdom and serves a population of around 780,000 in Leeds and up to 5.4 million in surrounding areas, treating around 2 million patients a year. In total the trust employs around 15,000 staff and provides 1785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital. Day surgery and outpatient services are provided at Wharfedale Hospital and outpatients services are also provided at Seacroft Hospital. The Leeds Dental Institute, although part of the trust, was not inspected at this inspection.

We carried out a follow up inspection of the trust from 10 to 13 May 2016 in response to the previous inspection as part of our comprehensive inspection programme in March 2014. We also undertook an unannounced inspection on 23 May 2016 to follow up on concerns identified during the announced visit.

Focussed inspections do not look across a whole service; they focus on the areas defined by information that triggers the need for an inspection. Therefore, we did not inspect all the five domains: safe, effective, caring, responsive and well led for each core service at each hospital site. We inspected core services where they were rated requires improvement. We also checked progress against requirement notices set at the previous inspection due to identified breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the March 2014 inspection, we issued a number of notices, which required the trust to develop an action plan on how they would become compliant with regulations. We reviewed the trust's progress against the action plan as part of the inspection.

We inspected the following locations:

At Leeds General Infirmary (LGI), we inspected the following domains:

- Urgent and emergency care (A&E) - safe and effective
- Medicine - safe, effective, responsive and well-led
- Surgery - safe, responsive and well-led
- Critical care - safe, responsive and well-led
- Maternity and gynaecology - safe
- End of life care - safe

We inspected the following domains for children's and young people's services at the Children's Hospital, which is reported in the LGI location report – safe, responsive and well-led.

At St James's University Hospital (SJUH), we inspected the following domains:

- Urgent and emergency care (A&E) – effective
- Medicine – safe, responsive and well-led
- Surgery - safe, responsive and well-led
- Critical care - safe, responsive and well-led
- Maternity and gynaecology - safe
- End of life care - safe

At Chapel Allerton and Wharfedale Hospitals, we inspected the safety domain within surgery.

We did not inspect the Leeds Dental Institute and we did not inspect the outpatients' services across the trust as these had previously been rated as good.

We did not inspect the caring domain across the trust as this was rated as good across all trust services at the previous inspection.

Summary of findings

Overall, we rated the trust as good. We rated safe as requires improvement, effective, responsive and well-led as good. We rated Leeds General Infirmary and St James's University Hospital as requires improvement, Chapel Allerton Hospital as good and Wharfedale Hospital as good.

Our key findings were as follows:

- Since the last inspection, the trust had invested time, effort and finances into developing a culture that was open, transparent and supported the involvement of staff, and reflected the needs of the people who used the services.
- Changes such as the development of clinical service units and governance arrangements that were in their infancy at the last inspection had been further embedded and embraced by staff in the organisation.
- Each clinical service unit had clear direction and goals with steps identified in order to achieve them.
- The leadership team had remained stable. Staff across the organisation were positive about the access and visibility of executives and non-executives, particularly the Chief Executive. There had been improvements to services since the last inspection.
- The leadership team were aware of and addressing challenges faced with providing services within an environment that had increasing demand, issues over patient flow into, through and particularly out of the organisation, including the impact this had on service provision; and the recruitment of appropriately skilled and experienced staff.
- The trust values of, 'The Leeds Way' were embedded amongst staff and each clinical service unit had a clear clinical business strategy, which was designed to align with the trust's 'Leeds Way' vision, values and goals. This framework encouraged ownership from individual CSU's.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.
- Staff reported across the trust that they were proud to work for the organisation and felt that they worked well as a team across the different sites.
- The trust invited all 15,000 staff to participate in the national staff survey, with a response rate of over 8,000 staff across the organisation. The survey showed that there was continuous improvement. The response rate for the NHS Staff Survey 2015 was 50%, this was better than the England average of 41%.
- At service level there were governance processes and systems in place to ensure performance, quality and risk was monitored. Each CSU met weekly and used the ward health check to audit a range of quality indicators including the number of falls, complaints, pressure ulcers, staffing vacancies and staff sickness. This information was then escalated to senior staff and through the trust's governance structure.
- There was a positive culture around safety and learning from incidents with appropriate incident reporting and shared learning processes in place. However, learning from Never Events was not consistent amongst all staff within theatres. All steps of the World Health Organisation (WHO) safety checklist were not consistently taking place: audit data and our observations supported this. The audit data provided by the trust did not assure us that national early warning score (NEWS) and escalation was always done correctly.
- There were occasions when nurse and care support worker staffing levels were below the planned number. Despite having a clear escalation process, non-qualified staffing levels did not always mitigate for the reduction in qualified nursing levels. Nursing, midwifery and medical staffing levels did not meet national guidelines in some areas, particularly surgery, theatres, critical care, maternity and children and young peoples' services. The trust was actively recruiting to posts and supporting a range of role development programmes to diversify the staff group, including supporting advance roles and role specific training for non-qualified staff.
- Arrangements and systems in place were not sufficiently robust to assure staff that the maintenance of equipment complied with national guidance and legislation.
- There were arrangements in place for assessing the suitability of patients who were appropriate to wait on trolleys on the assessment ward. However, these were not consistently applied, or risk assessments undertaken. There was a lack of robust assurance over the oversight of patients waiting on trolleys.

Summary of findings

- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. In accordance with trust policy, a two stage consent process including two patient signatures was not consistently evidenced in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- There was a much improved mandatory training programme. However, there were still low completion levels in some training, particularly resuscitation and role relevant safeguarding.
- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated there was no evidence of risk compared to the England average.
- There were suitable arrangements in place for the prevention and control of infections, including policies, procedures and a dedicated infection prevention control team. Areas visited were clean and staff generally adhered to good infection control practices.
- The trust responded to complaints and concerns in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns.
- The trust took into consideration the needs of different people when planning its services and made reasonable adjustments for vulnerable patient groups.
- There was clear guidance for staff to follow within the care of the dying person's individual care plan when prescribing medicines at the end of their life. Patients' individual needs and wishes at the end of their life were represented clearly in the documentation.
- Policies and guidelines were based on the latest national and international guidelines such as from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine.
- On the whole, patients received pain relief in a timely manner and were able to access food and drinks as required.
- Arrangements were in place to alert staff when patients were in receipt of treatment or admitted with special needs or were vulnerable, including living with dementia and learning disabilities. Staff had received training on how to support patients and individualise care to meet specific needs.
- Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients, although there was some inconsistent practice over care of patients receiving rapid tranquilisation treatment.

We saw several areas of outstanding practice including:

- There were outstanding examples of record keeping in the care of the dying person care plan. We saw that staff recorded sensitive issues in a clear comprehensive way to enable safe care to be given.
- The development of Leeds Children's Hospital TV allowed families to explore the wards and meet the teams.
- Organ transplantation which included a live liver donation and transplant programme had been undertaken, which was the largest in the UK. Other aspects of the transplantation programme included Neonatal organ retrieval and transplantation, Life Port Trial, Kidney Transplantation, QUOD Trial, Quality in Organ Donation National Tissue Bank, Revive Trial, Organ Care System and Normothermic perfusion, Support for Hand Transplantation.
- Procedures such as minimally invasive oesophagectomies were being performed. The colorectal team were using sacral nerve stimulation for faecal incontinence.
- There is a consultant led virtual fracture clinic. This allows patients to be assessed without attending the hospital and then have the most appropriate follow up. This reduces unnecessary hospital attendances.
- Revolutionary hand transplant surgery had taken place within plastic surgery.
- Nurse-led wards for patients who were medically fit for discharge had been introduced to allow the service to adapt their staffing model to meet the needs of patients.
- In response to patient carer feedback the acute medicine Clinical Service Unit had introduced John's campaign. This allowed carers to stay in hospital with patients with dementia.

However, there were also areas of poor practice where the trust needs to make improvements.

Summary of findings

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure all staff have completed mandatory training and role specific training.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.
- The trust must review the admission of critical care patients to theatre recovery areas when critical care beds are not available to ensure staff are suitably skilled, qualified and experienced.
- The trust must review how learning from Never Events is embedded within theatre practice.
- The trust must review the appropriateness of out of hours' operations taking place and take the necessary steps to ensure these are in compliance with national guidance.
- The trust must review the storage arrangements for substances hazardous to health, including cleaning products and sharps disposal bins to ensure safety in line with current procedures.
- The trust must review and address the implementation of the WHO Five Steps to Safer Surgery within theatres.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must review the function of the pre theatre waiting area in Geoffrey Giles theatres and ensure that the appropriate checks and documentation are in place prior to patients leaving ward areas.
- The trust must ensure that all equipment used across core services is properly maintained and serviced.
- The trust must ensure that staff maintain patient confidentiality at all times, including making sure that patient identifiable information is not left unattended.
- The trust must ensure that infection prevention and control protocols are adhered to in theatres.

In addition the trust should:

- The trust should review and improve the consent process to ensure trust policies and best practice is consistently followed.
- The trust should review the availability of referral processes for formal patient psychological and emotional support following a critical illness.
- The trust should review the provision of post-discharge rehabilitation support to patients discharged from critical care.
- The trust should ensure that appropriate staff have access to safeguarding supervision in line with best practice guidance.
- The trust should continue to monitor the safe and correct identification of deceased patients before they are taken to the mortuary and take necessary action to ensure this is embedded in practice.
- The trust should continue to work towards improving the assessment to treatment times within the ED department. The trust should also continue to work towards improving ambulance handover times and reduce the number of handovers that take more than 30 minutes.
- The trust should ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

We rated the emergency department as good because:

- We found that the department was effective. Patients were able to access treatment seven days a week, 24 hours a day delivered by staff from a number of different disciplines such as nurses, doctors and allied health professionals.
- Patients were treated by competent staff who followed nationally recognised pathways and guidelines. Records were audited to make sure that pathways and guidelines were followed correctly.
- On the whole, patients received pain relief in a timely manner and were able to access food and drinks as required.
- Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients.

Medical care (including older people's care)

Good



We rated medical care as good because:

- The service took into consideration the needs of different people when planning its services and made reasonable adjustments for vulnerable patient groups. The service responded to complaints and concerns in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.
- The trust values, of 'The Leeds Way' were embedded amongst staff and each clinical service unit had a clear clinical business strategy.

However:

- There were occasions when nurse and care support worker staffing levels were below the

Summary of findings

planned number. Despite having a clear escalation process, non-qualified staffing levels did not always mitigate for the reduction in qualified nursing levels.

- Patients identified as appropriate to wait on a trolley's on the assessment ward were not in line with the trust criteria and did not have a documented risk assessment.

Surgery

Requires improvement



We rated surgical services as requires improvement because:

- We were concerned that two Never Events had occurred relating to the wrong site anaesthetic block. Guidelines in place since 2010 were not embedded and not followed in both incidents. Learning from Never Events was not consistent amongst all staff.
- We found examples of the controlled drugs policy not being followed in relation to second signatures for administration.
- All steps of the World Health Organisation (WHO) safety checklist were not consistently taking place and audit data and our observations supported this.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- Mandatory training figures for resuscitation were below the trust target of 80%.
- The 18 week referral to treatment time indicator of 90% was not being achieved by all surgical specialities.
- The number of operations cancelled was higher (worse) than the England average.
- We were not assured that the operations taking place out of hours were always appropriate and we were concerned that the senior management team did not have oversight of this.

Summary of findings

- Whilst risk registers reflected risks to the service, several had been on the register for three years. Short term mitigation was still in operation which was affecting the ability to provide long term solutions.

However:

- A number of audits relating to patient safety were carried out and the results were publically available.
- We observed good documentation and appropriate use of antibiotics.
- Emergency equipment was checked daily.
- Nurse staffing was being managed well despite vacancies in a number of areas.
- Enhanced recovery pathways were in use and being developed for other specialities.
- We found good examples of meeting individual care needs of patients and ongoing collaborative working to further improve patient care.
- Staff reported an improved culture. Staff were engaged and able to escalate any concerns.

Critical care

Requires improvement



We rated critical care services as requires improvement because:

- Both ward J54 and ward J81 had shortfalls in their staffing levels to meet the peoples' needs and to ensure people received safe care and treatment at all times, in line with relevant guidance. Data provided showed that during the four months, Ward J54 was 88% compliant and ward J81 was 69% complaint with the expected staffing levels.
- The GPICS standards stipulate that 50% of nurses working in critical care units should have a post registration qualification in critical care. SJUH was not compliant with this with 39% of staff compliant with the standards; plans were in place to address this.
- The outreach team did not work out of hours the current arrangements included medical and nursing support from the critical care units to the wards. However there were plans to introduce a 24/7 approach just after our inspection in May 2016 and staff had been recruited to this team.

Summary of findings

- The critical care units could not demonstrate full compliance with GPICS 'safe use of equipment' standard which states that all staff must be appropriately trained, competent and familiar with the use of equipment. Staff we spoke with during the inspection told us they received training on equipment and were confident in using them. However information supplied by the trust on high risk equipment training showed low percentages of staff compliance with equipment training.

However:

- The leadership change at Leeds Teaching Hospitals NHS Trust has promoted management team visibility, accessibility and engagement with staff. To address the 'us and them' culture between the two main hospital sites an external facilitator was employed to help staff build useful relationship between the two hospital units.
- There was a good safety culture. Staff demonstrated an open and honest culture when responding and reporting incidents. When mistakes were made practices were reviewed, training and support was offered to staff so they learnt from mistakes.
- Safety huddles were taken up by staff and they were confident to speak up about problems.
- Environments were clean and there were effective infection, prevention and control practices embedded across the units.
- There were good handover processes in place amongst medical, nursing and multidisciplinary staff.
- Staff took into account the circumstances of each patient, their personal preferences and their coexisting conditions when planning and delivering care. The complaint policy and the procedures were well advertised and people told us they knew what to do if they were dissatisfied with the service.

Maternity and gynaecology

Good



We rated maternity and gynaecology services as good because:

Summary of findings

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Equipment was available to meet people's needs.
- Records relating to women's care were of a good standard. Risks to women were identified, monitored and managed to keep them safe. Records were kept secure in line with the data protection procedures.
- Systems were in place to protect patients from abuse and staff were aware of the procedures to follow.

However:

- Medical staffing levels did not meet national guidelines.
- Not all staff were up to date with mandatory training.
- Some of the delivery suite furniture was not fit for purpose and could not be effectively cleaned.

End of life care

Good



We rated end of life care as good because:

- Safety incidents were investigated when things went wrong and lessons learned were widely shared among staff to reduce the risk of re-occurrence. Staff were open and honest when they spoke with patients and families about incidents.
- There was clear guidance for staff to follow within the care of the dying person individualised care plan when prescribing medicines at end of life.
- There were some very good examples of record keeping in the individualised care plans; patients' individual needs and wishes at end of life were represented clearly in the documentation.

St James's University Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; End of life care

Detailed findings

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Background to St James's University Hospital

There are approximately 86,000 attendances a year in the A & E department at St James's 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.

Our inspection team

Our inspection team was led by:

Chair: Diane Wake, Chief Executive of Barnsley Hospital NHS Foundation Trust

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical, surgical and obstetric consultants, a junior doctor, senior managers, nurses, a midwife, a palliative care specialist and children's nurses.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

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

As this was a focused inspection we did not look across the whole service provision; we focussed on the areas defined by the information that triggered the need for the focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

Prior to the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisation.

We carried out the announced inspection visit on 10 – 13 May 2016, with an unannounced inspection on 23 May 2016. During the inspection we held focus groups with a range of staff including nurses, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also held focus groups with community groups who had experience of the trust services.

Facts and data about St James's University Hospital

In total the trust employs around 15,000 staff and provides 1785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital.

Leeds is the third largest city in England and the trust served a population of over 761,000 people. The health of people in Leeds is varied compared with the England average. There were people living in a variety of communities. The age profile, health and level of deprivation of the population varied. Rural and semi-rural

areas had a mix of people of a wide range of ages and backgrounds. Waterfront areas were made up of younger professionals. Inner city areas had mixed ages and larger culturally diverse populations.

Deprivation is higher than average in Leeds and over 21% (29,800) of children live in poverty. Life expectancy for both men and women is lower than the England average. There are higher than average rates of obesity, smoking and alcohol related health issues. There are more early deaths from cancer and heart disease than the England average. (Public health profile 2015).

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	N/A	Good	N/A	N/A	N/A	Good
Medical care	Requires improvement	N/A	N/A	Good	Good	Good
Surgery	Requires improvement	N/A	N/A	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	N/A	N/A	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Good	N/A	N/A	N/A	N/A	Good
End of life care	Good	N/A	N/A	N/A	N/A	Good
Overall	Requires improvement	Good	N/A	Requires improvement	Good	Requires improvement

Notes

Urgent and emergency services

Effective

Good



Overall

Good



Information about the service

St James's University Hospital (SJUH) is situated in the suburbs of Leeds. It is one of two urgent and emergency services (also known as A&E, emergency department, or ED) departments close to the centre of Leeds.

Between April 2014 and March 2015 the department at SJUH saw 85,363 patients in A&E.

Between April 2014 and March 2015, 99% of the patients seen at SJUH were over the age of 16 years. The children's A&E department is based at Leeds General Infirmary (LGI), located in the centre of Leeds. There is a formal system in place for transferring children to LGI via emergency ambulance.

The department had a number of different patient areas. The resuscitation room had five 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 LGI. There were eight trolley bays allocated for the initial assessment of patients who arrived by ambulance. Following initial assessment, patients were then moved to bays in the blue or green areas.

There was a minor injuries and illness department for patients who walked in to the department. This was open 365 days a year.

The department also housed a clinical decision unit (CDU). This was a short stay ward area mainly occupied by patients from the A&E department who fulfilled strict admission criteria.

The conversion rate (percentage of those patients attending who were subsequently admitted) to a hospital ward at this trust was 18.4% in 2014/2015. There was no specific data for this site.

We carried out this inspection because when we inspected the trust in 2014 we did not rate the effectiveness of the department. At this inspection, we

only inspected the effectiveness of the department because in 2014 the department was rated as 'good' for the four other domains, 'safe', 'caring', 'responsive' and 'well-led'.

During our inspection we visited the main A&E and the CDU. We spoke with eight members of the nursing team of different grades, four doctors and eight patients and observed care being delivered. We also looked at the computer systems used in the department and reviewed information sent to us by the trust and other stakeholders such as the Clinical Commissioning Groups, the Trust Development Authority (TDA) and NHS Innovation (NHSI). Additionally, we reviewed national and local audit and survey results.

Urgent and emergency services

Summary of findings

We rated the emergency department as good because:

- Patients were able to access treatment seven days a week, 24 hours a day delivered by staff from a number of different disciplines such as nurses, doctors and allied health professionals.
- Patients were treated by competent staff who followed nationally recognised pathways and guidelines. Records were audited to make sure that pathways and guidelines were followed correctly.
- On the whole, patients received pain relief in a timely manner and were able to access food and drinks as required.
- Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effective as good because:

- The department worked within up to date national and international guidelines and patient care pathways reflected these guidelines.
- Patients received pain relief in a timely manner and procedures in the department meant that pain levels were reviewed regularly as part of dignity rounds.
- Patients received care from competent staff who had received a comprehensive induction and were appraised regularly. There were processes in place to address poor performance and staff were encouraged to develop and improve their skills and knowledge.
- Staff were able to access information relating to patients and worked with other health professionals to ensure that patients received coordinated care and treatment.
- The department provided a 24 hours, seven day a week service for patients.
- Patient outcomes were on the whole as expected or better than expected with only a few areas for improvement identified by national surveys and audits. Work was underway to make improvements and audits were planned and carried out to provide assurance of improvements.
- Staff understood the basic principles of the Mental Capacity Act (2005), and were aware of their responsibilities in relation to restraint and Section 136 of the Mental Health Act relating to detained patients.

Evidence-based care and treatment

- Policies and guidelines used by the department were based on the latest national and international guidelines such as from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine.
- The department used pathways such as for sepsis and fractured neck of femur. These were evidence based and audited regularly. We had no concerns about the results of the audits.

Urgent and emergency services

- Staff were able to access clinical guidelines and pathways using a computer and mobile phone application called CEMBOOKS. This meant that staff of all disciplines and grades could access up to date guidance. We did a random check of guidelines and found that they had been regularly checked to make sure they were up to date and still relevant.
- The trust provided us with evidence of participation in Royal College of Emergency Medicine (RCEM) audits and local audit activity. We saw that when standards were not met, action had been taken to implement changes and re-audits had been planned. For example, the Procedural Sedation Audit had identified poor completion of documentation and a new recording document had been designed and introduced. Similarly, the Venous Thromboembolism (VTE) Audit had led to the introduction of a new pathway of care for applicable patients.
- Local audits showed that patients received care that was in line with evidence based guidance.
- The department carried out simulation exercises in order to improve the response of staff to pressurised situations and the subsequent care and treatment patients received.

Pain relief

- We looked at the records of eight patients and saw that in five cases, pain relief had been given appropriately. In one case, the patient had refused pain relief.
- According to the latest results of the CQC A&E survey carried out in 2014, the trust performed worse than expected when patients were asked how many minutes they had waited for pain relief after asking.
- However, staff told us that as a result of the survey, all patients were asked about their pain levels and offered pain relief as soon as they saw a clinician.
- We spoke with five patients. All but one patient told us they had received pain relief quickly. We heard patients being offered pain relief and saw patients receiving medication quickly. We heard staff discussing pain levels with patients and asking them how they usually controlled their pain.
- We saw that pain scores were documented in patient records and reviewed appropriately.

Nutrition and hydration

- We saw that staff carried out dignity rounds in the department. Patients were offered drinks. When patients had health conditions that meant they needed to eat regularly, we saw that they were able to access food.
- Assistance was available to patients who were unable to eat or drink unaided.
- We only spoke with one patient who had eaten the hospital food. They told us that the food was, 'okay'.
- We asked staff whether food and fluid intake was monitored. They told us that records were amended to show when patients had eaten or had a drink but would only be monitored if there were any cause for concern about the patient's nutrition or hydration status, such as they had been admitted with dehydration.
- According to the latest results of the A&E Survey carried out in 2014, the trust performed about the same as other trusts when patients were asked whether they were able to get suitable food and drinks when they were in the A&E Department.

Patient outcomes

- The trust performed about the same as other trusts for two of the effective elements of the 2014 A&E survey, whether staff did enough to control pain and whether patients were able to access suitable food and drinks in the department. The trust performed worse than other trusts for patients waiting for pain relief. This had been addressed since the survey by the introduction of dignity rounds.
- The IT system in the A&E had been adapted to ensure that consultants had final 'sign off' of patients. This meant that patient cases were reviewed by a consultant before the patient was discharged from the system.
- The department took part in Royal College of Emergency Medicine (RCEM) audits. The results of some audits showed that the department needed to improve compliance with RCEM guidelines. We saw that re-audits had taken place to ensure results had improved because of changes made.
- The department had no CQUIN (Commissioning for Quality and Innovation) targets for 2015/2016. In 2014/2015 the department met 11 out of 12 targets for the A&E Asthma CQUIN.

Competent staff

Urgent and emergency services

- Information sent to us by the trust showed that 99% of staff in the Urgent Care Clinical Service Unit (CSU) underwent appraisal between April 2015 and March 2016.
- Senior staff told us that the period between April and June was classed as appraisal season when the majority of staff underwent appraisal. Any staff absent were given their appraisal on return to work.
- Staff told us that they had undergone appraisal in the last 12 months. They told us that the appraisal was meaningful, supportive and enabled them to identify any training needs they had.
- Staff told us that there was informal supervision sessions held during team meetings. Formal supervision was carried out by identified line managers.
- All of the staff we spoke with, both nursing and medical told us that there were procedures in place to support them with revalidation.
- Senior staff told us that the department had recently employed a large number of newly qualified staff. To ensure that all staff had the appropriate skills to work in an A&E, the trust had designed a comprehensive 16 week induction programme. This consisted of both theoretic and practical training. Staff were assessed by the two clinical educators in the department and had to demonstrate competency in key skills before being able to work unsupported.
- Preceptorship and mentorship were in place to support newly qualified or employed staff.
- We spoke with a number of newly qualified staff. They all told us that the induction had prepared them and given them the confidence to carry out their roles. Staff felt supported to ask questions and told us that more senior and experienced staff were always happy to assist.
- Staff told us that there were opportunities within the department to progress. For example, a number of nurses were undergoing training to become Advanced Care Practitioners.
- There were clear lines of management in the department. Managers told us that they worked with staff and monitored performance as a way of identifying any training needs. Staff were also encouraged to identify their own training needs.
- If poor performance was identified, staff were supported to attend training and work closely with more experienced colleagues. The trust also had policies and procedures in place that were followed when all other options had been exhausted.

Multidisciplinary working

- The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted.
- There was good access to mental health clinicians within the department with 24-hour telephone access to psychiatric liaison staff.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals such as physiotherapists and occupational therapists attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- The department worked closely with the ambulance trust, local GPs and the out of hours' service to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.

Seven-day services

- The emergency department offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24-hour period.
- There was 24-hour seven-day access to diagnostic blood tests. The department had some point of care testing which meant that some blood tests could be carried out in the department. Radiology tests such as x-rays and scans were carried out as and when needed and were available 24 hours every day.

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays. There was also a link to patient information held by GPs such as past medical history and current medications.

Urgent and emergency services

- Patients transferred to other services or sites took copies of their medical records with them. Additionally, the referring clinician gave a verbal handover to the receiving department to ensure that important details were captured.
 - Clinical guidelines and policies were available on the trust intranet.
 - The electronic system used by the department automatically issued letters to patients' GPs once the patient was shown as discharged from the department. This meant that GPs received discharge letters in a timely manner and could make any relevant adjustments to medications quickly when appropriate.
- Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- We spoke with staff about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
 - Training figures for MCA training were at 98% for Level 1 and 80% for Level 2 across all staff groups. The trust target was 95%.
 - Staff understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they implied consent when the patient agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them.
 - An initial assessment of patients' capacity was made at triage and where concerns were identified, a more detailed assessment would be made each time the patient needed to make decisions. The department were able to access Independent Mental Capacity Advocates (IMCAs), who are independent patient advocates to support patients who were deemed to lack or have fluctuating capacity.
 - Staff we spoke with about restraint told us that they would always use the least restrictive constraint and would only use physical restraint as a last resort. This was in line with the trust policy.
 - Staff underwent conflict resolution training as a way to de-escalate situations and reduce the need for either physical or chemical restraint.

Medical care (including older people's care)

Safe	Requires improvement	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The Leeds Teaching Hospitals NHS Trust provides medical care, including older peoples care across two sites. Medical services at St James's University Hospital (SJUH) are spread across four different clinical service units (CSU). The acute medicine CSU includes; acute medicine, older peoples medicine and general medicine, diabetes, endocrinology and infectious diseases. The cardio-respiratory CSU includes; cardiology, and respiratory medicine and the abdominal medicine and surgery CSU includes endoscopy, urology, hepatology, renal services and gastroenterology. The Leeds cancer CSU includes medical and clinical oncology.

SJUH provides medical care over 34 medical wards comprising of 714 inpatient beds and 24 day-case beds. The medical wards covered specialities including, elderly medicine, general medicine, respiratory medicine including an adult cystic fibrosis unit, acute admission wards, infectious diseases, gastroenterology and oncology.

The trust has one of the highest numbers of admissions in the country. Between September 2014 and August 2015 there were 73,896 medical admissions to Leeds Teaching Hospitals NHS Trust, approximately, 43,700 were at SJUH. Of these admissions, 61% were emergency admissions, 8% were elective admissions and 31% were day cases.

The above services were inspected during an announced comprehensive CQC inspection in March 2014 in which the service was rated as requires improvement overall. We rated caring and effective as good and safe, responsive and well-led as requiring improvement.

During our follow up inspection, we reviewed the safe, responsive and well-led domains. We visited the

following ward areas: wards 8, 11, 31, 21, 9, 29, 26, the acute respiratory care unit, wards 27, 30, 28, 31, 14, the joint acute medical assessment (JAMA), wards 16 and 19. We reviewed medical outliers on wards 54 and 42. We spoke with 65 staff, including doctors, nurses, healthcare assistants, ward managers, matrons and consultants. We spoke with 27 patients. We looked at the records of 23 patients and reviewed 10 prescription charts. Before the inspection, we reviewed performance information from, and about, the trust.

Medical care (including older people's care)

Summary of findings

We rated medical care as good because:

- The service took into consideration the needs of different people when planning its services and made reasonable adjustments for vulnerable patient groups.
- The service responded to complaints and concerns in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.
- The trust's values of 'The Leeds Way' were embedded amongst staff and each clinical service unit had a clear clinical business strategy.
- However, there were occasions when nurse and care support worker staffing levels were below the planned number. Despite having a clear escalation process, non-qualified staffing levels did not always mitigate for the reduction in qualified nursing levels.
- Patients identified as appropriate to wait on a trolley's on the assessment ward were not always in line with the trust criteria and did not have a documented risk assessment.

Are medical care services safe?

Requires improvement



We rated safe as requires improvement because:

- Patients who were identified as appropriate to wait on a trolley for a bed on an assessment ward did not consistently reflect the trust's criteria. Patients did not have documented risk assessments and the lack of an assessment room on two of the assessment wards resulted in delays in reviews by medical staff.
- Registered nurse and care support workers staffing levels were regularly below the planned levels in some areas. Non-qualified staffing levels did not always mitigate for the reduction in qualified nursing levels.
- Hazardous substances used for cleaning and medicated body scrub was not always securely stored.
- Some wards we visited appeared cluttered with limited room for the storage of equipment. Safety testing stickers had expired on emergency equipment, for example three defibrillators.

However:

- Staff understood their responsibilities to raise concerns and report incidents and near misses. Nursing staff received feedback about incidents through team meetings, the 'safety matters' bulletin and in safety huddles.
- Medical records and nursing care plans were accurately completed and up to date.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are in place. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. There were no never events reported in the service between October 2014 and February 2016.
- Serious incidents are incidents that require reporting and further investigation. SJUH reported 39 serious incidents between March 2015 and February 2016. Falls and Pressure ulcers that met serious incident criteria were the most frequently reported serious incidents.

Medical care (including older people's care)

- A root cause analysis (RCA) is a structured method used to analyse serious incidents. The trust held multidisciplinary meetings to analyse the information, identify the root cause and contributory factors, and generate action plans.
- We reviewed RCA's; two related to a fall resulting in serious injury and one related to a category 3 pressure ulcer. All investigations identified the root cause, included recommendations and had a timed action plan. They also identified areas of good practice to be shared. Examples of learning from the RCA's included moving patients deemed at high risk of falls out of side rooms and encouraging the presence of ward pharmacist at safety huddles.
- Between March 2015 and February 2016 there were 5815 incidents reported within medical services at SJUH to the national reporting learning system. Of these incidents, 4804 resulted in no harm to patients, 921 resulted in minor harm, 76 in moderate harm, and 12 severe harm. Two incidents were not categorised. The most commonly reported incidents were pressure ulcers accounting for 1634 of all incidents reported. Falls, slips and trips accounted for 1435 of all incidents and staffing resources accounted for 309 incidents reported. Other themes of incidents included medication errors and access, admission, transfer and discharge.
- The trust had worked hard to reduce the number of falls. The service had introduced daily multidisciplinary safety huddles, educated staff on the importance of footwear, introduced falls bays to cohort high risk patients and increased the use of one to one staffing for high-risk patients. In 2014/15 the trust saw a 32% reduction in the number of falls.
- On the previous inspection there was a mixed response to how well local incidents were reported and learned from. Individuals did not always receive feedback on incidents they reported. During this inspection we found all staff understood their responsibilities to raise concerns and near misses and to report safety incidents using the electronic recording system including junior doctors.
- Staff received feedback on incidents reported. Any lessons learned from incidents were shared at team meetings, via a 'safety matters' electronic bulletin and in safety huddles. We saw minutes from staff meetings where lessons from incidents were discussed. Minutes from a ward meeting on ward 19 documented a serious incident where a patient had self-harmed. Lessons learned were shared with staff and included, improving communication with psychiatry and improving recognition of 'at risk' patients.
- The trust had set up a working group to develop a risk assessment for enhanced supervision for acute adult inpatients. We reviewed a draft of the document and saw evidence of a comprehensive risk assessment. Patients who were confused and wandering and presented a risk to themselves and others, displaying violent and aggressive behaviour, expressing intent to self-harm or were under mental health section were identified as high risk. Recommendations for these patients included, one to one care by either a care support worker, security or a mental health nurse.
- Staff gave us examples of changes in practice that had been implemented. Examples included; replacing pull cords with snap cords following a patient safety incident and increasing the attendance of personal safety training for staff.
- All wards we visited held daily safety huddles. All members of the multidisciplinary team were encouraged to attend including medical staff, domestic staff and clinical support workers. The safety huddles were used to share any learning from incidents and identify any patient safety issues including, pressure ulcers, falls, high national early warning scores (NEWS), patients under a deprivation of liberty safeguard (DOLs) and any patients with a hospital acquired infection. Staff spoke positively about the safety huddles and felt they had created a sense of ownership amongst staff to improve patient safety.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of the duty of candour and spoke about being open and honest with patients and their relatives. Following a RCA we saw evidence of duty of candour letters sent to families along with the outcome of the investigation.
- We saw a 'Quality and Safety matters' poster informing staff about the duty of candour displayed on ward 9.
- Each CSU had monthly mortality and morbidity meetings, individual cases were discussed and required

Medical care (including older people's care)

actions were documented with timescales. Any lessons learned from mortality and morbidity meetings were shared via a 'lessons learnt bulletin' and across other specialities.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The trust displayed some aspects of the safety thermometer on all the wards we visited. Wards displayed the number of days since a patient fall and the number of days since a pressure ulcer. They did not display the catheter related urinary tract infections and venous thromboembolism. However, the percentage of harm free care was displayed.
- Ward 27 had gone over 365 days since a case of Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. difficile) infection, 131 days since a hospital acquired pressure ulcer and 2 days without a fall.
- During the previous inspection in December 2013, three elderly care wards achieved less than 80% harm free care.
- The percentage of harm free care amongst the elderly care wards had improved since our previous inspection. We reviewed the safety thermometer information for all the elderly care wards from January 2016 to April 2016. The average percentage of harm free care over the four months was above 90% for all the elderly care wards with the exception of ward 28 which scored 87%. In January 2016 the ward scored 82%, in February 2016 the ward scored 92%, in March 2016 the ward scored 90% and in April 2016 the ward scored 85%.
- Ward managers recorded and submitted the number of falls, pressure ulcers, urinary tract infections and the percentage of harm free care on to the CSU ward healthcheck. In January 2016; 118 falls were recorded, 4 new pressure ulcers were reported and 0 urinary tract infections were reported. The average percentage of harm free care across medical services SJUH was 93%.
- Information was displayed on 'how to prevent falls' and certificates were awarded to ward teams for fall-free days.

Cleanliness, infection control and hygiene

- The environment in the ward areas appeared clean and well maintained. Daily cleaning checks were displayed and up to date.
- We observed most staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in most of the areas we visited.
- Hand sanitising gel and sinks were available on the entrance to all the wards we visited.
- The number of days since a healthcare-associated infection was displayed on all the wards we visited and recorded on the trust's monthly ward healthcheck.
- Hand hygiene audit results for the last 3 months were displayed on all the wards we visited. Ward 21 was 100% compliant in February and March and 80% compliant in April. Ward 8 and ward 29 were 100% compliant in February, March and April.
- Monthly infection control audits were undertaken. Hand hygiene audits showed good compliance, the trust completed 595 audits between July 2015 and February 2016 and medical services were above 95% compliant with hand hygiene.
- In the past 12 months there had been 4 cases of MRSA and 42 cases of C. difficile, the trust identified 15 of these cases as being due to a lapse in care within medical services at SJUH.
- During the previous inspection concerns were raised about the number of cases of C. difficile on ward 19. Between April 2013 and March 2014, 12 cases of C. difficile were reported. The trust investigated each individual case to identify any specific themes. Staff produced a video that was available on the trust intranet to share their experiences and discussing how lessons had been learnt. Changes to clinical practice included; a review of micro-bacterial prescribing, the introduction of stickers into medical notes to prompt a review of antibiotics after 3 days and discussion at daily safety huddles of patients with MRSA or C. difficile. Between 2014 and 2015, the number of cases of C. difficile on ward 19 had reduced to 2.
- Patients with healthcare-associated infections were appropriately isolated. We observed staff caring for patients requiring isolation. Signage was used to advise staff and visitors not to enter without appropriate protective clothing. We observed most staff using appropriate protection when entering the room and disposing of the same appropriately when they left.

Medical care (including older people's care)

- On ward 26 we observed a doctor enter an isolated bay without personal protective equipment (PPE) or adhering to infection control procedures. We brought this to the attention of nurse in charge who told us they would speak with the doctor concerned.
 - From February 2015 to February 2016 there had been 10 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) within medical services across the trust.
 - A yellow tray system was used by staff when serving meals to identify patients that had a healthcare-associated infection.
 - Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
 - Monthly cleaning audits were completed in February 2016. All patient environments were above 95% compliant with the exception of ward 8, 27, 12 and 92. The audits did not have an action plan.
 - At trust level 94% of acute medicine staff had completed their infection prevention and control training, compared to the trust target of 80%.
 - Data from July 2015 to February 2016 for the acute medicine CSU and cardio-respiratory CSU showed above 95% compliance with central and peripheral venous catheter hygiene and urinary catheter care.
 - Equipment was identified as being clean using cleaning assurance stickers in most clinical areas. The label contained the date the equipment had been cleaned. Ward 26 did not use cleaning assurance stickers. They did have a cleaning rota for commodes but no other assurances that other pieces of equipment were clean.
 - Each ward had an infection, prevention and control champion who was responsible for developing and sharing best practice in relation to infection prevention control.
 - We found the bathroom and toilet on ward 30 to be unclean. We raised this with the ward manager who promptly asked the domestic to attend to the bathroom.
 - We checked the resuscitation trolleys on all the wards we visited and daily checks had been completed by staff on all wards with the exception of ward 11, where we found 5 days in April where daily checks had been missed.
 - None of the resuscitation trolleys were secured with tamper proof seals. This meant that there was a risk that emergency medications and resuscitation equipment was accessible and staff may not know if the equipment in the trolley had been used.
 - We checked the 'safety tested' stickers used on equipment to identify when it had been tested and serviced. On wards 16, 11 and 9 the defibrillators on the resuscitation trolleys had all passed there due date for servicing.
 - On ward 26 and JAMA we found unsealed containers used to dispose of sharp objects including needles left out in ward areas. There was an increased risk that patients could access the contents of the containers and sustain a needle stick injury.
 - Bariatric equipment was available on some wards and could be ordered. Staff said equipment arrived on the ward promptly.
 - Pressure relieving equipment including mattresses, cushions and gel heel pads were readily available for patients and could be ordered by staff using an electronic ordering system.
 - In the sluice areas on wards 14 (elderly care ward) and on ward 26 (acute medical admissions ward) we found hazardous substances used for cleaning not stored securely. The doors to the sluice on both wards were unlocked. Both wards cared for patients who could be confused and vulnerable and were at an increased risk of obtaining the substances.
 - During times of increased capacity in the hospital, patients were transferred to the assessment wards (ward 26, 27, 28 and 29) before a bed space was available. A maximum of three patients could be waiting on trolleys by the nurse's station. Staff said, on occasions nursing assessments were completed with the patient while they waited on trolleys. Ward 29 and 28 did not have a suitable room for staff to take patients to complete the nursing assessment. On ward 28, we observed a member of staff completing the nursing assessment with a patient who was hard of hearing and on a trolley by the nurse's station. We raised this with the trust and they addressed the situation immediately.
- ## Environment and equipment
- Some of the wards we visited had a lack of space for the storage of equipment such as hoists, chairs and mattresses. This made the ward area appear cluttered. For example on ward 26 and 29 we observed equipment obstructing a fire exit. We brought this to the attention of the ward manager.

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- Medical staff said that the lack of an assessment room on the assessment wards meant they had to wait till a patient was in a bed space to complete their examinations. If staff were concerned about the integrity of a patient's skin, they would transfer patients off the trolley and onto a bed while they waited for a bed space or side room to become available.

Medicines

- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed balance checks in line with the trust policy.
- On ward 8 and 9, nursing staff were able to single sign for some controlled drugs (Tramadol, Temazepam, and Morphine oral solution). This was in line with the trust policy.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. Room temperatures were also monitored and recorded.
- In most areas, we saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range. However, on ward 9 we saw the fridge temperature had been above the maximum temperature since 11 April 2016. If stored at an incorrect temperature, the safety and efficacy of medication can be affected. Staff said the fridge had been reported to pharmacy.
- Ward 26 was an acute medical admission ward and cared for patients who could be confused and wondersome. We found medicated body wash used for patients with MRSA in an unlocked cupboard on the ward. This was accessible and increased the risk of patients and visitors obtaining the substance.
- At trust level 80% of acute medicine staff had completed their medicines administration and safety training; this was in line with the trust target of 80%.
- Each CSU completed monthly antimicrobial medicines audits. We reviewed the audit results for the acute medicine CSU. In December 2015 the percentage of antibiotics reviewed after 3 days was 52%. Recommendations to improve 3 day review rates included a sticker on the drug chart alerting a review at

- day 3, an advertising and education campaign and better use of doctors' handover sheets and board-rounds. Results from the monthly antimicrobial audit showed an improvement. In January 2016 the review rate had increased to 68% and in February 2016 the review rate had increased to 81%.
- We reviewed 10 prescription charts and found medication had been administered as prescribed and at appropriate times and allergies had been documented. During our previous inspection we found oxygen was not routinely prescribed. We reviewed the prescription charts of 11 patients on oxygen and all had oxygen prescribed with the exception of one patient.

Records

- On most wards, records were stored in trolleys in the doctor's room or by the nurse's station. Nursing care plans were stored in files and kept at the ends of patients' beds. However, on ward 29, records were kept in unlocked trolleys by the nurses station, at times this was unattended, leading to a potential risk of confidential patient information being accessed.
- Information governance training was included in the trust's mandatory training programme. Training records showed 90.6% of staff in the acute medicine CSU, 87.1% of staff in the abdominal medicine and surgery CSU and 86.7% of staff in the cardio-respiratory CSU had completed the training. This was above the trust target of 80%.
- Each CSU completed monthly medical and nursing health record keeping audits. Key findings were summarised along with recommendations. Audit results were feedback to staff via email and at clinical governance meetings.
- On ward 28 we found an ID card left in the computer. This belonged to a doctor who had subsequently left but was still being used by the current team to access IT systems.
- Patient records were multidisciplinary. All professions involved in a patients care documented in the patient's medical records. Staff felt this improved communication.
- We reviewed 15 sets of paper records. Daily medical reviews were clearly documented along with a working diagnosis and treatment plan. We saw evidence of discussions with families documented in medical records. Not all medical staff recorded their General Medical Council (GMC) number.

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- Nursing records were up to date and appropriate risk assessments were completed. We saw evidence of a range of risk assessments including; falls, pressure ulcers and nutrition and hydration.
- Patients assessed as having a pressure ulcer were on appropriate care plans and had 'turn charts' to document their position.
- We reviewed the medical records of 7 medical outliers, in 6 sets of records daily medical reviews were documented. In one set there was no documented review for four days.

Safeguarding

- All staff we spoke to knew how to escalate safeguarding concerns. Staff were clear about what was seen as a safeguarding concern. All staff knew how to make a safeguarding referral and said that they received a timely and appropriate response.
- Staff gave examples of safeguarding referrals they had made. Staff described making safeguarding referrals for patients admitted with pressure ulcers and when they had concerns about financial abuse of a patient.
- The trust had a dedicated safeguarding team who were available for advice and support. Staff knew who the safeguarding team were and how to contact them.
- The trust used an electronic referral system for all safeguarding referrals.
- The trust collected training data by CSU and not by individual locations. Safeguarding vulnerable adult's Level 1 and 2, and safeguarding children Level 1 were included in the trust's mandatory training programme.
- Training records submitted by the trust showed 93.2% of staff within the acute medicine CSU had completed safeguarding vulnerable adult's Level 1 training; this was above the trust target of 80%. However, only 76.7% of staff had completed safeguarding vulnerable adult's Level 2 training. 93.2% of staff in the CSU had completed safeguarding children Level 1 training.
- 94.9% of staff in the cardio-respiratory CSU and 95.2% of staff in the abdominal medicine and surgery CSU had completed safeguarding vulnerable adult's Level 1. 94.4% of staff in the cardio-respiratory CSU and 95.3% of staff in the abdominal medicine and surgery CSU had completed safeguarding children Level 1 training. This was above the trust target of 80%. However, only 72.5%

of staff in the abdominal medicine and surgery CSU and 65.5% of staff in the cardio-respiratory CSU had completed safeguarding vulnerable adults Level 2 training.

- Female genital mutilation (FGM) was included as part of safeguarding training. Not all staff were aware of the process but knew who to contact if they had concerns.
- All volunteers had a disclosure and barring service (DBS) check. Staff on the wards were given information about the volunteers before they came onto the wards.
- Following the Savile Enquiry volunteers now wore green polo shirts and they were now identifiable on the ward.
- A charity that provided support to the ward had an office at the entrance to the ward. Following the Savile Enquiry all charities now had offices in a non-patient area of the hospital.
- Staff completed risk assessments for visiting clergy and community leaders and they would not be left unattended on the ward.

Mandatory training

- The trust offered comprehensive mandatory training to staff. Modules included; equality and diversity, fire safety, infection, prevention and control, dignity at work, moving and handling, the Mental Capacity Act and risk and safety training.
- All staff said they were up to date with their mandatory training, and new starters said they completed all their mandatory training as part of the induction process.
- Staff could access their mandatory training record electronically. The training record used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training sessions.
- Staff said training was accessible and they could complete e-learning or attend face to face training. Staff said they were given time to attend mandatory training.
- On the previous inspection the compliance with mandatory training within medicine was 56.2%.
- The trust did not collect mandatory training data by individual location but by CSU. However, they did have a robust system in place that allowed staff and the trust to know when mandatory training was due to expire.
- Data provided by the trust showed that the acute medicine CSU was above the trust target of 80% for all mandatory training with the exception of fire safety where 72.1% of staff were compliant and adult's resuscitation where 67.6% of staff were compliant.

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- The abdominal medicine and surgery CSU were above the trust target for all mandatory training with the exception of fire safety where 67.1% of staff were compliant and resuscitation adults where 68.9% of staff were compliant.
- The cardio-respiratory CSU was above the trust target of 80% for all mandatory training with the exception of fire safety where 71.1% of staff were compliant, resuscitation adults where 77.4% of staff were compliant and resuscitation children where 50% of staff were complaint.

Assessing and responding to patient risk

- Staff knew how to identify and respond if a patient was deteriorating. They told us they used the NEWS to record patients' observations and to assess if a patient's condition was improving, deteriorating or stable. The score from the NEWS acted as a trigger to escalate concerns to medical staff on the ward.
- Monthly audits of NEWS charts were completed by each CSU. Between April 2015 and February 2016 within the acute medicine CSU, on average 95.5% of patients had the correct NEWS score, however, 67.4% of referrals for 'at risk' patients were completed. Between December and February the percentage of referrals for 'at risk' patients had improved. In December 2015, 88.2% of referrals for 'at risk' patients were completed, in January 2016, 86.4% and in February 94.1%. The service had introduced patient safety huddles which allowed the team to identify any patients they were worried about and decide what actions needed to be taken.
- We reviewed 10 observation charts and found that the NEWS scores were completed appropriately and, where necessary, patients had been escalated.
- Patients that attended JAMA were seen by a nurse or senior health care support worker within 15 minutes who completed observations and initial investigations, for example, blood tests and electrocardiogram (ECGs). If patients' NEWS score was four or more or three or greater in one category nurses referred the patient for immediate review by a doctor or advanced nurse practitioner. The critical care outreach team provided support to the unit if required.
- Patients who required non-invasive ventilation were cared for on the acute respiratory care unit. We reviewed 6 observation charts and found they were completed correctly. The unit had temporarily moved whilst the ward was being decorated and did not have a central monitoring system. The unit ensured a member of staff was in each bay. The ward was planning on trialling an electronic recording system for NEWS.
- A critical care outreach team was available 24 hours a day, seven days a week to support staff with patients who were at risk of deteriorating, patients whose NEWS score triggered a review and patients on NIV. Staff said the team were very responsive and patients could be escalated to level 3 beds if required.
- The acute medical wards had twice daily consultant ward rounds and reviewed all new admissions.
- From the previous inspection in December 2013 concerns were raised about patients being transferred to wards prior to their bed spaces being ready. We reviewed this practice and found that all the assessment wards still had 'trolley patients'. Each ward could take up to three patients. Patients were transferred to the assessment wards (wards 26, 27, 28 and 29) on trolleys and waited for a bed rather than waiting in accident and emergency.
- The trust had criteria for patients who waited on a trolley for a bed and an escalation policy. Any patients that had suffered a seizure, was scoring more than 4 on the NEWS, required source isolation, were actively withdrawing, were oxygen dependant or had a psychiatric illness were not suitable to wait on a trolley bed. Staff were aware of the criteria and how to escalate any concerns.
- On ward 27 we saw a patient waiting on the corridor for a bed who had taken an overdose. This was not in line with the trust criteria.
- Senior staff said all trolley patients were risk assessed to ensure patients were appropriate to wait on a trolley. We reviewed the documentation for a patient waiting on a trolley; there was no documented risk assessment. Ward managers and staff in accident and emergency said they did not use a documented risk assessment. The trust had no oversight of the types of patients allocated to wait on a trolley on the assessment wards.
- We saw one patient on ward 29 and two patients on ward 27 waiting on trolley's and in chairs by the nurse's station. Staff said patient observations were checked within 15 minutes of arrival to the ward. We reviewed an observation chart and found the patient had their observations checked within 15 minutes and were scoring less than a 4 on the NEWS chart.

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- Staff said if a patient was on a trolley and began to deteriorate they would increase the frequency of their observations, request a review by the doctor and escalate it to the matron and the patient flow team and prioritise a bed for the patient.
- Ward 30 and 31 were rehabilitation wards for patients who had no further ongoing medical needs but required a period of rehabilitation. Out of hours if a patient deteriorated staff would contact the GP on call service, or in an emergency situation would contact '999' for an ambulance and the patient would be transferred to accident and emergency.
- The trust had worked hard to reduce the number of falls. The service had identified steps to reduce falls by discussing falls at daily multidisciplinary safety huddles, educating staff on the importance of footwear and increasing the use of one to one nursing for high-risk patients. In 2014/15 the trust saw a 32% reduction in the number of falls.
- A number of wards cohorted high risk patients into a designated falls bay and had a care support worker allocated to the bay to supervise patients.
- Ward 26 used the clinical institute withdrawal assessment for alcohol (CIWA). CIWA is a ten item scale used in the assessment and management of alcohol withdrawal.
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. When a patient was identified as 'at risk' staff had completed the appropriate care plan.
- Ward 14 was designated for patients who were medically fit for discharge and did not require any further medical intervention. Patients would stay on the ward whilst they waited for a package of care or a care home. Staff said they did not record patient observations. Staff had access to medical staff and the critical care outreach team if they were concerned about a patient.
- Failure to manage aggressive and violent patients was identified on the acute medicine CSU risk register. Some staff said they had completed personal safety training to educate staff on de-escalation and break away techniques, but they did not receive specific managing violence and aggression training. Staff said if they were unable to calm a patient they would contact security.
- Some staff said medication would be used to calm the patient if they were at significant risk of harm to

themselves or others. As a last resort staff would use intramuscular rapid tranquilisation. Staff reported inconsistencies in the frequency of recording patient observations. The National Institute for health and care excellence guideline on violence and aggression: short-term management in mental health, health and community settings (2015) state, after rapid tranquillisation the side effects should be monitored including the patients pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. This should be monitored every 15 minutes if the maximum dose has been exceeded. Some staff said they would not change the frequency of patient observations from four hourly, some said they would do them hourly and others two hourly. All staff said they would have a staff member sat with the patient.

Nursing staffing

- The service used the Association of United Kingdom University Hospitals (AUKUH) acuity and dependency tool. The acuity and dependency tool was developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.
- Senior staff said staffing levels were reviewed twice a year. All ward managers could access the shared drive and monitor the establishment numbers to keep the information up to date.
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the local and corporate risk register. Controls put in place by the trust to reduce the risk included a clear escalation process and discussion at daily operational performance (DOP) meetings, use of bank and agency staff, staff deployment from other clinical areas and projects focusing on recruitment, mentorship and retention of staff.
- All wards we visited confirmed they had vacancies. Ward 29 had 12 whole time equivalent (WTE) vacancies, ward 9 had 12.25 WTE vacancies and ward 28 had 9 WTE vacancies.
- Staff were clear about the escalation process used if staffing levels fell below the planned number. Ward managers would book agency staff or offer staff additional shifts. Any unfilled shifts would be escalated to the matron and discussed at the DOP meetings.

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Matrons would review staffing throughout the day and move staff to support wards that were short staffed. Staff understood why this happened and appreciated the help they received from other wards when they were struggling.

- We saw evidence of the induction checklist agency staff completed.
- Wards displayed the planned and actual staffing figures. On some wards, the actual number of staff on duty were lower than the planned number. For example on ward 11, there planned staffing was 6 registered nurses and 5 care support workers on an early and a late shift and 5 registered nurses and 3 care support workers on a night shift. The ward actually had 5 registered nurses and 4 care support workers on an early shift, 4 registered nurses and 5 care support workers on a late shift and 4 registered nurses and 2 care support workers on a night shift.
- We reviewed the planned and actual information for all the medical wards. We found qualified nursing levels for the wards were not always achieved. For example on ward 28, between the 23 March 2016 and the 22 May 2016, we found 5 days when registered nursing staff was over 100%, 44 days when the levels were between 80% and 100% and 14 days when registered nursing levels were below 80% with one day when the registered nursing level was below 62%. We looked at the non-qualified staffing levels between the 23 March and 22 May we found 56 days when non-qualified staffing levels were above 100% and 6 days when they were between 80% and 95%. For 6 days both the registered nursing levels and the non-qualified staffing levels were below 100%. For example on the 5 April 2016 the registered nursing levels were 70.7% and the non-qualified staffing levels were 81%. Therefore the non-qualified staffing levels did not mitigate for the reduction in qualified nursing levels.
- On ward 10, between the 23 March 2016 and the 22 May 2016, we found 18 days when registered nursing staff was over 100%, 27 days when the levels were between 80% and 100% and 17 days when registered nursing levels were below 80% with one day when the registered nursing level was below 64%. We looked at the non-qualified staffing levels between the 23 March and 22 May we found 31 days when non-qualified staffing levels were above 100% and 14 days when they were between 98% and 66%. For 30 days both the registered nursing levels and the non-qualified staffing levels were below 100%. For example on the 27 April 2016 the registered nursing levels were 72% and the non-qualified staffing levels were 66%. Therefore the non-qualified staffing levels did not mitigate for the reduction in qualified nursing levels.
- On ward 15, between the 23 March 2016 and the 22 May 2016, we found 5 days when registered nursing staff was over 100%, 42 days when the levels were between 80% and 100% and 15 days when registered nursing levels were below 80% with one day when the registered nursing level was below 64%. We looked at the non-qualified staffing levels between the 23 March and 22 May. On every day non-qualified staffing levels were above 100%. Therefore the non-qualified staffing levels were used to mitigate for the reduction in qualified nursing levels.
- On some wards we saw high patient to nursing staff ratios. Ward 31 had 27 patients and often had two nurses resulting in a nurse to patient ratio of 1:13.5. Ward 8 had 30 patients and on occasions only had two nurses resulting in a nurse staff to patient ratio of 1:15.
- We reviewed electronic rostering information and found staff that were moved to provide cover on wards not achieving the planned staffing levels were recorded. However staff that were moved for two to three hours were not always recorded. The trust was looking at enhancing the current electronic rostering system to capture this data for the future.
- At times of increased capacity the assessments wards could have an additional three patients waiting on trolleys. Staff said this would be escalated but they would not get extra staff to care for the trolley patients. Staff felt trolley patients had an impact on the workload and at times could feel unsafe.
- Staff said trolley patients would be transferred to the assessment ward even if the ward was below its planned staffing levels. In most cases the nurse in charge would care for the trolley patients as well as their allocated patients and coordinate the ward. On the 10 May 2016 ward 27 had five additional patients waiting on trolleys for a bed. The actual qualified nurse level was 76.5%.
- Staff sickness in January 2016 was highest on ward 29 (14.8%), ward 91 (14.1%) and ward 14 (10%).
- There was a mixed response from patients about the length of time taken to answer call bells, some patients said that the ward was often short staffed and patients

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had to wait for call bells to be answered, others praised staff for responding in a timely manner. On ward 9 patients told us that nursing staff were visible on the ward and responded in a timely manner.

- Ward 11 had an eight bedded respiratory care unit. The unit commenced patients and cared for patients on non-invasive ventilation (NIV) and tracheostomies. Planned staffing for the unit was three nurses and two care support workers. British Thoracic Society Guidelines confirm patients receiving non-invasive ventilation (NIV) are managed at level 2 nursing levels (1:2 nursing staff to patient ratio) in the first 24 hours to allow for frequent blood gas monitoring. The planned staffing for the unit did not meet this recommendation.
- Senior managers were aware of the risks of staffing shortages across the service and were proactively trying to recruit nursing staff. Initiatives included having a rotational post within respiratory, developing band 4 practitioners, recruiting from overseas, increasing the number of ward clerks on a weekend and introducing pharmacy support with medication rounds on the respiratory wards.
- Some wards had introduced a 'bed making team' who were responsible for making beds, topping up patients water jugs, stocking up clinical areas with PPE equipment and giving out meals.
- Some ward managers were not supernumerary and reported finding it challenging to complete management and administrative tasks such as staff appraisals due to short staffing and the need to provide clinical care on the ward. Ward managers on ward 27 and 30 said they were supernumerary.
- The trust was in the process of developing advanced care practitioners. There were nine staff in training and one member of staff had qualified.
- We observed a nursing handover and found results of investigations; nursing and medical tasks, discharges and patients risks were clearly communicated. Staff completed and updated an electronic handover document.

Medical staffing

- The medical staffing skill mix showed the trust had a slightly lower proportion of consultants, middle career and junior doctors than the England average, and a higher proportion of registrars. Consultant staff made up 33%, compared to the England average of 34%, middle career doctors (with at least 3 years in a chosen

specialty) made up 3%, compared to the England average of 6%. Registrars made up 43%, compared to the England average of 39% and junior doctors were 20%, compared to the England average of 22%.

- There was consultant cover available Monday to Friday for all specialities. Consultant out of hours cover was provided at weekends and at night.
- A medical registrar was available at all times, 7 days a week, 24 hours a day.
- The medical and elderly assessment wards had consultant cover 7 days a week. Out of hours there was a registrar and a junior doctor on each ward and a consultant on call.
- The trust had an on call respiratory consultant 7 days a week including bank holidays. The respiratory service provided a 7 day service with daily ward rounds and multidisciplinary team handover on each respiratory ward. Out of hours the acute respiratory care unit had a registrar and a consultant on call.
- Medical patients who were outliers on non-medical wards were allocated a medicine consultant to oversee their care. Consultants visited the wards to review patients. We reviewed the medical records of 8 medical outliers and found they had all had a medical review daily with the exception of one patient.
- The trust had redesigned the acute medicine CSU junior doctor rotas in response to staff feedback. There are a minimum of four junior doctors during the evening and several working new "twilight" shifts.
- All out-of-hours junior doctor shifts were paired with a more senior doctor. Junior doctors were not expected to cover wards without direct help.
- All shifts incorporated a full 30 minutes at the start and end to allow a full handover to take place and meeting had been relocated to dedicated accommodation.
- In March 2015 the percentage of locum use within the acute medicine CSU was 6.3% and within the cardio-respiratory CSU it was 3%.
- On ward 9 patients said they were seen by a doctor regularly and in a timely manner.
- Ward 31 and 30 were rehabilitation wards. Consultants carried out ward rounds twice a week and medical cover was provided Monday to Friday 9am-5pm. Out of hours staff would contact the GP on call service or in an emergency would dial '999'.

Medical care (including older people's care)

- Staff identified challenges around recruitment of consultants on acute medical wards. The service had 2 WTE vacancies. The service was developing advanced care practitioners and physician assistants to provide support to medical staff.
- Junior doctors confirmed that consultants were easily accessible if needed and that training was accessible. Junior doctors were involved in the rotas and each CSU had a leadership fellow who acted as a liaison between the consultant and junior doctors when making decisions about staff rotas.

Major incident awareness and training

- The trust had appropriate policies with regard to major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Some staff were not clear on their specific role in the event of a major incident but were aware on how to access the major incident policy for guidance via the trust intranet.
- The trust considered seasonal risks when planning medical beds within the trust.

Are medical care services responsive?

Good



We rated responsive as good because:

- The service took into consideration the needs of different people when planning its service, for example the use of 'medically fit for discharge' wards.
- The service consistently met the referral to treatment time standard for patients on an incomplete pathway.
- The service provided reasonable adjustments for vulnerable patient groups such as those living with dementia and those who have additional needs due to learning disabilities.
- The service were aware of the challenges around access and flow and had 16 ongoing work streams focusing on improving patient flow.
- Complaints and concerns were dealt with in an open and timely manner.

However:

- Up to three patients could be waiting on a trolley on the assessment ward whilst they waited to be allocated a bed. We found a lack of governance around the types and number of patients who waited on trolleys.

Service planning and delivery to meet the needs of local people

- The trust worked closely with local clinical commissioning groups (CCG's), stakeholders, patients and staff to plan and deliver services to meet the needs of local people.
- The trust strategy focused on developing ambulatory pathways, and avoiding unnecessary hospital admissions. The trust had held a workshop with key members across the organisation including lead clinicians, ward sisters, matrons and CCG's, to look at where medical assessments happen and look towards reorganising care pathways to improve efficiency.
- In a response to the increased demand on capacity and number of medical outliers, the trust worked closely with community partners. For a 6 month trial period, the trust took over the running of ward 31 from another trust. The aim was to cohort patients who were waiting rehabilitation and reduced the number of patients who were outlying on other wards within the hospital.
- The trust made further attempts to reduce the number of medical patients outlying on other wards by designating two wards in the hospital as 'medically fit for discharge' wards.
- Ambulatory care was provided on JAMA, 18 cubicles were available 24 hours a day, seven days a week. Twelve of these cubicles were bed spaces, patients that required admission occupied these beds, staff told us this was due to a lack of capacity in the acute medicine bed base.

Access and flow

- The NHS has a national indicator of 18 weeks from referral from a general practitioner to treatment time. Between December 2015 and February 2016 all but one of the medical specialties was performing at 90% or above for the RTT. Each specialty within the service individually achieved the target with the exception of gastroenterology which achieved 83%.

Medical care (including older people's care)

- Between September 2014 and August 2015 there were 73,896 medical admissions to Leeds Teaching Hospitals NHS Trust, 43,700 were at SJUH. Of these admissions, 61% were emergency admissions, 8% were elective admissions and 31% were day cases.
- Emergency and non-elective patients were admitted via accident and emergency or JAMA. Patients were then transferred to an acute assessment ward for further investigations, and would be transferred to a base ward if they required ongoing care and treatment.
- Between February 2015 and January 2016 the trust reported 73% of patients were not moved during their inpatient stay, 16% of patients were moved once, 6% were moved on two occasions, 4% were moved on three occasions and 2% were moved on four occasions or more. Staff said the number of bed moves reflected patient flow throughout the trust and was based on clinical need.
- We reviewed the number of patients moved wards after 10pm. In November 2015 649 patients were moved, in December 2015 774 patients were moved and in January 2016 836 patients were moved after 10pm. This represented a small number of patients for the size of medical services at SJUH.
- One patient told us they were moved wards at around 3:45am in the morning. The patient reported they were well informed of the move and the reason for it happening.
- There had been no mixed sex accommodation breaches in the last 12 months.
- The average length of stay for patients at SJUH was above the England average for elective and non-elective admission. For elective admissions the average length of stay was 5.5 days compared with the England average of 3.8 days. For non-elective admissions the average length of stay was 8.6 days compared with the England average of 6.8 days.
- The trust had 18 work streams focusing on improving patient flow. The work streams focused on reducing avoidable hospital admission, and reducing patient's length of stay. Two of the work streams had been completed and the remaining were ongoing. Examples of different work streams included concentrating consultant cover in the morning on the admission wards to improve timeliness of discharge, conducting an audit of readmitted patients over the age of 70 years to identify any key themes and auditing the common delays in patient pathways and implementing any recommendations.
- Data provided by the trust showed in March 2016 there were 310 medical outliers and in April 2016 there were 290 medical outliers.
- In May 2016 the trust held a workshop with staff to explore ways to reduce admission rates with the overall aim of reducing the number of medical outliers. The workshop identified a process to reduce admission rates through the development of a frailty assessment model. However, the workshop identified the need for further collaborative working with other organisations.
- All outliers were linked to the ward they were transferred from and remained under the care of the consultant. We reviewed medical outliers nursed on the surgical wards. Patients were allocated a consultant from either elderly medicine or general medicine. Staff on surgical wards told us elderly medical consultants visited outliers once per day but for general medical patients consultants did not always visit every day.
- From the previous inspection in December 2013 concerns were raised about patients being transferred to wards prior to their bed spaces being ready. We found that all the assessment wards still had 'trolley patients'. Each ward could take up to three patients. Patients were transferred to the assessment wards (wards 26, 27, 28 and 29) on trolleys and waited for a bed rather than waiting in accident and emergency.
- At a local level, ward 27 collected data on the number of patients waiting on trolleys and the length of time it took for patients to be moved into a bed space. We reviewed this data and found on the 8 May 2016, two patients waited on trolleys. One waited for 2 hours 30 minutes and the other 2 hours. On the 9 May 2016, four patients waited on trolleys. The waiting time ranged from 2 hours to 3 hours. On the 10 May 2016, five patients waited on trolleys. The waiting times ranged from 2 hours 30 minutes to 5 hours. The clinical director was made aware of any trolley waits and all patients were discussed at the DOP meeting.
- We requested further data from the trust on the number of patients waiting on trolleys on the assessment wards and the length of time it took for patients to be moved

Medical care (including older people's care)

in a bed space. The trust said they did not collect this data. The trust had established a task group to agree a process and governance framework to enable the trust to monitor and take any action.

- The trust had a team of hospital flow managers and bed managers who were responsible for patient flow throughout the hospital. The trust held DOP meetings to discuss capacity within the hospital.
- Ward 11 had opened in January 2016 to support winter pressures. Matrons monitored the staffing levels on the ward daily and staff were released from other CSUs to support the running of the ward.
- Wards had discharge coordinators to support discharge planning. Staff were proactive in commencing discharge planning and used daily board huddles to discuss patient discharges.
- Home planner documentation was being introduced to the wards. The document was completed by the discharge coordinator with patients and relatives and used to support hospital discharge.
- The trust was working closely with external partners and had good links with community services. The early discharge assessment team (EDAT) team worked on the acute assessment wards, 7 days a week, to support discharges and identify patients who could be discharged with intermediate care.
- In March 2016 the acute medicine CSU reported 140 delayed transfers of care. In April this had reduced to 129. Delayed transfers of care were patients who were medically fit for discharge and awaiting either a package of care, care home placement or further rehabilitation.
- The trust had attempted to cohort delayed transfers of care. Ward 14 and 16 were allocated to patients deemed medically fit for discharge and who were waiting for a package of care or care home placement. Staff said the average length of stay could be up to 6 weeks.
- High bed occupancy levels, the high volume of medical outliers and patients who are medically fit for discharge and the impact on patient flow were identified on the acute medicine CSU's risk register.

Meeting people's individual needs

- Interpreting services were available for patients whose first language was not English. Staff explained the process of booking an interpreter to us however, some staff reported a delay in getting interpreters to the ward.

On ward 19 staff gave an example of using written notes to communicate with a deaf patient as a British sign language interpreter was not available until the end of the week.

- Staff allowed relatives to stay on the ward for patients whose first language was not English, but said they would use an interpreter to discuss sensitive medical information.
- We saw a system of magnets in use on boards and by beds, to identify patients living with dementia (forget me not symbol), learning disability (get me better logo) or who were deaf or hearing impaired and patients who had other specific needs, such as falls risk or pressure sores.
- The trust used the 'Forget Me Not' symbols to identify patients with dementia. A nursing specialist assessments was undertaken when patients with dementia were admitted into hospital, this triggered the completion of 'Know Who I Am' documents, which were kept at the end of patients' beds and enable staff to have a better insight into individuals and their likes and dislikes.
- The older people's wards had adopted a dementia friendly approach. The wards had visual signage on both the walls and doors and along the corridor, used coloured toilet seats and installed red doors for bathrooms and toilets.
- The trust had identified dementia champions. Their role was to promote the use of 'forget me not', know who I am booklet and appropriate use of risk symbols at the bedside to identify dementia patients and their risk factors.
- Ward 14 had a reminiscence activity room for dementia patients. The Women's Royal Voluntary Services ran creative sessions with patients. Staff said movies were shown using a pop up screen resembling an old cinema.
- Staff said they could refer carers to a dementia carer support workers. They offered a variety of support including; listening to the carer, support with discharge and help with grants and benefits.
- The trust supported John's Campaign, a campaign that was developed in order to allow families and carers to stay on the ward with patients with conditions such as dementia. This was discussed at older people's sister meeting and was been rolled out across the wards.

Medical care (including older people's care)

- The trust provided training data on the number of staff who had completed dementia training. Within the acute medicine CSU, 403 members of staff had completed Level 3 dementia training. From the data provided, it was not clear out of how many staff this was.
- There was a specialist nurse for learning disabilities. Staff described using a 'get me better!' hospital passport, which detailed personal preferences, likes/dislikes, anxiety triggers and interventions.
- On ward 9 there was a 'hospital communication book' which included some finger-spelling, Makaton and pictures which was used for communication with patients who were deaf or who had a learning disability.
- We saw a wide range of information leaflets were available to patients on all of the wards. Some of these were past their review date. For example we saw an 'infection prevention and control' leaflet that was due for review in May 2014 and a 'how can we prevent pressure sores' leaflet that was due for review in November 2012. Out of the 12 information leaflets we saw, 8 were overdue their review date.
- Staff we spoke with explained that they could easily access bariatric equipment, and equipment arrived on the ward within an hour. This included access to special beds, wheelchairs, chairs and hoists. Staff also got support from the moving and handling team.
- Staff explained that they would hold multidisciplinary meetings to discuss and plan complex discharges. The majority of patients said they felt well informed and involved with discharge plans, they reported that all their preferences had been taken into account and they had been involved in decision making.
- The trust had an acute psychiatry service that staff could access 24 hours a day, seven days a week. The elderly medical wards had a daily visit from the psychiatrist to review any patients identified as needing input.
- Ward 8 had created a kitchenette for relatives to use, using ward donations.
- On ward 30 and 31 volunteers came on to the ward to do activities with patients in the day room.
- Every afternoon on wards 14, 16, 30 and 31 patients were offered afternoon tea and homemade cake.
- We reviewed complaint data provided by the trust. Between March 2015 and February 2016 the service received 80 complaints. Themes of complaints included hospital discharge plans, lack of communication about care and treatment and care received on the ward.
- We saw complaints posters and leaflets available on all wards we visited and 'speak to sister' and 'are you concerned about the number of nurses looking after you?' posters encouraging patients and visitors to raise any concerns or questions.
- Some patients said they did not know how to make a formal complaint but they would speak to the nurse in charge if they had any concerns.
- Staff were able to describe how they would deal with a complaint, and understood the role of the patient advice and liaison service (PALS) and formal complaints process.
- We reviewed four complaints letters and found an apology was offered when care fell below the expected standard; the trust was responsive to concerns raised and staff met with the families concerned.
- The service held fortnightly reviews of all complaints with the patient relations team and key CSU members. Sharing of lessons learnt from complaints was through CSU governance meetings. Any themes from complaints were shared with staff through ward meetings and the CSU newsletter.

Are medical care services well-led?

Good



We rated well-led as good because:

- The trust had a clear vision and strategy. Each individual CSU had devised a clinical business strategy, giving ownership to staff.
- The trust values included being patient centred, fair, collaborative, accountable and empowered. This was known as 'The Leeds Way'. The values were well embedded amongst staff.
- Managers and staff had a good understanding of what risks their services faced and mitigated against these wherever possible.
- At a local level we saw strong leadership of services and wards from clinicians and ward managers.

Learning from complaints and concerns

- Each ward recorded and submitted the number of complaints to the CSU ward healthcheck. In January 2016, no formal complaints were made to the service.

Medical care (including older people's care)

- Staff spoke positively about the culture within the organisation and recommended the trust as a good place to work.

However:

- Concerns were raised at the previous inspection about patients waiting on trolleys on the assessment wards before a bed was available. The trust had introduced a standard operating procedure and criteria however, we found a lack of oversight into the type of patients that were allocated to wait on a trolley.

Vision and strategy for this service

- The trust vision, values and goals focused on being the best for specialist and integrated care, and aimed to be the best for patient safety, quality and experience.
- Staff worked together to develop the trust values known as 'The Leeds Way'. The five values were to be patient centred, fair, collaborative, accountable and empowered. The values were well embedded amongst staff we spoke with. We saw posters throughout the wards and hospital displaying 'The Leeds Way' values.
- Ward managers told us that 'The Leeds Way' values were integral to staff appraisal.
- Each individual CSU was responsible for developing a clinical business strategy. This framework encouraged ownership from individual CSU's.
- There were clear strategic plans in place for all medical services that linked to the trust's five year strategic plan.
- The management team were able to explain the strategy for acute medicine. The focus included, more integrated working, developing joined up working between accident and emergency and acute medicine, admission avoidance and developing ambulatory pathways.

Governance, risk management and quality measurement

- Each CSU held monthly clinical governance meetings. We reviewed minutes from meetings and saw discussions about patient care and safety, complaints, clinical effectiveness and outcomes, a review of RCA's and incidents and any learning to be shared. Any lessons learnt were disseminated to staff via ward managers and CSU new letters.
- The service had governance processes and systems in place to ensure performance, quality and risk was monitored. Each CSU met weekly and used the ward

- healthcheck to audit a range of quality indicators including the number of falls, complaints, pressure ulcers, staffing vacancies and staff sickness. This information was reviewed at head of nursing and matrons meetings and at clinical governance meetings.
- Trust wide and CSU risk registers were in place and were regularly reviewed and updated. Risk registers were reviewed quarterly at clinical governance meetings and twice a year by the Trust Board. If any risks were identified outside of the meeting, they were added to the risk register.
- We reviewed the CSUs risk registers. Risks were categorised using a risk matrix based on the likelihood of the risk occurring and the severity of impact. All risks were given a current risk rating. Key controls were put in place to reduce the risk and assurances to assess if the controls were effective.
- The longest standing risk on the acute medicine risk register was from April 2015 and was reviewed in March 2016. There were four risks from this date. One of the risks related to high occupancy levels, high numbers of medical outliers and patients who are medically fit for discharge and was given a risk score of 20. Controls put in place to mitigate the risk included actions in place including use of additional beds, an agreed approach to the management of medical outliers by consultants and relevant specialities and increasing pharmacy cover, 7 days a week to support discharges.
- Every six months, each CSU attended the trust risk management meeting chaired by the Chief Executive to discuss the CSU risk register.
- Concerns were raised at the previous inspection about patients waiting on trolleys on the assessment wards before a bed was available. The trust had introduced a standard operating procedure and criteria however, we found a lack of clinical oversight into the types of patients that were allocated to wait on a trolley on the assessment wards.

Leadership of service

- At ward level staff told us they felt well supported by their ward managers and senior staff. All staff described an open door policy and said ward managers were approachable.
- All ward managers were enthusiastic, and told us they were well supported by their matrons who gave support with day to day operations, including nurse staffing.

Medical care (including older people's care)

- Not all ward managers had dedicated management time due to staffing shortages and the need to provide clinical care on the ward. This impacted on their ability to spend time on management and administrative issues such as staff appraisals.
- We saw matrons were visible on the wards we visited and observed one matron answering call buzzers on a ward. Ward managers all reported that matrons had a 'hands on' approach, were proactive and visited the wards daily. Staff described matrons as approachable and supportive.
- Staff spoke positively about the Chief Executive and senior leadership team and the changes they had made in the organisation. Staff said they did regular walk arounds in clinical area and spoke with staff.
- We saw that the trust had a whistleblowing policy that provided guidance on how to raise concerns. Staff said they knew how to raise concerns.
- Staff and volunteers told us they enjoyed working for the trust and support staff such as porters and domestics told us they felt part of the team.
- Physiotherapist working on the acute wards said members of the CSU had spent time with them to gain a better understanding of their role.
- Three members of staff on ward 31 felt unsupported by the trust during their transfer from another. However, they felt well supported on a local level.
- The ward healthcheck was used on all wards to audit a range of quality indicators. Any wards that were rated red for three consecutive months were placed in escalation and got support from the corporate nursing team. Staff spoke positively about the team and said they supported staff to make changes and drive improvements.

Culture within the service

- Staff told us they felt proud and enjoyed working for the trust. Staff felt part of the team they worked in.
- Staff felt confident to raise any concerns about patient safety and that managers would listen and would take appropriate action. We saw posters displayed on wards providing information about how to speak to the sister or matron if people had concerns.
- Junior medical staff said they felt supported by senior medical colleagues and consultants.

- Staff gave positive feedback regarding the culture in the organisation and described the trust as a good place to work. They felt the culture encouraged staff to be open and honest and to report incidents and learn from them.
- Staff felt that the senior leadership team had brought about a change in the culture within the organisation; staff described a new, proactive way of working.
- The trust and individual CSU held annual award nights to recognise and celebrate staff success.

Public engagement and staff engagement

- Friends and family test results were displayed. On ward 19, 91.2% of people would recommend the service, on ward 9, 100% of people would recommend the service, and on ward 11, 93.8% of people would recommend the service.
- Staff felt engaged to participate in the ward healthcheck which audited a range of care quality indicators including patient falls, complaints and pressure ulcers. Wards were awarded certificates in recognition of a reduction in the number of falls and pressure ulcers. Staff felt this was very positive and created a sense of ownership amongst wards.
- The trust held Schwartz rounds. This was a forum for hospital staff from all backgrounds to come together to talk about the challenges of caring for patients. It offered staff a confidential and safe environment to share patient care issues and to offer support to each other.
- Staff felt confident to raise any concerns about patient safety and that managers would listen and would take appropriate action.
- Ward 21 had volunteered to be involved in a patient and public engagement research study.
- Staff meetings took place regularly on most of the wards. Information was shared with staff via an e-bulletin. Staff felt well informed and up to date with issues within the trust.

Innovation, improvement and sustainability

- Patient safety huddles had been introduced to reduce patient harm and enhance a patient safety culture. The safety huddles enabled staff to share any learning from incidents.
- The service was supporting the development of staff through the development of an accredited acute medicine course for registered nurses.

Medical care (including older people's care)

- Nurse-led wards for patients who were medically for discharge had been introduced to allow the service to adapt their staffing model to meet the needs of patients.
- In response to patient carer feedback the acute medicine CSU had introduced John's campaign. This allowed carers to stay in hospital with patients with dementia.
- Within respiratory medicine, senior consultant ward rounds occurred 7 days a week to improve patient care.
- In June 2015 the former CSUs' (digestive diseases and hepatorenal) merged to become the abdominal medicine and surgery CSU. This enabled more collaborative working amongst the medical and surgical teams and offered a better quality care and experience for patients, as well as timelier access to services when patients required cross-service care.

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

Information about the service

The Leeds Teaching Hospitals NHS Trust (LTHT) provides surgical care across four sites. Elective and non-elective surgical services at St James's University Hospital (SJUH) are managed by five clinical service units (CSUs). They provide a range of services including day surgery, general surgery, lower and upper gastrointestinal surgery, breast surgery, urology, ophthalmology, ear, nose and throat, maxillofacial and transplant surgery.

SJUH has 303 inpatient beds and 42 day-case beds spread over 15 surgical wards and a surgical assessment unit (SAU). There are 22 operating theatres within four theatre suites, Chancellor, Geoffrey Giles, David Beevers and Bexley. The trust has one of the highest numbers of admissions in the country; between September 2014 and August 2015 there were 63,358 surgical admissions to LTHT. Approximately 57% of these were admitted to SJUH. Of these, 48% were day case admissions, 26% were elective admissions and 26% were emergency admissions.

In March 2014 the CQC carried out an announced comprehensive inspection and overall we rated surgical care as requires improvement. We rated safe, responsive and well-led as requires improvement, effective and caring were rated as good.

This inspection took place on the 10, 11, 12 and 13 May 2016 and was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection. During our inspection we visited each of the theatre suites, the SAU and eight surgical wards.

We spoke with 54 staff of various grades including doctors, nurses and support workers. We also spoke with operating department practitioners (ODPs), administration staff, domestic staff and members of the management team. We reviewed 14 sets of patient records and medication charts.

We observed care and the environment, handovers and safety briefings. Prior to the inspection we reviewed the hospital's performance data.

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Summary of findings

We rated surgery as requires improvement because:

- We were concerned that two Never Events had occurred relating to the wrong site anaesthetic block. Guidelines in place since 2010 were not embedded and not followed in both incidents. Learning from Never Events was not consistent amongst all staff.
- We found examples of the controlled drugs policy not being followed in relation to second signatures for administration.
- All steps of the World Health Organisation (WHO) safety checklist were not consistently taking place and audit data and our observations supported this.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- Mandatory training figures for resuscitation were below the trust target of 80%.
- The 18 week referral to treatment time national indicator of 90% was not being achieved by all surgical specialities.
- The number of operations cancelled was higher (worse) than the England average.
- We were not assured that the operations taking place out of hours were always appropriate and we were concerned that the senior management team did not have oversight of this.
- Whilst risk registers reflected risks to the service, several had been on the register for three years. Short term mitigation was still in operation which was affecting the ability to provide long term solutions.

However:

- A number of audits relating to patient safety were carried out and the results were publically available.
- We observed good documentation and appropriate use of antibiotics.

- Emergency equipment was checked daily.
- Nurse staffing was being managed well despite vacancies in a number of areas.
- Enhanced recovery pathways were in use and being developed for other specialities.
- We found good examples of meeting individual care needs of patients and ongoing collaborative working to further improve patient care.
- Staff reported an improved culture and were engaged and able to escalate any concerns.

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Are surgery services safe?

Requires improvement



We rated safe as requires improvement because:

- We were not assured of consistent sharing of learning around never events.
- Geoffrey Giles theatres had some areas which required more robust adherence to safety and infection prevention and control procedures.
- We found instances of second signatures missing from controlled drug administration records.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. Patients were not always given their copy of the consent form. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- The post brief did not always take place following surgery and audit data supported this.
- There were staffing shortages within theatres and fill rates for registered nursing staff from February to April 2016 were between 38% and 55%.
- Training compliance figures for resuscitation were below the trust target of 80%.

However:

- A variety of audits were undertaken in relation to patient safety in addition to the safety thermometer. This information was available to the public.
- Resuscitation equipment was checked daily in the areas we inspected.
- We saw evidence of generally good medicines management, supported by prescription charts being fully completed. We also saw good audit and review in relation to antibiotic use.
- Record keeping was generally of a good standard, except in relation to consent, and we saw evidence of appropriate escalation for deteriorating patients. Staff training and quality improvement work in relation to the deteriorating patient was evident.
- Despite having nursing vacancies, staffing was managed well on the wards with appropriate assessment and response to any staffing shortages.

Incidents

- Never Events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Between October 2014 and September 2015 there had been three Never Events within surgery at the trust. Two were attributable to the SJUH site, one related to a retained swab following surgery and one related to a wrong site anaesthetic block. A second incident of wrong site anaesthetic block occurred within six months at Chapel Allerton Hospital. We reviewed the investigation reports and related action plans of the Never Events. They included a review of service delivery problems and contributory factors; a root cause was identified with associated recommendations and lessons learned. Areas of good practice were also noted and an action plan developed.
- We reviewed the recommendations and action plans in relation to the retained swab never event. There was a focus on the impact of human factors and consistency with regards guidelines and processes within theatres. Accountable items and completion of the World Health Organisation (WHO) safety checklist were a particular focus. We observed pre-printed white swab boards and swab safe used in theatre. Human factors are the way individual characteristics combined with the work environment and organisation can influence behaviour and affect health and safety.
- Whilst on inspection staff told us about a more recent never event of wrong lens implant surgery which occurred in January 2016. The investigation showed that appropriate processes had not been followed. Staff told us of changes in practice such as ward staff not leaving theatre until biometry had been done. Biometry is a test to measure the shape and size of the eye. Following this, standard operating policy guidance was developed and seen displayed in theatre.
- The staff we spoke with gave a mixed response with regards to learning from Never Events and some staff were not aware of any. However other staff were able to give details of the different never events, saying never

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events were in the 'risky business' newsletter. Some staff also said their managers and team leaders attended monthly incident review meetings and following these they were provided with feedback lessons learned.

- Incidents were monitored through the trust's CSU governance meetings and we reviewed minutes of these. There was a variety of ways in which information relating to incidents was shared. This included a trust wide safety brief which was circulated via email to all trust staff and discussion at senior nurse and team meetings. Safety huddles were also used to share information and some incidents were discussed in the theatre debrief.
- Trust policies for reporting incidents, near misses and adverse events were embedded within surgery. Incidents were reported on the trust's electronic reporting system. Staff of various grades could tell us how they would report an incident and many could describe the process for a recent incident they had reported.
- The 2015 National NHS Staff Survey showed the number of staff reporting errors, near misses or incidents witnessed in the last month was less than the previous year. In 2014 92% of staff had reported incidents; this had dropped slightly to 88% in 2015. The national average for the same time period was 90%.
- A total of 2,386 incidents had been reported within surgery at SJUH between March 2015 and February 2016. Of these 80% resulted in no harm. Staff told us that the main themes of incidents were pressure ulcers and falls.
- In response to this, quality improvement work was in progress with the help of an external agency. Part of the work was focused on reducing falls; with the aim of reducing the number of falls by 50% on 14 pilot wards. The work was to be undertaken with the trust wide falls team and J83 was one of the wards to initiate the interventions.
- Incidents were reviewed by ward managers but also seen by the matrons. The surgical wards held twice daily safety huddles where incidents were highlighted. High risk patients were also identified such as those at risk of falls. Within the operating theatres a safety huddle also took place. We observed this; staffing and equipment were discussed as well as the message of the week which was pressure area care.
- We were provided with examples of change in practice following incidents. For example, following an incident

with sliding scale insulin, only staff nurses are to record blood glucose levels for patients receiving this. The clinical educator was auditing the use of identity cards for accessing the blood glucose machine to ensure there was no sharing of cards. We saw information relating to this incident in a ward newsletter, reminding staff to follow trust policy.

- We were told about an incident where the wrong patient was given an intravenous antibiotic. The staff reported an open culture in relation to this and how the incident was used to raise awareness and vigilance amongst staff.
- Serious incidents are incidents that require further investigation and reporting. Between March 2015 and February 2016 there were eight serious incidents attributed to SJUH. They occurred in different areas and there were no themes identified. A root cause analysis was undertaken to investigate serious incidents. Following this an action plan was generated.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014. Staff spoke about being open and honest and we observed information for staff about the duty of candour displayed in ward areas.
- The investigation reports we reviewed evidenced the duty of candour requirements being met. For example an apology and explanation was given to the patient and their relatives following the retained swab Never Event.
- We saw evidence of mortality and morbidity reviews by each surgical speciality and we looked at meeting minutes and presentations. Each had a different forum for the discussion of mortality and morbidity. For example within plastic surgery the review took place within their audit meeting. Vascular surgery had dedicated mortality and morbidity review meetings; each displayed evidence of discussion and lessons learned.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at

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risks such as falls, pressure ulcers, venous thromboembolism (blood clots), and catheters and urinary tract infections (UTIs). The data is collected monthly.

- This data was seen displayed in ward areas. The percentage of 'harm free care' for the surgical wards at SJUH from January 2016 to May 2016 was between 83% and 100%. At SJUH there were 48 pressure ulcers, 14 falls with harm and four catheter UTIs recorded via the Patient Safety Thermometer between March 2015 and February 2016.
- The trust was one of 20 hospitals participating in a pilot scheme called 'open and honest care'. The information gathered was available on the trust's website for the public to view and was updated each month. It included data on pressure ulcers, falls, Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile rates. Patient and staff experience surveys and safety thermometer data was also shared.
- Data was collected by each ward and displayed within the ward health check dashboards by each CSU. This information was red, amber and green (RAG) rated to show areas of improvement and decline. For example data from December 2015 to January 2016 showed ward J47 was improving in relation to patient falls as the number had reduced from three to zero.
- VTE (blood clots) risk assessments were carried out within the trust. Data showed that from February 2015 to February 2016 each of the surgical CSUs at SJUH had achieved above the trust target of 95% for completing these.

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed in clinical areas on the number of days since the last Clostridium difficile and Methicillin-Resistant Staphylococcus Aureus (MRSA) infection. There had been seven cases of MRSA within the trust during 2015/2016, and one case since April 2016 which was within surgery. This was above the trajectory of zero.
- The previous report had identified Clostridium difficile rates were higher than expected for the trust. During 2015/2016 110 cases were reported against a trajectory of 119, indicating an improving picture.
- 'Reduce the risk of Clostridium difficile' audits were done by each ward as part of the high impact interventions (HII). HII are care bundles designed to

ensure high quality patient care by means of continuous audit and review. A total of 14 HII were completed each month including areas such as central line insertion and urinary catheter insertion.

- In addition to this audits were undertaken in relation to infection prevention and control. This included hand hygiene audits and ward health check data.
- We reviewed data in relation to each of these areas for each CSU, which was red, amber and green (RAG) rated to indicate the level of compliance. For example, within abdominal medicine and surgery hand hygiene compliance was between 92% and 97% from July 2015 to February 2016. This information was also displayed in ward areas.
- Information specific to each CSU was collated in performance dashboards. This included MRSA and Clostridium difficile rates. For example within the head and neck CSU there had been no reported cases of MRSA between February 2015 and February 2016. However there had been one case of Clostridium difficile in November 2015 and three in December 2015.
- Infection prevention and control training was mandatory and compliance rates within surgery at SJUH were above the trust target of 80%.
- The trust had a policy for MRSA screening for emergency patients. Elective patients were screened at pre assessment. We reviewed compliance rates with screening and noted they were generally above the trust target of 95%. The main exception to this was the head and neck CSU which had compliance rates between 88% and 94% from February 2015 to January 2016. However the figure for February 2016 had increased to 95%.
- Single rooms were available for those patients requiring isolation; signage was in place to advise anyone prior to entering an isolation room. There was an isolation bay in Geoffrey Giles PACU at SJUH; it was noted the disposable curtains did not have a date to indicate when they had last been changed.
- The wards and theatres had infection control link nurses who attended regular meetings and gave feedback to their teams.
- With the exception of one member of staff in theatre, bare below the elbows guidance was adhered to by staff in the clinical areas we inspected. We observed good hand hygiene and appropriate use of personal protective equipment (PPE).

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- Alcohol gel and hand wash basins were available at the entrance to wards and departments with notices encouraging visitors and staff to use them. There was also good access and supply of PPE including gloves, eye protection, masks and aprons within the operating theatres.
- Equipment cleaning labels were used and this provided assurance that re-usable patient equipment had been cleaned and was ready for use. We saw these in some areas; however commodes on wards J42 and J43 did not have them in place although they were visibly clean.
- The surgical wards had their own domestic staff and the house keeper on J42 showed us the cleaning schedule for the ward.
- We observed separation of clinical and non-clinical waste in line with trust policy in ward areas.
- Within the operating theatres we saw different coloured waste bags in use. Operating theatres in David Beevers theatres had a yellow bag attached to the anaesthetic machine and an orange bag at the other end of the operating theatre. We spoke with staff about the two different coloured bags and it was not clear why there were two colours within theatres. In PACU there were small orange bags attached to the side board near to the head end of each trolley bed. There were also some yellow bags elsewhere in the PACU area. Staff were unclear about the different coloured bags and what waste would be suitable for orange bags and yellow bags. This was raised with the trust who said they would investigate this.
- The general environment of PACU in the different theatres we visited was clean and uncluttered. Bexley theatres were clean and well maintained.
- In the Geoffrey Giles theatre suite the lockers outside the changing rooms had theatre scrubs, used hats and food wrappers on top of them. One of the theatres had a clinical waste bin which was overflowing. We observed black bin bags being used for recycling; however these were seen hanging from storage shelves. We also observed a sharps bin on the floor which had no lid and contained non-sharps.
- Surgical site infection surveillance was carried out across Leeds Teaching Hospitals. Each quarter a different speciality was selected. Specific to SJUH surveillance of breast surgery was undertaken in quarter three of 2015, it remained within the national benchmark.

Environment and equipment

- Ward areas and theatres were visibly clean and tidy and generally free from clutter. However there were several pieces of equipment stored in corridors in Geoffrey Giles theatres which could cause an obstruction.
- Geoffrey Giles theatre had undergone a project to review storage, standardising where equipment was stored in each anaesthetic room making it easy to locate items.
- In the sluice room within David Beevers theatres it was noted that the vinyl on the wooden cupboard fronts was peeling off. This presents as an increased cross infection risk as damaged surfaces cannot be cleaned as effectively.
- We were told there was a rolling programme of equipment replacement.
- Bariatric equipment was available from the equipment pool and we were not told of any issues in accessing this. Ward staff told us high-low beds had to be ordered but could be obtained when needed. High-low beds can be used for patients who are at risk of falling as they lower to the ground, meaning a patient is less likely to injure themselves if they get out of bed.
- At the previous inspection concerns had been raised over the quality of the outsourced central sterile services department. This had improved with a new provider now being used. We spoke with many staff in different theatres and no issues were raised. Sterilisation of equipment took place off site and was returned the following day.
- We inspected equipment for evidence of safety checking. This is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at all types of equipment and with the exception of a two patient warming machines which were due for testing in May 2015 and November 2015, all had in date safety checks.
- In ward areas resuscitation trolleys were easily located on main corridors. Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). We inspected resuscitation equipment in four of the wards and were assured that daily checks had been undertaken. However it was noted that none of the

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trolleys had tamper proof seals. This meant that staff could not be assured that equipment was still in situ following checks being completed as the contents of the trolleys were easily accessible.

- The resuscitation trolleys in theatre also did not have tamper proof seals; however we saw documented evidence of daily checks being completed. There were two resuscitation trolleys in Geoffrey Giles PACU, we asked two staff where the checklists were for the trollies. We were directed to a general safety checklist attached to a cupboard door. We asked about individual checklists but were told there wasn't one. Another nurse found the individual checklists which had been completed and informed us the resuscitation team had visited the day before and brought updated checklists.
- We observed a difficult airway trolley outside PACU, in a clearly marked area. The trolley was clean and labelled clearly.
- 'Hypo kits' were seen in ward areas to treat patients with a significantly low blood sugar.
- The previous report had highlighted the SAU as being cramped with no showering facilities for patients. A new unit had been built which had a seated waiting area, ensuite single rooms and a treatment room for minor procedures. The bays were spacious with showering facilities.
- We observed the pre-operative waiting area in the Geoffrey Giles theatre suite. The area had space for four patients but was cramped. We saw three female and one male patient in this area, it appeared crowded but the patients raised no concerns and only stayed there for approximately ten minutes.

Medicines

- Medicines administration and safety training formed parts of the trust's mandatory training. Compliance rates for surgery were above the trust target of 80%.
- Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed the controlled drugs records on four wards. Accurate records were maintained and balance checks were performed in line with the trust policy. The only exception was a second signature missing for the administration of a controlled drug on J42.

- In Geoffrey Giles PACU the controlled drug record book was not locked away. In theatre seven there was a note on the controlled drug record book reminding a doctor to sign for two controlled drugs administered on 24 March 2016.
- Controlled drugs procedures had been on the abdominal medicine and surgery CSU risk register since 2015. Weekly assurance checks were being reviewed by the head of nursing.
- We observed fridges for storing medications and found these to be locked and temperatures recorded daily.
- In ward areas medicine trolleys were locked and secured to walls when not in use. Patients own medications were stored in individual lockers accessed by a key pad.
- Intravenous fluids were stored in clinical rooms, which could only be accessed with a swipe card.
- We reviewed 12 prescription charts which were all fully completed including patients' allergy status. Four patients had been prescribed antibiotics, only one had not had a review following three days of it being prescribed.
- We reviewed audit data relating to the use and prescribing of antibiotics within each clinical service unit (CSU). The results were generally positive with review dates in place for 92% to 100% of charts reviewed. The chief pharmacist and the clinical governance pharmacist lead said there were robust systems in place for monitoring antibiotic use. We saw stickers in use to remind staff to review antibiotics on day three of them being prescribed. There were also prompts on the prescription charts.
- We saw information displayed on medicines in patient profile summaries (MAPPS) in ward areas. This is a way of accessing patient information about medication as well as providing them with reminders about when to take medications. This information could be printed off and given to patients on discharge.

Records

- We reviewed 14 sets of records across the surgical wards and theatre. We found them to be completed appropriately and each contained completed risk assessments on topics such as Malnutrition Universal Screening Tool (MUST); skin integrity and falls.
- We were told that consent to surgery is most often done on the day of surgery and that patients didn't always get a copy of their consent form. From the 14 sets of notes

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we reviewed 11 of these required consent for surgery. We found three patient copies had been removed from the notes meaning they had been given to the patient. However, the remaining eight were still in the medical notes. All of the 11 patients had been consented on the day of surgery.

- We reviewed a further ten consent forms and all patients had been consented on the day of surgery. Six sets of notes contained patient copies of consent forms. Several of these patients were undergoing elective surgery.
- We reviewed audit data provided by the trust on consent from October 2015 to December 2015 looking at 30 patients across three surgical specialities. It showed that two out of 30 patients were consented in advance of their procedure.
- The General Medical Council (GMC) guidance on consent: Patients and doctors making decisions together, states: "Give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks".
- We discussed this at the senior management meeting and with consultants. We were told elective patients were seen by a consultant several weeks prior to surgery and a follow up letter was sent explaining the procedure and associated risks. A full and frank discussion took place allowing patients to think about their intended procedure; there was no opportunity to provide a consultant at pre assessment to enable patients to sign their consent form. The trust felt assured that patients were adequately informed prior to surgery. However the trust consent policy of a two stage consent process was not consistently followed.
- We also discussed the observation regarding the majority of patients not being given copies of their consent form. The management team agreed this was something to be reviewed and if patient copies were not going to be given should they be removed from the consent form? The trust felt assured that the clinic letters patients were sent provided sufficient information about their surgery.
- Consultants told us about patients on non-surgical wards getting to theatre with no completed consent form. This was supported by conversations we had with theatre staff about the pre-wait patient area in Geoffrey Giles theatres. The phrase 'gate keeper' was used and we were told that on occasion patients arrived in the

pre-wait area, from non-surgical wards, not having their consent to surgery completed. Staff were then required to ring the ward and liaise with staff to try and sort out the problem.

- We were told incident forms were completed if patients arrived in theatre without the appropriate checks and documentation in place. We reviewed incident data from March 2015 and February 2016 and found no evidence of consent forms not being completed on arrival to theatre.
- We visited the Ophthalmology day unit and found unattended patient medical records in a patient area (approximately 200 sets). This was raised with staff at the time who said the notes were in preparation for the following day. Lockable storage was available but staff said due to the limited space it was not used. On our unannounced inspection notes were in the same place. We were told the ward was locked overnight and no-one had access, and staff monitored them during the day.
- Medical records and nursing documentation was stored securely in other clinical areas we visited.
- Electronic discharge summaries were completed for patients and a copy sent to their GP.

Safeguarding

- Staff received mandatory training in safeguarding of vulnerable adults and children. All staff completed Level 1 safeguarding for adults and children. Adult Level 2 safeguarding training was completed by band six and seven staff. Training was recorded per CSU and was RAG rated with green being above 80%.
- Training for the CSUs specific to surgery at SJUH (with the exception of the theatres and anaesthesia, and head, neck and ophthalmology, which was cross site) showed compliance rates for adults and children's safeguarding Level 1 at above 80%. Level 2 training for both adults and children was variable with figures between 23% and 100%. It should be noted these figures were for a small number of staff; on a ward it may have only been three staff members who required such training which would account for the broad variances in compliance.
- Staff told us safeguarding training was available online.
- Trust protocols around safeguarding were easily accessible and staff were aware of what signs to look for and how to escalate any safeguarding concerns.
- There was a safeguarding team who were available for advice.

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Mandatory training

- The staff we spoke with stated that mandatory training was well organised and training incorporated 23 elements including fire safety, information governance and equality and diversity.
 - Mandatory training was highlighted as an area for improvement at the previous inspection. At this inspection, we noted significant improvements with most areas achieving above 90% compliance.
 - The main exception to this was resuscitation training where compliance figures were between 69% and 74%. Some staff mentioned issues with availability of basic life support and immediate life support training. We were not told of a specific plan to address this, however we were told the training was provided by the hospital resuscitation team and the volume of people needing training was a challenge.
 - There were designated training coordinators in clinical areas. They had oversight of training in their area and received a spreadsheet each month showing RAG rated compliance rates. We saw these displayed in clinical areas, for example on ward J42 overall compliance was 85%. Ward sisters spoke positively of the new training interface and how it recorded and monitored mandatory training.
 - We observed three random staff electronic training files and all staff were up-to-date with their mandatory training.
 - In theatres they had a half day for audit each month so this time was used to complete mandatory training.
 - During this inspection, many staff were undergoing their annual appraisal and many stated that it was a good process. This was an area of concern highlighted at the previous inspection. We saw evidence of appraisal meetings being booked for those members of staff yet to have one completed. Appraisal rates were between 90% and 98% at SJUH against a target of 95%. The time-frame for completion of appraisals had not been reached during the inspection.
- exception was one patient on ward J45 who had NEWS score of five; there was no evidence in the medical or nursing notes that this had been escalated in-line with trust policy.
- The deteriorating patient intervention bundle was launched in June 2015 following collaborative working with 16 wards utilising the 'Model for Improvement' as a framework for testing new interventions. Following testing of these interventions and making changes in their areas the 'Deteriorating Patient Intervention Bundle' was launched in June 2015. This focused on patients with a serious infection (sepsis) and acute kidney injury. Part of the work with an external agency also focused on reducing the number of avoidable cardiac arrest calls by 70% on the pilot wards. This looked at things such as ensuring correct calculation and escalation of NEWS scores and timely identification of patients approaching end of life care.
 - We reviewed audit data on deteriorating patients from April 2015 to February 2016 which looked at eight aspects including correct NEWS scoring and referrals for 'at risk' patients. This data was per CSU. The data showed an overall improvement for the eight areas. For example with abdominal medicine and surgery (AMS) in February 2016, the total of completed actions was 95%. Between May 2015 and October 2015 it had been between 82% and 90%. This meant more patients were being identified early as being at risk of deterioration and the appropriate escalation and monitoring took place.
 - We observed falls prevention being discussed at safety huddles and high risk patients being identified. We also observed cohorting of patients who were assessed as high risk of falls to ensure they were monitored more closely. We also saw external agency staff being used to provide one to one supervision.
 - The AMS risk register highlighted a lack of a robust patient tracking system for surgical patients. This resulted in clinical teams experiencing difficulty in locating patients during ward rounds. The risk register stated this presented a risk that patients would not be reviewed promptly because the manual tracking system in use was reliant on individual's completing it; this risk was added to the risk register in March 2016.
 - The surgical staff we spoke with did not highlight this as an issue. However, we were told that only the on-call registrar carried a bleep. Due to poor mobile coverage if the registrar was needed nursing staff would have to go

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and find them in person. The majority of staff said this was not an issue and if they needed a doctor they could get one. We did observe registrars returning to wards following the ward rounds to review patients or ask staff if they had any concerns.

- We were told it could be difficult accessing the medical team for medical patients on surgical wards. We observed a nurse spending ten minutes trying to locate the correct doctor. On J42 during handover it was noted a medical patient was transferred despite an alert in the IT system saying 'not to lodge'; this was escalated by the day team.
- A bleep system was not in use so the relevant medical ward had to be contacted by phone. We did see a list of doctors to contact which staff reported had improved the process.
- We saw information about sepsis training for all clinical staff. Additional study days were provided on managing acutely ill patients and staff we spoke with who had attended gave positive feedback. We observed a management pathway for patients with a high NEWS score displayed in the SAU.
- Staff told us about a simulated session run in theatres about the deteriorating patient; staff said they found this a useful learning exercise.
- There was a critical care outreach team who would come and support ward staff if a patient was deteriorating. Since the last inspection the team had increased its provision to provide 24 hours a day, seven days a week service.
- The hospital followed the five steps to safer surgery procedures and WHO safety checklist. We reviewed audit data relating to this which was collected per speciality and per theatre suite. Audits were done monthly and reviewed ten patient records.
- Data from February 2015 to February 2016 showed compliance to be 79.8%-100% for pre brief, 42.5%-100% for post-brief, 98.8%-100% for sign in, 98.2%-100% for time out and 86.4%-100% for sign out.
- Data per theatre suite showed compliance rates for Geoffrey Giles theatres were significantly lower. Overall pre brief was completed only 52.5% of times and post brief 42.3%. We were not aware of any specific plan to address this.
- Additional audits were completed for specific theatres by other staff. For example an audit was conducted of theatres three and four in Geoffrey Giles by a junior

doctor in February 2016. This identified generally excellent compliance but it noted the absence of radiologists from the team brief and safety checks. Recommendations were made to invite them to join.

- We observed aspects of nine WHO checklists in David Beevers and Geoffrey Giles theatres. We observed four team briefs, three of which had good engagement from all team members. The briefing sheet was completed, equipment and instruments were discussed a clear finish time identified. The acute theatres held a team brief prior to every patient being sent for and this was observed during our inspection.
- The fourth was attended by all key staff including surgeon and anaesthetist. Key questions were asked including if the operating list was as published. Each patient was discussed including any issues regarding infection and what equipment was required. However there was a slight disruption to the brief because a member of staff partly entered the theatre through the side door to ask the registrar a question, the registrar then left the theatre to take a call. Ideally, the brief should not be interrupted.
- In the five remaining observations we observed the sign in, time out and sign out all completed as required. However as the audit data showed, the post brief did not occur. From our discussions with theatre staff they told us the post brief was the more difficult stage to do as the surgeon may leave theatre soon after skin closure to write the notes. Also there may not have been any issues with the operation. However, theatre staff we spoke with said there would be a post brief if something had not gone according to plan during the patient's time in theatre.

Nursing staffing

- The service used three staffing acuity tools, including the safer nursing care tool, to review staffing establishments based on patient dependency. Professional judgement also formed an important part of this process.
- Senior management said staffing levels were reviewed every six months. From the previous inspection staffing levels had improved however nurse staffing was still identified as a concern on the risk registers.

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- There was a clear escalation process for staffing concerns and staffing was discussed at daily operational performance (DOP) meetings. NHS professionals were used to fill any gaps in staffing as well as redeployment of staff from other areas.
- Within the trust, there was active and ongoing recruitment of staff, particularly nursing and medical staff.
- With the exception of the ophthalmology ward all areas we visited had some nurse staffing vacancies. For example within the AMS CSU there were 103.1 whole time equivalent (WTE) vacancies. However, the feedback from staff on the wards was that there had been an improvement with regards to staffing levels. Comments such as 'less use of agency' and 'staffing much improved' were made.
- We reviewed overall bank and agency fill rates for the wards at SJUH for February 2016 to April 2016. They were between 93% and 94% for registered staff and 91% and 94% for unregistered staff.
- We reviewed data relating to staffing fill rates for individual wards at SJUH from October 2015 to January 2016. For registered staff these were between 92% and 130% with the exception of ward J82 which was between 81% and 87%. Fill rates for the same time period for unregistered staff were 82% to 185%. We were informed that the electronic rostering system did not take into account flexible working to support some staffing gaps. For example, if a staff member was used from another area to help for a couple of hours, such as on the SAU where they had access to surgical nurse practitioners.
- Staffing was co-ordinated by matrons during the day and nurse practitioners at night. We were told it was fluid throughout the day so can flex as needed. Staff on the wards we visited told us they help each other out and sometimes sorted out staffing issues between themselves. Electronic rostering was in use which enabled staff to easily view staffing in other areas. If a ward/department was short of staff or needed some help for a period of increased activity, staff could see if other wards could support them without needing to escalate to a matron. In a focus group we were told by health care support workers they could be moved regularly to support other areas but staff had no issues with this.
- We were given an example of the escalation of staffing concerns from the previous week. One of the wards had produced their next rota and staffing numbers were low. This was escalated to the matron and a plan was put in place in advance.
- Ward J43 had 10 WTE vacancies. We were told of interim plans to support the ward in terms of staffing. This included moving staff from other areas for a short time until some vacant posts were recruited to. We reviewed staffing rotas for this area for April 2016 and found actual staffing levels were higher than the planned for both registered and unregistered staff.
- Within theatres and anaesthetics there were 63.7 WTE vacancies, this data was for SJUH and LGI. Data on fill rates for registered staff in theatre from February 2016 to April 2016 was 38%, 90% and 55% respectively. Staff reported challenges particularly in PACU, however staff did say the recent increase in the number of band six nurses had improved staffing skill mix. We were told PACU was run on four staff for eight theatres. We reviewed rotas for April 2016 and found that actual staffing levels were only slightly below the planned (4085 and 3869).
- In David Beever theatres we were told five staff were currently going through induction and would soon be added to the rota.
- There were induction checklists used for new staff, bank and agency staff to orientate them to the area. We were told of a buddying system for support workers, where new staff would pair up with a more experienced worker. Bank staff were also allocated mentors.
- We observed four formal nursing handovers on separate wards and handover between theatre and recovery staff. We also observed safety huddles on the wards and in theatre. Informal handovers took place as required throughout the day.
- The nursing handovers were well structured and a clear plan for each patient was identified. The reason for admission and medical history was given. Patients due for discharge, or who were living with dementia or at risk of falls, were highlighted.
- During one particular handover we observed, from theatre to PACU, the curtains were drawn as the patient was distressed. Clinical information was handed over by the anaesthetist and a handover prompt sheet was displayed.

Surgical staffing

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- We reviewed medical staffing and spoke with consultants, middle grade and junior doctors. Medical cover was available on-site 24 hours a day. Consultants were available 24 hours, with on-call cover provided at evenings and weekends. The on-call rota for surgery provided two consultants each day; one consultant specialising in upper gastrointestinal surgery and the other in lower gastrointestinal surgery. Each consultant was present for a minimum of ten hours per day and had no other clinical commitments whilst on call. The consultants were on call for several days at a time to ensure appropriate continuity of care.
- The on call consultants were supported by two specialist registrars. One was for acute patients only, the second helped to support theatres and cover referrals from Leeds General Infirmary.
- In addition there was a resident surgical officer (RSO) who was based on the SAU and provided 24/7 cover.
- Foundation year doctors supported the wards and the SAU. Surgical nurse practitioners (SNP) were also available to provide support; a further four SNPs were due to qualify towards the end of the year (2016).
- The percentage of middle grade and junior doctor's was below the England average. However the consultant and registrar group was higher. We discussed gaps in the middle grade rota with the senior management team as it had been highlighted as a concern from discussions with staff. We were assured gaps were covered using locums and some internal cover from consultants.
- We reviewed medical agency and locum use from January 2015 to March 2016 across the CSUs.

Rates remained consistent, for example in theatres and anaesthetics percentages were between 7.4% and 12.4%.

- We observed a medical handover which had full team attendance and we saw good participation and engagement.

Major incident awareness and training

- The trust had a major incident plan and business continuity plans. These were available to staff on the trust intranet.
- Staff reported that there had been good planning and provision by the trust during the recent junior doctor's strikes.
- There were protocols for deferring elective activity to prioritise unscheduled emergency procedures.

Are surgery services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Only two surgical specialities were performing above 90% for the 18 week national indicators.
- The number of cancelled operations was worse than the England average.
- Data from the productive operating theatre and our observations showed delayed theatre start times.
- We lacked assurance that the operations performed after 10pm were always appropriate.
- Information relating to patient flow and decision times to admit patients were not routinely recorded in the surgical assessment unit. The lack of data meant the responsiveness of the unit was not being measured and there was the potential for mixed sex accommodation breaches.

However:

- There had been collaborative work streams to improve services for patients.
- We were provided with examples of recognition and management of individual needs of patients.
- We saw evidence of sharing and learning from complaints.
- Enhanced recovery work was in place for some specialities and being developed for other to improve patient pathways.

Service planning and delivery to meet the needs of local people

- For service planning, senior staff worked with local commissioners of services, the local authority, other providers, GPs and patient groups to co-ordinate care pathways. Integrated care was one aspect of the trust's five year strategy. This included working with the Health and Social Care Transformation Board looking at city-wide working to provide more 'joined up' care for patients.
- Another aspect of this was developing the Leeds Academic Health Partnership. This aimed to develop collaborative working between NHS trusts, universities and local authority, with the focus on improving patient outcomes.

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- Use of information technology allowed patient information to be accessed more easily, for example, information produced by GPs. This meant the hospital was alerted of any risks prior to a patient's admission so staff could begin to plan ahead. For example if a patient had previously had any safeguarding referrals made.
- The trust was building partnership arrangements with other surrounding hospital trusts to be able to offer specialist care to patients closer to home.
- The AMS CSU formed in June 2015 following the merger of the Digestive Diseases and Hepatorenal CSU's. This enabled more collaborative working between medicine and surgery. In turn, the care and experience for patients was better with timelier access to services.
- The trust had signed up with NHS England to be an early implementer of seven day services. A seven day service was already provided for acute services. This included a full range of diagnostics, consultant-directed interventions and ward rounds. SJUH provided a 24 hours a day, seven days a week service for acute surgical specialities and acute operating theatres.
- Following discussions with staff, it had been highlighted that some operations taking place 'out of hours' were not always appropriate. This was discussed with the senior management team who did not have any concerns.
- On our unannounced inspection we looked at operations out of hours. We saw from the night before a manual evacuation of a patient's bowels had taken place at 1am. This was not felt to be appropriate and the consultant in theatre agreed.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) provides guidance and classification on surgical interventions. The categories are immediate, urgent, expedited and elective. The guidance is clear that these categories relate to the procedure being undertaken and not the theatre list which is being utilized. Immediate relates to life or limb saving interventions. Urgent relates to acute onset or deterioration of conditions that threaten life, limb or organ survival. These two categories can and should be operated on within minutes and hours respectively. This includes use of theatres at night for both categories.

Access and flow

- Data on theatre utilisation showed varying results due to the different operations performed in each theatre. The percentages for day surgery in David Beevers theatres were between 69% and 72% for the three theatres in January 2016. The elective theatres in Geoffrey Giles had an average usage of 83% for January 2016. The acute theatres, located in Geoffrey Giles had an average utilisation of 61% for January 2016.
- The SJUH site had a robotic theatre for performing some urological procedures. A urology pathway had been developed to treat patients who were diagnosed with cancer within a week.
- Emergency theatres were accessible seven days a week and elective lists ran six days a week. The ophthalmology day unit had between four and six lists a day, Monday to Friday.
- Theatre one in the Geoffrey Giles theatre suite was an acute theatre and ran 24 hours, seven days a week. Theatre two was also an acute theatre and ran from 8am to 6pm. Morning sessions Monday to Friday were 'ring fenced' for urology, gynaecology and thoracic procedures. This theatre was also shared with the transplant team.
- From the discussions we had and the data reviewed we were not assured that the operations being performed at night were always appropriate. We requested data from February 2016 to April 2016. The data showed 155 operations were performed between 10pm and 8am, 91 of which commenced prior to 1am. From 1am up to 7.59am, there were 64 cases. The data was broken down by the trust and showed there were 13 laparotomies / laparoscopies, 11 transplants, nine laparoscopic appendectomies, six emergency obstetric cases, four emergency lines, three emergency thoracic cases, two colectomies and six abscesses. This gave a total of 54 leaving ten operations unaccounted for.
- At SJUH 625 (1.5%) of the 42,331 scheduled operations between January 2015 and December 2015 were cancelled. This was higher (worse) than the England average of 0.8%. Of these cancelled operations, 63 were not treated within the 28 day target.
- For quarters two and three of 2015/2016 the percentage of patients whose operation was cancelled and were not treated within 28 days had dropped to 3%, which was below the England average of 5%.
- We were told by several staff that a lack of critical care beds had had a significant impact on theatres. For example, operations being cancelled on the day and

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some patients requiring high dependency or intensive care having to remain in PACU. 20 operations were cancelled due to lack of critical care beds from January to March 2016.

- The senior management team were aware of the issues with critical care capacity. There was a willingness to improve, however the ability to recruit nurses was identified as a challenge. The trust acknowledged the impact this was having on patient flow. Plans such as working with partners for repatriation, escalation and close team working had been implemented to work together to prioritise patient flow.
- We observed daily prioritising of patients who could be 'stepped down' from critical care, and the use of high observation beds as an alternative to critical care. We also observed the director of operations meeting which looked at bed availability and planning for the day. It was identified that there had been one patient in PACU overnight so they were a priority to be moved to critical care.
- The electronic theatre system generated daily operating lists. Elective patients were booked six weeks in advance. The system was able to produce several reports including start times and theatre utilisation; such information was then able to be analysed.
- The productive operating theatre (TPOT) was in use at SJUH. This is a project designed to help theatre teams to work together more effectively and improve the quality of patient experience, as well as the safety and outcomes of surgical services. Data relating to this was updated each week and we saw information displayed within theatres. For example in Bexley theatres TPOT data showed for April 2016 late starts were at 77.9%. In Geoffrey Giles acute theatres one and two, we saw a 'know how we are doing board'. Data for April showed 100% late starts, 12% cancelled operations, 28% early finishes, 36% late finishes, and in session utilisation 69.5%. This gave a mixed picture in relation to performance.
- For example, during our inspection we observed a theatre list in theatre one (Geoffrey Giles) which was due to start at 8am. At 7.50am the first patient had not been consented which created a delay and the second patient had not been kept nil by mouth. A decision on bed availability for the third patient was being waited upon and consequently the list didn't start until 9.30am.
- There were processes in place to try and avoid theatre delays. For example we observed a meeting where all the theatre lists were reviewed to try and identify and resolve any issues the day before.
- At trust level, only two of the surgical specialties (Cardiothoracic Surgery and Ophthalmology) were performing at 90% or above for the 18 week referral to treatment national indicator (Complete Admitted) in February 2016. The following specialties were all performing under 70%: Ear Nose & Throat (ENT) (59%) and Oral Surgery (29%), although the total number of completed pathways (with a known clock start) were relatively low for both ENT (100) and Oral Surgery (70).
- Overall trust performance for the surgery core service was 81.3%, which was above the England average of 75.8% in February 2016. RTT remained on the risk register for all CSUs with plans in place to review activity and report through trust performance meetings.
- Data from January 2016 to March 2016 showed at SJUH there were 228 operations cancelled on the day; 103 of these were due to no ward beds being available. This was from a total of 15,170 operations at this site and Leeds General Infirmary.
- The average length of stay for elective urology was similar to the England average (2.2 days against 2.1 days). For elective general surgery the average length of stay was better (less) than the England average. Data from September 2014 to August 2015.
- The average length of stay for non-elective surgery was higher (worse) than the England average. 5.8 days compared to an England average of 4.2 days for general surgery and 4.7 compared to 3.1 for urology. Data from September 2014 to August 2015.
- Enhanced recovery programmes were in place for some elective surgical procedures such as hemicolectomies (bowel resections). Enhanced recovery is a programme to improve patient outcomes and focuses on optimal recovery and discharge for patients. We were told about, and saw work in progress, in relation to enhanced recovery for prostate cancer surgery. This work was being undertaken with an external agency which supports health care transformation.
- We had mixed feedback from staff in relation to medical patients on surgical wards. Some junior doctors told us their productivity was being affected as they told us too much time was spent locating patients. We were told this was due to electronic records not always being updated.

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- There were medical patients on surgical wards during our inspection. For example, J47 had nine medical patients and J43 had four. On ward J45 there was one medical boarder, we were told during the previous week there were issues over which consultant was responsible for the medical patients. A rota was reviewed and showed it was a particular consultant; however they were on annual leave.
- On ward J84 we observed a whiteboard which noted medical and surgical outliers. We were told this was updated daily. Staff reported no issues in knowing which consultant outlying patients were under the care of.
- We reviewed incident data from March 2015 to February 2016 and found six incidents relating to the delay or difficulty in obtaining medical assistance; the incidents related to different surgical wards.
- A purpose built SAU was opened in 2015 which improved patient experience and flow through the hospital. The SAU took admissions directly from GP referrals and from the emergency department at SJUH and LGI. A telephone triage system was in place for GP referrals; referrals from the emergency department were done via a telephone call with the RSO.
- Patient flow on SAU was monitored using a white board which was written on by hand. Various staff within the unit added information to the board, such as time of arrival and when a patient was ready to be transferred to a ward. Although the staff on the unit understood the board, as someone new to the department it was not clear what was happening with each patient. When a patient left the department the data on the white board was wiped away, however some of the data was captured in the patient's medical and nursing records. The data was not recorded centrally. We asked about audit data relating to the number of admissions and outcomes and were told this data was not routinely collated.
- We observed the electronic system in the pre wait area of Geoffrey Giles theatre. Staff updated the system when the patient was ready and theatre staff then took the patient to the anaesthetic room.
- We were told of situations where, due to lack of beds on the ward, patients were moved from Bexley theatres PACU to Geoffrey Giles PACU. Bexley theatres did not have an acute theatre therefore PACU closed at 7pm. The impact of this was that Geoffrey Giles PACU could be

busy with patients remaining there for a longer period of time than necessary. There were 48 patients classed as overnight stays in PACU between February 2015 and February 2016.

Meeting people's individual needs

- The wards were accessible for people who used a wheelchair or walking aids. Disabled toilets and showering facilities were available in the ward areas we visited.
- Assessments took place on admission or during pre-assessment to identify individual patient's needs. This information was used to inform care planning. We spoke with a patient's parent who was 'very impressed by the staff's responsiveness and willingness to respond to the specific needs of their autistic son'. This included a side room being made available and extra time taken to explain things to him.
- We also observed a patient who had sustained a previous head injury which resulted in them having limited communication. The nursing documentation showed notes from discussions with carers on how to best communicate with the patient to enable them to make their needs clearly known.
- We also observed ongoing assessment, for example, during the nursing handover on ward J43 it had been identified that a patient required a number of subcutaneous injections to administer medication. Staff suggested the insertion of a cannula to remove the need to keep injecting the patient.
- Translation services were available for people whose first language was not English. We asked staff about translation services and were told it was booked online, and translators would either come in or translate over the phone. Staff told us there were no issues with accessing and using this service.
- Leaflets and diet information was available in different languages. Physiotherapy staff told us they gave patients written information on post-operative care and exercises, they were also available in languages other than English.
- From speaking with staff and reviewing records we were assured that staff were aware and responsive to the needs of different people. Different food choices were available and chaplaincy for different religions and faiths.
- We observed a discussion between a ward sister and the bed manager over a patient due for admission that had

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complex needs. It was felt that the ward they were currently on was not suitable as it would be difficult for the staff to meet their individual needs as they received nutrition via a nasogastric tube. An alternative ward was identified with staff who were used to that method of feeding patients.

- We observed a flow chart for discharging patients who may have required additional support due to experiencing mental health issues.
- A flagging system was in place for patients with a learning disability. The hospital also had a specialist nurse for learning disabilities. Staff spoke about 'Get Me Better' which identified personal preferences and any methods which would help reduce anxiety.
- We saw 'Know Who I Am' documentation for patients living with dementia. 'Forget Me Not' symbols were also displayed to identify patients to staff.
- Dementia training was provided for staff and most wards and departments had dementia champions.
- We did note that for patients who had been in hospital for a significant period of time there was a lack of activities to keep them occupied and provide variety to their day. This was identified by some staff as something on their 'wish list'.

Learning from complaints and concerns

- Data from March 2016 to April 2016 showed there had been 11 complaints relating to surgical services at SJUH. Themes of the complaints were, care and treatment and communication.
- Data on complaints was also incorporated in the CSU performance dashboards. For example, the head and neck and abdominal medicine and surgery (AMS) CSU dashboard for January 2016 showed no complaints had been received.
- Posters on how to complain were seen in clinical areas and PALS leaflets were available. There was also a pilot to have PALS services in reception areas to make them more accessible.
- Staff told us they always attempted to resolve specific issues at ward level and encouraged patients to speak out if they had concerns as early as possible.
- The number of complaints received was observed on designated displays in ward areas. In staff rooms we saw more detailed complaints data displayed. For example,

on ward J43, PALS complaints information was displayed with any themes identified. We also saw information on a formal complaint, directing staff to the complaints file for the action plan.

- Staff told us themes of complaints were in relation to discharge from hospital and nursing care.
- We were provided with an example of a complaint by a senior nurse about a dependent patient and their individual needs. Issues were raised in relation to leadership, hand hygiene, diabetes care and communication. Following this, daily hand hygiene checks were completed and work taken on escalation of concerns. The action plan was discussed at senior nurse meetings to share learning.
- Complaints were discussed at CSU clinical governance meetings.

Are surgery services well-led?

Good



We rated well-led as good because:

- The individual clinical service units (CSU) had a clear strategy which linked to overall trust strategy with patients and staff integral to its success.
- The Leeds way and the values and behaviours associated with it had become embedded amongst staff.
- We found evidence of good governance arrangements and quality information updated monthly in dashboards.
- All staff spoke of a positive change in culture. Staff felt engaged and proud to work for the trust.
- We saw positive leadership at all levels and staff felt confident in escalating concerns.
- Friends and family test data was positive with over 90% of patient saying they would recommend the service.
- There was a range of innovative work and research being undertaken by the trust to develop their services. For example, transplant surgery and urology cancer pathways.

However:

- We were not assured that the senior management team had oversight of operations taking place out of hours.

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- Although the risk registers accurately identified risks to the service, mitigation of these risks was impacting longer term plans. Several of the risks had been on the registers for three years.

Vision and strategy for this service

- We reviewed the overall trust strategy which had a clear focus on collaborative working and integration of services. Patients and people were key to the success of the strategy with recognition of the importance of clear communication and the skills and experience of the workforce.
- We reviewed the CSU's local strategies which were aligned to the overall strategy. There was a focus on quality and patient experience. Each CSU had a clear direction and goals with steps identified in order to achieve them. For example within the AMS CSU the aim was to be a centre of excellence for organ transplantation; the use of technology and innovation featured highly in the strategy to achieve this.
- Most of the staff we spoke with made reference to 'The Leeds Way'. The five values underpinning this were to be patient centred, fair, collaborative, accountable and empowered. Staff were clear about the trust's vision of being patient centred.

Governance, risk management and quality measurement

- Surgical services at SJUH were in five of the 18 CSUs. Each CSU and clinical speciality held monthly governance meetings. We reviewed several meeting minutes across the CSUs. There were discussions on incidents and clinical issues as well as performance, patient care and finance.
- We reviewed performance dashboards for each CSU which displayed data for individual wards on a range of areas. The dashboards were RAG rated and indicated an overall direction for each ward. They included patient safety information such as falls, as well as staffing vacancies and sickness rates; this information was discussed at weekly CSU meetings.
- Corporate and CSU risk registers were in place. We reviewed and discussed the content of the CSU risk registers with the senior management teams. All risks were given a risk rating and the risks and issues identified reflected the current risks to the service. For example the RTT in ENT had been identified. Dedicated management had been put in place. This had improved

the 18 week target and there had been no six week breaches. However the dedicated management had impacted on the ability to focus on longer term plans and pathways. This risk had been on the register since 2013.

- We were concerned that there had been two never events relating to wrong site anaesthetic block. Both investigations showed the 'stop before you block' process was not embedded. This guidance has been in place since 2010.

Leadership of service

- Staff were overwhelming positive about leadership in the trust at all levels. Comments such as 'very motivational and inspirational' were used to describe individuals.
- We spoke with ward managers who felt exceptionally well supported by their matrons. A ward manager who was new in post reported having weekly one to one meetings in which their learning needs were identified and plans developed to meet them.
- Staff of all grades spoke positively of the visibility and approachability of matrons and more senior staff. Several staff spoke of how they felt listened to and that they were encouraged to voice their opinions.
- The matrons were present in clinical areas each day and had weekly meetings with the head of nursing to share information.
- Performance dashboards helped inform ward staff and the management team on a number of quality indicators. Any areas rated red for three consecutive months were placed in escalation and additional support was given.
- We spoke with staff that were new to trust and they felt the trust had a lot to offer in terms of learning and progression; staff spoke positively about this.
- The hospital was one of five trusts to take part in the NHS Improvement Partnership working with

NHS Improvement and an external agency. The programme is about ensuring the trust provides the highest quality care whilst reducing inefficiencies in the service. The five year programme focuses on learning from the experiences of others and empowering clinical teams to have continuous quality improvement across the organisation.

Culture within the service

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- Many of the staff we spoke with made reference to 'The Leeds way'. We did not receive any negative comments from staff. Many said there had been a notable change in the culture of the hospital; the culture was more open and staff felt listened to.
- The staff who had been involved in the learning from the wrong site cataract surgery never event told us there had been a 'no blame' culture in relation to this. Learning was undertaken with the involvement of staff in a supportive way.
- Staff at all grades felt confident to raise concerns.
- Comments were made such as 'I feel proud to work here' and 'it's one of the best places I've worked'.
- Although within theatres where there were some staffing challenges, staff reported good morale and peer support.
- We observed good working relationships between nursing and medical staff.
- Staff reported how small changes had made a big impact. For example the, 'hello my name is' campaign to ensure everyone introduced themselves, and getting a thank you at the end of a shift.
- Staff told us about monthly question and answers sessions with the trust's Chief Executive and improved communication between departments. Staff said they 'felt they knew what's going on in other areas' which has been an improvement.
- Junior doctors told us the Chief Executive came to their trust induction which they thought was excellent practice.
- Staff felt there was improved sharing of information with dedicated notice boards in clinical areas around performance.
- Link nurse roles had been developed to improve staff engagement within clinical issues.
- Nurses attending the urology audit day engaged well with consultants and were able to make them aware of specific nursing issues.
- We were told that consultants led certain teaching days and these would, in the future, also be attended by staff nurses and health care support workers. This would provide an opportunity for ward and theatre staff to meet.
- Staff felt that the appraisal process was effective and it was a process which supported them in taking on additional roles and responsibilities. For example, the staff involved in the urology enhanced recovery programme received a full week of training which included looking at standardising the certain procedures, discharge planning, reducing length of stay and patient experience.
- Nursing teams were involved in the development and planning for the new surgical assessment unit.

Public engagement

- Friends and family test (FFT) data was collected and information relating to this was displayed in ward areas.
- Data for surgery at SJUH showed a 40% response rate which was above the England average of 36%. Over 90% of patients said they would recommend this service for most wards at this site.
- Information relating to FFT was also included in the performance dashboards and provided an overall direction for each ward. For example, ward J43 was showing an improving picture in January 2016. Response rates were 44% with 100% recommending the ward.
- In addition the trust conducted compassion in care audits. This data was collected monthly and RAG rated for each area. Patients were asked five questions based on whether their care had been compassionate and if they had felt involved. Data for the head and neck CSU saw overall percentages to be between 91% and 100% between April 2015 and February 2016.

Staff engagement

Innovation, improvement and sustainability

- Organ transplantation which included a live liver donation and transplant programme had been undertaken which was the largest in the UK. Other aspects of the transplantation programme included Neonatal organ retrieval and transplantation: Life Port Trial: Kidney Transplantation: QUOD Trial: Quality in Organ Donation National Tissue Bank, Revive Trial: Organ Care System and Normothermic perfusion: Support for Hand Transplantation.
- Work was ongoing in relation to Viral Hepatitis C and the trust is a designated site for implementation of Hep C eradication therapy.

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- Procedures such as minimally invasive oesophagectomies were being performed. The colorectal team were using sacral nerve stimulation for faecal incontinence.
- There was a focus on research with 80 trials being run across all specialities by 20 research nurses.
- A Glaucoma Monitoring Unit had been established to ensure all follow up glaucoma patients had screening and a virtual follow up review.

Critical care

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

Information about the service

Leeds Teaching Hospitals NHS Trust delivers services to a population of around 760,000 and provides specialist services for more than five million people.

Adult critical care is a key support service to the majority of surgical services for post-operative care as well as being a key service in its own right providing care for acutely unwell patients being admitted from wards, acute theatres or directly from A&E.

Adult critical care takes a lead for care of the deteriorating patient and manages the critical care outreach services and the resuscitation service.

Critical care at St James's University Hospital (SJUH) consists of Ward J53, General ITU with 21beds, ward J54 HDU and elective surgery with 14beds. And additional 14 beds are outside of the clinical service unit (CSU). There were 10 respiratory HDU beds on J10 with 4 thoracic and oncology beds on J84.

We visited wards J54, 81and J84 and spoke with patients and relatives who were happy to speak with us. We interviewed a range of multidisciplinary staff and managers. We observed staff handover and attended meetings as observers.

We looked at care records of patients these included, two medical and four nursing records; we looked at four medication administration charts and read minutes of meetings.

At the last CQC inspection in 2014, we identified issues relating to trust leadership, increasing pressure on critical care beds, an 'us and them' culture between the two main hospital sites and the lack of engagement between staff,

insufficient medical cover, the quality of the handover and support on the high dependency unit on Ward L39 at Leeds General Infirmary, which was overseen by the surgical services unit rather than the critical care service.

Critical care

Summary of findings

We rated critical care services as requires improvement because:

- Both ward J54 and ward J81 had shortfalls in their staffing levels to meet the peoples' needs and to ensure people received safe care and treatment at all times, in line with relevant guidance. Data provided showed that during the four months, Ward J54 was 88% compliant and ward J81 was 69% complaint with the expected staffing levels.
- The GPICS standards stipulate that 50% of nurses working in critical care units should have a post registration qualification in critical care. SJUH was not compliant with this with 39% of staff compliant with the standards; plans were in place to address this.
- The outreach team did not work out of hours, the current arrangements included medical and nursing support from the critical care units to the wards. However there were plans to introduce a 24/7 approach just after our inspection in May 2016 and staff had been recruited to this team.
- The critical care units could not demonstrate full compliance with GPICS 'safe use of equipment' standard which states that all staff must be appropriately trained, competent and familiar with the use of equipment. Staff we spoke with during the inspection told us they received training on equipment and were confident in using them. However information supplied by the trust on high risk equipment training showed low percentages of staff compliance with equipment training.

However:

- The leadership change at Leeds Teaching Hospitals NHS Trust has promoted management team visibility, accessibility and engagement with staff. To address the 'us and them' culture between the two main hospital sites an external facilitator was employed to help staff build useful relationship between the two hospital units.

- There was a good safety culture. Staff demonstrated an open and honest culture when responding and reporting incidents. When mistakes were made practices were reviewed, training and support was offered to staff so they learnt from mistakes.
- Safety huddles were taken up by staff and they were confident to speak up about problems.
- Environments were clean and there were effective infection, prevention and control practices embedded across the units.
- There were good handover processes in place amongst medical, nursing and multidisciplinary staff.
- Staff took into account the circumstances of each patient, their personal preferences and their coexisting conditions when planning and delivering care. The complaint policy and the procedures were well advertised and people told us they knew what to do if they were dissatisfied with the service.

Critical care

Are critical care services safe?

Requires improvement



We rated the service as requires improvement for safety because:

- Both ward J54 and ward J81 had shortfalls in their staffing levels to meet the peoples' needs and to ensure people received safe care and treatment at all times, in line with relevant guidance. Data provided showed that during the four months, Ward J54 was 88% compliant and ward J81 was 69% compliant with the expected staffing levels.
- Guidelines for the Provision of Intensive Care Service (GPICS) standard for equipment and the Medicines and Healthcare Products Regulatory Agency (MHRA), which is responsible for ensuring that medicines and medical devices are acceptably safe, stipulate that all equipment must conform to the relevant safety standards and be regularly serviced. During our inspection we found equipment had service stickers to show that they had been checked however data supplied by the trust showed that they were not fully compliant and maintenance records indicated there was between 43.8% and 69.6% compliant on the units.
- The outreach team did not work out of hours, the current arrangements included medical and nursing support from the critical care units to the wards. However there were plans to introduce a 24/7 approach just after our inspection in May 2016 and staff had been recruited to this team.

However:

- There was a good safety culture on the units. Staff demonstrated an open and honest culture when responding and reporting incidents. When mistakes were made practices were reviewed, training and support was offered to staff so they learnt from mistakes.
- Safety huddles were taken up by staff and they were confident to speak up about problems.
- Good handover process was in place amongst medical, nursing and multidisciplinary staff. Staff were familiar with the arrangements in place to respond to emergencies and major incidents.

Incidents

- Staff understood their responsibilities to identify, report and record incidents and near misses. They demonstrated an open and honest culture when responding to incidents. They said when incidents happened there was not a blame culture within the service and the cause of the incident was analysed. Where practices could be improved this was done and staff received training and support to do this.
- Managers were able to verbalise the process for reporting incidents internally and externally and how they investigated and managed the incidents.
- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The trust reported that between October 2014 and September 2015 there had been no never events within the critical care units at both sites.
- National Reporting and Learning System (NRLS) enables the public including professionals to upload patient safety information. The information for this trust revealed that in twelve months prior to the inspection there was one serious incident; where a patient developed a grade 4 pressure ulcer. A grade four pressure ulcer is the most severe type of pressure ulcer.
- Mortality case Reviews were shared amongst staff to identify good practice and lessons to be learnt. Mortality was discussed at Clinical Governance / Audit meetings on a monthly basis. We reviewed meetings from the meeting on 12 January 2016 and saw evidence of this in the minutes. The emphasis was on reviewing practice and embedding lessons learnt from case reviews in the care and treatment of patients.
- We also found that annual Mortality and Morbidity meetings were held to review themes over the previous year. The last meeting was held on 10 February 2015; we saw minutes of this meeting and saw the next meeting was held on Thursday 17 March 2016.
- Matrons and nurses had a good understanding of the Duty of Candour Regulation. They explained how they applied the regulation when dealing with mistakes and the process for giving a written apology to people who used the service.

Safety thermometer

Critical care

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm. It allows staff teams to measure harm and the proportion of patients that are 'harm free' from the following pressure ulcers, falls, urinary tract infections (UTI) in patients with a catheter and venous thromboembolism.
- The results of safety thermometer readings were available to staff on the units. Staff informed us that each month on the same day the data was collected within the units.
- Between September 2014 and September 2015 the annual Safety Thermometer check results for both sites SJUH and LGI disclosed 21 pressure ulcers, four falls with harm and two catheter associated urinary tract infections. The analysis highlighted that there were no apparent trends for all three indicators and there were no incidents of venous thromboembolism reported during this time.
- We checked the Safety Thermometer data on two units - wards J54 and J81 as ward J53 was closed.
- J81 accommodated patients requiring high dependency Level 2 care. Safety Thermometer reports between September 2015 and March 2016 demonstrated that 92.86% patients received harm free care. The harm identified were patients developing grade 2 and grade 3 pressure sores and UTIs. There were no falls or incidents of venous thromboembolism identified on this unit.
- J53 was closed and had not submitted data since 2013. The trust confirmed that when J53 was open, patients on J53 were registered as J54 regardless of bed location and data was submitted as J54.
- J54 accommodated patients with Level 3 care needs as well as Level 2. Therefore patients' needs were high and complex, requiring increased care, treatment and monitoring. The data between September 2015 and March 2016 averaged at 88.24% as patients receiving harm free care. 11.76% patients experienced harm due to developing pressure ulcers, UTIs and deep vein thrombosis (DVT). The above data was in line with the national average for such services.
- Staff informed us when incidents of pressure sores, UTI and DVT were identified they met as a multidisciplinary team and considered the possible cause and agreed on actions they needed to take and shared the information at handover sessions. We observed medical and nursing handover where staff discussed such issues at the beginning.

- The trust informed us that the prevalence of pressure ulcer was reduced by 30% after the introduction of the pressure ulcer huddle in both sites.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare-associated infection.
- We found the areas occupied by patients and the clinical areas within the units were clean and free of offensive odour.
- Sharps bins we saw were less than 1/3 full and all bins in use had a date and were signed by a member of staff in line with the local policy.
- Nurses and Band 2 health care assistants informed us that cleaning patient areas and equipment in use were their responsibility. The equipment and the bed areas we saw were clean.
- Critical care hand hygiene results for wards J54 and J81 between April 2015 and February 2016 on average was 92.7% compliance. The trust expectation was a 100%.
- We observed staff adhering to infection control policy and using personal protective equipment (PPE) when delivering personal care. Staff told us there were sufficient PPE and other disposable consumables for their use and our observations during the inspection confirmed this.
- We saw antiseptic wash available to all visitors and staff on the units. We observed people entering and exiting the units, decontaminating their hands by using the wash.
- Eight incidents relating to infection control were reported between October 2014 and September 2015, and they were categorised as 'infection'.
 - On seven occasions, the inability to isolate patients within two hours was stated as the reason. The units had side wards but the main ward areas were open plan with curtains dividing bed areas. Therefore timely isolation of patients had not always been possible.
 - On one occasion there was a delay or failure to order a test for an infection.
- We noted that there wasn't any designated area for respiratory isolation of patients i.e. providing negative air pressure in a side room. Negative air pressure prevents infection spreading out from the isolation room on to the other areas in the unit.
- Staff confirmed that they had attended training on infection prevention and control as part of their

Critical care

mandatory training. However, we were unable to report on the training compliance of the staff on each unit as this information was not available for each unit and was held centrally within the CSU.

- Care records showed that patients admitted to the unit had their Methicillin resistant Staphylococcus Aureus MRSA status checked. Trust information confirmed that during October 2014 and September 2015 patients admitted to the CCU were found to be MRSA free.
- MRSA, Clostridium difficile (C.diff) infection rates reported by ICNARC infection control data showed that SJUH performed within expectations. The results showed that there was no C.diff infection reported during 2013/2014.
- The case mix programme figures from 1 April 2014 to 31 March 2015 indicated that 15% of admissions to the unit were high risk sepsis patients. This was similar to other matching units where the patients admitted had 14.7% risk of sepsis.
- However unit-acquired infections in blood on ward 54 were 4%, which was more than similar type of units where it was 1.7%. The matron was mindful of this and promoted rigorous infection prevention amongst the multidisciplinary staff and continued monitoring.
- Adult Critical Care Antimicrobial Medicines Audits were carried out and reported each month. Eight months between July 2015 and February 2016 showed on average 90% compliance was achieved against the trust policy and professional guidance. The audit included when an antibiotic was prescribed, when it was reviewed, how long patients were on antibiotics and if patient allergies were considered.

Environment and equipment

- Guidelines for the Provision of Intensive Care Service (GPICS) standard for equipment and the Medicines and Healthcare Products Regulatory Agency (MHRA), which is responsible for ensuring that medicines and medical devices are acceptably safe, stipulate that all equipment must conform to the relevant safety standards and be regularly serviced. During our inspection we found equipment had service stickers to show that they had been checked however data supplied by the trust showed that they were not fully compliant and maintenance records indicated there was between 43.8% and 69.6% compliant on the units.
- The critical care units could not demonstrate full compliance with GPICS 'safe use of equipment'

standard which states that all staff must be appropriately trained, competent and familiar with the use of equipment. Staff we spoke with during the inspection told us they received training on equipment and were confident in using them. However information supplied by the trust on high risk equipment training showed the percentage of staff who had attended from each unit as:

- 64.2% of staff on ward J81 HDU and
 - 60.3% of staff on ward J54 ITU had received training. Furthermore
 - 65.5% staff involved in the call out resuscitation team and
 - 15.8% medical staff had attended equipment training within the two sites.
- We asked for further information from the trust in relation to staff training in the use of equipment in CCU. The trust supplied us information which showed:
 - Each unit across critical care had allocated Key Trainers for each piece of equipment used.
 - Training was delivered by the unit Clinical Educators and Key Trainers and when completed this was recorded on MELVIS (staff training database).
 - Each member of staff had a list of competencies for completion which were logged on MELVIS and reviewed at appraisal and follow up review meetings.
 - Training for new pieces of equipment was delivered by trainers provided by the company in the first instance and followed up by Key Trainers.
 - Competencies were submitted by the company to MELVIS as part of the training contract.
 - Each unit had a dedicated Clinical Educator who was available to work with staff at the bedside to support training if needed.'

Medicines

- A pharmacist visited the units each day. They informed us that they checked the prescribing, recording, handling, storage, security and disposal of medicine used in the units.
- Nursing staff were aware of the policies on administration of medicine and disposal of controlled drugs.
- The trust data confirmed that 98% of adult critical care staff had completed their Medicines Administration and Safety training, compared to the trust target of 80%.

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- Local microbiology protocols for the administration of antibiotics were in use and audits carried out and the compliance was 90%.
- We looked at four medication administration charts. We found the information was clear, dated and signed. Allergies were noted and when medication was not administered reasons were recorded.
- Ward/unit health checks were carried out each month when medication errors were monitored and action taken to minimise them. We noticed a reduction in the reported errors in January 2016 from December 2015.

Records

- Individual care records of patients and staff were managed in a way that kept people safe.
- We found the systems; processes and practices were communicated to staff to ensure safety of people on the units.
- Information about the patients and staff were kept in two formats, paper and electronic. Electronic information was stored securely and access was given through password protection. The paper records were kept securely on the units and in the offices.
- We looked at two medical/multidisciplinary and four nursing records. Records were legible, following each episode staff had updated their records, most signatures were legible, however all doctors wrote their personal identification number following their signatures so they could be recognised.
- Staff told us that they had received training on information governance and were able to discuss the importance of maintaining accurate records, confidentiality and adhering to data protection.
- They knew the process for transferring information to other areas and told us they followed the local policy.
- Patient Observations charts within the CSU were audited monthly by staff to ensure accurate record keeping. Audit summary report for 2015/2016 showed that record keeping was timely and accurate; it also highlighted some shortfalls such as 24hr cumulative fluid charts were not always completed correctly and that sometimes NEWS scores were not correct. Staff told us that monthly results were shared with them at handover.

Safeguarding

- There were arrangements in place that reflect relevant legislation and local authority safeguarding requirements to safeguard patients and staff from abuse.
- Staff understood their responsibilities and told us that they adhered to the trust safeguarding policies and procedures.
- They said safeguarding training was mandatory and they had attended and kept up to date with it. Staff knew the trust lead for safeguarding and informed us that the person was approachable and helpful therefore they were able to discuss matters freely.
- The trust data confirmed that, 97% of adult critical care staff had completed their Safeguarding Children Level 1 training, compared to the trust target of 80%.
- And 97% of adult critical care staff had completed their Safeguarding Vulnerable Adults Level 1 training, and 69% had completed their Safeguarding Vulnerable Adults Level 2
- The trust did not collect mandatory training data by individual location but by CSU. They had a robust system in place that allowed staff and the managers to know when mandatory training was due to expire.

Mandatory training

- Staff could access their mandatory training record electronically. The training record used a traffic light system to notify them when their training was due and staff received an alert. Managers received an email when staff had registered for training sessions.
- The training records for medical and allied health professionals were not held within the CSU; however we were informed that they had the same traffic light system which informed them as well as their line managers of their training status
- Staff and the managers informed us that the system was dependent on staff being up to date with their training before they were able to organise supervisions or performance reviews. This helped to monitor staff compliance with mandatory training.
- Training figures provided by the trust showed mandatory training rates were above the target of 80%.
- The trust did not collect mandatory training data by individual location but by CSU. However they had a robust system in place that allowed staff and the trust to know when mandatory training was due to expire.
- We were informed that all staff could access their mandatory training record electronically. The training

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record used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training sessions.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out during pre-operative visits for patients who came in for elective procedures. All emergency admissions had their risk assessments completed within 12 hours or as soon as possible following admission to the units.
- We saw eight nursing records and four medical notes where we found risk management plans and updated plans as changes happened. We noted patients' risks were managed positively. For example when a patient was at risk of developing pressure sores, before delivering care and treatment staff ensured the patient was free of pain, discomfort and not agitated so that tissue viability could be assessed and treated safely.
- Within critical care units deteriorating patients were identified promptly and treated. However those on the wards were assessed by outreach team with the help of NEWS scores. Decision to transfer patients on to the critical care unit was made by the consultant.
- We were informed during out of hours the critical care nurses were called out to the ward to assess patients who were deteriorating. Staff told us that this did not have any negative impact on patient care on the units.
- Consultant reviews of patients took place every 12 hours which helped with responding to the changing needs and the related risks.
- Staff talked to us about how they coped with medical emergencies and patients with challenging behaviour. They said that they had a clear process to follow and there was always a matron available to help if they needed.
- In the CSU's risk register we saw an example of how staff responded to a patient with challenging behaviour in a unit and how it was mitigated.
- The trust supplied us with the following clarification on when a patient would remain in Post Anaesthetic Care Unit (PACU). The information clarified that 'in the event that a patient has had a planned (elective) procedure and was managed in PACU following the procedure whilst a bed was made available, the patient was managed by the PACU/anaesthetic team, with support from critical care/outreach if this was required.'

- Acute patients awaiting critical care bed were managed in PACU by the staff with additional support provided by critical care nursing staff and the anaesthetist. Patients in PACU that required critical care were discussed and escalated at the daily 8am meeting, which was chaired by a senior member of the clinical management team. Action was actively taken to expedite discharges from critical care, including the review of all elective patients and to prioritise those who were in PACU.'

Nursing staffing

- Both ward J54 and ward J81 had shortfalls in their staffing levels to meet the peoples' needs and to ensure people received safe care and treatment at all times, in line with relevant guidance.
- Over the twelve months between January 2015 and December 2015 the nurse staffing model in the critical care units within both sites have been changed to accommodate the needs of the service. This meant there has been an increase in Band 8A, Band 7 nurses and the introduction of Band 1 health care assistants. However there has been a decrease in Band 2 health care assistants and bands 4 and 5 nurses. This had resulted in the drop of whole time equivalent staff from 387.22 to 379.84 making an overall reduction of 2%.
- The CSU supplied us with the planned and actual number of staff on duty to cover each unit from October 2015 and January 2016. We were assured that staffing levels were planned using GPIC Standards, which specifies the staff patient ratios according to the levels of care.
- The data provided showed that during the four months, Ward J54 was 88% compliant and ward J81 was 69% compliant with the expected staffing levels.
- We found arrangements were in place to use bank and agency staff. Agency staff on arrival to the unit completed a check list with the help of one of the nurses so that they were familiar with the unit. The matrons told us that they used the same agency to ensure continuity of staff.
- We observed handover during shift changes. Staff followed a structured approach to shift handover to promote situation awareness. The nurse who was in charge of the unit shared information on any patient safety alerts, quality and safety issues, any key performance updates and staffing capacity with the team of staff who had arrived on duty. They then went over each patient and gave all staff a summary update.

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Medical staffing

- There were thirteen consultants in post with intensive care interest. All consultants were FFICM consultant intensivists. All ward rounds were led by a consultant intensivist with FFICM.
- There were 16 consultants providing cover. Of these, 14 provided on-call cover, 2 provided daytime and weekend cover only.
- Weekday cover was provided in blocks of 4 and 5 days and weekend cover provided in blocks of 3 days.
- The consultant rotas showed that Monday to Friday two consultants covered the critical care patients between 8am until 8pm. At the weekend two consultants provided cover between 8am and 6pm. But between 6pm and 8am the following day one consultant provided on call cover.
- GPICS standards outlines that a consultant intensivist leads multi-disciplinary clinical ward rounds within intensive care must occur every day including weekends and national holidays. The rotas demonstrated that weekends and national holidays had the same level of consultant cover as weekdays.
- HDU and outreach patients were covered by another critical care consultant from Monday to Friday between 8am and 12midday. Between 12midday and 8am a consultant on J54 provided the cover.
- Junior medical staff worked additional on call duty and locums were employed to fill in the gaps. One advanced nurse practitioners (ANP) provided day time cover for ward J81 (HDU)
- In addition there was a respiratory medicine registrar on rotation and four critical care advanced nurse practitioners (ANP) supplementing junior medical staffing gaps.

Major incident awareness and training

- Staff verbalised the arrangements in place to respond to emergencies and major incidents. They said this was discussed during their induction training. They also told us that the up to date information was kept on the computer and hard copies were held in staff offices.
- The matrons informed us when the policy was reviewed and if changes were made staff were informed of them at staff meetings.
- Managers were aware of the seasonal risks and they said that at the clinical services unit governance meetings they discussed the contingency plans.

Are critical care services responsive?

Requires improvement



We rated the service as requires improvement for responsive because:

- LTHT provided specialist critical care service for a large geographical area therefore sometimes the demand for the service exceeded the resources they had causing problems with the access and flow to the critical care units. This resulted in cancellations of surgery, delays in admission to CCU when patients were critically ill, discharging patients from the unit out of hours and the increase in the readmissions to the unit following discharge. Staff and the management teams held three times daily bed meetings within all the sites to enhance the flow and discharge of patients.
- SJUH performed worse than expectations in out-of-hours discharges to the ward and unplanned readmissions within 48 hours.

However:

- Staff took into account the circumstances of each patient, their personal preferences and their coexisting conditions when planning and delivering care.
- The complaint policy and the procedures were well advertised and people told us they knew what to do if they were dissatisfied with the service.

Service planning and delivery to meet the needs of local people

- Planning of the services involved the local health and social service commissioners. There were regular discussions between the trust and the commissioners about the provision of the service and this included the service level agreement for critical care services and the capacity for providing regional specialities.
- Patients after receiving treatment on critical care units did not have any formal follow-up when they were discharged home. The outreach team supported patients whilst they were in-patients but did not have any formal follow up contact once patients were discharged.

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- There was a formal follow up clinic, run monthly by a consultant with participations from ICU nurses. However, it was not clear whether these clinics were compliant with Guidelines for the Provision of Intensive Care Service (GPICS).
- GPICS Core Standards highlight the need for specialised critical care follow up clinics once patients were discharged home. This was due to patients following discharge from critical care showing complex physical and psychological problems that lasted for a long time. These patients benefited from the support offered by a specialised critical care follow-up clinic. Patients requiring rehabilitation and emotional support were referred to The West Yorkshire Adult Critical Care Operational Delivery Network where patients were signposted to different services by the network team and some services were free and the others, patients needed to pay for.

Meeting people's individual needs

- The criteria for admission to the critical care units did not discriminate against people by their age, gender or ethnicity.
- The members of the multidisciplinary professionals we spoke with were fully aware of the relevant legislation with regards to diversity, equality and human rights.
- Nursing staff and the matrons informed us that they did have patients with dementia and patients with disabilities including learning disability on the units. They said all older patients above 70 years were screened for dementia and they have had training on caring for patients with dementia.
- Staff said although they have had discussions about helping people with learning disability they were exploring appropriate training and the introduction of 'hospital passport' for those patients who did not have one.
- A matron told us that they were looking into the admission process to make sure if a person with a learning disability was booked in for admission they are reminded to bring with them their communication book, such as the hospital passport. They said that staff needed to be mindful that the information in "Hospital passports" and know that such information may also be available from community learning disability teams and the patient's GP. They assured us that work was in progress to achieve compliance.
- We found from the records and when speaking with staff that they took into account the circumstances of each patient, their personal preferences and their coexisting conditions when planning and delivering care. This was in line with NICE QS15 Statement 9. Tailoring healthcare services to the individual.
- Staff and the matron informed us that information was available in a different format if it was needed by patients and/or relatives.
- Staff told us that the translation service provider had changed this year and that they had not had an opportunity to use the service yet.

Access and flow

- The total number of admissions to the critical care units within the LTHT between 1 April 2014 and 31 March 2015 was measured by the ICNARC case mix programme to be 1,153 patients. These numbers did not include all of the critical care units as data was not submitted by them all.
- At the point of discharge into the community following treatment and recovery 797 (89.1%) patients were discharged from the acute hospital and 98(10.9%) died on the wards before discharge. This meant patient survival after 60 days following admission to the unit was 70% and similar units had around 75% survival rate. The data did not consider the complexities of patients' conditions and reported purely on the patient numbers.
- The Intensive Care society identifies 80% as an average occupancy for critical care to accommodate the frequently changing needs of emergency and elective services. Adult critical care bed occupancy between January 2015 and January 2016 at both sites ranged between 70% and 85%. The national average for this time period was around 80% to 90%.
- SJUH performed worse than expectations for two indicators in the 2013/14 ICNARC case mix programme. They were out-of-hours discharges to the ward and unplanned readmissions within 48 hours.
- The ICNARC data between 1 July 2015 and 30 September 2015 for ward J54 showed mixed results compared to other similar units. Some examples were;

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- Out-of-hours discharges of patients from this unit to the wards between 10pm and 6:59am were 7.6% this was higher than other similar units which averaged at 2.8%.
- The delayed discharges which were more than 8 hours after the reported time when a patient was fully ready for discharge on this unit was 2.3%, which was better than 5.2% in similar units.
- Non-clinical transfers of patients out to another critical care unit in another acute hospital from ward 54 was 0.6% and in similar units it was 0.5%.
- Unplanned readmissions from the wards within 48 hours of discharge were 2.2% which was greater than similar units, which was 1.5%.
- Critical care beds on ward J54 were used flexibly to accommodate both Level 3 and Level 2 patients.
- However, ward J81 did not participate in the ICNARC data collection due to a lack of staff to carry out the data collection. Staff were not sure when this would be addressed.
- According to GPCIS (2015) standards discharges should occur within four hours of the decision being made by a consultant. Between April 2015 and March 2016 information from the trust showed that at LGI between 56% to 79% (3448 patients in total) waited over four hours to be discharged from the critical care units. Of these between 13%-21% (858 patients in total) were out of hours discharges.
- Data showed between January 2015 and December 2015 there had been 27 ventilated patient care for outside of the critical care units. Some staff within recovery had been trained to care for level three patients.
- A peer review audit of the service was undertaken in November 2015 identified patient flow to be a key challenge for the CSU operationally as well as in relation to compliance with the D16 specifications. D16 specifications underpin the NHS standard contract for adult critical care.
- Key areas of non-compliance were discussed under admission and discharge from Critical Care Units.
 - Admissions to Critical Care:- where elective cancellation rates particularly in cardiac surgery at the LGI was problematic and the delay in admission to a critical care unit within the 4hr of decision was an issue.
 - Discharge from critical care:- where out of hours discharges and delayed discharges were seen as

significant areas of non-compliance. An average of 80% of patients stepping down from Ward J81 at SJUH were delayed more than 4hrs. The re-admissions within 48hrs back to SJUH ward J54 also remained a concern.

Learning from complaints and concerns

- The trust had a process for categorising and handling complaints and concerns.
- People were able to raise their concerns with staff on the units or with the Patient Advice and Liaison Service (PALS) or make a formal complaint to the trust.
- The complaint policy and the procedures were well advertised and people told us they knew what to do if they were dissatisfied with the service.
- Staff and the managers informed us that there had not been any formal complaints in the last six months which they were aware of. We noted there had been two complaints relating to care of patient in November 2015 and delay in diagnosis in January 2016. These have been investigated following the trust's complaints policy.
- The trust data showed that there were 820 complaints investigated in 2014/15. This may be due to people knowing how to make a formal complaint.

Are critical care services well-led?

Good



We rated the service as good for well-led because:

- Staff members and managers were fully conversant with 'The Leeds Way' which encapsulated their values. The values underpin patient-centred approach, fairness, collaborative working, being held accountable for their action and empowering staff to carry out their responsibilities.
- Monthly 'Ward Health check' measurements of the key performances helped staff and management identify trends and take action in a timely manner. There was a criterion for escalation, if a unit /ward scored worse in three areas.
- Staff said the managers were visible and approachable. They said the board members often shared the same transport between the hospitals and were accessible to staff and people who used the services.

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- Staff commented that they felt valued by their line managers and colleagues.
- A volume sensor which was referred to as the 'Big Ear' was used in some units to monitor and sense the sound levels. On ward 81 at SJUH it was used to help staff control the levels of noise so patients were able to rest.

However:

- Guidelines for the Provision of Intensive Care Service (GPICS) 2015 were not fully complied with, but the trust had outlined some of the mitigations and had plans to address the shortfalls. The gaps included instead of 50% nursing staff working in the units having post-registration qualification in critical care nursing only 37% had them and there was a lack of seven day physiotherapy cover for the patients.
- Out of three critical care units only one submitted data for ICNARC. ICNARC is a standardised national data collection process. It is recognised as a national clinical audit which promotes local and national quality improvement. It is recommended that all critical care units in England should provide data analyses. SJUH was not compliant with this.
- In November 2015, the West Yorkshire Critical Care Operational Delivery Network (WYCCODN) identified a significant trust-wide focus on patient flow, particularly in relation to step-downs from critical care units.

Vision and strategy for this service

- Staff members and managers were fully conversant with 'The Leeds Way' which encapsulated their values. The values underpin patient-centred approach, fairness, collaborative working, being held accountable for their action and empowering staff to carry out their responsibilities.
- Staff did not have any unit specific visions or strategies but they said that they took ownership of 'The Leeds Way' and applied it to their units.
- The managers told us that they did not have a specific local unit or CSU strategy.

Governance, risk management and quality measurement

- We found a number of work streams underway to ensure effective governance to support the trust strategy and deliver good patient care.

- A risk register was maintained by the critical care CSU and reviewed during quality assurance meetings by the CSU leads including the clinical quality leads. The register highlighted the ongoing risks with details of action taken to mitigate the risks.
- The director of quality for trust informed us that all risks were weighted and scored during the three monthly CSU meetings on the projected harm. If a CSU risk scoring was 10 or above, they said it would be reviewed twice a year by the Risk Management Committee, which was chaired by the Chief Executive.
- Our findings concluded that SJUH was not fully compliant as data collection for ICNARC took place on ward 54 only. We were informed by staff that the lack of data submission was due to insufficient staff in their department. Staff were not sure when this would be addressed.
- There were gaps in compliance with GPICS standards 2015, instead of expected 50% of critical care nursing staff only 39% had a post-registration qualification.
- A monthly 'Ward Health check' was carried out to monitor key performances. The areas audited included patient safety issues, staffing, staff attendance and incidents. The audit helped to identify the direction of travel for each key performance within each unit. For example in the general intensive care J54 there were seven medication administration errors reported in December 2015 but in January 2016 there was a reduction of four errors reported. In December 2015 it was reported that 83.3% harm free care was delivered in ward J81 and in January 2016 it was 85.7% which showed a better outcome for people.
- As part of quality measurement in November 2015, the West Yorkshire Critical Care Operational Delivery Network (WYCCODN) undertook a peer review process to assess the compliance of LTH's core critical care units against the D16 service specification. The trust and the CSU were asked to consider the following recommendations:
 - A significant trust-wide focus on patient flow, particularly in relation to step-downs from critical care. This would support not just D16 compliance, but CQUIN compliance, elective throughput, timely admissions from emergency departments.
 - Development of a clear time-line for the integration of thoracic HDU and orthopaedic HDU into core adult critical care (ACC) units.

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- Negotiation with commissioners for an appropriate tariff payment.
- Development of the consultant establishment in ACC to support ward-round and on-call requirements.
- Business plan proposals in adult therapies are supported around additional physiotherapy posts to support 7-day working in ACC.
- Critical care nursing staff to be supported through a new post-registration academic module at Leeds Beckett University, commencing in Sept 2016.
- Progression of a business case to support ICNARC data collection on outstanding critical care units (J81 and L04/05). We noted that work was in progress to address the above recommendations.
- Matrons and the head of nursing for the CSU told us they supported staff with behaviour or performance issues with the help of their human resource team. They said that they avoided a blame culture, helped staff overcome their issues and contribute to the teams.
- Multidisciplinary staff we came into contact with worked collaboratively and shared responsibilities to deliver good quality care.
- Multidisciplinary staff we spoke with understood what the Duty of Candour meant. They said it is all about sharing accurate and factual information with patients and/or their representatives to help them understand what had happened. Offering verbal and written apologies and maintaining transparency was also discussed.

Leadership of service

- The adult critical care management team structure included both sites. This was to ensure joined-up working and share expertise. Managers had offices within both sites so meetings could be held in either site and staff were able to attend and promote joined-up working.
- Multidisciplinary staff told us that managers were not only visible they also consulted them about the activities on the units and listened to what they had to say. They said they were reassured by the present management team

Culture within the service

- It had been identified by staff within the two separate hospitals that the staff culture was different. Therefore to encourage and help staff merge an external facilitator was introduced to the staff group. Staff told us that they had one to one and/or group conversations with the facilitator where they received advice on how to work together as a team and not lose their identity, expertise and enthusiasm in what they do. Staff gave positive comments about the external facilitator who had worked to narrow the gap in the culture of staff from the two sites.
- Staff said the managers were visible and approachable. They said the board members often shared the same transport between the hospitals and accessible to staff and people who used the service.
- Staff commented that they felt valued by their line managers and colleagues.

Public engagement

- Staff explained due to the circumstances patients and their representatives were not conducive to giving feedback at the point of discharge from the unit. They said sometimes members of the outreach team gave them verbal feedback from patients on the wards. They were exploring other ways such as developing support groups for patients and their representatives and provide opportunity to be engaged with people who had used the service.
- The information with regards to Friends and Family Test (FFT) reflected trust level feedback and not CSU or unit level. However nationally, there has been an increase of 36.34% in patient involvement.
- FFT performance at LHT has declined over the second quarter of 2015/16 period. As the number of eligible patients increased, response numbers have remained constant. This has resulted in the decreased 19.8% FFT response rate.
- A newly formed working group called PERT (Patient Experience and Risk Team) which had membership with representatives from all patient experience groups, quality and risk groups that work under the Director of Quality. The reports will include CSU level data on patient feedback, risks, incidents and lessons learned.
- Patients and relatives we spoke with were happy with the care they received. They commented that nurses and doctors were committed to the job and often too busy and rushed.

Critical care

- We saw evidence of public engagement where staff had listened to people's comments and purchased more comfortable seating for the visitors waiting area with the money donated by patients and relatives.
- On all critical care units hot drinks machines were made available for families and they were looking into purchasing these for HDU areas. These will be funded through patient/relative donations.
- Through donations they have purchased radio's and personal DVD players. Staff explained due to the equipment in HDU it was difficult to get a good reception through indoor aerials. Therefore they were looking at other alternatives such as streaming.

Staff engagement

- Staff told us that they had completed the staff satisfaction surveys and that they were waiting to hear the overall outcome from the managers.
- They said in the last two years they had seen changes which have been conducive to good team working. They were proud to talk about the 'Leeds Way'.

Innovation, improvement and sustainability

- Introduction of Band 1 health care assistants (HCA) have enabled Band 2 HCAs the chance to help nurses with

delivering personal care to patients. Band 1 staff performed non-clinical duties which included supporting, cleaning bed space and equipment, ensuring stocks were maintained.

- A volume sensor which is referred to as 'Big Ear' was used in some units to monitor and sense the sound levels. We saw the use of a big ear in the General HDU at St James's University Hospital University Hospital.
- Team Brief completed before every handover by medical staff. We observed a handover and saw the prompt list used at handover. It covered, update on staff introduction, staffing and capacity, infection control, coroner's referrals, death certification, training and education, audit data collection, communication points such as patients safety alerts, quality safety issues and performance update.
- Coffee morning with ex-patients was held in May 2016 which was a success and staff envisaged to continue this every three to four months to develop a patient driven service.
- Following a complaint from a relative, two Band 6 nurses had developed a Patient journey diagram from admission to surgery to returning to HDU. This was displayed in the waiting area for relatives. Due to its success the CSU was considering using such diagram in other areas to keep relatives better informed.

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Safe

Good



Overall

Good



Information about the service

Leeds Teaching Hospitals NHS Trust offered a full range of maternity and gynaecology services. It is a tertiary unit and therefore provided care for and advice to clinicians caring for women with complex needs.

Services were provided across two sites, at St James's University Hospital (SJUH) and Leeds General Infirmary (LGI). Separate reports have been written for each site. The governance and management arrangements were the same and are reflected in both reports.

The service at SJUH included gynaecology, pre conceptual care, an early pregnancy unit, antenatal, intra partum, obstetric theatres and postnatal care. The home birth team was based at LGI hospital and was for low risk pregnancies.

The maternity service at SJUH delivered 4,726 babies between April 2014 and March 2015.

The still birth rate for 2015 across Leeds Teaching Hospital NHS Trust was 27. This had reduced year on year from 70 in 2011. (A stillbirth is a baby born dead after 24 completed weeks of pregnancy.)

The service offered both medical and surgical termination of pregnancy (TOP). Between April 2014 and March 2015, there were 42 medical and 67 surgical terminations carried out. There were processes in place to ensure the sensitive disposal of pregnancy remains.

In March 2014, CQC carried out an announced comprehensive inspection and rated the service as good overall. We rated effective, caring, responsive and well led as good. The safe domain required improvement and this was because the medical and midwifery staffing levels did not meet national recommendations.

This inspection took place on the 10, 11, 12 and 13 May 2016. It was part of an announced focused inspection to follow up the outstanding requirements from the previous

inspection. We inspected the gynaecology ward, early pregnancy assessment unit, antenatal clinic, antenatal day unit, maternity assessment centre (MAC), antenatal and postnatal wards, delivery suite and obstetric theatres.

We spoke with five women who used the service and three of their partners, and 39 staff. This included midwives, midwifery support workers, student midwives, ward domestics, doctors, anaesthetists, consultants and senior managers. We also held staff focus group meetings to hear their views of the service they provide. We observed care and treatment, inspected six sets of care records (five maternity and one gynaecology,) and we reviewed the trust's audits and performance data.

We reviewed information about the population of Leeds. We found deprivation was higher than average when compared to the England average. Life expectancy was lower; teenage pregnancy (under 18 years of age) was significantly higher and the rate of sexually transmitted infections was worse than the England average.

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Summary of findings

We rated maternity and gynaecology services as good because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Risks to women were identified, monitored and managed to keep them safe.
- Records relating to women's care were of a good standard.
- Multidisciplinary teams worked closely together and there was evidence women attended joint clinics for those who had medical problems, for example diabetes and obesity.

However:

- Medical staffing levels did not meet national guidelines.
- Not all staff were up to date with mandatory training.

Are maternity and gynaecology services safe?

Good



We rated maternity and gynaecology services as good for safe because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Risks to women were identified, monitored and managed to keep them safe.
- Records relating to women's care were of a good standard. Records were kept secure in line with the data protection procedures.
- Systems were in place to protect patients from abuse and staff were aware of the procedures to follow.

However:

- Medical staffing levels did not meet the national guidelines of 98 hours a week labour ward cover.
- The trust was not meeting its 80% target for mandatory training, for example, for children and adult resuscitation.

Incidents:

- There were no Never Events reported in maternity of gynaecology services between October 2014 and September 2015. Never events are serious, preventable patient safety incidents that should not occur if the available preventive measures are in place.
- Between March 2015 and February 2016, there were 708 incidents reported in gynaecology and maternity services. Of these, 663 were reported as no harm caused, 37 reported as minor injury, 7 as moderate harm and one was reported as severe harm caused.
- No common themes were identified in the moderate harm injuries.
- Between October 2014 and September 2015, there were four serious incidents reported in maternity services: one intrauterine and two neonatal deaths. All three incidents had taken place at LGI. The fourth incidents investigation had not been completed at the time of our inspection.
- A root cause analysis (RCA) had taken place in all three cases, which highlighted lessons learnt and contributing

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factors. A RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons are learnt, to prevent the same incident occurring again. Summaries of recommendations and action plans were shared with staff and commissioners of the services.

- Lessons learned had been shared with all staff via email, monthly and quarterly risk maternity management reports and discussed at the monthly perinatal morbidity meeting. Actions and feedback was also provided to staff via bulletin, displayed on staff noticeboards.
- The risk management midwife sent out emails and memos to staff relating to incidents. These included, risks, themes, trends and lessons learnt. There were daily team updates at staff handovers, newsletter and staff briefings taking place and we observed some of these during our inspection.
- Staff were able to give examples of feedback received from the serious incidents and lessons learnt. These included the recommendation for the development of a rolling maintenance and repair process for the cardiotocography (CTG) machines. CTG is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy. The replacement of the machines had taken place.
- Perinatal mortality meetings were held. We saw minutes of the Safeguarding Children's Board, Child Death Overview panel; they discussed neonatal deaths. The meeting were attended by a multidisciplinary team of staff, including a consultant in public health, consultant neonatologists, obstetricians, the head of midwifery, the risk management midwife, bereavement support midwife and safeguarding midwife.

Duty of Candour:

- The duty of candour (DOC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014.
- Prior to the introduction of the DOC regulation, communications were sent out by the trust explaining

the DOC and included presentations to raise awareness. This was supported by a trust wide Quality and Safety Matters briefing, which was circulated in April 2015 and recirculated again in March 2016.

- An e-learning tool was available for all staff to complete on the trust intranet.
- The DOC had been included as part of the 'Being Open,' and the 'Serious Incident' procedures. It was also being included as part of the Root Cause Analysis training and Lead Investigator training.
- Staff told us, they understood the need to be open and honest with families when things went wrong.
- We saw an example of DOC, where a women's care had not gone according to plan. They had received an explanation from the consultant involved in their care and the Risk Midwife. A letter of apology was sent from the Chief Executive of the trust. This showed the trust was open and transparent with patients about their care and treatment when things went wrong.

Safety thermometer :

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at patient harms such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The trust had started to use the maternity safety thermometer towards the end of 2015. Data showed that between October and November 2015, they had 95.7% harm free care. In January 2016, they had 100% harm free care across all services.
- All areas inspected displayed information collated from the previous month. It showed patients had received harm free care in April 2016. For example, on delivery suite we saw how it had been 365 days since a patient developed a pressure sore and no one had ever had a fall.
- Prevention of venous thromboembolism (VTE) documentation had been correctly completed in all care records we inspected.

Cleanliness, infection control and hygiene:

- Displayed in the delivery suite were the details of three midwives who were responsible for infection control on the unit.

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- The patient led assessment of the care environment showed the trust scored 99% for cleanliness against an England average of 98% in 2015.
- The areas we visited were visibly clean and equipment had stickers on them, which showed they were clean.
- On the delivery suite and wards we saw carbonated books which reflected the cleaning of each room and equipment once a patient had vacated. We saw a copy of the record was put into the patients notes who next occupied the room. This provided evidence the room and equipment had been cleaned and by whom.
- Between July and December 2015 the trust wide audit showed there was 100% compliance for the decontamination of shared patient equipment.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of wards and departments. There was clear signage encouraging visitor and staff to wash their hands.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- The trust completed a monthly audit of staff hand hygiene. Within women's services, between April 2015 and February 2016 the audit showed the antenatal ward, delivery suite and postnatal ward had achieved 100% compliance. All areas we inspected had achieved 100% compliance in March to April 2016.
- Departments and wards displayed 'Open and honest care' boards. For example, the information on the board on delivery suite showed there had been no cases of either Methicillin-resistant Staphylococcus Aureus (MRSA) bacteria, or Clostridium difficile infections.
- In the delivery suite rooms, worn, wooden units were in use. The fabric of the units was not suitable for the environment as they could not be effectively cleaned. Managers and staff informed us that an audit of the furniture had taken place and the trust were in the process of making a business case to replace the worn furniture.

Environment and equipment:

- The unit had two rooms for bereavement (the 'Snow drop' rooms), for women and their family, who were experiencing the loss of an infant. In the interest of sensitivity and privacy, the rooms had separate access from the main labour ward.
- Antenatal and ultrasound services had recently undergone a major refurbishment. The early pregnancy

unit and the gynaecology assessment /treatment unit had also undergone a redesign and refurbished. Staff reported positive feedback from patients on making these areas a more pleasant environment.

- Resuscitation and emergency equipment checks were taking place in each area we inspected. For example, in delivery suite and theatres, daily checks had taken place between January and May 2016. This meant the equipment would be safe to use in an emergency.
- In one of the theatres, there were several disposable instruments out of date. This was brought to the attention of the theatre staff and they removed the out of date equipment immediately.
- Equipment was available to meet people's needs. For example, oxygen and CTG machines. Staff reported fifty CTG's machines had recently been purchased to replace ones which had been identified as likely to fail and not fit for purpose.

Medicines:

- Medicines were stored in locked cupboards and trolleys in clinical areas. However, during our visit one of the wards had an emergency trolley stored in a patient accessible area. The trolley contained medicines. This was brought to the attention of the staff at the time and the trolley was moved to a clinical secure area. The medicines were stored correctly.
- We also brought to the attention of the delivery suite staff, the sharps waste disposal bin, which was located in one of the delivery suite rooms. The bin was open and there was a risk of someone being able to put their hand in and remove the contents.
- Nurses and midwives told us they received support from the hospital pharmacist, when necessary.
- Medicines that required storage at a low temperature were stored in a specific medicines refrigerator. Temperatures checks had taken place and satisfactory records maintained.
- Records showed controlled drugs were stored and checked in line with hospital policy.
- Appropriate recordings were made in the four medicines charts we inspected.

Records:

- An audit was carried out on the record keeping of women's care during labour in October 2015. The results were encouraging for general observations of maternal wellbeing during labour for example, temperature,

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pulse and blood pressure. However, more specific observations, such as abdominal palpation, contractions and the third stage of labour were not well documented. An action plan had been written to address the shortfalls. A repeat audit would take place in July 2016. One of the themes of the week in the risk management team newsletter, dated March 2016, referred to the audit and reminded staff of the actions they should be taking. This included following the maternal observation guidelines during labour.

- Record keeping audits in each unit and ward area took place each month. The information audited included, documentation, twice daily recording, risk assessment monitoring, referral for at risk patients and recording fluid balance where appropriate. For example, from April 2015 to February 2016, nine months out of an 11 month period, delivery suite scored 100% in all areas. The remaining two months they scored between 92.9% and 95.2%. The antenatal ward scored between 75 to 100% and the postnatal ward scored between 82.6 and 100% for the same time period.
- All of the clinical records we inspected were of a good standard of record keeping. When not in use data protection procedures were in place to keep records safe.
- The maternity records showed each woman had a named midwife or consultant, (if the patient was of a high risk patient), responsible for their care. Each record contained antenatal assessments and screening, and a clear pathway of care, which described what women should expect at each stage of their labour.
- Risk assessments had been completed in each record we inspected.
- The documentation included, a situation, background, assessment, recommendation (SBAR) transfer record. This was used when handing over the care of a patient to another member of staff. The tool is used in maternity services where there may be multiple handovers between staff. It assists in improving communication, therefore helps in keeping patients safe.

Safeguarding:

- Access to the delivery suite and wards was via an intercom system which enabled staff to monitor people visiting these areas. There were environmental systems and procedures in place to protect the security of new born babies.

- The trust had a safeguarding adult policy and a child abduction procedure, which linked into the children's safeguarding policy.
- Risk assessments and pathways of care were in place to identify women and children at risk.
- The trust had a named midwife for safeguarding who was a resource for staff and who provided support for vulnerable women. They were responsible for managing child protection and domestic violence issues.
- Staff we spoke with told us they understood their responsibilities for identifying and reporting any concerns.
- Safeguarding training was mandatory. The trust was not able to easily provide a breakdown of their safeguarding training statistics for each site. However, they confirmed 95.15% of maternity and gynaecology services had received Level 1 training and 74.8% had received Level 2.
- Relevant staff had face to face safeguarding training which met both the requirements of the Level 2 and 3 training. Seventy four point seven percent of staff had received this training. Most midwives we spoke with confirmed they had received Level 3 safeguarding training.
- The trust also confirmed midwives participated in initial case conference meetings with social care; follow up review meetings from case conferences; pre -birth planning meetings and strategy meetings on the wards. This participation contributed to the staffs Level 3 safeguarding competencies.
- The trust's safeguarding adults at risk policy identified female genital mutilation (FGM) and guidance in relation to the mandatory process of both reporting and recording newly identified cases of FGM.
- Staff had training and were aware of the procedure and action they would take in reporting.
- The policy directed staff to contact the safeguarding children team, social care and the police where they were concerned about the risk of FGM for a child. The trust had developed a Standard Operating Procedure that provided guidance to staff with regard to FGM. The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. It is mandatory for all acute trusts to report to the Department of Health, on the number of patients who have a family history, or had FGM.

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- The hospital had a Perinatal FGM service, which was led by one of the midwives. The aim of the service was to improve the perinatal experience and outcome for both mother and baby, whilst providing health information/ advice and protecting children.

Mandatory training:

- Mandatory training included topics such as, safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act 2005, equality and diversity, dignity at work, fire safety, and resuscitation.
- Compliance with training was managed through a RAG (red, amber green) rated system, through to CSU and trust level. The trust was not able to easily provide a separate breakdown of their training statistics for each site.
- Compliance rates for the CSU/trust were 80% or above and rated green; 70 – 79.9% amber and less than 70% red.
- In women's services the compliance for mandatory training ranged between 48.5% – 97%. Fire safety was seen as amber, 74.4%. The resuscitation children's and adults training were rated as red. They had achieved 48.5% and 68.4% compliance respectively. The trust had seen this as a priority and had arranged update training. During our visit, staff were seen attending update training.

Assessing and responding to patient risk:

- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Modified Obstetrics Early Warning System (MOEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. All five records we inspected contained completed MOEWS tools. The trust had carried out an audit of the medical staff handovers on delivery suite, between January and February 2016. The audit showed that where applicable, the MOEWS score/deteriorating patient risks had been discussed at each handover during the audited period.
- Trust data showed between April and September 2015, and January to February 2016, there was 100% compliance for referrals of 'at risk' patients and 85.7% compliance across the trust in women's services for October 2015. There were no 'at risk' patients in November and December 2015.

- The World Health Organisation (WHO) devised a safer surgery checklist, which included five steps that should be taken when a patient had an operation. A checklist was used in gynaecology and had been adapted for obstetric procedures.
- An audit of the maternity checklist was carried out from October to December 2015 of five elective section lists. It included 12 cases and was carried out over the LGI and SJUH sites. The results for the SJUH showed 66% of the checklist had been completed. The low result was mainly attributed to staff not signing out at the end of the procedure. The learning and action for staff had been recorded and this included a timescale for completion.
- Staff we spoke with were aware of how to use the checklist. The one set of notes we inspected where a woman had a caesarean section, the surgical checklist had been completed.
- There were clear processes in the event of maternal transfer by ambulance; including, transfer from homebirth to hospital.
- We saw evidence the unit used the 'fresh eyes approach' a system that required two members of staff to review foetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation. In October 2015, 20 records were audited for compliance with foetal monitoring guidelines. Although staff were not always meeting the recommendation of hourly recording relating to CTG monitoring, they were meeting the guidelines standard of two hourly. One of the themes of the week in the risk management team newsletter, dated March 2016, referred to the audit and the action to be taken by staff. This included the hourly recording of the fresh eyes approach to CTG monitoring.

Midwifery staffing:

- The midwife to birth ratio was 1:29 against the nationally recommended Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007) ratio of 1:28.
- The maternity staffing levels were based on the birth rate-plus methodology and factored in the complex case mix of women in Leeds. Between November 2015 and December 2016, an annual review of the staffing was carried out by the Women's service Clinical Governance and Risk Management Forum. The Head of

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Midwifery presented it to the Maternity Services Clinical Governance, Governance, and Risk Management Forum. Six monthly further reviews were to take place in line with the National Institute for Health and Care Excellence (NICE) guidance and staffing levels remained on the risk register.

- The data factored in the corporate guidance in terms of leadership, annual leave and study. The recommendations supported an increased establishment to 359 midwives and an increase of 10.8 maternity support workers to support a midwife to birth ratio of 1:28. Information provided by the trust stated the Trust Board had an agreed investment plan to support the midwifery staffing numbers incrementally, from a ratio of 1:33 in 2014, to the current average of 1:29.
- The trust information also stated that the gynaecology nursing acuity was in accordance with the trust's nursing tools. It supported the seven-day access for the Early Pregnancy Unit, which was factored into the April 2016 budget.
- Although 1:1 care from a midwife in labour was not monitored, all of the women we spoke with confirmed they had received 1:1 care throughout their labour. Women had a named midwife responsible for their care.
- We did not receive any concerns from women who had received treatment or care.
- Between June and September 2015, the vacancy rate was 15 whole time equivalent staff. In October 2015, the maternity dashboard showed no vacancies and in November 2015, the vacancy rate was seven against the trust target of less than five. From August to December 2015, both qualified and unqualified agency staff were used and the amount of staff was recorded as a positive; below the trust target of five.
- We heard how the 'bed manager' midwife established the bed status twice daily and had an overview of the unit. The day to day management was in collaboration of this manager, team leaders and consultant of the week. Out of hours, a delivery suite coordinator carried out this role. One of the co-ordinators told us that if there was a problem with staffing, the co-ordinators would also discuss this with their counterpart on the LGI site.
- There was a 'Safe Staffing Levels and Escalation Protocol' to assist staff address staffing shortfalls. Changes were made where needed to ensure sufficient staff and this may have included moving staff between

sites (LGI or SJUH) to maintain safety. A risk assessment form was used prior to the movement of staff. This meant staffing levels were monitored, better organised and staff allocated appropriately.

- All staff was aware of the 'Safe Staffing Levels and Escalation Protocol' to assist staff address staffing shortfalls and this was monitored through the incident reporting system.
- Staffing levels of planned versus actual were displayed on the notice boards in the delivery suite, wards and department. For example on the 10 May 2016, delivery suite planned staffing should have been 11 midwives and three care support workers, pm 10 midwives and three support workers, and at night 10 midwives and two support workers. Actual staffing was the same as planned for the qualified staff and a care support worker less on each shift. In addition there were two band seven midwives and a nurse in charge. On the postnatal ward on the 11 May 2016, there was an extra qualified member of staff to the planned staffing figures in the morning and afternoon.
- Information provided by the trust, showed in January 2016, the delivery suite actual staffing achieved was 79.9% and unqualified 77.1%. It also stated 'Care Support Worker (CSW) establishment reduced from 13.99 WTE to 10.75 WTE agreed at budget setting in January '2016. 'Uplift of Band 6 WTEs.' On the postnatal ward for the same period, they achieved 118.6% compliance actual qualified staffing and 104.6% non-qualified.
- Information also provided showed in February 2016, 8.6 Whole Time Equivalent (WTE) qualified agency staff, 3.5 WTE unqualified staff covered vacant shifts in maternity services across the trust. In March 2016, 10.3 WTE agency qualified staff and 0.10 qualified bank staff were used and 4.3 WTE unqualified agency staff. In April 2016, 9.10 WTE qualified and 3.8 WTE unqualified agency staff covered vacant shifts.
- They confirmed that the majority of times, vacant shifts were covered. Staff also told us that the trust had their own secure intranet, staff social network site. They were able to send out a request at short notice for staff to cover shifts and they found this system was effective.
- The staff told us the trust were advertising for staff, but were struggling to recruit.
- We heard how new staff had been recruited. Some had not yet started work at the hospital as they were working through the recruitment checks.

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- The Board Assurance Framework May 2016, showed the Trust Board had agreed and had in place, a five year investment plan for nurse staffing. They had identified the risks and had assurance and action plans to address the shortfalls.
- The trust was working with the universities in the sponsoring of staff, with a view to the encouragement of more staff to work at the Leeds hospitals.

Handover meetings:

- We saw a handover taking place from day to night staff on the delivery suite and postnatal ward. The form used, contained information about learning, and updated within the service. Clear comprehensive information was provided. Information was included about safeguarding, translation services, staffing levels and the number and dependency levels of women and where appropriate, their babies.

Specialist staff/lead roles across the trust included:

- A lead midwife for the maternity strategy and matron leads for risk, safeguarding and public health.
- Specialist midwives for foetal medicine, diabetes, FGM support and teenage pregnancies including Family Nurse Practitioner (FNP) links.
- Midwifery leads for peri-mental health, bereavement and substance misuse.
- A specialist “Hammla” team for supporting vulnerable women, including women from black and minority backgrounds and travelling communities.
- Two community teams, Leopold and Malvern supported women in the deprived areas of Leeds.
- Gynaecology services had nurse practitioners; colposcopy, hysteroscopy and uro- gynaecology specialists.

Staffing of the second obstetric theatre:

- Records showed this theatre was used an average of twice a week in the previous three months. The band 7 midwife told us that there was always two band 7 staff on duty. One of these grades of staff were identified at the beginning of each shift as the midwife who would go into theatre to ‘scrub’ for operations when required. At the current time the band 7 midwives on delivery suite were able to ‘scrub’ when needed. However, the staff also told us that new staff coming into the unit might not all have had the training. This future concern had been added to the risk register. The coordinator in

charge at the time of the inspection told us that they had worked at the unit for several years and there was only one occasion when a midwife who was able to ‘scrub’ was not available. The coordinator said that they identified this to the anaesthetist at the beginning of the shift and on that occasion a planned theatre list was cancelled.

- The annual review of staffing, carried out by the Women’s service Clinical Governance and Risk Management Forum confirmed the trust did not have a full theatre team to support this service. The risk had been added to the risk register and was monitored.
- A business case had been made to support the provision of theatre staff to meet the needs of the service on both LGI and SJUHT sites. The project was being led by the Head of Nursing for theatres.

Medical staffing:

- The CQC data pack showed there were 38% (82 WTE) consultants employed by the trust, compared to the England average of 35%. Three percent, middle carer (At least 3 years at Senior House Officer (SHO) or a higher grade within their chosen specialty), 55% registrars and 4% junior doctors (foundation year 1-2). This compared with the England average of 8% middle grade doctors, 50% registrars and 7% junior doctors.
- From April 2014 to June 2015, the average number of hours per week consultant presence on delivery suite was 60 hours.
- At inspection consultants, doctors and midwifery staff confirmed there was 60 hours consultant presence on delivery suite each week.
- Cover was provided from Monday - Friday 8.30am to 6pm and an on-call consultant was present until 7pm each week day evening.
- Weekend consultant presence was from 8.30am until 12.30 mid-day. Outside of these hours, the consultants were non-resident on-call. However, the consultants told us that when on-call, several of them chose to provide onsite cover.
- Insufficient consultant obstetric staffing levels had been recorded on the risk register. The risk register identified there should have been 98 hours cover. This was in line with the size of unit and the Royal College of Obstetricians & Gynaecologists (RCOG) best practice standard for consultant labour ward cover. The trust had

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identified there was a deficit of 3.5 WTE consultants and although not in post at the time of the inspection, two consultants had been appointed and due to start work in June and August 2016.

- Following the inspection the trust notified CQC that the two consultants they had appointed were now in post. They told us the consultant's job plans were being reviewed and the rotas redesigned to improve consultant cover; this was in the process of consultation. They said these changes would achieve 83 hours planned consultant presence per week from January 2017.
- Additionally, consultant support was provided through the on-call cover arrangements over and above this to further increase consultant presence at the service.
- A business case for a further two consultants was being developed to achieve 98 hour labour ward consultant presence and the trust were in discussions with commissioners about this.
- Staff reported they had no issues speaking with a consultant when needed and they were always contactable.
- Daily antenatal and postnatal ward rounds took place in line with current guidance and staff reported consultants were supportive and contactable when required.
- We observed the medical handover on delivery suite which was attended by the consultant, medical staff, anaesthetist and the lead midwife. The handover was comprehensive and included feedback about women on the unit and those who may have caused concern.
- In addition, there was a first and second on call doctor for acute gynaecology, Monday to Friday, 8.30am until 5pm. After these hours the first on call doctor worked until 11pm. After this time acute gynaecology and the gynaecology wards, were covered by the first on call doctor from delivery suite. There was a third tier who

worked a 1:6 ratio of non-resident, partial shift, from 5pm until 9am the following day; with 24 hours off post on call. These doctors covered both obstetrics and gynaecology at SJUH.

Anaesthetist cover:

- A resident consultant anaesthetist was based on the delivery suite, Monday to Friday 8am to 6pm.
- In addition to the consultant anaesthetist, a middle grade trainee anaesthetist was resident 24 hours a day, 7 days a week. This grade of staff was dedicated to maternity and only allowed to be on call once they have been assessed as competent.
- Out of hours, the trainee anaesthetist was supported by a resident consultant. This could also be another trainee anaesthetist should (the consultant be in theatre) and a second theatre be needed, or additional assistance required.
- A further on call consultant anaesthetist was available for advice or practical help, when required.
- In addition to the delivery suite cover, anaesthetic antenatal clinics were held and these included specialist educational, monthly clinics for obese patients.

Major incident awareness and training:

- There were clear escalation processes to activate plans during a major incident or internal incident, such as shortfalls in staffing levels or beds shortages.
- There was a trust wide major incident 'command' plan and each unit had a plan which was part of the trust plan. The major incident plan was reviewed annually.
- Eighty four percent of midwives had attended skills and drills training. This was an annual 'rolling programme with training dates set for the year. The training was also attended by multi professional staff and included scenario based on maternal and neonatal emergencies.

End of life care

Safe	Good	
Overall	Good	

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. All these services were involved in end of life care at St James’s University Hospital (SJUH).

Specialist palliative care services were designed to meet the needs of the local population. Demographic data was taken account of in the local end of life care annual plan.

Specialist palliative care is the total care of patients with progressive, advanced disease and their families. Care was provided by a multi-professional team who have undergone recognised specialist palliative care training. The specialist palliative care team had both a clinical and educational role and led end of life care at the hospital. They provided a seven day face to face service.

The Specialist Palliative Care team (SPCT) were based in the Robert Ogden Macmillan centre at SJUH. The team incorporated the SPCT and end of life care team and were part of the Oncology Clinical Support Unit (CSU).

The executive lead for end of life care was the chief medical officer. There was a clinical director and a general manager who had managerial oversight of the service. The head of nursing and lead clinician provided clinical leadership.

From September 2014 to August 2015 there had been 2851 deaths in the trust. Between April 2014 and March 2015 there had been 1255 referrals to the specialist palliative care team.

As part of our inspection, we specifically observed end of life care and treatment on wards and other clinical areas. We looked at eight sets of patient care records, including medical notes, nursing notes and medicine charts, and 21 do not attempt cardio pulmonary resuscitation orders (DNACPR). We visited the bereavement service, chapel and prayer room, mortuary, and emergency department (ED). We spoke with 22 staff including ward nurses, the

bereavement officer, the mortuary team, doctors, porters, the SPCT, and senior managers. We also spoke with two relatives and one patient who was receiving care. Before our inspection, we reviewed performance information from, and about the trust.

End of life care

Summary of findings

We rated end of life care to as good because:

- Safety incidents were investigated when things went wrong and lessons learned were widely shared among staff to reduce the risk of re-occurrence. Staff were open and honest when they spoke with patients and families about incidents.
- There was clear guidance for staff to follow within the care of the dying person individual care plan when prescribing medicines at end of life.
- There were some very good examples of record keeping in the individual care plans; patients' individual needs and wishes at end of life were represented clearly in the documentation.

Are end of life care services safe?

Good



We rated for end of life care services as good for safety because:

- When something went wrong incidents were investigated and lessons learned had been communicated widely and cascaded appropriately. Senior managers and front line managers were involved in carrying improvements forward.
- There was an open and honest culture and staff understood their responsibility for transparency if something went wrong.
- There was compliance with infection prevention and control, and medicine safety procedures.
- The standard of record keeping was very good and supported the management of risks to patients. Risks were reviewed regularly and assessment was patient centred.
- Specialist nurse and medical staffing was in line with national recommendations.

However:

- Safety issues related to the mortuary environment. There was frequent water ingress during rainstorms while procedures were taking place.
- Staffing shortages in the mortuary and frequent 'borrowing' of staff from the Leeds General Infirmary was needed to maintain the service.
- A high percentage of incidents had occurred in relation to deceased patient having no ID wristband when they were taken to the mortuary.

Incidents

- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are in place. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. There were no never events reported in end of life care between October 2015 and February 2016.

End of life care

- The electronic incident reporting system included a prompt asking staff if the incident was in relation to an end of life patient. This enabled reporting and analysis of incidents to take place.
- There had been 29 incidents reported between April 2015 and February 2016 in end of life care at the hospital.
- Twenty of these incidents, (69%) related to deceased patients having no identification (ID) wristbands or incorrect ID wristbands when they arrived in the mortuary. One incident was the release of the wrong deceased patient to funeral directors. This mistake was realised and the deceased person was returned four days later. The trust reported this incident to the Human Tissue Authority (HTA) as a reportable incident and submitted a full report after an investigation. (The HTA is a regulator involved with mortuaries and human remains).
- We discussed the ID issues with senior managers. They acknowledged this had been a problem in the past and had taken action with relevant wards to address the problem. The director of operations had initiated spot-checks to check procedures were being followed. We spoke with ward managers who told us they had conversations with individual staff about the issue. We also spoke with staff who said they had received emails to remind them about correct identification of patients. We saw lessons had been learned in some areas.
- Mortuary staff told us incidents of unlabelled deceased patients still took place. After our inspection we saw that one incident had been reported in May; ward J29 sent a deceased patient to mortuary without any ID wristbands.
- Mortuary staff told us the bereavement policy was being reviewed and would include information for staff on identification of deceased patients.
- Examples of other incidents included communication problems between hospital departments, and medical notes not being 'tracked' to the correct location.
- Staff we spoke with understood their responsibilities to raise concerns and report safety incidents. They told us they learned about incidents which had occurred in other areas by reading weekly 'lessons learned' bulletins.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff we spoke with were aware of duty of candour and told us of the need to be open and honest if something went wrong.

Cleanliness, infection control and hygiene

- We observed staff complying with the 'bare below the elbows' policy, using correct handwashing techniques and also use of sanitising hand gels. Staff wore personal protective equipment, such as gloves, aprons and theatre scrubs (in the mortuary) as required by the trust policy.
- Areas we visited looked clean and tidy.
- Porters told us they were responsible for cleaning the concealment trolley after each use (the trolley was used to bring deceased patients from the ward to mortuary).
- Staff in the mortuary told us they had not been able to keep up to date with the cleaning of a hoist used to move deceased patients due to staffing shortages.

Environment and equipment

- We saw evidence of water ingress from the flat roof in the mortuary. The ceiling and floor was stained in the post mortem area. Staff told us it rained in frequently during heavy rainstorms. There were buckets on the floor to catch rain when we visited the area.
- One of the hydraulic trolleys in the mortuary which had an oil leak posed a slip hazard to staff. They had reported this but repairs had not been carried out. We reported it to senior managers and it was repaired the same day.
- The mortuary had a secure access and exit by electronically locked doors. The entrance for funeral directors was screened from public view, and was secure.
- We saw that McKinley syringe pumps with safety features were supplied by the equipment 'pool' and maintained by staff in the medical physics department. (Syringe pumps are used to administer subcutaneous medications to patients).
- Other equipment for end of life patients such as pressure relieving mattresses and electric profiling beds were in use on the wards

Medicines

End of life care

- We saw medicines in wards and clinical areas were stored safely. Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.
- Patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of pain and other symptoms.
- We looked at six medicine charts and saw anticipatory medicines had been prescribed appropriately. Prescriptions and administration records were completed accurately and clearly.
- There was clear guidance for medical staff to follow when prescribing medicines at the end of life. The guidance was within the care of the dying person's individual care plan, and included pain and symptom management guidance, the use of anticipatory medicines and the use of syringe drivers.
- The specialist palliative care team and end of life care teams kept electronic records which meant risks to patients could be handed over effectively and communicated to colleagues.
- There was some duplication of electronic and paper records. This had been reviewed at the end of life care group April 2016. It was too soon to say if changes put in place would reduce the duplication.
- All of the 21 DNACPR forms we reviewed were stored correctly at the front of the notes, only one had handwriting which was difficult to read, the others were all legible.
- In all of the situations where the patients did not have the mental capacity to participate in discussions about resuscitation, there was evidence a conversation had taken place with family members. Twenty of the 21 forms had been countersigned by a consultant; this meant safe decision making had taken place.

Records

- We looked at eight sets of patient records and 21 do not attempt cardiopulmonary resuscitation (DNACPR) forms.
- We found that the standard of record keeping in the care of the dying person booklet was very good. This multidisciplinary booklet prompted staff to record sensitive issues in a clear comprehensive way to enable safe care to be given.
- Records showed timely interventions had taken place and documentation was contemporaneous (written as soon as possible after care interventions).
- When a patient was identified as nearing the end of life, this personal care plan was commenced. Staff could record discussions they had with patients and their families, the care which had been given and could evaluate key issues. The care booklet also contained symptom management guidance and visual guides for staff on the safe use of syringe pumps. This meant that safe practices could be communicated to staff and carried out.
- All of the care records we viewed were completed appropriately, accurately and legibly.
- The care records we saw were all stored securely.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. The safeguarding policy review date had been extended in order to update it for the trust. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and we observed staff discussing safeguarding on the wards.
- The trust had a dedicated safeguarding team who were available for advice and support. Staff we spoke with knew how to contact them.
- The trust collected safeguarding training data by clinical support units, not by individual teams, so it was not possible to ascertain if the specialist palliative care team and end of life care teams were up to date with safeguarding training.
- We spoke with two porters who told us they had not received any safeguarding training.

Mandatory training

- Mandatory training was provided to all staff and the type and level of training was identified as part of individual job roles. Examples of training included; priorities for care at end of life, fire safety, infection, prevention and control, resuscitation, dignity at work, moving and handling, the Mental Capacity Act (2005), equality and diversity, and risk and safety training.

End of life care

- Staff could access their own electronic mandatory training record. The system used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training or were overdue the sessions.
- We did not know the level of compliance for the SPCT or end of life teams as this was not broken down to team level by the trust.

Assessing and responding to patient risk

- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.
- Changes to a patient's condition were recorded in medical and nursing notes and in the care of the dying person care plan. We saw advice and support from the SPCT regarding deteriorating patients had been sought where appropriate.
- Specialist palliative care was provided from 8.30am to 5pm from Monday to Friday, and 9am to 5 pm at weekends. There was also 24 hour access to palliative care advice. At the weekend, one clinical nurse specialist worked across the trust reviewing patients face to face and giving telephone advice. There was also an on call palliative care consultant out of hours who gave medical advice and support.
- We saw evidence in care plans that when patient's needs increased; staff had assessed and monitored their safety. For example when someone could no longer swallow medication.
- A graded response observation chart and National Early Warning System (NEWS) scores were used to monitor for patient deterioration. This was a scoring system in which a score was allocated to physical measurements such as blood pressure, temperature, respiratory rate and level of consciousness. The score from the NEWS acted as a trigger so staff could to escalate concerns about patient risk.
- Some wards were also taking part in a trial using a safety checklist when a patients NEWS score was 5 or above. The checklist included evidence of nurse and doctor reviews.

- We saw some wards were also taking part in another trial, using stickers on patient notes as a summary of escalation plans and resuscitation status if someone deteriorated.

Nursing staffing

- The trust wide specialist palliative care team had a clinical and educational role and there was a whole time equivalent (WTE) team leader, and six clinical nurse specialists who worked across a rota which provided cover seven days a week. This totalled 8.4 WTE nursing staff.
- Staffing levels had been reviewed and there were plans to employ a further clinical nurse specialist to allow for two staff to work on a weekend.
- The trust wide end of life care team consisted of one WTE lead nurse, two WTE band 6 end of life nurses (and also another WTE band 6 in a seconded post), and a WTE discharge facilitator. Together they totalled 5 WTE nurses. In addition, there was a 0.4 WTE organisational learning facilitator and 1.6 WTE admin support to the team.
- There was a plan for end of life care discharge facilitators to work seven days a week in order to achieve safe discharge at end of life. This would be funded by the 'Better Care Fund' (an NHS England funding programme).
- Specialist nurse staffing in end of life care met the minimum recommended levels (Commissioning Guidance for Specialist Palliative Care 2012, this is the most recent commissioning guidance). However, the staffing guidance recommends hospitals with cancer centres, (as SJUH has) require more than the minimum number of specialist nurses. It was a caveat (caution) in the guidance that hospitals with a cancer centre will need more specialist nurses; it was not possible for us to determine how many more might be needed
- Clinical leadership was provided by the lead nurse for end of life care and the lead clinician.
- Two nurses on ward J28 and two from J29 told us they felt they didn't have enough time, due to being short staffed, to properly care for patients who were dying.

Medical staffing

- Medical staffing for end of life care included a consultant who was the trust wide clinical lead; there were also four other consultants who supported both palliative care and end of life care, who together provided 31 sessions,

End of life care

or PAs a week, (Programmed Activities). A full time doctor worked 10 PAs a week; this meant there was the equivalent of just over three full time consultants. Two of the consultants worked full time providing direct clinical care and supporting professional activities such as teaching and research.

- There were also two other middle grade (staff grade) doctors, who together provided 13 PAs a week.
- The medical staffing was in line with the national minimum recommendations for hospital specialist palliative care (Commissioning Guidance for Specialist Palliative Care 2012), which recommends a full time doctor per 250 hospital beds. SJUH had around 1000 beds.
- Face to face cover and telephone advice was available seven days a week by doctors on an on call medical rota.

Other staffing

- There were two mortuary staff at the hospital; both were senior anatomical pathology technologists. One person was full time, the other worked 30 hours a week. There had been an additional locum staff member for two

years; however they were no longer employed by the trust, which left a vacancy for an anatomical pathology technologist. Staff told us this was a cost saving measure. We could not corroborate this was the case.

We saw that staff had to be regularly borrowed from the mortuary team at Leeds General Infirmary to cover busy periods, holidays and sickness. We spoke with senior managers about this; it had already been discussed at the monthly clinical support unit meetings. We did not request this information.

Major incident awareness and training

- Potential risks to the interruption of mortuary services had been planned for. The mortuary had a policy of how to respond in the event of a major incident with fatalities.
- There were arrangements in place with the Leeds General infirmary and a neighbouring trust to respond to major incidents and staff told us there were practices with emergency services to review plans.
- Staff we spoke with were clear about their roles and responsibilities in the event of a major incident.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure all staff have completed mandatory training and role specific training.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.
- The trust must review the admission of critical care patients to theatre recovery areas when critical care beds are not available to ensure staff are suitably skilled, qualified and experienced.
- The trust must review how learning from Never Events is embedded within theatre practice.
- The trust must review the appropriateness of out of hours' operations taking place and take the necessary steps to ensure these are in compliance with national guidance.
- The trust must review the storage arrangements for substances hazardous to health, including cleaning products and sharps disposal bins to ensure safety in line with current procedures.
- The trust must review and address the implementation of the WHO Five Steps to Safer Surgery within theatres.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must review the function of the pre theatre waiting area in Geoffrey Giles theatres and ensure that the appropriate checks and documentation are in place prior to patients leaving ward areas.

- The trust must ensure that all equipment used across core services is properly maintained and serviced.
- The trust must ensure that staff maintain patient confidentiality at all times, including making sure that patient identifiable information is not left unattended.
- The trust must ensure that infection prevention and control protocols are adhered to in theatres.

Action the hospital **SHOULD** take to improve

- The trust should review and improve the consent process to ensure trust policies and best practice is consistently followed.
- The trust should review the availability of referral processes for formal patient psychological and emotional support following a critical illness.
- The trust should review the provision of post-discharge rehabilitation support to patients discharged from critical care.
- The trust should ensure that appropriate staff have access to safeguarding supervision in line with best practice guidance.
- The trust should continue to monitor the safe and correct identification of deceased patients before they are taken to the mortuary and take necessary action to ensure this is embedded in practice.
- The trust should continue to work towards improving the assessment to treatment times within the ED department. The trust should also continue to work towards improving ambulance handover times and reduce the number of handovers that take more than 30 minutes.
- The trust should ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 (1) Care and treatment must be provided in a safe way for service users</p> <p>How the regulation was not being met:</p> <p>Within surgical services audit data showed that national early warning score (NEWS) and escalation was not always correctly implemented.</p> <p>Routine operations were regularly taking place out of hours.</p> <p>Within the Jubilee theatre suite we observed a broken alcohol dispenser. We observed a fridge in the recovery area with what appeared to be blood stained fluid in the bottom. In the changing rooms in Jubilee theatres, we observed blood stained clogs in a storage bin and on the floor which were to be used again. We also observed staff walking around theatres in heavily stained clogs. Lockers in the changing rooms in Geoffrey Giles theatres had theatre clothes, used hats and food wrappers on top of them. One of the theatres had an overflowing clinical waste bin.</p> <p>There were unsealed sharps containers on Ward 26 at SJUH. Hazardous substances used for cleaning were not stored securely in the sluice areas on Wards 14 and 25 at SJUH.</p>

Requirement notices

On occasion patients arrived in the pre-wait area of Geoffrey Giles theatres, from non-surgical wards, not having their consent to surgery completed. Staff were then required to ring the ward and liaise with staff to try and sort out the problem.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1) Systems and processes must be established and operated effectively to:

(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

How the regulation was not being met:

There were arrangements in place for assessing the suitability of patients who were appropriate to wait on trolleys on the assessment ward. However, these were not consistently applied, or risk assessments undertaken. There was a lack of robust assurance over the oversight of patients waiting on trolleys.

During our inspection, within the ED department at LGI we saw that patient identifiable information was left on

This section is primarily information for the provider

Requirement notices

display on monitors in patients' bays on four occasions. The information on display did not relate to the patient in the cubicle at the time. This was a breach of patient confidentiality.

Learning from the two Never Events related to wrong site anaesthetic block was not embedded. The 'stop before you block' guidance was not always adhered to.

Within surgical services a number of risks identified on the risk registers had been present for over two years, despite recent review and mitigating actions being put in place but for many they were still ongoing.

Out of six critical care units only four submitted data for ICNARC. ICNARC is a standardised national data collection process and it is recommended that all Critical care units in England should provide data to benchmark services.

Across services we found equipment used had not always been properly maintained and serviced.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

How the regulation was not being met:

Requirement notices

Nurse staffing levels in some clinical areas were regularly below the planned number. This included surgery, critical care, maternity and children and young peoples' services.

Consultant labour ward presence was 60 hours per week and these were our findings at the previous inspection in March 2014. The Safer Childbirth Standards 2010 recommends 98 hours for units who deliver 5000 births.

Within children's services there were gaps in the junior doctor rotas, which meant there was a risk of the service not providing adequate clinical care. These gaps were filled with locum doctor shifts or by consultants covering.

Specialist nurse staffing levels did not meet national recommendations related to being a specialist cancer centre.

Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

How the regulation was not being met:

At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 37% of nursing staff.

Mandatory training compliance did not meet the trust's target in several areas including accident and emergency, medical care, critical care, maternity services and children's services.

This section is primarily information for the provider

Requirement notices

Level 2 and Level 3 children's safeguarding training compliance in children's and maternity services was below the trust target of 85%