Care Quality Commission

Leeds Teaching Hospitals NHS Trust

Leeds General Infirmary

Quality Report

Greater George Street
Leeds
LS1 3EX
Tel: 011324327799
Website: www.leedsth.nhs.uk/

Date of publication: 07/01/2014
Date of inspection visit: 17-20 and 30 March 2014

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

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Leeds General Infirmary is one of seven hospitals forming the Leeds Teaching Hospitals NHS Trust, which is one of the largest in the United Kingdom. The trust serves a population of 751, 485 in Leeds and surrounding areas. In total, the trust employs around 15,000 staff. Leeds General Infirmary has 590 inpatient beds.

We inspected the children's hospital and its services, which share the Leeds General Infirmary site. The children's hospital was located within the buildings and facilities of the main hospital and was not easily identifiable as a dedicated service. There was no formal executive lead and oversight of children's services, which were provided across other clinical service units in addition to those in the children's hospital. Children's cardiac surgery is a specialist service provision at the hospital and as such was not assessed as part of this inspection.

Leeds General Infirmary provides accident and emergency services for adults and children, surgical, critical care, maternity and family planning services. Medical services provided are cardiology, neurology and stroke services only. There is a 24-hour percutaneous coronary intervention (for heart attacks) and thrombolysis (for strokes) service.

Many new initiatives had recently been introduced in the hospital, including the new management and governance structure, which has created 19 Clinical Service Units across the hospital sites. It is acknowledged that these have not yet had time to become fully established, and some services had adapted more quickly than others.

Staff were positive about the changes brought in by the new leadership at trust level and reported that the executive team were more visible, especially the Chief Executive. Staff told us that there was a much more open and honest culture, with patient care a priority. However, many of the strategies and initiatives were still in their infancy, and as such a safety culture was not yet fully embedded in the hospital.

The hospital displayed information on their safety performance on ward areas and this was used to highlight where there were shortfalls to drive improvement. There were systems in place to identify risk and report incidents. However, we found that not all staff groups were consistently reporting incidents and lessons learnt from investigations were not routinely shared across clinical service units and other hospitals in the trust.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Access to services was generally good; patients' needs were generally responded to appropriately and in a timely manner.

Patients were positive of their experience in the hospital and reported that staff were kind, kept them informed and they were involved in decisions over their treatment. Patients felt treated with dignity and respect. On the whole, analysis of patient surveys showed patients experience at the hospital was good, although some concerns had been raised about communication with some clinicians, staffing levels and some staff attitudes.

Staffing

Nurses worked hard to meet the needs of patients and took pride in working in the hospital. However, there were nursing and medical staff shortages across a number of areas, which meant that the necessary experience and skills mix, did not always meet Royal College and national recommendations for best practice. Medical cover out of hours was a particular concern. There was a training programme in place, but not all staff had completed their mandatory training and access to training was problematic at times.

Cleanliness and infection control

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

Summary of findings

Medicines management

There were good arrangements in place to ensure the safe storage, administration, handling and recording of medication. Generally medication was managed appropriately.

Complaints management

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There were clear arrangements to assess, monitor and report risk with a new governance and reporting structure in place, which was still to become established. A safety culture was not yet fully embedded in the hospital. We found good reporting of incidents among the nursing staff, but this was not seen as a priority for all clinical staff. Lessons learnt from incidents were shared within departments or among the clinicians concerned but there was limited sharing between clinical service units and other trust hospitals.

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

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

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

Attendance at mandatory training was low in some areas and staff did not always have access to the necessary training to maintain their skills or gain new ones, for example - in children's safeguarding and with access to some medical teaching.

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

Are services effective?

Good

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

Clinical audits were taking place, but although there was an annual clinical audit programme and a central Clinical Audit Database this was still in its relative infancy and therefore there was a lack of clarity over what was being audited, the outcomes and how this information was captured. Junior doctors in some areas reported no active involvement or encouragement to be involved in clinical audit or quality improvements.

Summary of findings

Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Are services caring?

Good

Staff were caring, compassionate and ensured that the patients' privacy and dignity were respected when attending to individuals' personal needs.

Patients told us they had been involved in decisions about their care and treatment. Nurses introduced themselves to their patients at all times. Doctors explained to patients their diagnosis and made them aware of what was happening with their care.

Analysis of patient feedback information showed that generally patients were positive about their experience, particularly in the cardiac, children's and accident and emergency services. For example, - the A&E Friends and Family test results were above the national average for recommending the A&E to friends and family for the four months from September to December 2013.

Are services responsive to people's needs?

Requires improvement

Access to services was generally good; patients' needs were responded to appropriately and in a timely manner. The hospital had been performing better than the A&E national targets since July 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. The hospital was performing similar to hospitals in other trusts in both cancelled operations and delayed discharges. Generally, the hospital was performing well with access to appointments and waiting times.

As the hospital did not accept general medical patients (who were transferred to the St James's University site) the hospital did not have the same capacity issues that other sites had. Patients were admitted promptly to the appropriate ward.

There was a focus on continuous quality improvement but further work was required on ensuring a consistent response the needs of people with dementia. Staff on the critical care units were concerned about the increasing bed pressures and increasing demands on the service, particularly because of the hospital's trauma centre status.

Apart from the teenage cancer unit, there were no dedicated facilities including recreational for young people. Young people over the age of 16 were admitted to adult wards without an assessment of the appropriateness for their stage of development

Are services well-led?

Requires improvement

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

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

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

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

Summary of findings

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

Accident and emergency

Good

The A&E department delivered services safely. There was sufficient nursing and medical staff to provide a safe service and the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practitioners. The department was clean with arrangements in place to manage and monitor the prevention and control of infection. There were systems in place for assessing, monitoring and addressing risk. Learning took place following incidents and complaints. However, we found that not all staff had completed mandatory training particularly safeguarding Levels 2 and 3 where appropriate. Due to the large number of children and young people attending the service, this required prioritising for attention.

Nursing handovers were comprehensive and thorough, covering elements of general safety as well as patient-specific information. The A&E used nationally recognised best practice guidelines and quality standards to monitor performance. There was good multidisciplinary working with a full range of trauma specialists available 24 hours a day. There was telephone access to mental health services, through the acute liaison psychiatry service (ALPS).

Patients and relatives were positive about the treatment and care they had received in both the adults' and children's A&E departments. We observed that patients were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department. The implementation of dignity rounds helped ensure that patients were as comfortable as possible and that their privacy and dignity was maintained. However, we found that there was a lack of formal capacity assessments, particularly for patients with dementia.

The trust had been performing better than the A&E national targets since June 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. There were a number of systems and services in place to ensure that A&E responded to patients' needs appropriately and in a timely manner.

At departmental level, there were effective procedures in place to ensure that the service was well led. Staff told us that they felt engaged and involved in service improvement and redesign work. Staff were supportive of each other.

Medical care (including older people's care)

Requires improvement

We found the medical wards to be clean and well maintained, but low nurse staffing numbers meant that safe care could not always be delivered. In addition, although there was a good culture of reporting incidents among the nursing staff, this was not seen as a priority for all clinical staff, and thus a genuine safety culture was not yet embedded at this hospital. The recent

Summary of findings

introduction of the 'safety board' on wards had been embraced by the staff and all spoke positively about it. There was a specific concern with regard to the prescription of certain medications on one of the wards; however, we had no concerns about the management of medicines elsewhere.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Clinical audits were taking place, but despite an annual clinical audit programme and a central Clinical Audit Database there lacked clarity over what was being audited, the outcomes and how this information was captured. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working. However, there was inconsistency with the quality and recording of the nursing and medical handovers, which meant that important information, such as the frequency of patient observations, was not always passed on. Not all staff had completed their mandatory training.

Data from the Friends and Family test as well as the CQC Adult Inpatient survey confirmed what we witnessed during the inspection. Staff were seen to be caring towards their patients and to be treating them with kindness and dignity. Patients were complimentary and full of praise for the staff looking after them.

LGI provided specialist cardiology, neurology and stroke services for the region. It did not accept general medical patients (who were transferred to the SJU site). As such, the hospital did not have the same capacity issues that other sites had. Patients were admitted promptly to the appropriate ward, although some patients then had to be transferred to an 'outlying' ward once their acute phase of treatment was finished as there were some delays in transferring them back into the community. Care for patients with dementia required further work.

Surgery

Requires improvement

Wards and theatres were clean and there was evidence of learning from incidents in most areas. There were arrangements in place for the effective prevention and control of infection. We found that there were inadequate levels of staff, both nursing and medical in some areas, particularly out of hour's medical cover and anaesthetist availability. We had concerns about the medical cover, the quality of the handover and support on the High Dependency Unit on Ward L39, which was overseen by the Trauma and Related Services CSU. Not all staff had completed their mandatory training.

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

Summary of findings

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

There was good multidisciplinary working with coordination of care between different staff groups, such as physiotherapists, nurses and medical staff. The portering service had been centralised and this limited their responsiveness to meet the needs of patients.

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

Intensive/critical care

Requires improvement

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

We found that mental capacity assessments and the deprivation of liberty safeguards were not part of the critical care process. Although ensuring staff were up to date with their training was coordinated by the Organisational Learning Department who monitor monthly and report to the Workforce Committee it appeared ad hoc and completion rates were low.

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

Patients were positive about the support and care received on the units and said they felt kept informed and involved. Staff were reported to be approachable and sympathetic to family and carers' needs.

Staff were positive about the relatively new leadership team and felt communication had improved. There was a focus on continuous quality improvement but staff were concerned about the increasing critical care bed pressures and increasing demands on the service, particularly because of the hospital's trauma centre status. We had concerns about the apparent 'us and them' culture between the two main hospital sites and the lack of engagement between senior medical staff, within the critical care CSU. There was very limited planned cross-site working and staff remarked that the culture across the two main hospital sites was different; this didn't encourage joined-up working.

Summary of findings

Maternity and family planning

Good

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

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

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

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

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

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

Children's care

Requires improvement

We found that children's services were generally safe; however, nurse staffing levels on the children's wards were identified as a risk as they regularly fell below expected minimum levels, which placed staff under increased stress and pressure. We also found there were gaps at middle-grade and junior doctor level and some medical staff were covering paediatric specialties without any specific paediatric training. Although there were initiative in place to share learning from incidents such as a trust-wide Learning Points Bulletin, and fortnightly Quality and Safety Matters briefing we found that not all staff were aware of serious incidents that had occurred within the trust. Staff reported that learning from lessons was improving, but that the some of the formal processes in place such as were still in their infancy.

Children's services were utilising national guidance, peer reviews and care pathways. In the areas where there were national peer reviews, we found that services were benchmarked against other services across the country.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. Patients and their relatives were

treated with care and compassion and felt involved in decisions about their care and treatment. There was an inconsistent approach to gaining patient feedback; although there were plans in place to adapt the Friends and Family test for children and young people and to develop an adolescent forum.

Apart from the teenage cancer unit, there were no dedicated areas for young people. Young people over the age of 16 were admitted to adult wards were not always assessed for the appropriateness for their stage of development. Although there was work in place to look at the transition from children's to adult services, there was no policy for such transitions within the trust. We found inconsistent approaches to transition, which did not always follow best practice guidance.

We found that aspects of the children's services were well led. However, there was no executive lead at board level. We found that there was no oversight of children's services across the trust, especially as not all children's services were managed by the children's Clinical Service Unit management team. There were no formal processes to share learning across all of the children's services and specialties. The overarching strategy and vision for the children's hospital were not displayed in ward areas or available on the webpage and we found that staff were not aware of the vision.

End of life care

Good

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

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

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

All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service. Staff were positive about the management and support given with end of life, although a number were not aware of who was the executive lead for end of life was for the trust.

Outpatients

Good

Outpatient areas were appropriately maintained and fit for purpose. Staff at all levels told us they felt encouraged to raise concerns and problems. Incidents were investigated appropriately and actions were taken following

Summary of findings

incidents to ensure that lessons were learned and improvements were shared across the departments. The infection control procedures were adhered to in clinical areas, which appeared clean and reviewed regularly. Staffing levels were adequate to meet patients' needs.

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

Patients told us they felt involved in their care and treatment and that staff supported them in making difficult decisions. The hospital provided interpretation services and patients told us that they felt their privacy and dignity were respected.

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

Summary of findings

What people who use the hospital say

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

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

Leeds General Infirmary scored 4.5 out of 5 stars on the NHS Choices website, with 82 people expressing views. Negative themes were staffing levels, poor attitude of staff, late and omitted medications. The hospital scored 4.5 stars for cleanliness, 4 stars for co-operation, 4.5 stars for dignity and respect, 4 stars for involvement in decisions and 4 stars for the same sex accommodation.

The 2013 Patient-led assessments of the care environment (PLACE) focuses on the environment in which care is provided and looks at cleanliness, food, hydration and the extent to which the provision of care with privacy and dignity is supported. The hospital scored 97.4% for cleanliness, 87.6% for food, 90.7% for privacy and dignity and 89.1% for facilities.

Healthwatch shared their 2014 survey, where 183 people shared their views and experiences of services across all of the five hospitals at the trust. At trust level, approximately 44% rated the service outstanding, 24% were rated as good, 7% were rated as satisfactory and 26% were rated as requiring improvement. Some areas received positive responses with comments raging from good to outstanding for the cardiac services, colonoscopy services, children's services and accident and emergency services. However, negative comments were received over the experience of waiting in the epilepsy clinic, waiting for care in orthopaedic areas and the lack of communication from the doctors in the children's heart surgery service.

Areas for improvement

Action the hospital MUST take to improve

- Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical, surgical and children's wards, including medical cover out of hours.
- Ensure that staff attend and complete mandatory training, particularly for the safeguarding of adults and children and maintaining their clinical skills.
- Ensure that doctors are able to attend teaching sessions and this includes specialist medication regimes and other clinical areas they cover for including children's services.
- Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.
- Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.
- Review the handover procedure for medical and nursing staff to ensure that the necessary information is communicated appropriately and effectively.
- Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.
- Review the arrangements on L39 High Dependency Unit to ensure there is appropriate critical care medical oversight and support in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.
- Ensure that there is a coherent and clear auditing system in place for the participation of national clinical audits and auditing of trust guidelines and that there is an appropriate recording system in place to capture this. Review the involvement of junior doctors in the audit process.
- Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

Summary of findings

- Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff act in the best interests of the patient and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.

Action the hospital SHOULD take to improve

- Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.
- Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.
- Ensure that 'do not attempt cardiopulmonary resuscitation' decisions follow best practice, and are appropriately recorded in patient records.
- Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.
- Review the information available for people who have English as a second language and make written information more accessible, including clinical decisions, how to complain and end of life care.
- Ensure that the provision of oxygen is appropriately prescribed.
- Ensure that all staff involved in patient care are aware of the needs of people with dementia and that the documentation used reflects these needs.
- Ensure that all early warning score documentation is fully completed on each occasion used.
- Consider displaying trend data over a period of time as part of the ward dashboards.
- Ensure that the windows on L26 are repaired and that the ventilation of the ward is appropriate to need.
- Review the use of the Family and Friends Test results to improve consistency across departments.
- Review the recruitment processes to ensure that they are efficient and timely.
- Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.
- Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.
- Review the bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems.
- Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.
- Review the security of the hospital in general, but specifically with regard to access to theatre departments.
- Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.
- Review the use of personal protective equipment on the critical care units to ensure consistent practice as part of the arrangements for the prevention and control of infection.
- Implement a seven day a week critical care outreach team.
- Review the IT system to ensure that all necessary information such as that identifying if a social worker is involved when Looked After children arrive at the hospital.
- Review the consent process to ensure that where appropriate the child or young person is involved in decisions and signatures are obtained.
- Appoint an executive lead for children's services to ensure that there is consistent oversight and shared learning across clinical areas.
- Consistently apply patient feedback processes across clinical support services.
- Develop facilities and recreational activities for older children and young adolescents in children's services.
- Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.

Summary of findings

Good practice

- In response to pregnant women who were travellers and asylum seekers, the trust set up a community midwife led service (Haamla) to assist in meeting their needs.
- The hospital in partnership with St James's University Hospital as part of the trust had received a Parliamentary Service Award for the multi-disciplinary team of the year for their diabetes in pregnancy service.
- The service had received a runner up award for services for antenatal screening of women with HIV.
- The children's and young people's service had developed dedicated arrangements for schooling that met all national standards and were rated as 'outstanding' by Ofsted.

Leeds General Infirmary

Detailed Findings

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

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett Consultant Radiologist

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

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

Background to Leeds General Infirmary

Leeds General Infirmary (LGI) is one of seven hospitals that form Leeds Teaching Hospitals NHS Trust and houses the Children's Hospital for the trust. The hospital is located within the city of Leeds. The hospital provides accident emergency services, surgical and medical services, critical care services, and maternity and family planning services. The site also houses the children's cardiac surgery service; this is a specialist provision and was not assessed as part of this inspection.

There are approximately 112,000 attendances in the accident and emergency department (A&E) each year, of which up to 31,000 are children (under 16 years old). Children are seen in the children's A&E, which is located next to the main A&E. The admission rate to a hospital ward at this site is about 33% for adults and 21% for children.

The hospital provides cardiology, neurology and stroke services and provides a 24-hour percutaneous coronary intervention (for heart attacks) and thrombolysis (for strokes) service.

Ambulance services transport patients with suspected cardiological or neurological problems to this site. All other ambulance patients are taken to the St James's University Hospital (SJUH) accident and emergency department (A&E). Any patient who walked into the A&E requiring medical input aside from cardiology or neurology would be stabilised first and then transferred to the other site under the care of the appropriate team.

There are four cardiology inpatient wards and three neurology and stroke wards including the hyper-acute stroke unit (HASU).

Surgical services include trauma and orthopaedic surgery, ENT, neurosurgery, spinal surgery, vascular, cardiac and plastic surgery. There are 11 wards, which provide surgical services and 19 operating theatres including day surgery theatres.

Adult Critical Care Clinical Service Unit (CSU) has 74 beds across Leeds Teaching Hospitals NHS Trust (LTHT). The

beds are split across two sites with three units at Leeds General Infirmary (LGI) including general, cardiac and neuro-surgical. There are six additional high dependency beds. LGI activity has risen particularly as a result of Major Trauma Centre designation from April 2013 increasing neurological and general trauma activity.

LGI provides obstetric and midwifery care. The service includes pre-conceptual care, early pregnancy care, antenatal, intrapartum and postnatal care. There is a neonatal intensive care unit providing a service for babies less than 27 weeks gestation and for high risk pregnancies, it has 31 neonatal cots.

The children's hospital was officially opened in 2012 following centralisation of inpatient children's services to Leeds General Infirmary (LGI) in 2010. There are 286 beds within the hospital and this number was increased during the winter months to deal with seasonal illnesses affecting children. The hospital provides a range of paediatric services including general surgery, medicine and paediatric intensive care.

In addition, the hospital provides tertiary-level specialties including paediatric neurosciences, cleft lip and palate, paediatric rheumatology, paediatric liver and transplantation, paediatric cardiology and paediatric nephrology. There were 16 intensive care beds for children and 20 surgical high dependency beds on dedicated wards including the cardiac high dependency unit (HDU), surgical HDU and the neonatal unit.

Leeds General Infirmary (LGI) provides obstetric and midwifery services, along with community midwifery care. It was a tertiary unit and therefore provided care for and advice to clinicians caring for women with complex needs. The service included pre-conceptual care, early pregnancy care, antenatal, intrapartum and postnatal care. The trust also had a tertiary neonatal intensive care unit (NICU) at both sites that provided medical neonatal care. At LGI, the service was for babies under 27 weeks' gestation and for high-risk pregnancies, and it had a total of 31 neonatal cots.

End of life care services are provided throughout the trust, with the specialist palliative care (SPC) team located at the Robert Ogden Centre at St James's University Hospital (SJU).

The hospital has a dedicated outpatient department (OPD) with dedicated outpatient staff. The outpatients department had 307,000 patients attend outpatient clinics in the last year.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits on 17, 18, 19 and 20 March and an unannounced visit on 30 March 2014.

Detailed Findings

During the visits we held focus groups with a range of hospital staff, including support workers, nurses, midwives, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit, outpatients, and A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

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

Good

Accident and emergency

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

Information about the service

There were approximately 112,000 attendances in the accident and emergency department (A&E) each year at Leeds General Infirmary (LGI), of which up to 31,000 were children (under 16 years old). Children were seen in the children's A&E, which is located next to the main A&E. The main reception area and resuscitation room were shared with the children's A&E. The resuscitation room had six bays and was equipped for four adults and two children. The admission rate to a hospital ward at this site was about 33% for adults and 21% for children.

In the adult A&E there were four trolley bays allocated for initial assessment of patients who had arrived by ambulance. Approximately 17% of patients arrived by ambulance. Following initial assessment, patients were then moved to one of 10 cubicles.

For patients who walk into the department, there were a minor injuries or illness service; this had three walk-in assessment rooms and six cubicles for treatment, including two that could be used for isolation purposes.

In the children's A&E there were 17 cubicles that were used for minor or major injuries and illnesses.

There was also a clinical decision unit (CDU). This was a short-stay unit that accepted adult patients, mainly from A&E, who fulfilled the criteria of one of 19 clinical protocols. There were seven male beds and eight female beds; these met the national criteria for same-sex accommodation. Additionally, there were two bays that could be used for A&E trolleys. There was also an observation area, which was a seated area for patients who were awaiting results or transport home.

LGI received all major trauma cases as it had been the designated major trauma centre for West Yorkshire since April 2013. It was also the main site for people with heart problems and who had suffered an acute stroke.

The A&E departments were part of the urgent care clinical service unit. They employed, across both the LGI and St James's University Hospital (SJU) sites, 24 A&E consultants, middle-grade doctors and over 200 qualified nurses, who were supported by 70 clinical support workers and nursery nurses. There was also support from 45 administrative and reception staff.

Good

Accident and emergency

Summary of findings

The A&E department delivered services safely. There was sufficient nursing and medical staff to provide a safe service and the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practitioners. The department was clean with arrangements in place to manage and monitor the prevention and control of infection. There were systems in place for assessing, monitoring and addressing risk. Learning took place following incidents and complaints. However, we found that not all staff had completed mandatory training particularly safeguarding Levels 2 and 3 where appropriate. Due to the large number of children and young people attending the service, this required prioritising for attention.

Nursing handovers were comprehensive and thorough, covering elements of general safety as well as patient-specific information. The A&E used nationally recognised best practice guidelines and quality standards to monitor performance. There was good multidisciplinary working with a full range of trauma specialists available 24 hours a day. There was telephone access to mental health services, through the acute liaison psychiatry service (ALPS).

Patients and relatives were positive about the treatment and care they had received in both the adults' and children's A&E departments. We observed that patients were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department. The implementation of dignity rounds helped ensure that patients were as comfortable as possible and that their privacy and dignity was maintained. However, we found that there was a lack of formal capacity assessments, particularly for patients with dementia.

The trust had been performing better than the A&E national targets since June 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. There were a number of systems and services in place to ensure that A&E responded to patients' needs appropriately and in a timely manner.

At departmental level, there were effective procedures in place to ensure that the service was well led. Staff told us that they felt engaged and involved in service improvement and redesign work. Staff were supportive of each other.

Good

Accident and emergency

Are accident and emergency services safe?

Requires improvement

Cleanliness, infection control and hygiene

- The department appeared clean and we saw staff regularly wash their hands and use hand gel between patients.
- The 'bare below the elbow' policy was adhered to.
- There were weekly hand hygiene audits within the department (a sample of five staff were observed and reported on). We saw a hand hygiene audit in progress, which resulted in a 95% attainment level.
- The hand gel dispensers were full and paper towels were available at all sinks and in toilet areas. We saw hand hygiene audits for April to December 2013, the majority of which achieved 100% for both compliance and technique. There were audits for peripheral intravenous cannula insertion, which achieved 100%.
- Patients were positive about the cleanliness of the department. Patients commented that the department was spotless and one person said, "It looks really clean to me."
- There were cleaning staff available 24 hours a day. There was a visible cleaning system in place whereby large red and green circles were displayed to denote when a trolley bay or room required cleaning or was clean.
- Sluice areas were clean and there were 'I am clean' stickers on commodes to indicate that they had been cleaned and were ready for the next person to use.
- There was a 'Diarrhoea and Vomiting in the Emergency Department Pathway'; this included screening for Clostridium difficile. Methicillin-Resistant Staphylococcus Aureus (MRSA) screening was undertaken if infection was suspected prior to admission to a ward.

Nursing staffing

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

Medical staffing

- There were 24 consultants employed by the trust to cover both the children's and adults' A&E at LGI and SJU. The trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practitioners as well as providing overseas emergency medicine training programmes.
- At the LGI there were consultants within the department from 8am to midnight, or later if the department was busy. There were usually three consultants on the floor during the day and two until midnight.
- Overnight, there was always a doctor of ST4 level (registrar) or above.
- Overnight, A&E consultants were on call (from their home): one to cover for major trauma and one for any other requirements.
- The junior and middle-grade doctor rotas had several vacancies; these were usually filled by using long-term locums.

- We were told that only six out of 19 SpR posts were filled on a permanent basis. This was recorded on the risk register. Evidence from a report from the Medical Deanery and comments made to us by some permanent middle-grade doctors indicated that they were not happy with their rotas. Currently, there was a six-week rolling rota, with doctors working one in three weekends and only seven-day shifts within the six weeks.
- Due to medical staff shortages, study leave was very hard to organise. Doctors commented to us that they felt training was not a priority.
- Junior doctors told us that consultants were contactable by phone if they needed any support.
- The trust was developing alternative staffing models to compensate for the local and national shortage of emergency medicine doctors. This included the development of a training programme for advanced practitioners and overseas emergency medicine training programmes. Across both sites there were currently three trained and four trainee advanced practitioners and four doctors on the overseas training programme.

Children's A&E – medical and nursing staffing

- We saw from the rotas that one consultant and one or two other doctors were allocated to paediatric A&E on a daily basis.
- There were two named lead consultants for paediatrics.
- There were paediatric trained nurses in the children's A&E. The trust had recently recruited staff and we were told that the department had been at full complement for the last month.
- We were told that a number of nurses were appointed to the children's A&E when newly qualified as paediatric nurses and so lacked experience of working in A&E. A concern was raised about there being not enough senior nurse expertise, especially when a nurse left the department to work in resuscitation.
- From the children's A&E rotas, we saw that there were three or four qualified nursing staff on duty during the day and two qualified staff overnight.
- The service improvement team was reviewing staffing within the children's A&E as part of a wider piece of work looking at the effectiveness of the department.
- On most day shifts in the children's A&E, there was a nursery nurse on duty with one or two care support workers.

Initial assessment of patients

- Patients (children and adults) who walked into the service were streamed by a receptionist on arrival. The receptionist entered a very brief history on the computer. The computer system indicated where the patient needed to be seen within the department, for example in the majors or minors area or in the children's A&E. The system also flagged if a person had a history of violence or aggression, or whether they were children under 16.
- Patients who came by ambulance were assessed by a senior experienced nurse who had specific training.
- On average, patients arriving by ambulance were assessed within four minutes.
- Records to the end of February 2014 showed that for the LGI A&E department 95% of patients received an initial full assessment in less than 17 minutes from their time of arrival, which was slightly worse than the contractual requirement of 15 minutes.
- The A&E service used Rapid Assessment and Treat (RAT) guidelines to stream patients appropriately. Those with a higher risk then underwent more formal triage (using the Manchester Triage guidance), which included taking a brief history and observations. Pain relief, X-rays and blood tests were organised if required.
- Patients with chest pain were highlighted by a heart symbol on the computer and transferred immediately to the majors area for tests, including an electrocardiogram (ECG). We looked at 12 sets of assessment notes and they demonstrated that these assessments were being completed appropriately and pain relief was given promptly (within 30 minutes).

Management of the deteriorating patient

- Patients who attended the department had their observations undertaken during their initial assessment. These were entered onto their computerised record (on the Symphony IT system), which automatically calculated their National Early Warning Score (NEWS) and prompted action, such as moving the patient to resuscitation.
- We saw that, where required, these observations were repeated and recorded while the patient was in the department.

Nursing and medical handover

- We observed both medical and nursing handovers.
- Nursing handovers occurred twice a day. In the adult A&E, each one commenced with a handover of

information about the current patients to the incoming staff. Handovers also included information on performance, dignity rounds, team briefings and staff training. All staff were then allocated areas. This was followed by a debrief for the day staff that included checking the controlled drugs, noting any safeguarding issues and any incidents, and positive praise for staff.
- Medical handover occurred twice a day and was led by the consultant on the department floor. We observed the consultant prioritise and allocate the medical team to specific areas.
- We did not observe fully and therefore cannot comment on handovers specific to the children's A&E.

Handover process to wards

- There was a clear protocol in place for the transfer of patients to wards. Patients with a NEWS (national early warning score – used to identify the deteriorating patient) score of five or above were transferred with a nurse escort. For other patients there was a checklist that was completed by A&E staff and given to the ward. We looked at nine checklists and they all had NEWS scores documented. The staff on the receiving wards told us that this system worked well for patients with a low NEWS score.
- Nursing staff phoned the ward in advance as part of the handover.
- Some concerns were raised by nursing staff on one ward that there was limited information and time to prepare before patients arrived from A&E.
- In the children's A&E, we observed that this process did not always work effectively. There was confusion for one patient and their relative as mixed messages were given as to whether the child needed to go straight to theatre or to the ward.

Incidents

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

Environment and equipment

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

Medicines

- Medicines were well stocked and in date.
- The controlled drugs (CD) were checked twice a day.
- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- The ambulance service had its own supply of drugs (non-CD) that was kept in the A&E.
- We observed the administration of medication and found no concerns.
- Allergies were flagged on the patient's record and patients were wearing red wristbands to indicate allergies.

Records

- The department stored information electronically using an IT system called Symphony.
- There was also printed documentation for nursing and medical staff that was used jointly on one record as well as specific proformas to follow for certain conditions, for example acute asthma.

- The quality of documents was audited as part of the monthly ward health check. The CDU scored 100% in February 2014. Audits of patient records for January and February 2014 showed that almost all were completed correctly.
- In the adult minor injuries area, we noted that patient information was displayed on the computer in the treatment rooms and was accessible. There was a risk that this may have cause a breach of patient confidentiality.

Mental Capacity Act, consent and Deprivation of Liberty Safeguards

- Overall, patients consent was obtained from patients appropriately and correctly.
- We were told that, for patients who did not appear to have capacity to consent to stay in A&E or to consent to tests, due to the influence of alcohol or other substances, there was documentation available including a missing person's assessment tool; these took account of the person's mental capacity, which was recorded on Symphony. The tool took account of the requirements of the Mental Capacity Act 2005.
- For patients who were confused and/or had dementia, the procedures were less clear. Staff were able to tell us which patients did not have capacity but this was not formally assessed or recorded. Staff stated that in such cases they would act in the best interests of the patient. This meant that patients were receiving treatment and tests to which they may not have been appropriately consented for.
- We saw that for patients, who had capacity, consent was gained appropriately, procedures were explained and all questions answered.

Mandatory training

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

Safeguarding

- Adult and child safeguarding training was part of staff induction and mandatory training for the urgent care clinical service unit. 86% of all staff had up-to-date training for level 1 child and adult safeguarding, including 90% of medical staff and 92% of nursing staff trained to level 1.
- Of those medical and nursing staff who required level 2 child safeguarding training, 51% had received it.
- Some 42% of nursing staff who required level 2 adult safeguarding training had received it.
- Some doctors were unsure about the level of safeguarding training they had received or should have received. We had insufficient evidence to confirm during the inspection whether the trust was working to the standards set by the College of Emergency medicine for all senior A & E doctors to have level 3 child protection training.
- We found that there was a lack of clarity over the number of doctors at ST4 or above who were trained in Level 3 child protection.
- Staff were aware of how to make a referral if they had any safeguarding concerns. Staff told us that safeguarding was everyone's responsibility.
- Safeguarding protocols and contact details were clearly displayed within the children's A&E.
- We observed that children were checked appropriately with regard to potential safeguarding issues.
- There was a system in place for routinely assessing every child who attended the department for any potential safeguarding issues.
- There was a weekly multidisciplinary child safeguarding meeting where concerns were raised and any actions agreed.
- Staff were able to give us examples of when they had raised a safeguarding alert.

Major incident awareness and training

- LGI had been the designated major trauma centre for West Yorkshire since April 2013.
- There was compulsory classroom-based major incident training for all nursing and care support workers.

Security

- There was a police office in reception and there were security staff available.
- Certain patients were flagged on the system as requiring security support.

Good

Accident and emergency

- We observed a rapid response when A&E staff requested security support from both the police and security.

Are accident and emergency services effective?
(for example, treatment is effective)

Use of national guidelines

- The A&E used a combination of National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with these and were updated.
- The department ensured that the A&E was managed in accordance with the principles in 'Clinical Standards for Emergency Departments' (CEM).
- The department provided us with a list of all audits completed during the past year and the dates. For example, a sepsis audit indicated that, if people required antibiotics while in resuscitation, they received them quickly. However, people in the major treatment bays often had a delay of two to three hours before antibiotics were given.
- In January 2014, an audit of the 'Investigation and management of febrile seizures in the paediatric emergency department' was completed. It noted that there was no current febrile seizure guideline or pathway in the Leeds paediatric A&E. The results showed that some of the audit standards were met and some were not. Areas found to be in need of improvement were investigations, documentation of clinical findings, and documentation of discharge plans.
- There were clear action plans indicating what improvements needed to be made as a result of the audits.

Outcomes for the department

- The unit contributed to all of the CEM audits – including consultant sign-off, renal colic, vital signs in major injuries and illnesses, fractured neck of femur, severe sepsis and septic shock. The renal colic audit indicated that the department was working to the required standards, although some actions were required to further improve patient care.
- Unplanned re-attendances for the trust were similar to the England average of between 7% and 8%. However, at the LGI A&E department the percentage for the year to the end of February 2014 was 6.4% which was lower than the England average.

Care plans and pathways

- There was a single document and computer record that all staff used for each patient.
- There were specific pathways for certain conditions, for example sepsis and acute anaphylaxis.
- The CDU had 19 clinical protocols that formed the admission criteria to the unit.
- Pain management was good on initial assessment; however, recording of further pain assessments could be improved. We noted pain management was good on initial assessment. However an A & E audit indicated that the recording of further pain assessments could be improved. The patients we spoke with us told us that their pain was reassessed.
- Patients made positive comments about pain management: for example, "I was asked how much pain I was in and was given medication. It was explained to me what it was." Relatives told us, "My child was asked directly about pain relief," and "X was asked about pain and asked to score it. They were given pain relief."

Multidisciplinary team working and working with others

- There was a specialist team based within the hospital that worked closely with the A&E for stroke patients. This was known as the 'Brain Attack Team'.
- There were close links to the radiology department, with open appointments for patients and easy access to scanning.
- The radiology department was situated next door to the unit and was easily accessible. There was cover 24 hours a day.
- The unit was involved in a regional network for A&Es and actively learned from other departments to improve its services.
- A primary care advice line (PCAL) enabled GPs to discuss concerns they may have about patients. It was run by qualified nursing staff and could refer patients directly to specialist units within the hospitals or offer outpatient appointments within 48 hours in specialty 'hot clinics'.
- There was an acute liaison psychiatry service (ALPS), which was available 24 hours a day. The service was

based at SJUH A&E and was available for telephone consultations and/or referrals for face-to-face consultations with patients at LGI. There was an interview room available that met the safety criteria: access was via two doors and there was a panic alarm.
- There was a Section 136 suite available 24 hours a day at the Becklin Centre at SJUH hospital. This provided a "Place of safety" for the police to take patients who met certain criteria in accordance with the Mental Health Act 1983 to be assessed by a doctor.
- We observed prompt and good discussions between consultants and junior doctors when advice was required.

Equipment and facilities
- There was appropriate equipment to ensure that effective care could be delivered.
- Equipment was routinely checked and monitored: for example, the resuscitation trolley was checked every day.
- Equipment was available to suit variable age groups and patient sizes, from infants to adults.

Seven-day services
- A consultant was present in the department from 8am to midnight during the week and at weekends. They were supported by one or two speciality registrars and at least three senior house officer-level doctors.
- LGI was a designated major trauma centre, and so there was a full range of trauma specialists available 24 hours a day, including orthopaedics, neurosurgery and radiology teams, so that people could be operated on immediately.
- A trauma consultant, who led the trauma care, was available 24 hours a day.
- Telephone access to mental health services through the ALPS nursing team was available 24 hours a day via the SJUH A&E office. Out-of-hours access to mental health medical advice was via an on-call service.
- Pharmacists were in the hospital on both Saturday and Sunday. For services out of hours there was an on-call pharmacist who was based at the SJUH site.
- A consultant was allocated to the children's A&E on weekdays. They were usually supported by a senior registrar and one or two senior house officer-level doctors.
- According to the rotas, it appeared that not all evening (up to 10.30pm) and weekend shifts had a designated senior registrar for children's A&E. There was support from other senior doctors or consultants in adult A&E.
- Overnight there was a designated senior house officer for children's A&E with support from senior doctors in adult A&E.
- There was access to paediatricians via the children's inpatient services for Leeds, which were based at the LGI site.

Are accident and emergency services caring?

Good

Compassionate care
- A&E Friends and Family test results were above the national average for recommending the A&E to friends and family for the four months from September to December 2013. Comments included; "We were in a panic with a young child who was short of breath. He was seen to instantly"; "I'd most definitely recommend it. The all-round care and support shown and given to my four-year-old boy was excellent"; "We have no faults with how our son was treated. It's great. They took time to make sure he was OK."
- Additional comments from the Friends and Family test in January and February 2014 included: "People were nice. I was in and out in less than two hours; my only complaint would be for more information"; and "We were seen very quickly and dealt with in a friendly manner." We noted some negative comments from the test but these were in the minority: for example, "Was not impressed with my time in A & E" and "The receptionist was rude."
- The 2013 Care Quality Commission Adult Inpatient Survey showed the department's performance was the same as that of other trusts nationally.
- Comments about A&E from the listening event held as part of the inspection included concerns about a shortage of doctors and that overall the care was good in the CDU but there was no access to call bells. Other comments included "A&E was perfect." Children were prioritised through the separate children's A&E at LGI.

Good

Accident and emergency

- We saw access to and use of call bells during our inspection. We observed staff responding promptly to the bells.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Patients told us: "The nurses' manner was very good – they introduced themselves and explained what they were going to do"; "I have spoken to staff and they always keep me in the know"; "The staff here take the time to explain how my care and treatment is going"; "Staff are very attentive and take the time to listen"; and "I'm not made to feel like I'm wasting their time; they take my concerns seriously and those of my child."
- We looked at patient records and found that they were completed sensitively and discussions had been held with patients and relatives.
- We saw that patients were routinely checked as part of a dignity round. This included checking if patients required any food or drink, whether they needed the toilet, were in pain and were covered up. These checks were recorded on the patient's computerised notes.
- The department used members of the trust's volunteer service. Volunteers wore a green T-shirt with 'Can I help you' written on the back. They told us that they helped support patients with basic queries and offered food and drink.

Patient involvement in care

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- We heard staff explaining and seeking consent from patients, including children and their relatives, for tests and treatments.
- As part of the service improvement plan for children's A&E, the children were being asked their views of the department. There were age-appropriate questionnaires: younger children had 'Oscar the octopus' and older children used a computer tablet design.

Emotional support

- We witnessed staff supporting patients and relatives throughout their stay in the department. Patients commented: "Staff are very kind"; "The staff here are very patient and understanding. They're very helpful. I'm satisfied with the staff"; and "I can't rate the staff highly enough. My child is happy here; he likes it here."
- Relatives of patients in the resuscitation area were appropriately supported and cared for by staff.
- We saw that toys were made available and placed next to a child while in resuscitation.

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

(for example, to feedback?)

Good

Access

- The trust had been performing consistently better than the national target since June 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged.
- There were no A & E trolley waits greater than 12 hours at the LGI for the year to the end of February 2014.
- Since May 2013, for patients who were admitted, 96% to 98% were transferred to a ward within four hours.
- Less than 2% waited between four and 12 hours for admittance from the decision to admit, except in January 2014 when this peaked at 4%.
- The total length of time spent in the A&E departments was better than the England average.
- The number of patients who left the trust's A & E departments before the 2 hour mark was less than the national average. This was then higher than average after 2 hours and after 4 hours this dropped to come in line with the England average.
- The percentage of patients that left LGI A&E before being seen for treatment was 2.7% at the end of February 2014 which was similar to the national average.
- The number of patients waiting in the A&E for between one and 3.5 hours was slightly above average but then fell in line with the England average after 3.5 hours.
- Patients began to leave the department without being seen before the two-hour mark; after four hours this dropped to come into line with the England average.

Maintaining flow through the department

- The trust had done extensive work in investigating the 'pressure times' in A&E, and had adjusted its staffing rota to try to alleviate the peaks of attendances.

Learning from this had been shared across the sites. In the children's A&E, a changed model of working to improve patient experience and flow through the department was to start in March 2014.

- There was a clinical decision unit to which patients could be admitted for up to 24 hours. There were clear protocols in place for admission to the unit.
- The department was proactive in working with commissioners and local GPs to introduce admission avoidance measures. For example, it had established direct admission care pathways to the CDU for patients with suspected DVTs (deep vein thrombosis), pulmonary embolism (PE) and cellulitis.
- The department had a clear escalation policy that was based on good practice from the CEM. We saw this in operation during our inspection.
- The department worked with other departments in the trust so that there was joined-up working at busy times.
- One paramedic mentioned that, "LGI are one of the best for handover … patients are never left in corridors" and "It doesn't seem to be busy here … unlike other hospitals on our patch."
- Some doctors commented that in the children's A&E there was a high number of cases in the evening that were more suitable for primary care if services were available and that further work needed to be done in this area to reduce inappropriate attendances.

Meeting the needs of all people

- There were adequate disabled toilet facilities within the department.
- A hearing loop was advertised at the reception desk.
- Within the department, there was information for staff on how to request a translator, although staff admitted that they would rarely do this.
- However, we found that there was very limited visible information about the Patient Advice and Liaison Service (PALS).
- Information for patients who have English as a second language was very limited. There was almost no visible patient information in languages other than English. When asked, most staff were unable to provide leaflets or information in other languages, specifically the main languages spoken in the community.
- There was age-appropriate information and toys available for children.

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

- Some GPs worked within A&E, primarily in the evenings and at weekends.
- A discharge summary was sent to the GP by email automatically when a patient was discharged from A&E. This set out the reason for admission and any investigation results and treatment undertaken. In the CDU, paper copies were sent. Staff told us that plans were in place to make all CDU discharge summaries electronic using a system called EDAN (electronic discharge advice note).
- There was a PCAL that had a dedicated telephone number or 'hotline' that GPs and other health professionals, for example physiotherapists, could use to speak with a senior nurse between the hours of 7am and midnight. PCAL received about 200 calls per day. The staff triaged the calls and used a proforma to determine whether the patient needed to be admitted to A&E or whether other care pathways could be activated. The PCAL could refer to outpatient clinics if required. Three-way calls could also be set up with on-call acute consultants, for example medical or paediatric.
- There was an early discharge team that undertook a number of assessments within A&E and CDU to enable a safe discharge. Assessments included reviewing mobility and, if required, arranging for falls clinic follow-ups or a referral to the intermediate care team.
- The urgent care clinical service unit worked as a unit across both sites. We saw that consultants moved between sites, depending on needs and priorities at each site.
- There was also liaison and movement of patients between the two CDUs, if required. If a patient could be effectively managed within the emergency department's CDU protocols, rather than being admitted to a medical bed, then they would be transferred to the other site if no CDU beds were available. We saw this with one patient who had been transferred from SJUH A&E to the CDU at LGI. We spoke with the patient's relative and they told us they were happy with the care they had received.
- There was an ALPS that was available 24 hours a day. The service was based at SJUH A&E and was available for advice and/or referrals for face-to-face consultations with patients. Some 70% to 80% of the work was conducted within SJUH A&E.

Good

Accident and emergency

- Ambulance staff commented that the system worked well and they were rarely left waiting in the corridor with a patient.
- Ambulance crews had clear protocols as to which A&E to take patients to: for example, they brought patients who had suffered trauma or had a probable heart condition to LGI.
- Ambulance crews knew that all children were to come to this A&E.
- We saw prompt liaison with paediatric doctors when a child was brought into the resuscitation room.

Complaints handling and learning from feedback

- There was a visible poster about how to complain and leaflets in the reception area. They were written in English.
- Information about how to make a complaint was not prominent in other parts of the department.
- There was no visible signage or leaflets about how to access the complaints information in other languages, although inside the complaints leaflet there was a telephone number to ring to receive the leaflet in other formats and languages.
- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, they would speak to the shift coordinator. If the shift coordinator was not able to deal with their concern satisfactorily, they would be directed to the PALS. If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in the complaints leaflets.
- The head of nursing for urgent care and the matron for the A&E received all of the complaints relevant to their services. A person was then allocated to investigate the concern. The department had an initial response turnaround time of three days. All responses to complaints were reviewed by both the general manager and the head of nursing. Action plans were developed if required.
- We noted from the trust's complaints register that there had been 15 complaints about LGI A&E from 1 July 2013 to 31 December 2013. The majority had been about medical care. 9 cases had been open for 50 days or more.
- Themes from both formal and informal complaints were collected on a quarterly basis and fed back to staff; we saw this recorded in minutes from a staff meeting. The minutes recorded 23 complaints for quarter three in 2013.

Are accident and emergency services well-led?

Good

Leadership of service

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

Culture within the service

- All the doctors and nurses we spoke with said they would bring their family here.
- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility.
- Openness and honesty were the expectation for the department and were encouraged at all levels.
- Staff worked well together and there was obvious respect not only between the specialties but across disciplines.
- The 2013 NHS staff survey indicated that staff engagement within the trust had improved from the previous year; however, the trust was in the lowest (worst) 20% when compared with trusts of a similar type. Within the urgent care clinical service unit, staff engagement was higher than both the average at this trust and at other similar trusts.
- The A&E service was well engaged with the rest of the hospital and did not operate in isolation.

- The paramedics we spoke with felt included within the department.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- We were told that monthly governance meetings were held at each site and overall for urgent care (the 'Urgent Care Clinical Governance Forum'). We saw from minutes that topics discussed included patient care and safety; clinical effectiveness and outcomes; risk management; and patient involvement, experience and public engagement. Actions required and completion dates were clearly indicated and followed through.
- We saw evidence of audits being undertaken and learning documented and shared: for example, monthly infection control audits, audits of patient records and a consent audit had been conducted in 2013. We saw hand hygiene audits for April to December 2013, the majority of which achieved 100% for both compliance and technique. There were audits for peripheral intravenous cannula insertion, which achieved 100%. Audits of patient records for January and February 2014 showed that almost all were completed correctly. The consent audit was part of a trust-wide audit; it indicated that improvements had been made in A&E and it noted a requirement to target the availability and distribution of the About Consent leaflets for patients.
- A quality dashboard for the CDU, known as the 'ward health check', was displayed so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to provide.
- Senior nursing staff told us that improvements were being made to quality and performance data and how they are shared with staff. We were told that a similar performance monitoring system to the ward health check was in development for the A&E.
- There were trust-wide nursing audits, which included the A&E and the CDUs. Audits covered positive identification of patients, medication errors, intentional rounding, records, cleaning and high-impact interventions. We saw copies of some of these for A&E. For example, a mandatory nursing audit of records found good standards of legible handwritten entries, accuracy and compliance with date and time but a poor standard in the use of abbreviations. Information was to be shared with staff and taken to the next governance meeting for action.
- The 'end of nursing shift handover' helped assess risk and quality on a daily basis. Prompts on the handover included noting any safeguarding incidents, saving lives data, controlled drug checks, teaching points, official missing persons, and significant events.
- The 'sister's handover checklist' included staffing issues, sick and resuscitation patients, any bereavements, staff accidents and new operational information.

Innovation, learning and improvement

- Innovation was encouraged from all staff members across all disciplines. Staff were involved in quality improvement projects and were able to give examples of practice that had changed as a result of these.
- A service improvement team had been working within the urgent care clinical service unit for some months and had redesigned patient flows at SJUH A&E. The learning from this had been used in the LGI A&E.
- Further redesign work was ongoing within the minor injuries unit at SJUH and in the children's A&E. An escalation model had been developed with specific triggers for the children's A&E to make patient flow through the department more efficient. The new system was to start from 24 March 2014. Staff had been given non-clinical time to help develop the new model. The flow of patients was being redesigned, with additional room space adjacent to the current children's A&E being used.
- A consultant had led the development of CEM (Clinical Emergency Medicine) Books, an interactive system available on the department's IT system and as an application for the smartphones used by staff. It

enabled real-time information to be shared with all doctors and across both sites. It included live situation reporting that was rated red, amber or green. It also allowed teams to communicate effectively with each other and to highlight key issues.

- Paramedics commented on how well the department was working with the ambulance service to improve pathways.
- We were told about various groups that had been set up to manage and improve urgent care services. These included an operational board, a strategic urgent care board and a non-elective working group.
- We were concerned that not all mandatory training had been completed, particularly regarding safeguarding for those who required this. There was a lack of clarity over expectation for this training for some of the medical staff and this needed addressing.

Requires improvement

Medical care (including older people's care)

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

Information about the service

The Leeds General Infirmary (LGI) provided cardiology, neurology and stroke services. It also provided a 24-hour percutaneous coronary intervention (for heart attacks) and thrombolysis (for strokes) service.

Ambulance services brought only patients with suspected cardiological or neurological problems to this site. All other ambulance patients would automatically be taken to the St James's University Hospital (SJUH) accident and emergency department (A&E). Any patient who walked into the A&E requiring medical input aside from cardiology or neurology would be stabilised first and then transferred to the other site under the care of the appropriate team.

In total, there were four cardiology inpatient wards (L17, L18, L19 and L20) and three neurology and stroke wards (L21, in which the hyper-acute stroke unit (HASU) was based, L27 and L26). We visited all of the wards during our inspection.

Summary of findings

We found the medical wards to be clean and well maintained, but low nurse staffing numbers meant that safe care could not always be delivered. In addition, although there was a good culture of reporting incidents among the nursing staff, this was not seen as a priority for all clinical staff, and thus a genuine safety culture was not yet embedded at this hospital. The recent introduction of the 'safety board' on wards had been embraced by the staff and all spoke positively about it. There was a specific concern with regard to the prescription of certain medications on one of the wards; however, we had no concerns about the management of medicines elsewhere.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working. The Sentinel Stroke National Audit Programme (SSNAP), which looks at the way a stroke service is organised and delivered against best practice standards, assigned the stroke service a grade E (this is the lowest of the five possible grades A-E). We also found that there was inconsistency with the quality and recording of the nursing and medical handovers, which meant that important information such as the frequency of patient observations, was not always passed on. Not all staff had completed their mandatory training.

Data from the Friends and Family test as well as the CQC Adult Inpatient survey confirmed what we witnessed

Requires improvement

Medical care (including older people's care)

during the inspection. Staff were seen to be caring towards their patients and to be treating them with kindness and dignity. Patients were complimentary and full of praise for the staff looking after them.

LGI provided specialist cardiology, neurology and stroke services for the region. It did not accept general medical patients (who were transferred to the SJUH site). As such, the hospital did not have the same capacity issues that other sites had. Patients were admitted promptly to the appropriate ward, although some patients then had to be transferred to an 'outlying' ward once their acute phase of treatment was finished as there were some delays in transferring them back into the community. Care for patients with dementia required further work.

Are medical care services safe?

Requires improvement

Cleanliness, infection control and hygiene

- The ward areas we visited appeared clean. We observed staff adhering to the 'bare below the elbow' policy and staff used the hand gel available to them to clean their hands in between treating and caring for patients.
- Weekly hand hygiene audits were undertaken by staff on the wards every Monday, and the results displayed on the ward noticeboard. In addition, comprehensive cleaning audits were undertaken monthly. Responsibility for the cleaning of specific areas and pieces of equipment was identified (i.e. nursing – commodes; hotel services – doors; estates – ventilation grills; and contracts – external glazing). There was a breakdown of scores for each area and an overall percentage score given.
- The trust had a tier one indicator alert for the number of cases of Clostridium difficile recorded. The incidence of methicillin-resistant Staphylococcus aureus (MRSA) infections was within the expected levels for the size of the trust.

Nursing staffing

- Nursing staff numbers for each ward were assessed annually using a verified acuity tool. On the whole, staff told us that recently they had been encouraged to increase their establishment of nurses, but that recruitment was currently under way and thus numbers had not yet increased significantly.
- Ideal and actual nursing levels for each shift were displayed daily on the ward noticeboards. Next to these was displayed an escalation policy (written at the beginning of March) for the correct procedure to follow when short-staffed.
- Staffing was felt to be a particular concern on wards L17, L18 and L21, by both the staff we spoke to and by the observations of our inspection team. The 'ward health check' provided by the trust corroborated that in February on those three wards there were 4.5, 7.2 and 6.1 whole-time equivalent vacancies respectively.
- In addition, it was noted by our team that many staff we spoke to were in acting up positions (covering more senior posts).

Requires improvement

Medical care (including older people's care)

Medical staffing

- Medical staffing depended on the specialty of the ward.
- There were consultant ward rounds twice a week on the neurology wards. Junior doctors reported that they were well supported by both registrars and consultants. We noted that there was some confusion with regard to the experience level of the more junior doctors, who were all referred to as senior house officers (SHO). In practice, the term SHO was being used to denote doctors ranging from an FY2 (who had one year's post-qualifying experience) to a CT2 (who had over three years' experience). Overnight, there was an SHO covering the main neurology ward with a registrar on site for support.
- There was a daily consultant ward round on the HASU, alongside an FY2. Out of hours the neurology registrar covered the stroke wards. All potential strokes were seen by a 'Brain Attack Team (known as BAT), led by a stroke specialist nurse. Thrombolysis was a consultant-delivered service.
- There was a twice daily consultant-led coronary care unit (CCU) ward round seven days a week. On the cardiology wards, there was a designated 'cardiologist of the week' who would see all new patients admitted to the wards daily (including at weekends). All other patients were seen twice a week by a consultant.
- The Percutaneous Coronary Intervention (PCI) service was consultant-led and was available 24 hours a day, seven days a week.

Management of the deteriorating patient

- The medical wards at LGI used an early warning score that was rolled out throughout the trust. As part of the observation chart, the expected escalation process was displayed.
- Although we noted that these charts were generally completed well, the box that should have been signed to indicate that a high early warning score had been recorded was not always complete.
- The CCU used a different observation chart, which recorded the increased monitoring undertaken in this area.

Nursing and medical handover

- We observed both medical and nursing handovers, in and out of hours.
- We found that nursing handovers comprised an electronic nursing handover sheet; this did not include the frequency of observations needed for each patient, which meant that this information was not being passed over to the next shift.
- There were different medical handover practices in place according to the specialty. The stroke team had a consultant-led handover every morning, with a more informal on-call handover in the evening at 9pm between the SHOs. There was an electronic handover system that was kept up to date by the SHOs and was reported to us as being used well.
- In contrast, there was a less formal handover between the neurology teams. Again, the electronic handover sheet was in place, but it was not clear whose responsibility it was to keep this updated. The neurology department was a negative outlier for handover on the General Medical Council's National Training Scheme Survey 2013.

Safety thermometer

- On every medical ward we visited there was a 'safety board' displayed clearly. This had been a relatively new initiative but all staff we spoke with were positive about it. It included the number of days since a fall, a pressure ulcer or an incident of infection such as MRSA or C. difficile. It also showed the ward's recent performance on the Friends and Family test. A 'ward barometer' summarised the overall safety performance as well as the percentage of patients receiving harm-free care in the past month.
- The data included only the previous month's performance and there was no trend data on display.
- Comprehensive risk assessments for falls and pressure ulcers were completed on admission and updated throughout the patient's stay.

Incidents

- Incidents were reported via an electronic Datix form. A copy was sent to the appropriate person responsible for the area in which the incident occurred. In addition, trusts are encouraged to report all patient safety incidents to the NRLS (National Reporting and Learning System) and all serious incidents and 'never events' to STEIS (Strategic Executive Information System).

Medical care (including older people's care)

- According to data collected prior to our inspection, the trust reported an expected number of incidents in total; however, when these were examined more closely, it was apparent that the trust had a significantly lower number of incidents resulting in death and severe harm.
- There was a mixed response to how well local incidents were reported and learned from. Nursing staff were well versed in how to report an incident and all said that they reported incidents frequently. Although staff commented that they did not always receive individual feedback on incidents they had reported, we were given minutes of ward meetings, which were held monthly, that demonstrated that themes of incidents were fed back to staff. Nurses who were not in attendance had to sign the minutes to show that they had read them.
- There was less of an incident-reporting culture among the medical staff. Both junior and more senior doctors told us that they rarely reported incidents and that it was more of a 'nurse's job'. There did not appear to be any regular opportunity for the medical staff to learn from incident themes.
- One 'never event' had occurred in the Critical Care Unit between December 2012 and October 2013 where a nasogastric (NG) tube had been inserted into the lungs rather than the stomach and the wrong chest X-ray had been assessed, leading to the patient receiving food down the tube. As a result of this and the subsequent investigation, practice surrounding NG placement and confirmation had changed completely. There were signs up on the wards indicating the change and junior doctors were all aware of the change to practice.

Environment and equipment

- The only area about which we had concerns regarding the safety of the environment was ward L26. We were informed by nursing staff that they were unable to open the windows and thus the ward area could get very warm. Last summer the trust had had to bring in industrial ventilation in order to bring the temperature down.
- Equipment was appropriately checked and cleaned regularly. Resuscitation trolleys were found to be checked regularly and to have the right equipment available.

Medicines

- We found that medicines were stored correctly, including in locked cupboards or fridges where necessary.
- We noticed that the SJUH site had recently (January 2014) introduced a new prescribing chart, but the old one was still in use at LGI. Although in the main we found that these were completed well, we noted that oxygen was not routinely prescribed. We were told that there was a separate form on which to note this, but it was not usually completed.
- Antibiotics were prescribed according to the trust guidelines, and we were informed that there was very active pharmacy input to ensure that clear stop dates and reasons for prescribing were documented. Any antibiotics deemed to be high risk (i.e. because of side effects or association with C. difficile infection) had to be cleared with microbiology or pharmacy prior to prescribing, whatever time of day or night.
- Concerns were raised by a neurology SHO regarding prescriptions of MS and chemotherapy drugs; they told us that there had been no formal training or induction regarding doses.

Records

- All notes on the medical wards across both sites were in paper format. We generally found the notes to be well maintained and in most cases the old notes were available. Current admission notes were kept in a separate folder and were completed well with clear dates and times and designation of person making the entry.

Mental Capacity Act, consent and deprivation of liberty safeguards

- Patients were consented appropriately and correctly. We saw examples of patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately and we saw that deprivation of liberty safeguards were applied.

Mandatory Training

- Not all staff were up to date with their mandatory training. Overall for the medical staff in December 2013, 68.6% had completed mandatory training. There was variation between specialities for instance Stroke services achieved 83.8% but only 57.8% of medical staff in cardiology and 63.2% of medical staff in gastroenterology had completed mandatory training by December 2013.

Are medical care services effective?

Requires improvement

Medical care (including older people's care)

(for example, treatment is effective)

Requires improvement

Use of national guidelines

- Both the stroke and cardiology wards administered care in line with National Institute for Health and Care Excellence (NICE) guidelines. These guidelines were printed on the admission proforma for patients with a stroke or acute coronary syndrome.
- According to the trust audit annual report, 49 of the 1,114 audits undertaken were related to national guidance, and a further 88 to trust guidelines. We were not able to see which guidelines in particular were audited and whether they related to medical services.

Outcomes for the department

- There were no outliers for mortality associated with medical conditions.
- The cardiology department contributed annually to the Myocardial Ischemia National Audit Project. The most recent data available to us (2011/12) demonstrated that, although the unit performed slightly worse than the national average for the percentage of patients receiving primary PCI within 90 minutes of arrival (86% compared with 92%), the unit performed well above the national average for the percentage of patients having the advised medications prescribed after their procedure, and for the percentage of patients with an NSTEMI (a type of heart attack) admitted to a cardiology ward.
- The Sentinel Stroke National Audit Programme (SSNAP) consists of two parts: an organisational audit (consisting of how the stroke service is organised) and a clinical audit (how the stroke service is delivered against nationally agreed best practice standards). LGI was in the middle half of the country in 2012 for the way in which the service was organised and delivered care. The results from the clinical audit 2013 assigned the service a grade of E. This is the lowest of the five possible grades (A-E).
- A trust-wide clinical audit forum was established in December 2012 in order to influence the type and choice of audit undertaken by clinical teams and to improve clinical engagement with the audit process. In May 2013 a clinical audit database was implemented.
- The 2012/13 annual report for clinical audit stated that 1,114 completed clinical audits were recorded on the database. Results and learning from clinical audits were shared locally through specialty governance or audit meetings. Medical audits were also shared at the clinical audit forum.

Care plans and pathways

- Comprehensive trust-wide nursing documentation, including assessments and care plans for pressure ulcers, falls, cannulas, catheters and bed rails, was used on all of the medical wards.
- Medical care plans were in place for acute heart failure, acute coronary syndrome, heart attacks (both NSTEMIs and STEMIs) and acute stroke.
- The coronary care unit also used a ward round proforma that had originally been developed by the SJUH acute medical unit. This used the acronym 'STAXCOD', with a standardised checklist for MRSA, Venous Thrombo-embolism, antibiotics, chest X-ray, cannula VIP score, oxygen and dementia

Multidisciplinary team working and working with others

- Multidisciplinary working was well established on the medical wards, including input from specialist nurses such as cardiac rehab and stroke nurses.
- Pharmacy input was available on site from 9am to 5pm, Monday to Friday. Pharmacists were in the hospital Saturdays and Sundays with telephone support from SJUH out of hours

Equipment and facilities

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

Seven-day services

- Patients on the coronary care unit were seen twice daily by a consultant, and any new patients admitted over the weekend would also be reviewed by a consultant.
- There was limited physiotherapy and occupational therapy input at the weekend.

Requires improvement

Medical care (including older people's care)

Are medical care services caring?

Good

Compassionate care and emotional support

- The CQC Adult Inpatient survey for 2013 found that the trust performed within expectations for all 10 areas of questioning. The Friends and Family test (FFT) was rolled out in the trust in April 2013 and overall the trust scored close to the England average.
- Out of the 66 wards across the trust, only one medical ward at LGI (L18) was below the trust average score of 71.
- Results of the FFT were displayed on every ward, and there were posters displayed encouraging patients to feed back so that they could improve the care provided.
- During our inspection we were impressed by the standard of care provided on the medical wards. Staff were responsive to patients' needs, and we witnessed multiple episodes of kindness from motivated staff.
- We saw that comfort rounds did not always take place consistently. This was usually the role of the clinical support worker, but due to a lack of staffing capacity they were not always able to do this.

Patient involvement in care

- We witnessed nurses introducing themselves to their patients at all times, and that patients referred to their nurses by their first name.
- We witnessed pharmacists explaining medication to patients and answering follow-up questions.
- Patients told us that the doctors had explained their diagnosis to them and that they were aware what was happening with their care.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

- Patients could be admitted to the medical wards via several different routes.
- Patients diagnosed as having an STEMI were transferred directly to the critical care unit (CCU) by the ambulance service. Other less urgent cardiology patients were seen in the A&E first and then referred to the cardiology department via the cardiology registrar on call.
- Patients who were thought to have had a stroke were seen by the BAT service in A&E. They underwent their investigations there and were given thrombolysis in the A&E (if appropriate) prior to being transferred to the HASU.
- Less urgent neurology patients were referred to the neurology department via the neurology registrar on call.
- Patients could also be referred by teams at the SJUH site. In these cases, patients were usually transferred directly to the appropriate ward.
- Patients could also be referred by their GP or another medical professional. In these cases, they contacted the PCAL team, which liaised with the most appropriate department to arrange a review or admission.

Maintaining flow through the hospital and discharge planning

- There was a central operational group, which worked across the trust to coordinate capacity and bed availability. The group liaised with individual wards according to bed status.
- Each of the medical wards undertook daily morning multidisciplinary board rounds where updates to patients' medical conditions and plans for discharge were communicated.
- There had recently been a decrease in the number of inpatient rehabilitation beds provided by the trust. This had impacted on the acute wards' ability to discharge patients no longer in need of active medical therapy; as a result, at the time of our visit there were eight stroke patients who were 'outlying' on the neurology ward. Access to community intermediate care (CIC) beds was limited and often led to medically fit patients remaining in hospital for longer than necessary.
- As a tertiary referral centre for both stroke and cardiology, LGI could receive patients from other hospitals and regions. Staff told us that there were rarely delays in repatriating patients to their local hospital.

Requires improvement

Medical care (including older people's care)

Environment

- Single-sex accommodation was provided on all the medical wards aside from the CCU; in line with national guidance, the CCU was exempt. All patients had access to either a male or female designated toilet or bathing facilities.
- The bathroom facilities on the CCU were currently not in use as they were awaiting repair. This meant that patients had to use the facilities on the main cardiology ward.
- Most of the wards had both a day room for patients and their relatives to use and a separate area for doctors and other multidisciplinary teams in which to work.

Meeting the needs of people

- Although there were processes in place for patients with dementia to be identified and receive increased input (e.g. the 'forget me not' initiative), we found varying consistency in their use. Staff who had undergone their Level 3 dementia training were given a 'forget me not' badge to wear on their uniform. We did not see these being worn.
- In addition, we noted that, although the admitting medical proformas on the SJUH site included a section for assessing patients for dementia, this was not included on the stroke or cardiology admitting proformas.
- There was an older service liaison team that provided psychiatric support on the medical wards. However, we were informed that the department was currently very under-resourced due to staff sickness and therefore, although they aimed to see patients within three to four days of referral, it often took significantly longer.
- On the HASU there was good support provided by the speech and language therapists for patients with aphasia following a stroke. We conversed (via pen and paper) with a patient who had been on the ward for several days and who wanted to convey to us just how supported they had been since their admission.
- Interpretation services were available in both the form of a language line (a telephone translation service) and face-to-face interpreters, who could be booked if required. In addition, the chaplaincy team had a group of volunteers who could help with translation.
- Interpretation services were easily available.

Communication with GPs and other departments within the trust

- A discharge summary was sent to the GP by email automatically when a patient was discharged from the unit. This set out the reason for admission and any investigation results and treatment undertaken.

Complaints handling

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, they would speak to the shift coordinator. If the shift coordinator was not able to deal with their concern satisfactorily. They would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was depicted on multiple posters in several languages.
- The matron for the medicine department received all of the complaints relevant to her unit. She would then speak directly with the staff member involved and they would write together to the complainant, offering to meet with them. The department had an initial response turnaround time of five days. Themes from both formal and informal complaints were collected and displayed in the staffroom. The department met monthly (all staff working in the unit, including ward clerks where possible) in order to help disseminate messages. In addition, the matron produced a monthly newsletter that was emailed to staff and that detailed the most recent complaints.

Are medical care services well-led?

Requires improvement

Leadership of service

- There had been a new structure developed recently and medical services were managed and led across the sites via a clinical services unit. This included cardiology, neurosciences and respiratory services.
- There were regular governance meetings taking place and the leadership structure consisted of a triumvirate of nursing, medical and managerial leads.
- All clinicians in senior leadership posts attended a clinical leadership and management course.

Requires improvement

Medical care (including older people's care)

Culture within the service

- We found that there was good leadership at a local level but some concerns were expressed over the 'acting heads' of nursing. There was good matron presence from Monday to Friday.
- Staff within the directorate spoke positively about the service they provided for patients.
- Quality and patient experience were seen as priorities and everyone's responsibility. This was supported by the positive FFT results and patient feedback.
- However, we found that the FFT was not used consistently: for instance, there were no forms in cardiology for responses and there were three separate feedback mechanisms in place.
- Staff reported that there was an open and honest culture.
- Staff reported that there was no 'silo' working and that they relied on each other and moved across wards to support each other. This applied across professional disciplines: for example, physiotherapists helped nurses with washing and would feed patients.
- Staff repeatedly spoke of a flattened hierarchy and how they were encouraged to speak up if they saw something they were unhappy about regarding patient care. One porter told us, "They even listened to me when I told them that we could save time by moving the sample collection point. Everyone has a voice here and you are encouraged to use it."
- Openness and honesty were the expectation for the department and were encouraged at all levels.
- Staff worked well together and there was obvious respect, not only between the specialties but across disciplines.
- Service-level staff survey data was not available, but overall the trust scored above average for staff engagement.
- The new structure empowered some consultants who reported that they felt more in control of their service and more able to sort things out now.
- Staff were well engaged with the rest of the hospital.
- Senior clinicians said that things were much better with the new initiatives within the trust.

Vision and strategy for this service

- The trust's objectives and vision were displayed on wards, together with pictures and the names of Trust Board members.
- We heard from staff the phrase - 'The Leeds Way' – and they were aware of the Chief Executive's weekly emails and newsletters.
- Staff reported an increased morale with the new team, and that the senior executive team was visible. Staff also reported the positive impact that the increase in nurse numbers had made.

Governance, risk management and quality measurement

- Quarterly governance meetings were held within specialities and all staff were encouraged to attend, including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed. At every other meeting, members of the anaesthetic team would attend to ensure cross-fertilisation of lessons learned.
- A quality dashboard was presented so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to provide.
- Despite recruitment activity being undertaken, there remained a risk to patients due staff shortages.

Innovation, learning and improvement

- Innovation was encouraged from all staff members across all disciplines. Every junior doctor and student nurse was involved in a quality improvement project and staff were able to give examples of practice that had changed as a result.
- There was a six-monthly 'innovation day' when staff displayed their recent projects. Members of the executive team would also attend.
- The stroke service scored low on the national audit and further actions were needed to address issues raised.

Requires improvement

Surgery

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

Information about the service

The hospital provides a range of surgical services including trauma and orthopaedic surgery, ENT, neurosurgery, spinal surgery, vascular, cardiac and plastic surgery. There was also a day surgery unit. There are 11 wards which provide surgical services at the Leeds General Infirmary, spread across several Clinical Service Units, with approximately 260 surgical inpatient beds. A total of 19 operating theatres are provided across three theatre suites including day surgery theatres.

We visited eight surgical wards including orthopaedic, neuro- surgical wards and vascular surgery. We also visited all the general operating theatres suites and day case theatres.

We talked with 25 patients and 33 members of staff including matrons, ward managers, nursing staff, physiotherapists and medical staff. We observed care and treatment and looked at care records for 12 people. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Wards and theatres were clean and there was evidence of learning from incidents in most areas. There were arrangements in place for the effective prevention and control of infection. We found that there were inadequate levels of staff, both nursing and medical in some areas, particularly out of hour's medical cover and anaesthetist availability. We had concerns about the medical cover, the quality of the handover and support on the High Dependency Unit on Ward L39, which was overseen by the Trauma and Related Services CSU. Not all staff had completed their mandatory training.

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

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

There was good multidisciplinary working with coordination of care between different staff groups, such as physiotherapists, nurses and medical staff. The portering service had been centralised and this limited their responsiveness to meet the needs of patients.

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

Cleanliness, infection control and hygiene

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

Nursing staffing

- Nursing numbers were assessed annually using a recognised staffing tool. This had identified a need to increase staffing levels in some areas. The trust were currently recruiting to these additional posts.
- Ideal and actual staffing numbers were displayed on every ward visited. Staff reported that they were often understaffed, but said in most areas this was improving. Bank and agency staff were used to fill shortfalls, although they were not always available. Staffing remained a key area of concern. On one ward (Ward 24) there had been 48 unfilled shifts for registered nurses and 23 unfilled shifts for healthcare assistants during February 2014 despite trying to obtain appropriately skilled staff from the bank or agency. Orthopaedic wards reported shortages of staff. For example, Ward 35 had one registered nurse below the planned staffing levels on each shift on 30 March 2014. On the night duty an agency staff member had been requested but did not arrive. Additional staff were moved from other clinical areas, but did not have relevant experience of the area. A review of the ward roster showed this was a regular

occurrence. On 16 March, on the night duty, there were three agency staff and one substantive care support worker to provide care for up to 26 patients. This was confirmed by staff.

- Where additional staffing was required to meet the specific safety needs of patients, systems were in place to request additional staffing. Most staff reported that patient safety was the priority; this had not previously been the case. We observed additional staffing on the day of inspection to support patients at high risk of falls.
- We spoke with two agency staff about their induction and support. Both reported they had received an induction and felt supported by ward staff. One raised concerns about the staffing levels and ability to provide a good level of care.

Medical staffing

- Junior doctors told us there were not enough junior doctors on the wards out of hours. Some doctors reported providing on call cover for up to 200 patients. They reported minimal senior input and support particularly out of hours. As medicine had been centralised at St. James's University Hospital, access to medical physicians was limited. This was particularly an issue on the orthopaedic wards, in particular out of hours.
- The recruitment process was lengthy; managerial staff reported it taking up to 12 months to process the recruitment of some staff groups. The executive team had recently worked to reduce this and this was having some impact at a local level.
- There was a lack of anaesthetic staff. There had been a recent reduction in trainee posts. Staff said that due to the shortfalls, unsupervised trainees were anesthetising patients. We reviewed the theatre lists for the week of our inspection and saw on three lists that this was the case. There was no peripatetic anaesthetist available to oversee trainees or provide emergency cover. Staff advised that theatre lists were rarely cancelled and felt under pressure to deliver against the targets.
- Locum anaesthetists had been employed and concerns were raised regarding their induction and support. We identified two recent incidents involving locums. These had been investigated or were in the process of investigation. In response to the increased use of locums and to minimise risk, guidance on the use of locums had been recently drafted and circulated but was not yet fully implemented.

Nursing and medical handover

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

Management of the deteriorating patient

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

World Health Organisation Safety Checklist

- Use of the checklist was embedded in surgical practice in most, but not all theatre suites at Leeds General Infirmary. We observed it being used in each of the theatres visited, with the exception of the theatres in Clarendon Wing. Here we observed that for three consecutive patients the checklist was either pre-completed before entering the theatre. We were informed by the trust that as these patients were for hand procedures; this part of the process was completed with the patient prior to entry into the theatre.
- A trust wide audit was performed quarterly and demonstrated over 95% compliance with the exception of the use of team debriefs. One outlying specialty (not named) recorded a compliance figure of around 80% and data issues were being addressed. A qualitative audit tool had also been piloted.

Safety Thermometer

- A ward healthcheck was undertaken on a monthly basis on each inpatient ward. This included the national safety thermometer information. The information was clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter

use with urinary tract infections and new pressure ulcers. Individual areas had developed improvement plans. There was no consistent dissemination or action planning.
- The healthcheck display was formatted so wards had to score above 70% before this was registered on the dial display. This 'set the bar' regarding the achievements expected and promoted a positive use of the data to promote safety.
- The trust had identified pressure ulcer prevention as a key area to improve.
- On Ward L39 (Orthoplastics) there was no displayed data readily available to demonstrate the safety performance of the unit.

Incidents

- We found the reporting of patient safety incidents was in line with that expected for the size of the trust.
- Staff we spoke with said they felt confident to report incidents. A few staff reported they did not get feedback regarding incidents they had reported.
- There have been 5 never events reported at the trust. Four of these related to surgical areas. We saw a serious incident investigation had been undertaken, task and finish groups established involving clinical staff and action had been taken to ensure learning from the incidents. We reviewed the action plans for surgical-related incidents and found the majority of the actions to minimise recurrence had been implemented. We found the action plan was not fully implemented in Clarendon Wing theatres and equipment tray checks were not completed in accordance with the trust's action plan.
- The affected patients had been fed back to.
- The investigation identified the arrangements to share the lessons learned. We found staff within the surgical areas were aware of the never events and were aware of safety priorities. However, staff in Clarendon Wing theatres were not aware off recent never events and learning.
- The 'speak out safely' campaign was being promoted particularly in theatres. This is a national campaign to encourage staff to raise concerns about poor care.
- We saw examples of how information was shared with staff. This included ward specific 'newsletters' and a trust-wide 'Quality & Safety Matters' newsletter.
- Staff were able to give us examples of where practice had changed as a result of incident reporting.
- Themes from incidents were discussed at weekly meetings.

Environment and equipment

- The environment on the surgical wards and theatres was mostly safe. A shower room on Ward L24 was rusty and the lip on the shower tray was lifting and presented a trip hazard. The ward manager had reported the issue but this had not been resolved.
- Patients within most of the surgical wards in Clarendon Wing who required surgery were transported to and from the Jubilee Wing via long public corridors. Surgical wards in Clarendon Wing were isolated from the rest of the hospital.
- Theatre staff told us that they received a poor service from the contractor for surgical sterile trays. They reported slow turnaround times and damaged and incomplete trays being provided.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards or available by request to ensure safe care.
- Systems were in place to obtain equipment and handle repairs. Most ward staff said this was done in a way that met patient need.
- National patient safety alerts regarding equipment were received and shared with staff. For example, on Ward L24 the ward manager laminated the alert and attached it to the relevant equipment to remind and inform staff.
- Ward security was variable throughout the hospital. Theatres were accessible without challenge.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked and audited.
- Medicines charts were completed. Where medicines had not been administered as prescribed, codes and an explanation were completed to indicate the reasons why.

Records

- All records were in paper format. Medical, nursing and health care professionals maintained separate documentation.
- In some areas records were stored in 'pigeon holes' at the nurse's station and not held securely.
- Medical health records keeping standards were audited at least annually. Actions to address issues had been identified. The most recent trust-wide audit supplied

showed the recording of date and time for each entry in the health records, recording of the author's name designation and contact details and inclusion of the patient's name and NHS number (where available), or case note number, on each page of the clinical health record were areas for improvement. It was not possible to break the information down to identify any specific results across the surgical CSUs.

- A ward assurance audit was completed monthly. This included auditing nursing care records. The results showed levels of compliance of over 90% in all surgical ward areas at Leeds General Infirmary.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Most staff were aware of the Mental Capacity Act 2005. The trust employed a mental capacity act coordinator and resources were available to support staff and we saw these displayed in some ward areas.
- However, in 3 records where mental capacity assessments were indicated, there was no documentation or indication that mental capacity had been assessed. Staff were unaware of any assessments or "best interests" decisions.
- We saw that an Independent Mental Capacity Advocate (IMCA) had been appropriately requested and obtained for one patient. There was no formal capacity assessment in these records.
- A trust-wide audit of consent had been undertaken in July and September 2013. It was unclear if all surgical specialties had submitted data (overall 61% participation rate). Patients were consented appropriately in most cases.
- Patients told us that they had felt informed and told us how they were consented. This was in accordance with national guidance.

Mandatory training

- We looked at staff mandatory training records. Overall trust information showed that medical staff and nursing staff were compliant with mandatory training in 56.3 and 64.7% of cases respectively at December 2013. This varied, however the majority of surgical wards showed more than a 60% compliance rate.
- Staff said that mandatory training was accessible but reported that more dates for attendance were required.

Learning culture

- Staff reported that mortality and morbidity meetings were held and included medical and nursing staff

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

Good

Use of national guidelines

- Emergency surgery is managed in accordance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery. Surgery out of hours was consultant led and delivered.
- Junior doctors in some areas reported no active involvement or encouragement to be involved in clinical audit or quality improvements. The trust provided us with some examples of completed audits at our request. These were not comprehensive and did not demonstrate actions taken to address any identified issues, such as the medical records audit.
- Audits of antimicrobial prophylaxis for surgery were carried out to check compliance with national guidance.

Patient outcomes

- Patient Reported Outcome Measures for surgery were within expected limits.
- A review showed there were no mortality outliers for relevant surgical specialties. This indicated that there had been no more deaths than expected for patients undergoing surgery at Leeds General Infirmary.
- Emergency readmissions following elective (planned) or emergency admissions compared favourably with national comparators.
- Day case surgery is performed below national expectations at 76.8% of cases in 2013. The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.
- The trust contributed to all national surgical audits for which it was eligible. We reviewed national adult cardiac data, the vascular society's national vascular registry and found outcomes were within the expected ranges.
- Clinical Service Units had performance dashboards that it used to monitor the quality of care they provided.

Requires improvement

Surgery

- Patients who were admitted with a fractured neck of femur were operated on the next day in 55% of patients, 82% within 2 days and 18% waited 3 or more days (The College of Emergency Medicine (CEM) Clinical Audits 2013-13).

Care plans and pathway

- Care pathways were in use, for example, for fractured neck of femur.
- The enhanced recovery programme was not in use.
- Nursing documentation was kept at the end of the bed and at the nurses station and was generally completed appropriately.

Multidisciplinary team working and working with others

- Daily 'board rounds' were carried out with members of the multidisciplinary team. Physiotherapists and occupational therapists were available and were regularly on the wards.
- In some areas, for example vascular surgery, the board round included the British Red Cross, who supported people on discharge including providing essential provisions.
- Ward pharmacists and technicians were available.
- An otho-geritarician, undertook ward rounds twice weekly on the orthopaedic wards.

Pain relief

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

Seven day services

- Medical staff reported 7 days a week, 24 hour access to radiological scans.
- Pharmacy was open 7 days a week but for shortened hours on both Saturday and Sunday. Out of those hours there was an on-call pharmacist to dispense urgent medications.
- Over the weekend, Consultant ward rounds took place to see new patients and review any patients were concerns were raised.
- A reduced physiotherapist service was available over weekend to see patients post-operatively or pre-discharge.

Are surgery services caring?

Good

Compassionate care and emotional support

- We reviewed the Friends and Family test results for the surgical wards for February 2014 and found these did not indicate any areas of risk. We also sampled the information for surgical wards we visited and found the Net Promoter score (proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent) indicated patients were overall satisfied with the level of care received.
- The CQC Inpatient Survey 2013 did not identify any evidence of risk.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. One patient said, "Everyone I've dealt with has been great" and another said, "The staff treat you the way they should."
- We saw that staff were very busy. Patients were aware of the lack of staff and reported that staff had little time to talk. Several patients reported waiting 10-20 minutes for call bells to be answered. One patient on an orthopaedic ward said it was 3 weeks before they had their hair washed.
- Most patients we spoke with appreciated that staff were busy and made allowances for any delays.
- We saw in some areas that comfort rounds (intentional rounding) were undertaken.
- We observed staff introducing themselves to patients and speaking with them in a professional manner.
- We saw curtains were drawn around bed spaces to maintain patient dignity.
- We looked at patient records and found they were completed sensitively.

Patient involvement in care

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

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Surgery

Requires improvement

Access

- Trust-wide information showed referral to treatment times in less than 18 weeks were below target at 85% against a target of 90%.
- Waiting times in spinal surgery had been identified as outside the targets. There was evidence of action taken to improve this.
- The number of patients waiting over 6 weeks for a diagnostic test was less than expected.
- Between July 2013 and September 2013 the bed occupancy rate for general and acute beds (which would include beds for surgical patients) was 85%. The national target is below 85% as high bed occupancy rates can affect the quality of care provided.
- The proportion of patients whose operations were cancelled was higher, but similar, to expected.
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason was higher but similar, to expected.
- The trust reported 855 last minute cancelled operations during the course of 2013.
- There was a dedicated separate team for emergency theatre.

Maintaining flow through the hospital and discharge planning

- Activity and patient flow coordination meetings are held 3 times a day in the main theatres. This was done in using a 'bunker' system. This was supported by theatre staff, medical staff and the bed management team.
- Bed managers worked closely with wards to ensure patient flow.
- Daily board rounds were undertaken and involved members of the multidisciplinary team, for example physiotherapists and occupational therapists.
- The trust had a policy on the transfer of patients to reduce the number of bed moves experienced by each patient. The transfer of patients was based on clinical need and should not occur between 10pm and 7am without a documented risk assessment. The clinical site manager was responsible for out of hours transfers. There was no further escalation within the trust for transfers between ward areas.
- All wards had an estimated date of discharge for most patients. Discharge planning documentation was available but was not consistently used.
- Electronic discharge summary was in use within surgical ward areas. Nursing staff reported that the shortage of junior doctors out of hours led to reported delays in prescribing and discharge of patients.
- Staff reported that portering services had been centralised. There were no longer dedicated theatre porters and each 'job' required a separate request. This had resulted in porters no longer combining jobs, for example, when a patient was returned to the ward and another patient was due to be taken to theatre, this was now a separate request. Staff reported this had caused delays. Managers were aware of this issue and monitoring the impact to enable the issue to be addressed.

Meeting the needs of people

- Staff said they had an increasing awareness about dementia and had attended a dementia awareness day. The clinical educator in one area had set up 'dementia cafes' to support people and their relatives.
- An interpreter service was available. We saw an example of the use of an interpreter to enable staff to meet the needs of the patient.

Equipment and facilities

- There was appropriate equipment available to ensure effective care could be delivered.
- In Clarendon Wing theatres, the patients were required to walk through the recovery area to reach theatre. Patients' names were displayed on a whiteboard in the admissions/waiting area and so readily observed by other parties.
- There was no usable bath for patients who required assistance as the bath leaked. The room was to be used as a store room. This meant some patients may not be able to access a bath. On ward L50 there were steps to a shower which was not suitable for orthopaedic patients.

Communication with GP's and other departments within the trust

- Electronic discharge summaries (eDANs) had been introduced. There was no data available to show how often these were used.

Requires improvement

Surgery

Complaints handling (for this service)

- Improvements to the handling of complaints were in progress. The Heads of Nursing reviewed all of the complaints relevant for their unit. The trust was supporting Clinical Service Units to improve complaint responses.
- If a patient or relative wanted to make an informal complaint then they would speak to the shift coordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint
- Themes from both formal and informal complaints were communicated to staff. Staff we spoke with demonstrated an awareness of complaints raised and lessons learned. These were shared at handover, ward and unit meetings.

Are surgery services well-led?

Requires improvement

Leadership of service

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

Culture within the service

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

Vision and strategy for this service

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

Governance and measurement of quality

- Governance meetings were held within the Clinical Service Units.
- Complaints, incidents, audits and quality improvement projects were discussed.
- Although data was collected, the analysis of the performance data was identified by the CSUs as a 'work in progress'. Additional resource was being considered to enable more detailed analysis of the data collected at CSU level.
- There was also recognition that there was no dedicated resource to support the delivery of the governance and quality agenda within the CSUs.
- Managers showed an understanding of the issues identified by staff providing 'hands on' care. Risk registers reviewed reflected these concerns.
- Risk registers across the CSUs were of variable quality. Some had assurances in place, while other CSUs had not tested the effectiveness of the some of the measure put in place.
- We had concerns about the oversight and staffing arrangements on the Clarendon Wing, in particular L39, which cared for Level 2 patients with the clinical leadership and support within the surgical clinical

service unit. This was not following national best practice guidelines for Critical Care Standards and has been drawn to the trust's attention. This is reported in the critical care section of the report.

Innovation, learning and improvement

- Staff reported there had been a significant positive shift in culture. However innovation was not yet systemically evident.
- We saw examples of the team learning from other providers. For example, the learning from the surgical never events had included visiting another large teaching hospital.

Requires improvement

Intensive/critical care

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

Information about the service

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

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

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

LTHT's Outreach service is managed via the Adult Critical Care CSU and is currently a day-time only service seven days a week.

Summary of findings

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

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

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

Patients were positive about the support and care received on the units and said they felt kept informed and involved. Staff were reported to be approachable and sympathetic to family and carers' needs.

Staff were positive about the relatively new leadership team and felt communication had improved. There was a focus on continuous quality improvement but staff were concerned about the increasing critical care bed pressures and increasing demands on the service, particularly because of the hospital's trauma centre status. We had concerns about the apparent 'us and them' culture between the two main hospital sites and the lack of engagement between senior medical staff,

within the critical care CSU. There was very limited planned cross-site working and staff remarked that the culture across the two main hospital sites was different; this didn't encourage joined-up working.

Are intensive/critical services safe?

Requires improvement

Cleanliness, infection control and hygiene

- The environment in the critical care and high dependency units was visibly clean including horizontal surfaces and high-contact surfaces / equipment touched by staff and patients.
- We observed staff, particularly nurses and doctors, clean their hands when required using either soap and water or alcohol hand-rub; this was usually before and after contact with a patient and/or their immediate environment.
- All staff followed the trust's uniform policy in clinical areas and had rolled up sleeves or wore a short sleeve top; staff did not wear wrist watches.
- There was varying practices among staff across the critical care units with regards to the use of personal protection equipment (PPE), mainly gloves and aprons. The standard of practice required was for all staff to wear gloves and an apron for all direct patient contact and to remove the PPE during other activities, for example, completing paperwork. The staff on some units were more consistent than others in ensuring PPE was worn for all direct patient contact.
- There was also varying practices across the units in relation to apron use and colour-coding. The understanding of staff on some units was to use light red coloured aprons during patient contact and yellow aprons for those patients with a known infection. Some units did not have a strict apron colour-code system and any coloured apron could be worn for any task; this was a potential source of confusion when caring for isolated patients.
- We observed staff, including nurses and designated cleaning staff, clean areas of the wards including bed bay areas. A chlorine-based product was consistently used for general cleaning / disinfection and staff understood the trust policy on using chlorine.
- According to information presented to the Trust Board in January 2014 MRSA blood infection rates for critical care were zero.
- Intensive Care National Audit & Research (ICNARC) data (July, 2013) and a related Quality Key Indicator (QKI)

report (November 2013) showed above national average figures for unit acquired infections in blood (presence of an infection in any blood sample) and the trust were closely monitoring this.
- The data above highlights the fact that there were no MRSA blood infections for the period described but higher than average infected blood samples not associated with MRSA.
- The number of unit acquired Clostridium difficile infections (CDI) was rising towards the end of 2013 for the Critical Care CSU and there were two cases in December 2013. Ward Healthcheck data for all CSU's showed no cases of CDI in critical care for February 2014 and no cases of MRSA blood steam infection for the same month.

Nursing staffing

- An overarching theme from data presented by the trust and from speaking with staff on the critical care units was that nursing staffing levels were below the required level and staff from external agencies were regularly required to maintain safe staffing levels.
- Staff were also sent, on occasion, to SJUH when staff shortages were identified, which staff acknowledged as causing low morale and compromising the ability to undertake elective activity on the cardiac units.
- Intensive care (with Level 3 patients) is synonymous with a 1:1 nurse-patient ratio. The Intensive Care Society (ICS) Core Standards (2014) identify a minimum ratio of 1:1 registered nurse / patient ratio to deliver direct patient care, with recognition that at times to safely meet the needs of some critically ill patients this may need to be higher. An additional supernumerary nurse in charge is required and an additional supernumerary registered nurse as bed numbers increase above 11 beds. (These numbers do not take into consideration maternity leave, sickness rates, the skills and competencies of the staff or the design and layout of a Unit).
- The ICS states that a more realistic figure to provide a nurse at the bedside at all times and run a full complement of beds is 7wte per bed.
- Nursing establishments had been reviewed by the CSU but with ongoing recruitment and retention issues the units were not currently operating at this level.
- The Critical Care CSU management team (clinical director, head of nursing and general manager) confirmed that nursing staffing levels were a key concern and risk and a high priority to tackle.
- Several issues were identified across all the critical care units in relation to staffing including problems with retention, recruitment, maternity leave, sickness, skill-mix and morale.
- Staff on a number of units felt nurse staffing levels were a potential safety concern because the agency staff used to achieve safe staffing levels required extra support from permanent staff, which impacted on their work-load. There were inconsistencies in the local induction of agency staff across all the units.
- Senior nursing staff commented how it wasn't always clear what competencies agency staff had which, again, impacted on the work-load of permanent staff because they needed to partially over-see the work of agency nurses as well as manage their own patients.
- Insufficient staffing levels is on the Adult Critical Care risk register and was described as being attributed to high levels of sickness/absence, which may result in a failure to protect patients and staff from serious harm; the risk rating was marked as amber.
- Steps had been taken to mitigate the staffing shortages to some degree and four non-registered nurses had been introduced on to the general HDU to assist with nursing care.
- Staff rotas, sickness, annual leave and study leave were managed through electronic-rostering (e-rostering) by the senior nurses on each critical care unit.
- The unit's risk register stated that the measures taken by the adult critical care management team had been deemed effective including ensuring staff requested leave in advance and closer monitoring of non-attendance.
- Use of bank and agency staff was seen as a key control mechanism to ensuring safe staffing levels for each shift but there were potential gaps because bank / agency staff were stated as not being reliable, particularly during day shifts.
- A care support worker said agency staff will be booked but may simply not turn up for the shift; this can then leave the ward short-staffed at very short notice until other staffing support can be found.
- The general manager for critical care acknowledged that some units had lost some experienced senior nurses which had compounded the problem and some staff had moved on to specialist nursing posts within the trust.
- Some nursing staff said morale was low and this was a mixture of several things including short staffing, work

pressure, high use of agency and e-rostering. Other reasons included being asked to work across other units and hospital sites on a regular basis and a lack of flexible working arrangements when returning to work from maternity leave.

Medical staffing

- We spoke with doctors of varying grades about medical staffing levels. There was consultant presence on site between 8am and 10pm. Consultants would sometimes stay after 10pm if required. There were a total of 14 critical care consultants and this was enough to provide a suitable on-call rota that ensured seven days a week out-of-hours contactable support.
- Junior doctors felt understaffed on occasion but felt staffing levels were never unsafe.
- The advanced trainee senior doctors, of which there were three, described how they worked well as a team and supported each where possible; cardiac, neurological and intensive care units were all covered by an advanced trainee senior doctor.
- We spoke with junior nurses on the general intensive care unit and they felt medical cover was adequate and did not describe any problems in terms of contacting junior/middle grade/senior doctors when necessary.
- The clinical director for adult critical care confirmed that the relatively recent loss of anaesthetic trainees was a risk and a challenge.
- The critical care risk register lists the above as a severe risk caused by Deanery reduction in training posts which may result in failure to protect patients from serious harm if there were insufficient doctors to review / manage patients on the ICU; particularly in responding to emergency situations.

Management of the deteriorating patient

- We spoke with the head of nursing for the adult critical care; the trust had implemented an early warning score system to assist staff in assessing whether a patient was deteriorating.
- We spoke with nursing staff on the units and there was a good overall understanding of the early warning score tool and how it's used across the trust.
- There was an outreach team that provided critical care support to patients on the general wards and cover was provided on the LGI site between 8am – 6pm seven days a week.
- The outreach team consisted of four senior (band 7 nurses and eight (band 6) nurses; there was also one senior physiotherapist. There were six nurses working at any one time across both main hospital sites with three usually at LGI.
- There was a consensus that the outreach team needed to extend its support to a seven day a week service and this was seen as essential to ensure safe and effective continuity of care when patients were handed back to the ward staff to manage at 6pm.
- A service review was undertaken in January 2013 and the business case was on-going in terms of extending the service to run seven days a week.
- There was concern raised by outreach staff that ward-based nurses, over a relatively long period, had become de-skilled which had led to a disproportionate and unsustainable reliance on the outreach. This in turn had reduced opportunities for ward-based nursing staff to develop their skills, for example, managing a tracheostomy or chest drain. The outreach team was set up to provide education and training to ward staff to manage the more complex patient but its focus had changed.
- A senior nurse in the outreach team felt that engagement with more senior members of the team wasn't always easy because they were based at SJUH site; there is potential here for improved cross-site working.
- In relation to Ward L39 (Orthoplastics), level 2 critical care was provided for up to 6 patients undergoing vascular, spinal, orthopaedic and plastic surgery. Nurse staffing on the unit was a particular concern partly because nursing staff were not critical care trained and the ward itself was not well supported by other units due to its isolated location.
- In relation to ward L39 (Orthoplastics), the unit was managed by the surgical teams, rather than critical care teams.
- Medical cover on L39 during the day was provided by an orthopaedic Senior House Officer (Foundation Year 2) who had been qualified for over two years. The medical cover out-of-hours was provided by the on-call teams for the specialties.
- There was no formal handover between the teams and the doctor on duty during the day reported they used the nursing handover sheet to update themselves on the care of the patients overnight.

- The senior house officer did not have experience of vascular, spinal surgery or critical care. Supervision and support was provided by anaesthetists from the main critical care areas; this was often by telephone with follow-up by an anaesthetist visiting the area when they were available.
- We raised our concerns with the trust, who reviewed the service provision and confirmed that there was a plastics SpR allocated to the ward, an orthopaedic SpR provided support if required; there was support from an on-call consultant surgeon for both plastics and orthopaedics with out of hours support to the unit is provided by the on-call resident plastics SHO and non-resident SpR (plastics). We were also informed that there was a resident senior trainee (ST3) and a SpR on-call or orthopaedics, supported by on-call consultant surgeons for both plastics and orthopaedics. There was also a resident vascular SpR/Fellow available for support if required.
- In the event of a patient deteriorating and requiring critical care intervention, support was provided by the anaesthetist (intensivist). During the day this would be provided by the critical care outreach team, out of hours support is provided by the outreach bleep holder (Anaesthetic SpR from ITU).

Nursing and medical handover within the unit

- There were two nursing handovers per day and a new critical care chart was started every 24 hours; the critical care charts themselves referred to three shift change-overs and this related to when there were shorter nursing shifts and one more handover per day. This created inaccuracies in documentation when patient risk assessments, planned care and safety checks were recorded.
- We observed a ward round at SJUH which involved several members of the multidisciplinary team including doctors, nurses and physiotherapy.
- We observed several medical handovers and they were detailed and comprehensive.
- We found there was good dialogue between consultants and junior members of the medical team.
- During one ward round the advanced nurse practitioner was involved and they provided key information to junior medical staff.

Safety Thermometer

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

Incidents

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

reported. There were 20 categories and by far the most reported concern related to inability to isolate a patient within two hours followed by the number of category 2 pressure sores received into the hospital. The other reports included lack of suitably trained staff, administration, out of hours transfer and lack of, delayed availability of HDU/ITU beds.
- All staff we spoke with was aware of how to report incidents via the Datix system.
- Staff described some relatively new initiatives to share learning from incidents including the critical care blog and the monthly adult critical care bite size letter demonstrating learning from incidents.

Environment and equipment

- We spoke with senior staff on the wards about equipment and it was commonly stated that some essential equipment was dated and due for replacement; however, staff said the equipment was well maintained. Ventilators and humidifiers were regularly stated as being old, for example, we noted that some ventilator systems were over 10 years old and some humidifiers were over 15 years old.
- The data we reviewed showed that the instances of ventilator breakdown did not seem to relate to the age of the machine but for humidifiers older than 13 years, the number of breakdowns did increase.
- We spoke with the senior staff at unit level about equipment and no reference was made to a rolling programme of equipment replacement / upgrades and it wasn't clear how the process was managed.
- We did observe two proposals on how to address the ageing equipment and it included rotating equipment between the critical care units and putting in bids to upgrade equipment.
- From speaking with the general manager for critical care it wasn't clear how well the proposals were progressing or whether new equipment was going to be ordered in the near future.
- Staff commented how their job was manageable with the equipment they had but that more up to date equipment and technology would permit improved patient care and treatment.

Medicines

- We checked clean utility rooms on the wards and found medicines were stored tidily in locked cupboards and controlled drugs were secure.
- We checked fridge temperatures and these were within the expected ranges but temperature recordings were not documented in a robust way.
- We noted a number of controlled drug incident reporting on the Datix system and all had been investigated.

Records

- Critical care standardised nursing documentation was kept at the end of the patients bed. On the reverse side of the 24 hour nursing chart all the protocols of care were printed as a reference point for staff.
- We reviewed four charts across the LGI critical care units in detail and overall, observations and assessments were consistently recorded and appropriate risk judgements were made in terms of the frequency of some observations.
- There were some inconsistencies with the periods at which staff revised certain risk scores and staff provided differing answers in relation to unit protocols. For example, MUST scores were not consistently revised and it was unclear what the expectations were.
- On L4, the Cardiac ICU, a ventilated patient's mouth care had not been documented as having been undertaken during the night in-line with the frequency recommended from the risk score and it was not possible to identify if the patient had received this care.
- Staff highlighted that there was a large amount of nursing documentation to be completed accompanied by some duplication of documentation. This was present because the CSU had its own critical care patient documentation but was also completing trust-wide generic documentation.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- We observed patients who lacked mental capacity due to their critical illness; two patients were restrained by the use of hand mittens to prevent the dislodgement of medical devices that were providing life-saving treatments or nutrition. While this was undertaken in the patient's best interests this was not documented within the nursing or medical records.
- The healthcare staff we spoke with were not clear about the legalities of the Mental Capacity Act (2005) and related Deprivation of Liberty safeguards.
- There were no evidence of the use of the two stage test to assess mental capacity or any evidence that deprivation of liberty was considered within critical care.

Staff acknowledged that using mittens was in the best interest of the patient because of the harm that can occur if devices are pulled out but there was no documentation to support why and how staff were making decisions involving restraint or how it might affect liberty.

Mandatory training

- We reviewed staff mandatory training records for two critical care wards at LGI and the proportion of staff whose training was in date for the first unit was 55% and the second unit was 61%. Compliance was the highest for corporate induction but very low for training for mental capacity and safeguarding, infection control, nutrition Level 1 and 2 and pressure ulcers.
- We spoke with a clinical educator about mandatory training and how staff progress was monitored; we also asked how they were assured staff were up-to-date with their knowledge and skills. The clinical educator could not provide us with assurance that staff were up-to-date with training. In addition they were unable to demonstrate how many new-starters had fully completed all the required competency packages in the time frames required.
- Overall, not just in relation to the topics mentioned above, mandatory training compliance was low and staff often stated how they did not have time to attend training sessions or work through e-learning on a computer. Staff also commented on the IT system and said it wasn't easy to access the online learning and there were often problems with passwords and logging in; this put them off accessing the training.
- Senior staff on the wards said ensuring staff received their necessary mandatory training was a challenge particularly in terms of freeing staff to compete training; this was because of staffing levels not being ideal and relatively high use of agency.
- Staff annual appraisal for the adult critical care CSU was also low; in the region of 50%.

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

Good

Use of national guidelines

- We noted that the critical care units at LGI followed a variety of national guidelines to determine best practice including that provided by the Intensive Care Society, Intensive Care Society Framework and NICE. Others included Intensive Care Medicine Guidelines and use of specific care bundles, for example, ventilator care bundles.
- Other guidelines being followed included assessments for delirium and pressure sore assessments.
- We discussed the use of clinical audits with the clinical director and there were two audit leads; one at LGI and the other at SJUH. Their role was to conduct mandatory and clinical audits. It was stated that mandatory audits were completed but evidence of other clinical audits assessing adherence to guidance used was less apparent. .
- Cross-city audit meetings had been set up to improve clinical audits and work was on-going. Clinical audits that had been conducted include hospital arrests, ventilator associated pneumonia and central line complications.

Outcomes for the unit

- The adult critical care CSU contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. The figures presented for 2013 demonstrated the CSU was within statistically acceptable limits for hospital mortality but outside these limits for unplanned readmissions within 48 hours.
- ICU length of stay, mortality and hospital mortality were comparable to case mix programme averages from January 2013 – July 2013

Care plans and pathway

- The LGI adult critical care units used standardised nursing critical assessment charts placed at the bottom of patient's beds; these were used to monitor and record data about patients' progress.

Intensive/critical care

- Other documentation included specific critical care nursing record booklets for Level 2 and Level 3 patients; these were three day care records. The nursing record booklets were clearly set out and we observed nursing staff completing these as necessary.
- Key headings within the booklets included isolation, escalation measures, infection control, daily events, ward round decisions, acute incidents, respiratory system, evaluation of care, cardiovascular, renal, nutrition, pain, wounds and communication.
- Care bundles were in place for certain situations including if a patient was ventilated or had a central line.
- There was evidence of team work within each unit and also across units. Staff acknowledged that if the neurosurgical unit was full and a major trauma patient with a head injury required admission, senior nursing staff would identify a less acute patient on L6 to be moved to L3 to enable the head injured patient to be admitted directly to the neurosurgical unit.
- Senior consultant staff highlighted the nursing difficulties surrounding recruitment and retention. Trust-wide capacity and patient flow issues impacted directly on critical care. Cancelled elective surgery, which requires critical care post-operatively, occurred because it was not always possible to secure a discharge / transfer to a ward of a medically fit patient from the critical care units in a timely fashion.
- Patients were often discharged to hospital wards after 10pm due to trust-wide capacity issues which goes against NICE best practice guidelines.

Consultant input

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

Multidisciplinary team working

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

Seven-day services

- There was good consultant presence on the critical care units including at weekends; the consultants were supported by a specialist registrar and a senior house officer level doctor.

Are intensive/critical services caring?

Good

Compassionate care

- Throughout the inspection we observed how staff, mainly nurses and doctors, engaged with patients and/or their families and relatives. We observed that staff treated people with compassion and in a dignified and respectful way.
- Patients looked comfortable and where appropriate were sat out of bed.
- Curtains were drawn around bed areas while care was delivered and privacy and dignity maintained.
- Some of the patients we observed were critically ill and were on ventilators. Staff were equally caring and respectful to those patients that may not have been aware of people and surrounding around them. Staff would inform patients of what they were doing even when it unlikely the person would be able to hear and/or understand what they were saying.
- We spoke with two families about the care and support being provided to their relative. One family member said, “Staff were very helpful and caring”. They described how the nurses would stop and listen to what family members wanted to discuss and were sensitive to distressing situations.
- Another family spoke highly of the medical and nursing team and had spent a significant amount of time on the unit with their relative. They said the nurses and doctors were, “Excellent” and they “Couldn’t fault the care”. Their relative had made much better progress than expected.
- The relatives had not encountered any problems in terms of visiting times and visiting times were at the discretion of the nurse in charge; this was particularly so for patients who were at their end of life.

Patient involvement in care

- Due to the nature of the care provided on the critical care units we visited, patients could not always be

directly involved in their care. However, we did speak with patients who were ready to be discharged from the critical care unit and they said, where possible, elements of their care were discussed and explained to them.

Emotional support

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

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

(for example, to feedback?)

Requires improvement

Maintaining flow through the department

- The information presented by the Department of Health for critical care bed capacity showed that the available beds for the trust was 89 with a percentage occupancy figure of 80.9% with the England average being 83.4%.
- The critical care bed spaces available at LGI were 49 although the number of funded beds was only 39.
- We spoke with the clinical lead about the 80.9% occupancy figure and it was likely this was determined using the available beds figure; the clinical lead stated that the actual percentage occupancy figure was much higher and well over 85%.
- Activity across the adult critical care CSU has seen a rise of around 8% over the course of 2013/14 and is forecast to deliver around 33,000 bed days of critical care.
- LGI activity had risen particularly as a result of the Major Trauma Centre designation from April 2013. Out-of-hospital cardiac arrest admissions had also been steadily rising.
- We reviewed ICNARC data and related quality reports and they showed that the LGI unit was below the CRG reference for delayed discharged to wards. It was however above the threshold for non-clinical transfers out. This may reflect problems of inadequate capacity on general wards, inefficient patient pathways and poor patient flow.
- The above data is an indication that the service was under significant pressure whereby patients may be being discharged from critical care beds too early and / or staff on some wards were not able to manage the patients as well as the critical care team may have hoped.
- Re-admission rates back to critical care beds were being negatively affected by the lack of seven days a week cover provided by the out-reach team and patients being discharged from critical care beds too early in order to free up beds for new admissions.
- Key performance indicator information provided by the trust showed signs of the pressures being placed on funded beds and the challenges faced by wards in coping with critical care discharge patients.
- We spoke with senior nurses on the critical care units and staff working for the out-reach team; there was agreement that patients were being held in critical care beds because of some wards being unable to manage the more complex patient, for example, someone with a tracheostomy or chest drain.
- For the second half of 2013 there had been a steady increase in patient operations being cancelled because of a lack of critical care beds; the number of discharges delayed beyond four hours had remained at similar levels throughout 2013 numbers have not been dropping, this is also the case for out of hours discharges.
- We attended a bed capacity meeting and observed how bed capacity pressures were managed; on this occasion there was little check and challenge surrounding the potential cancellation of elective surgery, which required critical care post-operatively, due to delayed discharges from critical care. A patient requiring transfer

from a ward on SJUH to critical care was also delayed due to a lack of capacity. It seemed the many options available to tackle bed pressures were not fully explored. An elective operation was cancelled but was not escalated to a general manager.
- We reviewed specific funded bed capacity graphs and noted the occupied bed days were not frequently at full capacity; we spoke with the general manager and this was partly due to staff shortages.

Meeting the needs of all people

- Staff were able to explain how they could access support for staff with physical and learning disabilities if needed.
- Interpretation services were available and staff were aware of how to access the service.
- Staff did comment that the interpretation service was not responsive enough which had a negative impact on the patient experience and their understanding of the care being provided.
- Some written information was available in different languages.
- During our visit we spoke with a family who's relative was acutely unwell and they had stayed overnight on a sofa bed next to the critical care unit. This was a positive observation but the room was relatively small and the capacity for other relatives to stay overnight at the same time was very limited.

Discharge and handover to other wards

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

Complaints handling

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

Are intensive/critical services well-led?

Requires improvement

Leadership of service

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

Requires improvement

Intensive/critical care

Culture within the service

- We spoke with a number of staff about the leadership of the adult critical care service and there was a theme; staff felt there had been an improvement since the formation of the CSU's and the appointment of the current managers / leads nine months ago and staff felt more direction was being provided.
- A ward manager felt the service leads were approachable and in-touch with the challenges being faced by the service including staffing.
- Staff felt communication had improved and learning from incidents and the critical care blog and bite size learning magazine had all been positive.
- Staff appeared concerned about the critical care service and the extra pressures created by the Major Trauma Centre; staff were also concerned about the number of agency staff used, dated equipment and the regular movement of staff between hospital sites.
- We spoke with the clinical lead, general manager and head of nursing about their perceptions of their impact on staff and the service. They felt the new structure was still embedding and there was a way to go before significant changes were felt.
- The senior team were confident about the direction of travel and acknowledged the difficulties ahead especially in terms of staff recruitment and working 'as one' between the two main hospital sites where critical care is delivered.
- The clinical lead acknowledged the work that needs to be done to engage staff at all levels between the two main hospital sites.
- Staff felt there was an 'us and them' culture across both sites, which was an historical mind-set at the trust.
- Staff commented that senior staff were based at SJUH and weren't very accessible; this made some staff on the LGI site feel less involved.
- There was very limited planned cross-site working and there was only one senior doctor that worked regularly at both sites.
- There was a sense from speaking with some doctors that the ethos between the main hospital sites differed which affected working relationships.
- There was a sense of willingness from the majority of all staff to ensure the success of the service but senior medical level engagement between the two hospital sites needed to improve.

Vision and strategy for this service

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

Governance, risk assessment and quality measurement

- From speaking with the clinical lead, general manager and head of nursing, they were clear where the challenges for the service were and priority areas.
- There was a staffing shortage and issues over the oversight of the high dependency unit on L39 to address as a priority to ensure that patients' safety is maintained.
- Discussions around risk and service improvement were held at monthly clinical governance meetings but attendance by medical staff was poor.
- The challenge with the clinical governance meetings had been engaging with a broader range of staff and cross-site clinical engagement.
- Complaints, incidents, audits and quality improvement projects were discussed.
- Information was cascaded to staff through ward team meetings and performance figures were placed in ward areas.

Good

Maternity and family planning

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

Information about the service

Leeds General Infirmary provided obstetric and midwifery services along with community midwifery care. It was a tertiary unit and therefore provided care for and advice to clinicians caring for women with complex needs. The service included pre-conceptual care, early pregnancy care, antenatal, intrapartum and postnatal care. The trust also had a tertiary neonatal intensive care unit (NICU) at both sites that provided medical neonatal care. At LGI, the service was for babies under 27 weeks' gestation and for high-risk pregnancies, and it had a total of 31 neonatal cots.

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

During 2012/13 the total number of deliveries at the LGI maternity service was 5,178.

We visited the antenatal clinic, antenatal day unit, maternity assessment centre (MAC), antenatal ward and postnatal ward, delivery suite and obstetric theatres. We spoke with 27 women who used the service and 29 staff, including midwives, doctors, consultants and senior managers. In addition to this we also held meetings with midwives, doctors and consultants to hear their views of the service they provide. We observed care and treatment, inspected several patients' care records in each area we visited, and reviewed the trust's audits and performance data.

Summary of findings

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

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

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

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

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

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

Good

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

Cleanliness, infection control and hygiene

- The maternity unit was visibly clean and all staff reported that they had infection control training. Policies were adhered to in relation to infection control; these included staff washing their hands, use of hand gel between patients and a 'bare below the elbow' dress code.
- Each clinical area displayed an infection prevention noticeboard and the latest monthly audits. For example, the antenatal clinic had scored 97% on domestic cleaning and 82% on cleanliness of nursing areas for the previous month.
- Between April and December 2013, there were no Methicillin-Resistant Staphylococcus aureus (MRSA) bacterial infections and one case of Clostridium difficile infection when screened on admission to the service.

Midwifery staffing

- The midwives to births ratio was 1:30, with the national guidance being 1:28. Staff were aware that midwife appointments had been made and there were further plans to address shortfalls.
- Ideal and actual staffing numbers were displayed on every ward and in some instances the actual staff working exceeded the required number. There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster. Staff reported cross-department and cross-site team working and the use of agency staff when needed to address shortfalls.
- The maternity service's weekly newsletter of 10 March 2014 advertised for midwives to become supervisors of midwives and informed staff about the course commencing in January 2015.
- Women told us that they had received continuity of care and one-to-one support from a midwife during labour.

Medical staffing

- Consultants were present on the labour ward between 8.30am and 6pm and on call outside these hours. Information we received from the trust specified that it operated a rota for the consultants; this identified a dedicated 60 hours per week on both delivery suites, and not the 98 hours that would be in line with national guidance.
- Junior doctors told us that consultants were contactable out of hours. Staff were managing the unit well and they had no concerns about patient safety.
- For consultant staffing, we were told that the workforce was in need of expansion and this had been an ongoing problem that had an impact on the out of hour's service. However, we were also told that the service remained safe.
- Management plans were in place to address the shortfall in the long term; however, there is a national shortfall of staff in this area. Information provided by the trust showed that, although there were 18 consultants in post, the deficit compared with the 98 recommended hours in the LGI and SJU sites combined equated to six consultants.
- There was 24 hours a day anaesthetic cover at trainee level, consultant cover is provided by the acute anaesthetist who is non-resident on call.

Nursing and medical handover

- We observed staff handovers in the delivery suite.
- Nursing handovers occurred twice a day. Staffing for the shift was discussed as well as any high-risk patients, and updates were provided on women at home who had the potential to impact on the staff's workload for the next 12 hours (for example, those with ruptured membranes awaiting induction of labour).
- There were consultant-led ward rounds every four hours.
- A 'situation, background, assessment, recommendation' (SBAR) transfer record was used when handing over care between clinical areas. The documentation was signed by both transferring and receiving midwives. The tool was used in maternity services when there may be multiple handovers between staff and it assists in improving communication. The information included on the SBAR comprised the date and reason for transfer, obstetric/labour history, current observations/findings and a plan of action.

Management of the deteriorating patient

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

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

Safety thermometer

- Safety thermometer information was clearly displayed at the entrance to each ward. This included information about falls, venous thromboembolism (VTE), catheter use with urinary tract infections and pressure ulcers. We also saw that performance audits of data across the service were collated and discussed at the monthly maternity service clinical governance forum. For example, performance over giving to patients VTE for the trust in February 2014 was 95.7% and the target was 95%. Where issues relating to the safety thermometer had been identified, in all areas we inspected staff confirmed that they were made aware of these through briefing sessions and newsletters. They were also told about any learning from the event and, where appropriate, preventative measures.

Incidents

- Between December 2012 and January 2014 there were four reported serious incidents and one neonatal death.
- We saw across the service that data relating to pressure sores was displayed for people to see. We saw that health education literature was available to inform people about the prevention of pressure sores and staff told us that they had been informed they needed tissue viability training (for the prevention of pressure sores).
- Staff stated that they were encouraged to report incidents. Themes from incidents were discussed at weekly meetings and we saw that staff received incident bulletin updates. Staff were also able to give examples where practice had changed as a result of incident reporting. For example, there was an incident where a vaginal swab had been left in place following a theatre procedure. We saw documentation showing that audits of swabs now took place following each theatre procedure to ensure that this did not happen again.

Environment and equipment

- The environment in the maternity unit was safe.
- Equipment was checked and cleaned regularly. Discussion with staff and checks of audit records showed us that resuscitation equipment had been audited between January and March 2014 in each of the wards and the delivery suite. Staff said that when the audits first started a number of staff had forgotten to complete them and for that reason they had not been compliant in all areas. The records showed that the scores each month were improving and compliance for March 2014 ranged between 82% and 100%.

Medicines

- Medicines were stored correctly and appropriate checks carried out. For example, in the antenatal and postnatal ward, audit checks were seen for the resuscitation medication and equipment for March 2014, when they scored between 94% and 100% compliant.

Records

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

Safeguarding

- Staff we spoke with knew the procedure for reporting allegations or suspected incidents of abuse for both adults and children; they confirmed that they had had training in this. They were also aware of the trust's whistleblowing procedures and the action to take.
- The trust's weekly newsletter of 10 March 2014 reminded staff about the whistleblowing policy and encouraged them to report and discuss concerns at an early stage before they became potentially serious incidents.

Mandatory training

- Ward and department managers told us they had access to their staff training records and ensured that staff were

up to date with mandatory training. For example, in the antenatal clinic we discussed the training matrix with the manager and confirmed that staff were up to date with their training.
- Staff told us they were up to date with mandatory training. This included attending annual cardiac and pulmonary resuscitation courses and training specific to their role.
- Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and support.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Use of national guidelines

- The maternity unit used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (e.g. Safer Childbirth: minimum standards for the organisation and delivery of care in labour). Clinical Negligence Scheme for Trusts (CNST) level one guidelines were seen to be available and neonatal guidelines were available on the intranet and displayed on labour wards in line with national guidance and recommendations.
- Medical students were encouraged to undertake clinical audits to assess how well guidelines were adhered to. The trust provided us with examples of audits completed during the year, which included the use of MOEWS in relation to 'Recognising the ill woman', adherence to standards set out in the trust's policy; and employing CNST maternity clinical risk management standards. The outcomes showed 100% compliance on admission to postnatal wards across the maternity services and 100% of ill patients had the correct action taken; however, admission to delivery wards could be improved and actions suggested were recorded.

Outcomes for the unit

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

Care plans and pathways

- Care pathways were used, such as the 'Enhanced Midwifery Care Pathway for the Management of Pregnant Women with a BMI (Body Mass Index) more than 40 kg/m2'.
- Care plans were of a high standard and comprehensive and clear records were kept. Patients had individual handheld records and, on the wards, documentation was kept at the end of the bed.

Multidisciplinary team working and working with others

- Specialist clinics also took place where multidisciplinary teams worked together: for example, clinics covering twin pregnancy, diabetic/endocrine disorders, female genital mutilation, and joint clinics with Leeds addiction unit and sexual health.

Pain relief

- Pain relief was available for birthing mothers. The people we spoke with on the postnatal ward confirmed that they had been offered a choice of pain relief while in labour.
- Epidurals were available 24 hours a day, seven days a week, and there was a dedicated anaesthetist.

Seven-day services

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

Are maternity and family planning services caring?

Good

Maternity and family planning

Good

Compassionate care

- In the maternity service survey for 2013, the trust scored the same as other trusts for care by staff during labour and birth. Care in hospital after the birth was reported as being worse than in other trusts. Staff were aware of this information. We were told by a matron on one ward that they ensured there were no handovers taking place when women were transferred from delivery, which meant that they had the time to provide the care needed for the new admission.
- The maternity Friends and Family test was still relatively new; although it was seen in clinical areas, not everywhere had the cards or box available for patients to submit their comments. The weekly staff newsletter dated 17 March 2014 reminded staff to encourage women to complete the form.
- Throughout our inspection we witnessed women being treated with compassion, dignity and respect. We saw that call bells were answered promptly. Women told us, "The staff are fantastic." They said that the staff had been exceptionally good, caring, efficient and they felt included in decisions about their care in the delivery suite. They said that they had been treated with respect and compassion.
- We looked at patient records and found that they were completed sensitively and detailed discussions had been held with women and their partners.
- Partners were encouraged to visit and visiting times were waived for mothers in labour. On the antenatal and postnatal ward, there were a number of single rooms. The manager told us that, if these rooms were used for women whose babies were in special care, their partners were able to stay overnight to support them.

Patient involvement in their care

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

Emotional support

- There was a lead nurse for bereavement and we were told that all midwives received bereavement training.
- In the event of a stillbirth, there were facilities in the delivery suite with separate doors to the unit to ensure that women did not have to walk through the unit.

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

Good

Access

- Bed occupancy was below 75%. (Royal College of Midwives recommends the bed occupancy rate for maternity should be below 75 %.)
- With the exception of one women who was seen 24 hours later than expected. Women spoken with confirmed they were seen throughout their pregnancy when expected and when visiting the service, they told us they did not have to wait to be seen.

Equipment and facilities

- Equipment was available for birthing mums, including a birthing pool, mats and cushions. One person told us they had used the birthing pool. However they had to come out of the pool when their labour failed to progress.

Maintaining flow through the department and discharge planning

- Women laboured in designated areas.
- The trust had an escalation policy to deal with busy times and shortages of staff.
- With the exception of the senior ward and unit staff, staff rotated between areas every six months. This ensured they had the knowledge and skills to work in different areas/locations should they be needed. Staff also worked flexible between units for example between the antenatal ward and delivery.
- Staff told us they followed the escalation procedure regarding staffing levels in relation to the antenatal

words. The unit would not close as they would continue to care for patients already on the ward. However new patients would be diverted to the other maternity site at the trust.

Meeting the needs of all people

- The needs of people with complex medical needs received shared care where needed. For example one person told us how their surgeon had been present at their planned caesarean section in case they were needed. They also had co-ordinated care during their antenatal period.
- We saw specialised clinics were available for people who had medical conditions such as diabetes. The trust had received a Parliamentary Service award; multi-disciplinary team of the year for their diabetes in pregnancy service.
- They had also received a runner up award for services for women with HIV, antenatal screening.
- Translation facilities were available and several information leaflets seen were available in different languages.
- In response to the needs of people such as travellers, and asylum seekers the trust set up a community midwife led service (Haamla) to assist in meeting their needs. Three part time midwives having a caseload of 10 to 12 patients. One of the aims of the service was to reduce mortality and morbidity rates within this vulnerable group. Leaflets were available in the antenatal clinics advising of the Haamla antenatal group for women, offering support, information and advice. Interpreters were also available in meeting these women's needs.
- A monthly TLC clinic and subsequent pregnancy support service was set up for women in their next pregnancy who had experienced, a miscarriage, stillbirth, termination of pregnancy for foetal abnormality or neonatal death. The clinic was supported by the SJUH's and Leeds General Infirmary bereavement support midwives.
- Ward noticeboards had information about meeting patient's cultural and religious needs. For example, circumcision.
- Women who requested a home birth were supported and cover provided by the midwives from the delivery suites on both sites across the trust. This had proved popular; although there had not been an increase in home births, it had allowed people to have their labour and delivery in their chosen place.
- Where possible, women in Leeds were offered a choice of midwife-led care or consultant-led care, depending on need. The majority of antenatal care was carried out in a community setting with input from appropriate professionals as required. These may include community midwives, GPs, consultant obstetricians and other specialists.
- Written information about bereavement services and support was available. The information could be provided in different languages on request. We were also told that translation services would be arranged where needed.

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

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

Complaints handling (for this service) and learning from feedback

- Data returns for 2013 showed no written complaints were upheld, and there had been no change from 2011/2012.
- Complaints were handled in line with the trust policy. If a patient or relative wanted to make a complaint there was information on how to do this; including, emailing, phoning, and face to face meetings. If the trust was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they

would be advised to make a formal complaint. Information relating to complaints was seen on ward notice boards, patient areas throughout the service and available in different languages.

- Patient were aware of how to complain and told us in the first instance they would speak with the staff on the ward. They also said they had confidence their concerns would be taken seriously and responded to.
- We also saw information on ward notice boards about the supervisor of midwives role and how they could be contacted should someone have a concern.
- The trust maternity services, monthly clinical governance risk management report for February 2014, detailed incidents reported in the last month. The service across both maternity units had received one new formal letter of complaint and six PALS concerns with a description of the action taken place to date. The Maternity Service, Clinical Governance Report, October to December 2013, stated there had been 12 formal complaints received. They also stated the service had responded to 22 informal PALS complaints this quarter. In both instances the information stated there had been a reduction in the complaints received from the previous month.
- Clinical areas were seen to have staff communication notice boards with details of new information and lessons learned from concerns, incidents, new guidelines and performance figures. We saw copies of the staff weekly newsletter which included information relating to complaints and incidents. Staff confirmed they all received the information and attended weekly team briefs to keep them informed.

Are maternity and family planning services well-led?

Good

Leadership of service

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

Culture within the service

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

Vision and strategy for this service

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

Governance and measurement of quality

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

Innovation, learning and improvement

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

Requires improvement

Services for Children & Young People

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

Information about the service

The children's hospital was officially opened in 2012 following centralisation of inpatient children's services to Leeds General Infirmary (LGI) in 2010. There were 286 beds within the hospital and this number was increased during the winter months to deal with seasonal illnesses affecting children. The hospital provided a range of paediatric services including general surgery, medicine and paediatric intensive care. In addition, the hospital provided tertiary-level specialties including paediatric neurosciences, cleft lip and palate, paediatric rheumatology, paediatric liver and transplantation, paediatric cardiology and paediatric nephrology. There were 16 intensive care beds for children and 24 surgical high dependency beds on dedicated wards including the cardiac high dependency unit (HDU), surgical HDU and the neonatal unit. There were also a range of outpatient clinics covering all specialties.

During 2012/13 at the children's hospital, there were 38,000 follow-up appointments and 14,000 new outpatient appointments in clinics. The children's hospital had 18,000 admissions for acute episodes of care and 11,000 elective admissions into inpatient wards.

We visited wards L9, L10, L30, L31, L32, L40, L41 and L52, the paediatric intensive care unit, the HDUs, children's diabetic outpatients, paediatric orthopaedic outpatients, and paediatric accident and emergency (A&E). We spoke with 39 patients or relatives and 53 members of staff, including consultants, registrars, junior doctors, matrons, ward sisters, staff nurses, student nurses, healthcare assistants, play specialists and the management team. We found that there were 15 paediatric wards throughout the hospital.

Summary of findings

We found that children's services were generally safe; however, nurse staffing levels on the children's wards were identified as a risk and we found that they regularly fell below expected minimum levels, which placed staff under increased stress and pressure. We also found there were gaps at middle-grade and junior doctor level and some medical staff were covering paediatric specialties without any specific paediatric training. Learning from incidents was not shared between clinical service units or throughout the trust and it was not clear that actions from serious incidents had been implemented or evaluated.

Children's services were utilising national guidance, peer reviews and care pathways. However, there was no clear overview across children's services of what guidance was implemented or which audits had been undertaken. In the areas where there were national peer reviews, we found that services were benchmarked against other services across the country.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. Patients and their relatives were treated with care and compassion and felt involved in decisions about their care and treatment. There was an inconsistent approach to gaining patient feedback; although there were plans in place to adapt the Friends and Family test for children and young people and to develop an adolescent forum.

Apart from the teenage cancer unit, there were no dedicated areas for young people. Young people over the age of 16 were admitted to adult wards without an

assessment of the appropriateness for their stage of development. Although there was work in place to look at the transition from children's to adult services, there was no policy for such transitions within the trust. We found inconsistent approaches to transition, which did not always follow best practice guidance.

We found that aspects of the children's services were well led. However, there was no executive lead at board level. We found that there was no oversight of children's services across the trust, especially as not all children's services were managed by the children's Clinical Service Unit management team. There were no formal processes to share learning across all of the children's services and specialties. The overarching strategy and vision for the children's hospital were not displayed in ward areas or available on the webpage and we found that staff were not aware of the vision.

Are services for children & young people safe?

Requires improvement

Cleanliness, infection control and hygiene

- Ward areas inspected were clean and we saw staff regularly washing their hands and using hand gel between patients.
- 'Bare below the elbow' policies were adhered to.
- We found that ward areas had dedicated housekeeping staff who had responsibility for ensuring that the ward area was clean.
- If patients were found to have either Clostridium difficile or Methicillin-Resistant Staphylococcus aureus (MRSA) they were isolated in a side room.
- We saw information in one ward area on the 'ward health check' board that displayed the number of 'harm-free' days since there were falls or infections on the ward. For example, we saw that it had been 223 days since there had been a Clostridium difficile infection on the ward. We also saw that the results of the latest hand hygiene audits were displayed on the board.
- However, we found that information on infections or hand hygiene audits was not consistently displayed in every ward area we visited.

Nursing staffing

- Nurse staffing numbers had originally been assessed using Royal College of Nursing (RCN) guidelines on staffing levels for children and young people. This identified that there were gaps on some ward areas and this was identified in the chief nurse's paper in December 2013.
- There were plans in place to start using a recognised acuity tool to determine dependency and staffing levels. Senior nurses and matrons had commenced training on how to use this tool.
- Ideal and actual staffing numbers were displayed on every ward. Staff reported that they were often understaffed on shifts and vacancies were filled with agency staff where possible, which meant that there were times when the right experience of staff was on duty to ensure patient safety.

- All of the ward areas displayed information on expected staffing numbers and the number of staff on duty that day. We found on the majority of wards we visited that actual staffing numbers were below the required numbers of staff that should be on duty.

Medical staffing

- There was consultant cover for the paediatric wards from 9am to 5pm five days a week. Out of these hours, trainees were resident and consultants were on call from home.
- Recruitment of additional paediatricians was being undertaken to increase the cover until 9pm seven days. There was consultant cover between 2pm and 9pm five days a week on the children's assessment and treatment unit (CAT).

Nursing and medical handover

- We observed both medical and nursing handovers. We saw staff take notes on individual patients and potential issues and saw future treatment plans being discussed.
- Nursing handovers occurred twice a day. Staffing for the shift was discussed as well as any high-risk patients or potential issues.
- There were consultant-led handovers each day. There was no information in the notes to confirm who information was handed over to.

Management of the deteriorating patient

- The department used the Paediatric Early Warning Scoring System. There were clear directions for escalation printed on the reverse of the observation charts. Staff were aware of the appropriate action to be taken if patients scored higher than expected.
- There was a trust-wide policy for the prevention and management of the deteriorating patient implemented in February 2014. On the CAT unit there was an escalation pathway to manage patients who deteriorated.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.

Safety thermometer

- The trust had adapted the adult safety thermometer and developed its own paediatric version. We were told that this needed further development to make it more pertinent to children.
- Ward areas had a ward health check display board at the main entrance to the ward. This included information on the number of 'harm-free' days, for example since there was a fall on the ward or a patient had acquired a hospital-acquired infection. However, as this was still in a pilot phase we saw information displayed in only one ward area out of the 10 wards we visited.
- In the care records, we saw that appropriate risk assessments were being completed on admission.

Incidents

- There were three serious incidents between December 2012 and November 2013, two of which related to child deaths and the other was in relation to a safeguarding children incident.
- All serious incidents led to a full root cause analysis. However, we did not see evidence of how this was fed back to staff or between clinical service units. In some clinical areas staff were able to tell us about the incidents; however, in other areas staff seemed unaware of the incidents.
- Staff stated that they were encouraged to report incidents and received direct feedback from their matron.
- In some wards, themes from incidents were discussed at team meetings and staff were able to give us examples of where practice had changed as a result of incidents. For example, one member of staff told us that, as a result of a safeguarding incident with a visitor, all visiting times had changed and staff were more aware and vigilant. However, we found that this was not shared by all clinical areas.

Environment and equipment

- The environment in the children's wards was safe.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards to ensure safe care.
- Play areas inspected were clean, and toys and games were age-appropriate for young children.
- The environment in the orthopaedic outpatient clinic was not suitable when there was a high volume of patients.
- We saw in the plaster room that there were trolley areas for two patients; however, confidentiality could not be maintained due to the close proximity to the next patient. Staff told us that they were aware of this and had raised this issue with their management team.

Requires improvement

Services for Children & Young People

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked and were maintained at the correct levels.

Safeguarding children

- We found that staff responded appropriately when there were concerns about the child's or young person's safety.
- Where needed, staff liaised with other agencies, for example social services, to protect the child or young person. For example, staff told us about, and we saw records of, discussions with social services to safeguard a child who had been admitted with head injuries.
- We found that staff were aware of safeguarding children procedures and acted accordingly. All NHS trusts are required to have a named doctor for safeguarding who provided advice and expertise for fellow professionals and promoted good practice within their organisation in line with the intercollegiate safeguarding competencies document (2010).
- For a period of time, due to staff sickness there were only two or three sessions a week of named doctor cover for the hospital; this was identified on the risk register and has now been resolved.
- Statutory guidance on 'Promoting the Health and Well-being of Looked-after Children' (2009) states that the NHS can only effectively meet the needs of looked-after children when it has systems and processes in place to actively track and target their health needs. We found that there were no flags or identifiers on the symphony IT system for looked-after children or to indicate whether a social worker was involved with the child.

Records

- All records were in paper format and healthcare professionals documented care and treatment in the patient records.
- We saw that, in some ward areas, documentation audits were undertaken weekly as part of the ward assurance checklist. We found that where issues had been identified actions had been implemented and re-audits had taken place.

Mental Capacity Act (over 16), consent and parental responsibility

- We saw that blank consent forms included a space for information and a signature for the parent or person who had parental responsibility and the child or young person to agree to treatment.
- When we looked at records, we found that often the child's signature had not been recorded; however, patients who were able to make decisions told us they felt involved and had agreed with their treatment.
- There was no formal documentation to assess a child's or young person's ability to make a decision. Further training had been planned on mental capacity for staff when assessing young people over the age of 16.

Mandatory training

- We looked at staff mandatory training records. The trust had a mandatory training plan and targets for training were reviewed each month.
- Some junior doctors told us that they had not had paediatric life support training or safeguarding training to comply with safeguarding board requirements. This included staff who were managed by different clinical service units.

Are services for children & young people effective?

(for example, treatment is effective)

Good

Use of national guidelines

- The children's CSU used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH) guidelines to determine the treatment they provided. Local policies were written in line with these and were up to date.
- At the multidisciplinary team meetings, any changes to guidance and the impact that it would have on practice were discussed. We observed a MDT meeting where these issues were discussed.

Outcomes for the unit

- The children's CSU participated in all of the national audits for which it was eligible, including the paediatric diabetes audit, feverish child audit, pain in children

audit and the national neonatal audit programme. We saw that recommendations were made where improvements were needed; however, we did not see any information on progress made against the recommendations.
- Peer reviews had been undertaken in the oncology and diabetic units.
- We found that there were no outcome measures reported for non-specialty areas.

Care plans and pathways
- In the records we looked at, we found that clear, objective outcomes were identified and documented from ward rounds.
- Nursing documentation was kept at the end of the bed and was completed appropriately.
- Care bundles were in place for specific situations, for example if the patient was cannulated or catheterised.

Multidisciplinary team working
- The ward had specialist paediatric physiotherapists and occupational therapists, all of whom would attend the morning ward round.
- Staff worked closely with other professionals and agencies, for example social workers and charities designed to support children and young people.
- Staff also told us they worked closely with other health partners to support children and young people, for example the patient's GP or health visitor and children's community nursing teams

Seven-day services
- Nursing cover for the wards was the same seven days a week. Medical cover was available out of hours..
- Patients had access to physiotherapists and occupational therapists. One ward had a dedicated therapy area.
- Routine radiology ran at the weekends with an on-call radiologist on site from 9am to 5pm. Computed tomography was available as an ultrasound service. Magnetic resonance imaging was available.
- Pharmacists were in the hospital from 9am until 5pm on both Saturday and Sunday. Out of those hours, there was an on-call pharmacist available on the phone.

Staff supervision and support
- We found that some areas had clear structures and processes in place to support staff through appraisals, individual meetings and supervision, including safeguarding supervision.
- However, we found that there was no consistent approach across all areas and some staff did not have access to individual meetings or safeguarding supervision. This meant that staff were not adhering to the trust policy on safeguarding supervision. We did not see any information indicating that the CSU had identified this as a risk.
- The management team and staff told us there was a concerted effort for all staff to have an appraisal before the end of March. One member of staff told us they had had their appraisal within the last two weeks but prior to that they had not had an appraisal for several years. Other staff we spoke with confirmed this.

Are services for children & young people caring?

Good

Compassionate care
- Throughout our inspection we witnessed children and their parents being treated with compassion, dignity and respect. We saw that call bells were answered promptly and people we spoke to said, "Fantastic overall care" and "I could not ask for more from them."
- We looked at patient records and found that they were completed sensitively and that detailed discussions had been held with children and their parents. However, we did find that records were often not 'person-centred'.
- Parents were encouraged to visit and visiting times were waived for children who were very poorly or distressed.

Patients involvement in their care
- Children, young people and parents felt that they had been involved in their care and decisions around treatment.
- One relative told us, "I am not only involved in the decision making; I feel I am in charge."
- There was an inconsistent approach to gaining feedback from patients and relatives. Some areas utilised their own tools, whereas other areas did not obtain feedback. In the areas where feedback was sought, we saw positive comments such as: "How fantastic every single member of your team has been"; "It's been a really scary time but the care and kindness have really helped us."
- At the listening event, patients and relatives told us that the care was "exceptional, amazing and excellent".

Requires improvement

Services for Children & Young People

- We found there was no survey data on patient experience available. There were plans in place to adapt the Friends and Family test for children and young people; this was due to start in April.

Emotional support and end of life care

- Relatives were invited to come back to the hospital to speak with the consultant and any other staff they wished to speak to. Staff told us that relatives could choose the timing of the appointment but this was usually six weeks after the child or young person had died.
- Bereavement memory boxes were available for parents or relatives to use to store any keepsakes.
- One person told us, "I feel so well supported I never have to ask twice for anything."
- Staff training was available on breaking bad news and bereavement. Support was available from the oncology specialist nurses throughout children's services for end of life care.
- Following the death of a child on the ward, a debriefing session was held for the staff involved and those who had formed a relationship with that child.
- There was a chaplaincy service that provided support to patients, relatives and staff who required religious, pastoral and spiritual care.
- There was a remembrance service every year for all bereaved parents with members of staff in attendance.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Requires improvement

Maintaining flow through the department

- Children referred to the paediatric department (either by the A&E or by a GP) were transferred to the CAT unit 24 hours a day. This was staffed by a consultant between the hours of 2pm and 10pm and by a specialist registrar the rest of the time.
- GPs had access to a 'paediatric hotline' or bleep holder.
- There was a clear escalation plan for when the ward was busy. Ward staff spoke daily with neighbouring paediatric units to anticipate surges in demand and potential shortfalls in beds.

Meeting the needs of all children

- There was no dedicated lead for patients with learning disabilities or physical needs. We asked staff about this and they told us they could access support from a learning disability nurse from the local community healthcare trust.
- A translation telephone service was available seven days a week and interpreters could be booked in advance for face-to-face consultations. In addition, the staff had a wide multicultural background in line with the population the hospital served, and therefore they told us they would usually use other staff members to help translate.
- There were multiple information leaflets available for many different conditions. These were available in all of the main languages spoken in the community.
- We found that there were good arrangements in place for the transition of young people into adult specialty areas. However, we found that transition arrangements were less consistent in general ward areas.
- There were clear plans in place to develop an adolescent forum and steering group to look at the issues around transition.
- Apart from the teenage cancer unit, there were no dedicated ward areas for young people in the trust.
- Young people aged 16 years and over were often admitted to adult wards and were not given a choice about whether they wanted to go to a children's or an adult ward. There was not always an assessment of the young person's stage of development or of whether an adult ward was appropriate for the patient; such assessments would be in line with the National Service Framework for Children and Young People (2003). We were informed by the trust following inspection that there was discussions with families and clinicians, but this was not a formal process."
- Information on the children's hospital webpage stated that services were provided up to the age of 16.
- There were dedicated arrangements for schooling that met all national standards and were rated 'outstanding' by Ofsted. This was an example of good practice.

Environment

- We found the ward areas were bright and decorated appropriately for young children.

- Play areas had toys for young children but had limited facilities for adolescents (computer games, etc.). We did see one ward area that had a separate room for young people. We found that most areas did not have separate recreational facilities for young people.
- Accommodation for parents was provided within the hospital grounds by a charity. There were also facilities for chairs to become beds so that parents could sleep next to their child.
- The children's hospital was not centralised in one part of the hospital. There were plans to move most ward areas to one location; however, the timescale for this was unclear. One relative told us, "We've been looking for the children's hospital but we can't find it." Another relative told us they did not know there was a children's hospital.

Communication with GPs and other departments within the trust

- A discharge summary was sent to the GP by email automatically when the patient was discharged from the department. This set out the reason for admission and any investigation results and treatment undertaken. We found that there was no data collected by the trust on discharges on the CSU indicator dashboard.
- Surgical teams would undertake daily ward rounds to the paediatric wards. Staff stated that it was not difficult to get advice from other specialties within the trust.

Outpatient clinics

- The majority of dedicated children's outpatient clinics were held on Clarendon Wing. However, there was no consistent approach to how outpatient clinics were run across the trust; this depended on the specialty or CSU.
- We observed one clinic with a high volume of patients. People told us they often waited for two to three hours to be seen. The last appointment for the clinic was at 4.30pm, but when we checked the next day we were told that the last patient left at 8pm.

Complaints handling

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, they would speak to the nurse in charge. If the nurse was not able to deal with their concern satisfactorily, they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was depicted on multiple posters in several languages.
- Complaints were discussed and themes and trends were fed back to staff through weekly MDT team meetings and the CSU Governance meeting.

Are services for children & young people well-led?

Requires improvement

Leadership of service

- There was no dedicated executive lead for children within the trust, as recommended by the National Service Framework for Children and Young People (2003). This meant that there was no oversight of children's services across the organisation, as not all children's services were managed by the children's CSU.
- There were no formal mechanisms to share learning between all of the services that cared for children.
- One serious incident root cause analysis had identified learning and actions that spread across two CSUs. We found that it was unclear whether actions from the root cause analysis had been undertaken and whether any audits had taken place to check whether actions had been implemented. It was also unclear who was responsible for ensuring that this happened.
- We found that there was a leadership structure to manage the services within the children's CSU.
- The management team had started 'leadership walk rounds' in the last couple of months. Due to the newness of the 'walk rounds', themes or areas for improvements had not yet been identified.

Culture within the service

- Staff within the CSU spoke positively about the service they provided for patients and about the management of the CSU and the trust. Staff told us they now felt more supported by the management team and their concerns were now being listened to and acted on.
- Staff told us they were encouraged to speak up if they saw something they were unhappy with regarding patient care.

- Staff worked well together and there was obvious respect, not only between specialties but across disciplines.

Vision and strategy for this service

- The vision for the children's hospital was available in the service profile; however, we did not see this information displayed in ward areas. We also found that staff were not aware of the vision.
- Staff had new name badges that included the logo for the children's hospital.

Governance, risk assessment and quality measurement

- Governance meetings were held within the CSU on a monthly basis. We saw minutes of one governance meeting that confirmed this.
- In some clinical areas, such as CAT, we found that complaints, incidents and audits were discussed and information displayed on a board in the staffroom. However, we found that there was an inconsistent approach across all areas and there was no assurance that themes and learning were shared consistently between areas.
- Ward areas had a 'ward health check' display board at the main entrance to the ward. This included information on the number of 'harm-free' days, for example since there had been a fall on the ward or a patient had acquired a hospital-acquired infection. However, we did not see information displayed in all of the ward areas.
- We found that there was a monthly governance MDT meeting where clinical issues, guidance, complaints and feedback were discussed.
- We had concerns about the staff shortages, particularly the lack of access to the appropriate skill and experience and the risks to patient care.

Innovation, learning and improvement

- Nursing staff told us they were encouraged to look at their own learning and could access study days. However, sometimes they were not able to attend planned study days due to staffing pressures.
- The CSU had produced a monthly newsletter for staff that captured incidents, themes and future changes.
- It was unclear to staff, particularly medical staff the mandatory training requirements and we were concerned that not all staff had the appropriate Level for safeguarding training to ensure the necessary action to protect children would be taken.

Good

End of life care

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

Information about the service

End of life care services are provided throughout the trust. The specialist palliative care (SPCT) team was located at the Robert Ogden Centre at St James's University Hospital (SJUH). The team comprised of consultant medical staff, specialty doctors, nurse team leaders, specialist palliative care nurses, a palliative care discharge facilitator, end of life care facilitators, a social worker and a pharmacist. SPCT is provided via a hospital advisory team and outpatients clinics. Currently, the SPCT service is available Monday to Friday, with consultant on-call advice available out of hours.

Summary of findings

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

Staff involved people in their care and treated them with compassion, kindness, dignity and respect. Staff showed a real commitment to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of death. However, we saw some inconsistencies when assessing a patient's capacity when making decisions about attempting resuscitation. We found that patients who lacked capacity were not always having this assessed and documented. All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service. Staff were positive about the management and support given with end of life, although a number were not aware of who was the executive lead for end of life was for the trust.

Good

End of life care

Are end of life care services safe?

Requires improvement

Cleanliness, infection control and hygiene

- We saw good practice with hand hygiene from staff, when caring for patients. Staff followed the hospital policies on the prevention of infection and control.
- We observed the facilities available following death in the hospital and found that there was an additional store for the deceased in the basement of the mortuary. We saw that it was in a state of dilapidation. The access corridor and stairs were unsafe due to flaking paint and slippery steps. The area was dirty and there were plants growing out of the brickwork. This area was unsafe and unsuitable for the respectful storage of the deceased. Staff said that the executive team had never been to visit this area.

Incidents

- Staff did not recall any incidents they had reported with reference to end of life care issues.
- One staff member said they would complete an incident report if they were not able to provide a side room for a patient receiving end of life care.
- Staff said they were encouraged to report incidents. They said they usually received feedback and were alerted to any themes from incidents. One staff member spoke of 'morning briefs' where the ward sister discussed any incidents that had occurred. They also said that they received a monthly written briefing from the ward sister to keep them updated on any themes, patterns and trends within the ward and the wider trust.
- Staff were able to give us examples of where practice had changed as a result of incident reporting. One said as an example that it had been highlighted recently that doctors needed to sign more legibly and to print names, designation and contact details when prescribing medicines.

Medicines

- Anticipatory end of life care medication was prescribed appropriately. We reviewed medication administration record (MAR) charts in a number of areas we visited and saw appropriate prescribing.
- Medical staff said that they followed the trust's clinical guidelines on anticipatory medication prescribing. They also said they were provided with excellent advice and support on this from the trust's SPCT team.
- Some nursing staff said that at times they needed to prompt doctors to prescribe anticipatory medicines. However, most said that this was managed well to avoid delays for patients and ensure good symptom management. One said, "Doctors are quick to prescribe anticipatory drugs and effective symptom control."
- Appropriate syringe drivers were available to deliver subcutaneous medication. Staff said that there was a pool of medical devices available and they could obtain a syringe driver within 20 minutes of it being prescribed. This included for those patients who were being discharged home. We were told that the keys to operate the syringe drivers were the same whether in the community or in hospital, making administration of medicines more prompt and timely.

Records

- We reviewed 17 DNACPR forms.
- We saw that 16 of the forms had been signed appropriately by a senior member of staff and showed evidence of valid discussion with the patient or their family if the patient lacked capacity. Medical staff were able to describe the procedures for DNACPR forms.
- We saw on one ward that a person who had a DNACPR form in place had improved in their medical condition. The clinician responsible for this person's care agreed that they needed to review this decision for DNACPR when we this was brought to their attention.
- The trust had carried out an audit of DNACPR with the results published in May 2013. The results of the audit showed that communication with patients and/or relatives was not routinely being recorded. Medical staff said that they were aware of the audit and the need to ensure that records improved.

Mental Capacity Act, consent and depravation of liberty safeguards

- We saw evidence of best interest meetings when discussions about DNACPR and end of life care took place. These included documented discussions of conversations with people's families or the involvement of independent mental capacity advocates (IMCAs).
- We saw that there were systems in place to review the needs of a patient with fluctuating capacity to consent in response to their changing needs.

Good

End of life care

Mandatory training

- The SPCT team had produced an education and training programme to deliver all aspects of palliative and end of life care training.
- We saw that this included an introduction to the palliative care team, communication skills, symptom management and end of life care and discharge.
- Despite this extensive training programme, not all staff were aware of it or knew how to access it. It was not seen as mandatory training by the trust.
- We asked for the percentage of staff who had completed training in aspects of end of life care. The trust was not able to provide this information as a percentage. However, it did provide us with a record of numbers of staff who had completed training in the last year.
- We were told that the SPCT team was promoting the development of end of life care champions through ward-based link nurses for palliative care and a senior clinicians' development programme.
- We spoke with a link nurse who was very positive about their role in educating ward staff. They said that they now felt more confident that end of life care was managed better on the ward and that early discussion took place with patients and their families when the patient was identified as being at or nearing the end of their life.

Are end of life care services effective?

(for example, treatment is effective)

Good

Use of national guidelines

- The SPCT team based the care it provided on the National Institute for Health and Care Excellence (NICE) Quality Standard 13: End of Life Care for Adults.
- We saw that there was information displayed on wards or available via the trust's intranet on the 10 key steps in caring for patients in the last hours of life. This is also based on the NICE quality standard mentioned above.
- We saw that the trust had acted on the Department of Health's National End of Life Strategy recommendations. They had introduced the AMBER care bundle. This is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may have only a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place should end of life care be planned.

Outcomes for the unit

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

Care plans and pathways

- The trust had responded to the national withdrawal of the LCP by developing its own guidance and care plan documentation for end of life care. Our review of this showed that it was a good tool to promote partnership working and all aspects of effective planning and discharge to enable death in the preferred place.
- We saw that there was clear guidance displayed in the office on one ward stating that the trust was no longer using the LCP and what this meant in practice for patients' care needs.
- Staff were aware of the guidance and documentation and how to access support from the SPCT team regarding its use. Staff felt positive and confident to use this. One said, "We are just getting comfortable with the new care plans at the moment."
- Some staff did not feel that they had received much training in the use of the new care plans but commented that having a palliative care link nurse on the ward was a good resource to ensure some training.
- Discussions with the chief medical officer and palliative care consultant indicated that the SPCT team had taken responsibility for the introduction and development of the new guidance and care plans for end of life care. However, there was no evidence of engagement with the Trust Board.

Good

End of life care

Multidisciplinary team working

- The SPCT team included a full-time social worker and a part-time pharmacist.
- The SPCT team met twice weekly with the multidisciplinary team caring for patients on end of life care. This could include consultants, pain consultants, chaplains and liaison psychologists.
- The palliative care consultant told us that they worked alongside district nursing and hospice staff to ensure rapid discharge and that people's preferred place of death was achieved. We were given information that indicated there was an increasing proportion of people dying at home rather than in hospital (34% in 2007; 39% in 2012).

Seven-day services

- The SPCT team was available from 9am to 5pm, Monday to Friday, with consultant on-call advice available out of hours.
- The palliative care consultant told us they were now looking to extend the availability of face-to-face support to seven days per week and were currently assessing the support networks they needed to put in place to facilitate this.

Are end of life care services caring?

Good

Compassionate care

- Throughout our inspection we saw that patients were treated with compassion, dignity and respect. However, on one ward we noted a patient was referred to by their bed number and not their name.
- Staff told us that side rooms were usually provided for people who were at the end of their lives. They said that patients would not be moved from a side room under any circumstances.
- Staff told us they usually had enough time to spend with patients and their relatives when they were delivering end of life care. They spoke of identifying priorities and treating people as individuals. This included making time for people's relatives and supporting families at this difficult time. One said, "It's important to give explanations on the stages of dying and how individual this can be for people."
- There was a relatives' room or office on most wards where sensitive conversations could be conducted.
- We looked at patients' records and found that they were completed sensitively and that detailed discussions had been held with patients and their families. We saw that people were given time to come to terms with the situation they were in.
- Patients' records showed that care plans were in place to ensure comfort and symptom management and control.
- Normal visiting times were waived and car parking permits were provided for relatives of patients who were at the end of their lives.
- A patient said they had no complaints, that their call bell was answered promptly, the food was good and staff treated them with respect.
- Staff demonstrated commitment and compassion to enabling good end of life care and dignified after-death care.
- We spoke with a specialist consent nurse for requested post mortems. They demonstrated their passion and commitment to ensuring a duty of care to the deceased as well as to the relatives. Memory boxes were provided for those who wanted them, for items such as locks of hair from their loved ones, plaster cast handprints and remembrance candles. The nurse offered reassurance, support and explanations to the bereaved and said that they could remain present for the post mortem of their loved one.
- Staff continued to treat patients with dignity and respect after their death. We saw that mortuary staff referred to the deceased people by their name at all times.
- There was a range of viewing rooms and a chapel of rest to enable relatives to spend time with their deceased loved ones. We saw that these had recently been redecorated but were very plain. The chapel of rest was multicultural, private and quiet, but rather small.
- The chaplaincy staff demonstrated a caring and compassionate approach towards patients, relatives and staff who may be distressed. The chaplaincy annual report of 2012 showed that 16,273 visits had been made throughout the trust, with 122 hours of pastoral counselling provided to staff.
- Bereavement office staff said they were proud of the service they delivered, comforting patients and making sure that people left confident and knowledgeable about what to do next after a death.

Good

End of life care

Patient involvement in care

- We were not able to speak to patients about their involvement in care as they were too ill. However, we saw from patients' notes that full discussions took place with patients and their families regarding care, treatment, prognosis, discharge and preferred place of death.

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

(for example, to feedback?)

Good

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

Discharge arrangements

- Staff showed a real commitment to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of death. One said, "We start the pathway, everyone gets together." Another spoke of the importance of acting swiftly to ensure home carers, district nurses and all medication and equipment was in place for people.
- A palliative care ambulance was available to enable rapid discharge. This could be booked outside of normal transport arrangements.
- The SPCT told us there was a dedicated palliative care discharge facilitator who facilitated discharge for all patients whose preferred place of death was home. They worked alongside community nursing staff to enable this.

Records

- We looked at 16 DNACPR forms. One person's DNACPR form stated that discussion with the patient had taken place, yet it was also noted that they lacked capacity to engage in this discussion, and it was unclear whether the person's capacity had been taken into account.
- We did not see documentary evidence of mental capacity assessments for patients identified as not having the capacity to discuss or consent to DNACPR decisions. This would be best practice and the trust had procedures and documentation for use in these circumstances. Some medical staff said they assessed capacity by considering CUIRB principles (conversation, understanding, information, retention and balance). However, they agreed that they did not always document this to show it had been done.
- A member of nursing staff said they did not think all doctors discussed or assessed people's capacity as much as they should. However, they said they thought improvements had been made regarding the involvement of patients and their relatives since the last audit of DNACPR documentation. However, given our observations at this inspection this was still work in progress.

Meeting the needs of all people

- Interpreters were available when necessary. However, information leaflets from the bereavement office on what to do after a death were not available in any alternative languages or formats. Staff said they may ask the interpreters to translate information if needed but said they had not done this as yet and usually relied on families.
- Multi faith chaplaincy was available 24 hours a day seven days a week. Arrangements had been made with the mortuary and local coroners to ensure where necessary, for religious and cultural reasons, bodies could be released promptly.

Facilities for relatives

- Rooms were available on site for relatives of patients at the end of their lives. Pull out beds were also available if relatives wished to stay in the room with their loved one.

Good

End of life care

- We noted there was a lack of literature/leaflets on end of life care available on the wards we visited.

Communication with GPs and other departments within the trust

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

Complaints handling (for this service) and feedback mechanisms

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint then they would speak to whoever was in charge of the ward or department. If their concern was not able to be addressed to their satisfaction in this way they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the hospital and was displayed on multiple posters in several languages.
- Staff were able to describe the above procedures for the handling of complaints. They confirmed that the findings from complaints were shared with them in order to improve the service delivery.
- No-one we spoke with could recall any complaints related to end of life care.
- During our inspection of the A&E department, we were told of a complaint received regarding the breaking of bad news after a sudden death and the appearance of the deceased. We saw from minutes of a staff meeting that this had been appropriately investigated and the findings shared with the A&E team.

Are end of life care services well-led?

Good

Leadership of service

- The trust told us their executive lead for end of life care was the Chief Medical Officer. However, none of the staff we spoke with had any awareness of this. They knew who the palliative care link nurse was on their ward and generally thought the lead must be someone in the SPCT.
- We received a report showing there had been a development programme for senior clinicians in end of life care, October 2011- April 2013. We were told that the programme had been designed to promote learning and changes in practice in end of life care issues such as communication, delivering bad news and issues such as DNACPR. Participants in this training now acted as an expert reference group for the implementation of the End of Life Care Strategy (2008) and NICE Quality Standards (2011).
- All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service.
- Staff said that they felt well supported by managers who worked alongside them.
- Staff said they felt they were well supported and given opportunity for de-brief before and after incidents of deaths. One said, “I can speak to other staff, you can speak to managers. When a person comes back really ill, managers ask us if we want to take a moment.”

Culture within the service

- The Chief Medical Officer told us, “The most important part of the job for me is to lead and support the nineteen Clinical Service Units, helping doctors and lead nurses to believe in themselves.”
- A palliative care link nurse spoke with pride about the work they were undertaking regarding end of life care and ensuring rapid discharge for patients when they wanted home to be their preferred place of death.
- Staff spoke positively about the service they provided for patients. One spoke of the importance of getting end of life care right. They said, “It’s crucial, you only have one opportunity.”
- Staff frequently spoke of the new executive team at the trust. This included the Chief Executive Officer, Chief Nurse and Chief Medical Officer. A number of staff said they had met them and felt confident that any concerns raised would be addressed. They said they were visible to staff, had systems in place for regular communication and were aware of the risks and issues within the trust.

Vision and strategy for this service

- The trust was rolling out “The Route to Success- Achieving Quality in Acute Hospitals” (from the National

Good

End of life care

End of Life care Programme), which sets out clear guidance for hospital teams on how to improve end of life care. The SPCT had secured funding to implement this.

- This guidance included; use of holistic assessment to include spiritual and psychological support, multi-disciplinary and partnership working, monitoring and acting on complaints, advanced care planning, carer's assessments and adequate palliative care consultant cover.

Governance, risk management and quality measurement

- We were told that the Chair of the Board was effective and chaired the Quality committee themselves to ensure this.
- Staff showed a commitment to improving quality and the patient experience. However, work was still required to ensure that mental capacity assessments were taking place and that systems ensured that patients and their families were appropriately involved in end of life decisions such as DNACPR.

Innovation, learning and improvement

- The palliative care team consultant spoke of how they wanted to improve palliative care within the city. They were currently looking at an initiative of a 'managed clinical network' to assist in the management and complexity of joint working in end of life care. They also spoke of an initiative they were supporting to introduce nurse led beds in care homes, working alongside a local hospice to facilitate this. They also said they were aiming to have discharge teams within the trust to be able to facilitate and improve rapid discharge. They said they were doing this as a response to an audit they undertook which recognised the need for this specialised role.

Good

Outpatients

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

Information about the service

Leeds Teaching Hospitals NHS Trust provided a range of outpatient clinics with just over one million patients attending each year. At Leeds General Infirmary (LGI), around 310,000 patients attended outpatient clinics. During the week of our inspection, there were 34 specialty services providing outpatient clinics at LGI. The hospital had a dedicated outpatient department (OPD) with dedicated outpatient staff. The trust employed 220 nursing staff (registered and unregistered) who were supported by approximately 350 administrative and reception staff to provide and support outpatient services.

We inspected cardiology, audiology, neurology, orthopaedics and trauma, plastics, vascular and Ear Nose and Throat clinics. We spoke with 22 patients and carers and 16 staff and looked at 15 sets of patient notes. We looked at the patient environment, the availability of equipment, cleanliness and information provided to patients.

Summary of findings

Outpatient areas were appropriately maintained and fit for purpose. Staff at all levels told us they felt encouraged to raise concerns and problems. Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learned and improvements were shared across the departments. The infection control procedures were adhered to in clinical areas, which appeared clean and reviewed regularly. Staffing levels were adequate to meet patients' needs.

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

Patients told us they felt involved in their care and treatment and that staff supported them in making difficult decisions. The hospital provided interpretation services and patients told us that they felt their privacy and dignity were respected.

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

Good

Outpatients

Are outpatients services safe?

Good

Cleanliness, infection control and hygiene

- Clinical areas were clean and we saw staff regularly wash their hands and use hand gel between patients.
- Staff adhered to the 'bare below the elbow' policy in clinical areas.
- Toilet facilities were clean.
- Daily and weekly cleaning checklists were on display within the outpatient departments (OPDs. Audits showed that clinic areas were cleaned consistently without gaps. Infection control audits had been completed six months ago and improvements had been implemented.
- An infection prevention and control link nurse had been attached to the OPD and had introduced continuous service improvement (CSI). The system involved nursing, estates, facilities and infection prevention and control staff.

Staffing

- There were adequate numbers of staff available to meet patients' needs. Staff cross-covered clinics across the five hospital sites. Staff told us there were enough staff for the clinics. In the trauma and orthopaedic clinic, staff told us there had been staff shortages but the situation had improved and three new plaster technicians had been recruited: two members of staff were starting in March 2014 and one was starting in April 2014. Staff in the OPD told us that a staffing review to reduce staffing had been cancelled and the trust was recruiting staff to outpatients. Patients told us that staff were busy but they felt that there were enough staff.
- Bank and agency staff were used to fill unexpected or planned absences. We looked at the bank shifts for LGI, which showed that 83% of bank shifts were filled to cover outpatient clinics with 9% of bank shifts partially filled and 8% of banks shifts left unfilled between October 2013 and December 2013.

Incidents

- We looked at 13 incidents reported between October 2013 and February 2014 by the OPD at LGI. Incidents reported included patient falls, documentation issues and medication incidents.
- Staff told us they did not always report missing notes as an incident but the medical records department did record the number of temporary notes for each clinic. Missing notes were escalated to the senior clinician, who would report to senior manager meetings, and concerns were discussed with the medical records library staff who were responsible for collating medical records for clinics. We looked at outpatient sisters' meetings in which missing notes were discussed and it was agreed that the outpatient matron would meet with administration staff to resolve the issues identified.
- The most recent serious untoward incident led to a full root cause analysis. The results of learning from this had been disseminated in face-to-face meetings and emailed to staff in a weekly newsletter. Staff stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at weekly meetings and staff were able to give us examples of where practice had changed as a result of incident reporting.
- An example was given of an incident in the OPD when prescription pads were found to be missing had brought to light the fact that prescription pads needed to be treated as controlled stationery. It was also found that each OPD had developed independent methods of securing and issuing prescription pads. The trust had reviewed the process for managing prescription pads and staff had implemented the new systems in their OPD area.

Environment and equipment

- The environment in the outpatient areas was safe and fit for purpose. Health and safety audits had been completed for the OPDs at LGI, which were fully compliant for 2013/14.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys in outpatients were centrally located and checked regularly.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked to ensure they maintained the correct temperature for medication requiring refrigeration.
- Patients were adequately counselled about new medication and written information was given.

- Prescription pads (FP10s) were locked away securely. Prescriptions are dispensed by community pharmacists.

Records

- Staff told us it was very rare for them not to have the full set of patient notes in front of them. However, we did find that only temporary patient notes were available for some outpatient appointments because the patient's permanent notes were not available. We looked at an incident for a complex patient whose notes were not available, which led to the consultation taking longer and more difficult due to not having a thorough medical history available.
- Some patient notes were difficult to navigate and it was hard to find the latest information relating to the outpatient appointment.
- Regular audits were undertaken to monitor the availability of records; these demonstrated that only 2% of records were not available for outpatient appointments during the previous quarter.

Mental Capacity Act, consent and deprivation of liberty safeguards

- We looked at patient notes and saw that patient consent was obtained appropriately and correctly.
- Staff told us they had completed training in the Mental Capacity Act 2005. However, we found that outpatient staff in most areas did not understand the Mental Capacity Act or how it related to outpatients in terms of best interest decisions and the vulnerable adult.

Mandatory training

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

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

- From December 2012 to February 2013, the trauma and orthopaedic outpatient clinic completed a survey of the patient experience. Recommendations from the audit included extra clinics and extra staff to reduce waiting times.
- Staff told us that new patients were given longer appointment times.
- Staff told us that they spent time talking with patients to explain their treatment plans and options.

One-stop clinics

- Cardiology services ran a one-stop clinic so that patients could access the treatment required at the time of their visit and within the department.
- The trust ran audiology clinics for hearing aid repair in local NHS clinics to allow easier access for people who found it hard to access appointments at the hospital. The department was reviewing the services in local clinics to possibly allow the fitting of digital hearing aids; this would reduce the waiting times for this service.

Multidisciplinary or specialist nurse clinics

- The trust had a nurse specialist-led atrial fibrillation (AF) clinic for cardiology. The AF clinic provided a one-stop clinic with individualised care and treatment plans for newly diagnosed AF patients.

Use of national guidelines and audits

- The trust had completed audits and surveys in the outpatient clinics. These included audits to understand why patients did not attend (DNA) the clinics. There was evidence of changes as a result of audits. The trust had implemented systems to send text messages or phone people to remind them about appointments, and the DNA rates had reduced to below 9% for outpatient clinics piloting text messaging.
- The hospital used the Yorkshire Ambulance Service NHS Trust for patient transport to outpatient appointments when required. It completed quarterly audits on waiting times for patients and conducted patient surveys about their experience of using the patient transport service. The trust transport department had completed a patient experience survey in August 2013, which had received 14 responses from patients attending outpatients at LGI. Transport for all patients had arrived on time to take them to the hospital. Following their appointments, 13 patients had waited up to 60 minutes and one patient had to wait between one and two hours for transport home. All the patients said that they were extremely satisfied with the service.

Availability of urgent or next-day clinics

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

Good

Outpatients

Are outpatients services caring?

Good

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- We looked at patient records and found that they were completed sensitively and that detailed discussions had been held with patients and their relatives. However, we felt that patient notes were difficult to navigate and it was hard to find information quickly about patient care and treatment.
- The environment in the OPD allowed for confidential conversations.
- Chaperones were provided where required.
- Patients who were kept waiting for appointments or transport were offered drinks and had their needs assessed.

Patient involvement in care

- Patients stated that they felt they had been involved in decisions regarding their care.
- Patients told us they were allocated enough time with staff when they attended outpatient clinics. Patients told us: “Care was good”; ”Brilliant care and good treatment”; and “Treatment is excellent.”
- Patients told us they had opportunities to ask questions. Staff explained the treatment and patients were able to talk with staff about any concerns.

Emotional support

- Patients and relatives told us they had been supported when they had been told difficult diagnoses and that they had been given sufficient support.

Are outpatients services responsive to people’s needs?

(for example, to feedback?)

Good

Key responsiveness facts and figures

- Analysis of data showed that there was no evidence of risk for referral to treatment under 18 weeks, non-admitted pathway, diagnostic waiting times for patients waiting over 6 weeks for a diagnostic test or for all cancers the 62 day wait for first treatment from an urgent GP referral.
- Cancellations, delays in clinics, waiting times and start times were displayed in the clinic areas. The hospital reviewed the rates monthly and had implemented changes to the management of clinics to reduce waiting times for follow-up appointments

Ensuring attendance

- Patients were sent an initial letter with a map of the hospital, information about where the clinic was in the hospital, what to expect, and a contact number for cancellations and postponing appointments.
- The hospital had improved the DNA rate by using text messaging and automatic telephone messaging.
- There was good signage on the main corridors directing people to clinic areas.
- Lifts had audio notices next to them and signage was also written in Braille.

Access for all patients

- Clinics for bariatric patients were based at St James’s University Hospital. (The term bariatric refers to a branch of medicine that deals with the causes, prevention and treatment of obesity.) There was support for patients with dementia and learning disabilities. Information was available for patients and their carers of the different services and support available. Outpatient clinics were wheelchair accessible. Visually and hearing impaired support was available, with signers available to attend clinics to support patients with a hearing impairment.
- Clinics had access to interpreters and also access to a telephone translation service.
- Written information was available in several languages and in large print on request.

Communication with patients and GPs

- Staff told us that letters were sent to the GP and the patient within one week of the outpatient clinic.
- Patients were given an email address and named contact person to speak with if they had any questions.
- The hospital audited GP referrals and their appropriateness and fed back the results to the GP.

Good

Outpatients

Seven-day services

- Cardiology services ran clinic lists on Saturday and Sunday mornings. Orthopaedic services was running a clinic on Saturday mornings.
- Radiology, phlebotomy and pharmacy were not always available to support the weekend clinics.

Environment

- Car parking was easily available and there was a set fee for parking for a single outpatient appointment irrespective of the length of time patients waited for their appointments.
- There was a large children's play area.
- There were coffee shops located in the main reception areas with a wide range of snacks and hot and cold drinks.
- Seats were comfortable.
- Patient transport was provided by Yorkshire Ambulance Service through a region-wide contract. We looked at the regional contract minutes for the ambulance service and found that it was achieving the performance indicator of 75% of patients not having to wait longer than one hour once they were ready to go.

Complaints handling

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

Are outpatients services well-led?

Good

Leadership of service

- There was a leadership structure for the department and staff understood the structure, who their line manager was and who they reported to.
- The executive directors and senior staff undertook regular 'walk rounds' in outpatient areas to 'go and see' the service and talk to patients.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility.
- Staff repeatedly spoke of a flattened hierarchy and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care. Staff told us they felt well supported. One member of staff told us they were very proud of the team they worked in and how well they had pulled together. They felt they supported each other. Staff told us they felt supported by the matrons for outpatients and felt that they could raise concerns.
- Staff felt that the department focused on the importance of a positive experience of patient care.
- Openness and honesty were the expectation within the department and were encouraged at all levels.
- Staff worked well together and there was obvious respect, not only between the specialties but across disciplines.
- Service-level staff survey data was not available, but overall the trust scored above average for staff engagement.

Vision and strategy for this service

The trust vision was visible on posters throughout the wards and corridors. Staff were able to repeat the vision to us at focus groups and during individual conversations.

Staff were aware that the trust had implemented an outpatient transformation project to improve the quality of outpatient services. Within the project, it was reviewing:

- DNA rates
- text and voice reminders

- hospital cancellations
- repeat hospital cancellations
- appointments cancelled by patients
- late additions (clinics booked with less than 24 hours before the start)
- the percentage of patients seen within 30 minutes
- patient insight
- clinic utilisation.

Governance, risk assessments and quality measurement

- Quarterly governance meetings and weekly team meetings were held within the CSUs and all staff were encouraged to attend, including junior members of staff.
- Complaints, incidents, audits and quality improvement projects were discussed at governance meetings.
- A quality dashboard for outpatients was presented so that senior staff understood what 'good looks like' for the service and what they were aspiring to provide.
- Staff on the front line had the same 'worries' as those at the top of the CSUs.

Innovation, learning and improvement

- The hospital had begun to use text messaging and automatic telephoning to remind people about appointments. This had reduced the DNA rates for appointments. In addition, appointments were now not booked until six weeks before they were required, which had also reduced the DNA rates for services using the scheme.
- Innovation was encouraged from all staff members across all disciplines.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder and injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) (1)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a)The carrying out of an assessment of the needs of the service user; and (b)The planning and delivery of care and, where appropriate, treatment in such a way as to – 1. Meet the service user's needs, 2. Ensure the welfare and safety of the service user Nursing and medical handovers were not consistently ensuring that the appropriate information was passed to the next shift of staff and recorded, which put service users at risk. There was a risk to patients due to a lack of anaesthetic staff, which had resulted in unsupervised trainees anesthetising patients. There was no peripatetic anaesthetist available to oversee trainees or provide emergency cover.

Regulated activity	Regulation
Treatment of disease, disorder and injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10: Assessing and monitoring the quality of service Provision (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –

This section is primarily information for the provider

Compliance actions

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

Reporting mechanism for incidents were not effective across all staff groups and lessons learnt from serious incident investigations were not shared across all clinical areas, departments and hospitals.

There was no critical care clinical oversight and support of L39 High Dependency Unit in accordance with the Critical Care Core Standards (2013). Handovers were not robust and there was no performance data for the area to assess and drive improvement.

There was no robust system in place for clinical audits or the audit of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.

There was no rolling programme for the replacement and upgrade of equipment in the critical care units.

There was a lack of information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy procedure.

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

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder and injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI, particularly on medical elderly care, children's services and surgical wards, including the availability of anaesthetists and medical cover out of hours and at weekends, in order to safeguard the health safety and welfare of service users. Regulation 23 (1) (a) & (b) HAS 2008 (Regulated Activities) Regulations 2010 Supporting workers. There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had completed their mandatory training or had the opportunity to attend training to enhance or maintain their skills or obtain further qualifications appropriate to the work they perform. Not all staff had received an appraisal or had appropriate supervision.