Care Quality Commission

Leeds Teaching Hospitals NHS Trust

Leeds General Infirmary

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

We inspected the following locations:

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

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

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

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

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

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

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

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

Summary of findings

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

Our key findings were as follows:

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

Summary of findings

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

We saw several areas of outstanding practice including:

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

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

Summary of findings

Importantly, the trust must:

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

In addition the trust should:

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated the emergency department as good because: • There were sufficient medical and nursing staff employed by the department and staffing levels were acceptable. Staff followed safeguarding processes to protect vulnerable adults and children from abuse and referred suspected cases of abuse to the proper authority in a timely way. Staff were up to date with annual appraisals. • The department had evidence-based policies and procedures relating to care and treatment, which were easily accessible to staff and were audited to ensure that staff were following relevant clinical pathways. Information about patients (such as test results) was readily accessible. There was evidence of different staff groups working well together throughout the department. The department offered services round the clock every day. Staff understood their responsibilities in relation to patients giving consent to treatment and the principles of the Mental Capacity Act 2005 that applied where a patient's capacity to consent was in doubt.
Medical care (including older people's care)	Good 	We rated medical care as good because: • Staff understood their responsibilities to raise concerns and report incidents and near misses. Nursing staff received feedback about incidents through team meetings, 'safety matters' bulletins and in safety huddles. • Safety thermometer data showed the service performed well. The service had introduced initiatives to reduce falls and pressure ulcers. • Staff were compliant with infection prevention and control measures and the service demonstrated good compliance with hand hygiene and cleaning audits. • Systems and processes for safeguarding were reliable and appropriate to keep patients safe. However:

Summary of findings

- Registered nurse and care support workers staffing levels were below the planned levels in some areas. The service had a clear escalation process for when staffing levels fell below the planned levels.

Surgery

Requires improvement

We rated surgical services as requires improvement because:

- Two Never Events related to a wrong site anaesthetic block and guidance on this had not been fully adhered to.
- Within Jubilee theatres we found some infection prevention and control practice issues.
- Supporting documentation for Mental Capacity Assessments could not be provided.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- We found from audit data and our observations that not all aspects of the World Health Organisation (WHO) safety checklist took place.
- The audit data provided by the trust did not assure us that national early warning score (NEWS) and escalation was always done correctly.
- Readmission rates for elective and non-elective admissions were higher than the England average. In vascular surgery this was 1.2 times the England average.
- Only two specialities were performing above 90% for the 18 week national indicators.

However:

- We saw evidence of the individual needs of patients being met. This included patients with a learning difficulty or living with dementia.
- Service planning was patient focused and collaborative working was in place with other organisations and trusts.
- Projects such as the productive operating theatre were in place to provide data on performance and improve teamwork.

Summary of findings

- The trust had a strategy which was patient focused and there was evidence of innovative work to develop services.
- We saw positive leadership at all levels with staff feeling able to escalate concerns and describing a positive change in culture.
- A range of information was collated monthly into dashboards which fed into good governance arrangements.

Critical care

Good

We rated critical care as good because:

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

However:

- The trust provided specialist critical care service for a large geographical area therefore

sometimes the demand for the service exceeded the resources they had causing problems with the access and flow to the critical care units particularly in relation to delayed discharges.

- During our inspection we found equipment had service stickers to show that they had been checked however data supplied by the trust showed that they were not fully compliant and maintenance records indicated there was between 73% and 93% compliant on the units.
- The critical care units could not demonstrate full compliance with GPICS 'safe use of equipment' standard which states that all staff must be appropriately trained, competent and familiar with the use of equipment. Staff we spoke with during the inspection told us they received training on equipment and were confident in using them. However information supplied by the trust on high risk equipment training showed low percentages of staff compliance with equipment training.
- The outreach team did not work out of hours the current arrangements included medical and nursing support from the critical care units to the wards. However there were plans to introduce a 24/7 approach in October 2016 and staff had been recruited to this team.
- Medical staffing did not achieve all of the requirements of the Guidelines for the Provision of Intensive Care Services GPICS (2015). Consultants were all experienced in critical care, however not all were trained as Faculty of Intensive Medicine (FICM).

Maternity and gynaecology

Good

We rated maternity and gynaecology services as good because**:**

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Records relating to women's care were of a good standard and were kept secure in line with the data protection procedures.
- There was a 'Safe Staffing Levels and Escalation Protocol' for staff to follow.

Summary of findings

- Women's privacy, dignity and independence was maintained wherever possible. For example, in antenatal clinic staff asked for chaperones in line with the trust's policy when carrying out intimate procedures.
- 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.

However:

- Medical staffing levels did not meet national guidelines.
- Not all staff were up to date with mandatory training.
- Due to insufficient dedicated theatre staff to 'scrub' and recover patients, midwives were taken away from their duties when a second theatre team was needed; this occurred an average of twice a week.

Services for children and young people

Good

We rated services for children and young people as good because:

- Staff were encouraged to report incidents and learning was shared.
- Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding. However, although the appropriate level training was given, the service was not meeting their target for safeguarding training for staff training and regular safeguarding supervision did not take place.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition.
- Plans were in place for the development of the children's hospital to centralise all children's services. The youth forum provided input into how services were developed. Transition arrangements were good with a lead transition nurse appointed to ensure consistency.

Summary of findings

- The CAT unit improved patient access to the hospital and avoided unnecessary admissions; however, the wait in the CAT unit for admission to the ward could be long at times. Some specialities had long referral to treatment times.
- Families knew how to make a complaint and appropriate information was available.
- Children's services had a clear vision and strategy. Staff were aware of the service and trust vision and values. There was an executive lead at board level for children's services. Staff spoke highly of their leaders and were proud to work for the children's hospital.

However:

- Neonatal consultants were covering both St. James's University Hospital and Leeds General Infirmary neonatal units out of hours on a weekend. There was not always sufficient nursing staff on every ward to meet the Royal College of Nursing (RCN) guidance and British Association of Perinatal Medicine (BAPM) guidelines. On five wards, the actual number of staff on duty did not meet the planned number on a regular basis. There were gaps in the junior doctors rotas, which were being filled with locum shifts or consultants were covering.
- We were not assured that all equipment had been safety tested.
- Staff were not meeting expected targets for safeguarding Level 2 and Level 3 training.

End of life care

Good

We rated end of life care as good because:

- Safety incidents were investigated when things went wrong and lessons learned were widely shared among staff to reduce the risk of re-occurrence. Staff were open and honest when they spoke with patients and families about incidents.
- There was clear guidance for staff to follow within the care of the dying person individual care plan when prescribing medicines at end of life.

Summary of findings

- There was enough equipment including syringe pumps to support safe care of end of life patients.

Leeds General Infirmary

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care

Detailed findings

Contents

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 urgent and emergency services, surgical and medical services, critical care services, services for children and young people, maternity and family planning services, end of life care and outpatients and diagnostic imaging.

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.

LGI provides medical care over 8 medical wards comprising of 144 inpatient beds and 16 day-case beds. The medical wards covered specialities including cardiology, neurology and stroke, including a hyper acute stroke unit. The trust has one of the highest numbers of admissions in the country. Between September 2014 and August 2015 there were 73,896 medical admissions to Leeds Teaching Hospitals NHS Trust, 20,500 were at LGI. Of these admissions, 37% were emergency admissions, 13% were elective admissions and 50% were day cases.

Surgical services include trauma and orthopaedic surgery, ear, nose and throat, 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

Detailed findings

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.

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).

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Julie Walton, Care Quality Commission

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

How we carried out this inspection

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

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

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

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisation.

We carried out the announced inspection visit between 10 – 13 May 2016 with an unannounced inspection on 23 May 2016. During the inspection we held focus groups with a range of staff including nurses, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. Prior to the inspection we set up stalls at Leeds General Infirmary and St James's Hospital to gather feedback from patients and the public.

Facts and data about Leeds General Infirmary

Budget: £1 billion

Staff: The Trust employs over 15,000 staff

Detailed findings

Specialist services: The trust is one of the largest providers of specialist hospital services in the country, with almost 50% of the overall income from specialist commissioners, NHS England. Specialist services generally fall into five groups – specialist children's services, cancer, blood and genetics, neurosciences and major trauma, cardiac services and specialised transplantation and other specialised surgery.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

Safe	Good
Effective	Good
Overall	Good

Information about the service

Leeds General Infirmary (LGI) is based in the centre of Leeds. It is one of two urgent and emergency departments (also known as A&E, Emergency Department or ED) provided by the trust. The other is at St James's University Hospital (SJUH) to the east of the city of Leeds.

LGI has been a major trauma centre for West Yorkshire since 2013. Being a major trauma centre means that LGI can treat patients with a very wide range of illnesses and injuries, including those who have been involved in serious accidents and incidents. Patients can arrive on foot, by road or by air ambulance landing on the helipad on the roof of the hospital. Patients who arrive by helicopter are escorted to the department by a dedicated team of staff. Within the department, there are three distinct areas where patients are treated. The minors department can treat patients with minor injuries such as simple fractures; the paediatric emergency department treats patients under 17 years with all types of illnesses and injuries; and the majors department treats patients with more serious illnesses or injuries. It is also the main site for people with heart problems and who have suffered an acute stroke.

There were approximately 115,105 attendances to the department at LGI between April 2014 and March 2015. Of the patients who attended LGI, approximately 31% were children (16 years old or under). 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 between both departments. The resuscitation room had six bays and was equipped for four adults and two children.

The admission rate to a hospital ward at this trust was 18.4%; there were no individual figures available for this site.

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

For patients who walked in to the department, there was a minor injuries or illness service with three walk-in assessment rooms and six cubicles for treatment. This included two cubicles that could be used to isolate patients with a suspected contagious condition. In the children's A&E there were 17 cubicles 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 specific 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 that was a seated area for patients awaiting test results or transport home.

Managers and staff regarded the two A&E departments as one large department set across two sites. The management structure and governance arrangements were uniform across the two sites. Both A & E departments were part of the urgent care clinical service unit (CSU). The CSU across the two sites employed 24 A&E consultants in addition to middle-grade doctors and over 200 qualified nurses, who were supported by 70 clinical support workers and nursery nurses. There was also support from a team of administrative and reception staff.

We carried out this inspection because when we inspected the trust in 2014 we did not rate the effectiveness of the department. We also found that safety in the department required improvement. At this inspection, we only inspected the effectiveness and safety of the department because in 2014 the department was rated as 'good' for the three other domains, 'caring', 'responsive' and 'well-led'.

Urgent and emergency services

During our inspection we visited the main A&E and the CDU. We spoke with 14 members of the nursing team of different grades, five doctors and eight patients and observed care being delivered. We also looked at eight clinical records and the computer systems used in the department. We reviewed performance information sent to us by the trust and other stakeholders such as Clinical Commissioning Groups, Trust Development Authority and NHS Innovation (NHSI). Additionally, we reviewed national and local audit and survey results.

Summary of findings

We rated the emergency department as good because:

- There were sufficient medical and nursing staff employed by the department and staffing levels were acceptable. Staff followed safeguarding processes to protect vulnerable adults and children from abuse and referred suspected cases of abuse to the proper authority in a timely way. Staff were up to date with annual appraisals.
- The department had evidence-based policies and procedures relating to care and treatment, which were easily accessible to staff and were audited to ensure that staff were following relevant clinical pathways. Information about patients (such as test results) was readily accessible. There was evidence of different staff groups working well together throughout the department. The department offered services round the clock every day. Staff understood their responsibilities in relation to patients giving consent to treatment and the principles of the Mental Capacity Act 2005 that applied where a patient's capacity to consent was in doubt.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated safe as good because:

- The environment of the department was clean, hygienic and well maintained. There were adequate staffing levels to provide safe care to patients. Medication was stored and dispensed safely and records were stored securely.
- Staff reported incidents of harm or risk of harm as common practice throughout the department and they told us of examples of staff learning from incidents, near misses and errors. The department had processes for identifying patients at risk of harm and for monitoring and escalating the care of patients if they began to deteriorate.
- Overall, staff mandatory training figures were above the trust standard. However, training levels for fire safety and resuscitation for adults and children were below the trust standard. An action plan was in place to ensure that all staff were fully up to date with their mandatory training.
- Staff were well rehearsed in their roles and responsibilities when major trauma cases came to the department. They worked efficiently and cohesively. Staff received regular major incident training.

However:

- We were concerned there were some breaches in patient confidentiality.

Incidents

- Leeds General Infirmary (LGI) reported no serious incidents between March 2015 and February 2016.
- LGI also reported 611, moderate, low or no harm incidents to the National Reporting Learning System between March 2015 and February 2016.
- There was evidence that the trust took action to learn lessons and informed patients when there had been errors or potential harm. This demonstrated that staff were aware of the Duty of Candour regulations and actively informing patients or their relatives when required. Staff demonstrated this through the information they provided when completing incidents on the electronic incident reporting system.
- The National Staff Survey 2015 showed that 32% of staff had witnessed potentially harmful errors within the last month. This is better than the result of the 2014 survey which was 36%.
- However, 88% of staff had reported near misses in the last month compared to 92% in the 2014 survey.
- The trust performed about the same as other acute trusts for the number of staff who thought that when near misses or incidents were reported, the organisation took action to ensure that they did not happen again. For example by adding extra security measures for people leaving treatment areas.
- Mortality and Morbidity meetings took place regularly across the trust and staff from the department routinely attended. We saw that any findings or lessons learned were reported at departmental meetings.

Cleanliness, infection control and hygiene

- At trust level, 99% of urgent care staff had completed Infection Prevention and Control training, compared to the trust target of 80%.
- Between January 2015 and January 2016, the trust reported seven cases of Methicillin Resistant Staphylococcus Aureus (MRSA) with a peak of three cases in September 2015. There was no specific information available for A&E.
- Between January 2015 and January 2016 the trust reported 148 cases of Clostridium difficile (C.diff), there were peaks of 16 in June and December 2015. The number of cases per bed days was worse than the England average and increasing slightly during the year. There was no specific information available for A&E.
- There were 73 cases of Methicillin-sensitive Staphylococcus Aureus (MSSA) between January 2015 and January 2016 with a peak of nine in September 2015 and January 2016. There was no specific information available for A&E.
- When we visited the department, we found it to be visibly clean. Patients' rooms were cleaned between patients and waiting area floors and seating were well maintained. Patients' toilets were clean.

- There were cleaning schedules in place and we confirmed that cleaning occurred as per the schedules in place. We saw staff completing the required tasks in line with schedules.
- The monthly hand hygiene audit results varied from 96% to 99% between July 2015 and December 2015.
- Ward Health check data between July 2015 and December 2015 relating to infection prevention and control was carried out by the head of infection prevention and control. This showed high standards of compliance with infection and prevention control standards.
- Staff could call cleaners to the department 'out of hours' if required however, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients. Clean and dirty equipment were clearly labelled as such.
- There was ample personal protective equipment (PPE) such as aprons and masks available to staff. We saw staff using this equipment routinely during our inspection. Patients also told us that staff washed their hands and used gloves and aprons.
- The department had a policy in place to ensure the safe isolation of patients who needed to be isolated. Patients who attended with potentially contagious conditions were cared for in cubicles with solid walls and doors. We saw examples of this during our inspection.
- We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment.
- Mattress checks were carried out by staff on a weekly basis. We randomly checked 10 mattresses and found no concerns.

Environment and equipment

- Consulting and treatment rooms were an acceptable size and contained the necessary patient equipment. As rooms had doors, privacy was maintained.
- We found that equipment in the department had been safety checked. All of the equipment we looked at had up to date tests.
- Servicing and maintenance of equipment was in line with manufacturer's guidelines. The medical electronics team co-ordinated equipment servicing and repairs throughout the trust. To ensure accuracy the medical electronics team also ensured that equipment was regularly calibrated.
- We saw that there were ample supplies of all equipment. This meant that if a machine suffered a mechanical breakdown, a spare one was available.
- Staff told us that resuscitation trolleys were checked regularly. We checked the resuscitation trolleys and found that checks had been carried out in line with the trust's policy.

Medicines

- At trust level, 95% of urgent care staff had completed Medicines Administration and Safety training, compared to the trust target of 80%.
- Medication was stored securely in the department.
- Controlled drugs were stored in line with national and trust policy and stock checks were routinely completed.
- Staff from the pharmacy department completed weekly checks of medication stocks held in the department and there was a system to make sure that any stock close to expiry was removed.
- Drug storage fridge temperatures were checked daily. We noted three occasions when one fridge had exceeded recommended temperatures. The thermometer had been reset but it was not clear if staff had taken any action to rectify the problem or check that the medication was still safe to use. We spoke with the senior nurse in charge who took action to contact pharmacy straight away.
- Staff used patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) in the department. They were up to date. We saw that staff had signed to say that they understood them and were working within their guidance.

Records

- During our inspection, we saw that patient identifiable information was left on display on monitors in patients' bays on four occasions. The information on display did not relate to the patient in the cubicle at the time. This was a breach of patient confidentiality.
- We looked at the records of nine patients in the main and paediatric departments. We found that the records completed by medical staff showed a clear history,

action plan and treatment plan. We had no concerns about the standard of nursing records. Staff carried out risk assessments as appropriate and dignity rounds were clearly documented.
- On the electronic record, we saw there was clear information about patients' presenting condition.
- Medication and pain scores were completed and the records demonstrated clear medical treatment plans.
- Patients had observations taken. All of the records we looked at contained the necessary information about the patients' National Early Warning Score (NEWS). A NEWS score is used to assist staff to identify deteriorating patients.
- The matron carried out quarterly record keeping audits. These showed good compliance to trust standards with no areas highlighted for improvement.

Safeguarding

- At trust level, 97% of urgent care staff had completed Safeguarding Children Level 1 training, and 81% had completed Safeguarding Children Level 2 training, compared to the trust target of 80%.
- At trust level, 97% of urgent care staff had completed Safeguarding Vulnerable Adults Level 1 training, and 85% had completed Safeguarding Vulnerable Adults Level 2 training, compared to the trust target of 80%.
- We looked at the processes and policies the trust had for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients or visitors who attended the department.
- The department held weekly safeguarding meetings with colleagues from the paediatrics department to discuss any patients of concern. The senior sister looked through the records of all children who had attended to make sure that any children at risk were identified and the relevant authorities informed. This was a robust system that made sure children were protected from harm.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated good working knowledge.
- There were referral processes for vulnerable adults and children. Health visitors routinely received information from the department about children who had attended for treatment.
- Safeguarding training included specific training about safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM). Staff in the paediatric department knew the signs to look for.
- The IT system used by the department routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about patients' welfare, the system also displayed an alert to staff that gave specific details about any risks to the patient or to staff. All staff were responsible for adding alerts to the system and the senior sister reviewed every patient to ensure none had been missed.

Mandatory training

- Staff told us they had accessed most mandatory training on the intranet. They reported few problems accessing e-learning (training courses on the intranet). Staff could access training from home if they wished to.
- The majority of mandatory training was meeting the trust standard of 80% averaged across all staff groups between April 2015 and March 2016. However, not all-training completion was meeting the trust standard, including adult and children's resuscitation, the Mental Capacity Act (2005) Level 2 and Fire Safety. The most significant shortfall was in resuscitation of children. This was at 36% against a trust standard of 80%. Other training not meeting the trust standard was only slightly below the 80% target.
- Training and non-training grade doctors were not meeting the standard for fire safety, infection prevention and control, mental capacity act level two, safeguarding children level two, resuscitation in adults and in children.
- Registered nursing staff were below the trust standard for resuscitation in adults and in children. Resuscitation in adults was 70% and children 44.4% against a trust target of 80%
- We discussed resuscitation training with senior clinical staff in the department who assured us that all relevant staff had either undergone, or were scheduled to undergo advanced life support, advanced paediatric life support or advanced trauma life support as appropriate.

Assessing and responding to patient risk

- At Leeds General Infirmary, the median time from arrival to initial assessment between March 2015 and February

2016 was six minutes. In the same period, the median time from assessment to treatment was 87 minutes, which is worse than the national standard of 60 minutes.

- Over the winter period (December 2015 to February 2016) there were 52 ambulance hand-overs delayed for over 30 minutes at Leeds General Infirmary.
- Between December 2015 and February 2016, there were no black breaches at Leeds General Infirmary. A black breach is when handovers from ambulance arrival to the patient being handed over to the Emergency Department took longer than 60 minutes.
- The trust performed 'about the same' as other trusts in the 2014 CQC A&E Survey questions relating to safety. Lowest scores were for questions relating to the length of time waiting for an examination by a doctor (6.5 out of 10) and the length of time waiting to speak to a doctor initially (6.6 out of 10). Scores for wait times with ambulance crews (8.9 out of 10), cleanliness (8.6 out of 10). Scores for safety in terms of perceived threat from other patients and visitors were higher at 9.4 out of 10.
- Patients were triaged by a nurse on attending the department using formal triage criteria. From this assessment staff decided whether the patient should be treated in the minors, majors or, paediatric emergency department.
- Patients had their observations taken regularly and the department used the national early warning score (NEWS) or paediatric advanced warning score (PAWS) to assist in identifying patients whose condition was deteriorating. Staff were fully aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. All patient records we looked at had a NEWS or a PAWS recorded.
- Patients with allergies wore a red wristband to ensure that they were easily identifiable. Staff recorded known patient allergies in patient records.
- There was emergency medical equipment in the department and staff were experienced at dealing with very sick patients. There were senior staff on hand to support less experienced staff 24 hours a day.

Nursing staffing

- The department did not use an acuity or dependency tool to determine staffing levels on a day-to-day basis.
- Staffing levels were formally reassessed on a six monthly basis to take into consideration changes in workload. Staff and managers told us staffing levels were frequently monitored and adjusted to ensure that staffing levels matched the demand for services.
- Information sent to us by the trust showed that between April 2014 and March 2015 there had been 46 whole time equivalent (WTE) nursing vacancies in the department, which was confirmed by the departmental management team. However, the matron told us about the action the department had taken since then to recruit new staff to the emergency department. This included running a recruitment campaign and working with local universities. The trust had recruited 47 new staff and recruitment was ongoing to ensure that vacancies were filled.
- Information sent to us by the trust showed that there was bank and agency staff use in department. From April 2014 to March 2015, bank use ranged from 9% to 15.3% with an average over the year of 11.5%.
- Prior to recruitment and our inspection, planned versus actual staffing levels had been around 85% however staff and managers told us this had improved over recent months as newly recruited staff took up posts.
- We found that the staffing levels in the department were acceptable and there was a flexible approach to sharing staff across the two A&E sites in the trust. There were times when actual staffing levels dipped below planned staffing levels. Staff we spoke with told us that this did not impact directly on patient care but did make shifts very tiring.
- Due to the number of newly recruited staff, many of whom were also newly qualified; some staff had concerns about the skill mix of staff on some shifts. To counteract this, all newly recruited staff had undergone an extensive induction to ensure they had the skills and competencies to work within their role and meet the needs of patients. There was also preceptorship in place to support these staff.
- The paediatric A&E was staffed by qualified children's nurses, nursery nurses and play specialists.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses. Seven nursing staff were in training to become

advanced nurse practitioners at the time of our inspection. Once qualified, they would be able to treat more unwell patients with a wider range of medical conditions.
- According to information provided to us by the trust, between April 2014 and March 2015, there was a staff turnover rate of 14.3% across all grades of nursing staff.
- The sickness rate for nursing staff was around 4%, which was better than England average
- Staff absences and annual leave were managed using overtime and internal bank staff.
- We observed handovers between senior nurses and between staff nurses. We saw that staff effectively communicated information such as why patients were attending and their care needs to colleagues at the start of shifts, or at break times.

Medical staffing

- Doctors staffed the A&E department 24 hours a day seven days a week. Emergency department consultant presence was also on this site 24 hours a day, seven days a week in line with major trauma centre service specifications.
- The trust employed more consultants (27%) by percentage than the England average (23%) but fewer middle grade doctors. The number of specialist registrars was better than the England average at 51% compared to 39%.
- The department employed a range of trust grade, training grade and junior doctors.
- The senior management team and senior medical staff told us that it was difficult to recruit doctors to the emergency department. They recognised this as national problem. In order to attract staff to the department, the trust offered research fellowship opportunities. This had proved successful and meant that locum use was limited.
- The department had a medical staffing vacancy rate of 7.1 whole time equivalent staff. This equated to 17.2% of the medical staffing workforce.
- Figures provided to us by the trust showed that locum use between April 2014 and March 2015 was on average 8% across the year. There was no breakdown of the grades of locum staff available.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- The trust reported to us that medical staff were fully up to date with revalidation requirements. Medical staff we spoke with confirmed this.

Major incident awareness and training

- The emergency department at LGI was a major trauma centre. This meant that in the event of a major incident in the region, patients attended LGI. The department received patients who had been involved in serious accidents and incidents. Patients were brought to the department both by road and by air ambulance.
- We checked the equipment the department held, which would be used in the event of a major incident. We found that this was stored securely, organised and appropriately accessible. We found that the department had an ample supply of high visibility clothing, hard hats, torches and radiation detection equipment.
- Staff in the department were aware of the role they would play if there were a major incident in the region. We also observed that staff worked as an organised and cohesive team when responding to trauma patients brought into the department. Each staff member was clearly identifiable and each person knew exactly what their role was in supporting and treating patients.
- We observed the initial care and treatment of patients brought to the department as emergencies. We saw that the processes for receiving such patients were smooth and well-rehearsed. Staff told us that such patients were a regular occurrence to the department.
- The department had a policy in place to manage patients presenting with suspected Ebola. There was sufficient equipment and a designated area of the department. Staff were aware of their roles and responsibilities in the event of a possible presentation and had previously put this in to practice very effectively.
- Staff received refresher training about major incidents approximately every three months.
- The department had business continuity plans in place in the event of system failures.
- The department had plans to manage increased demand on the service, such as over the winter period.
- Security staff were easily accessible if required.
- The department could be locked down easily to ensure the safety of patients should the need arise. Staff were aware of their roles and responsibilities in such a situation.

Urgent and emergency services

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

Good

We rated effective as good because:

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

However:

- The number of patients returning to the department unplanned was higher than the national average.

Evidence-based care and treatment

- Policies and guidelines used by the department were based on the latest national and international guidelines such as the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine.
- The department used clinical pathways for conditions such as sepsis and fractured neck of femur. These were evidence based and subject to national audit. We had no concerns about the results of the audits.
- Staff were able to access clinical guidelines and pathways using a computer and mobile phone application called CEMBOOKS. This meant that staff of all disciplines and grades could access up to date guidance. We did a random check of guidelines and found that they had been regularly checked to ensure they were up to date and relevant.
- The trust provided us with evidence of participation in Royal College of Emergency Medicine (RCEM) audits and local audit activity. We saw that when standards were not met, action had been taken to implement changes and re-audits had been planned. For example, the Procedural Sedation Audit had identified poor completion of documentation and a new recording document had been designed and introduced. Similarly, the VTE (venous thromboembolism) Audit had led to the introduction of a new pathway of care for applicable patients.
- Results from the 2014/15 Royal College of Emergency Medicine audit on the initial management of the fitting child indicated that all children actively fitting on arrival had their blood glucose checked and documented and all children had eye witness history recorded. This met the fundamental standard of 100% for both areas. For the remaining developmental standards, Leeds General Infirmary performed between the upper and lower England quartiles.
- Leeds General Infirmary had mixed performance in the 2014/15 Royal College of Emergency Medicine audit on Mental Health in the Emergency Department. They were in the upper England quartile for four out of five measures. They were between the upper and lower England quartiles in the final measure relating to management of mental health. The department scored less well for liaising with specialist mental health teams. Two comparators were in the lower England quartile and one was between the upper and lower quartiles. Since the audit, the department had improved their communication with specialist mental health teams. Our specialist mental health inspector found that the systems and processes in place were robust and appropriate.
- Leeds General Infirmary had a mixed performance in the 2013 Royal College of Emergency Medicine on

Consultant Sign-off audit. They were in the upper England quartile for two measures, the lower England quartile for one measure and between the upper and lower quartile for the final measure. Changes had been made to the IT system that meant consultants had to review and complete final sign off before the patient could be discharged.

- Local audits showed that patients received care that was in line with evidence-based guidance.
- The department carried out simulation exercises in order to improve the response of staff to pressurised situations and the subsequent care and treatment patients received.

Pain relief

- We looked at the records of nine patients including three children. Five required pain relief and this was given appropriately. Two patients had declined pain relief.
- According to the latest results of the CQC A&E survey carried out in 2014, the trust performed worse than expected when patients were asked how many minutes they had waited for pain relief after asking.
- However, staff told us that because of the survey, all patients were asked about their pain levels and offered pain relief as soon as they saw a clinician. Pain levels were also reviewed when staff carried out dignity rounds.
- We spoke with five patients. All but one patient told us they had received pain relief quickly. We heard patients being offered pain relief and saw patients receiving medication quickly. We heard staff discussing pain levels with patients and asking them how they usually controlled their pain.
- We saw that pain scores were documented in patient records and reviewed appropriately.

Nutrition and hydration

- Staff carried out dignity rounds in the department. These were documented in patient medical records. Patients were offered drinks. When patients had health conditions that meant they needed to eat regularly, we saw that they were able to access food.
- Assistance was available to patients who were unable to eat or drink unaided.
- None of the patients we spoke with had eaten the hospital food, but understood that they could access food if they needed to.
- We asked staff whether food and fluid intake was monitored. They told us that records showed when patients had eaten or had a drink. Monitoring would occur using food or fluid charts if there was cause for concern about the patient's nutrition or hydration status, such as if they had been admitted with dehydration.
- According to the latest results of the A&E Survey carried out in 2014, the trust performed about the same as other trusts when patients were asked whether they were able to get suitable food and drinks when they were in the A&E Department.

Patient outcomes

- The trust performed about the same as other trusts for two of the effective elements of the 2014 A&E survey. First, whether staff did enough to control pain and second, whether patients were able to access suitable food and drinks in the department. The trust performed worse than other trusts for patients waiting for pain relief. This had been addressed since the survey by the introduction of dignity rounds.
- The IT system in the A&E had been adapted to ensure that consultants had final patient sign off. This meant that a consultant reviewed patient cases before the patient was discharged from the system.
- The department took part in Royal College of Emergency Medicine (RCEM) audits. The results of some audits showed that the department needed to improve compliance with RCEM guidelines. We saw that re-audits had taken place to ensure results had improved because of changes made.
- The department had no CQUIN (Commissioning for Quality and Innovation) targets for 2015/2016. In 2014/2015, the department met 11 out of 12 targets for the A&E Asthma CQUIN.
- At Leeds General Infirmary, the unplanned re-attendance rate within seven days was 6.8% between March 2015 and February 2016. This was worse than the 5% national standard.

Competent staff

- Information sent to us by the trust showed that 99% of staff in the Urgent Care Clinical Service Unit (CSU) underwent appraisal between April 2015 and March 2016.

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

Multidisciplinary working

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

Seven-day services

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

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays. There was also a link to patient information held by GPs such as past medical history and current medications.
- Patients transferred to other services or sites took copies of their medical records with them. Additionally, the referring clinician gave a verbal handover to the receiving department to ensure that important details were communicated.

- Clinical guidelines and policies were available on the trust intranet.
- The electronic system used by the department automatically issued letters to patients' GPs once the patient was shown as discharged from the department. This meant that GPs received discharge letters in a timely manner and could respond in adjusting medications or treatments when appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- Training figures for MCA training were at 98% for level one and 80% for level two across all staff groups. The trust target was 95%.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us they considered implied consent when patients agreed to a procedure. We saw evidence of staff explaining procedures to patients and patients agreeing to them.
- An initial assessment of patients' capacity was made at triage and where concerns were identified, a more detailed assessment would be made each time patients needed to make decisions. Staff were able to access Independent Mental Capacity Advocates (IMCAs) when required. These are independent patient advocates to support patients who were deemed to lack or have fluctuating capacity and had no family members to support them.
- Staff we spoke with about restraint told us that they would always use the least restrictive option and would only use physical restraint as a last resort. This was in line with the trust policy.
- Staff underwent conflict resolution training as a way to de-escalate situations and reduce the need for either physical or chemical restraint.

Medical care (including older people's care)

Safe	Good
Effective	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Leeds Teaching Hospitals NHS Trust provides medical care, including older peoples care across two sites. Medical services at the Leeds General Infirmary (LGI) are across two different clinical service units (CSU). The cardio-respiratory CSU includes; cardiology and the centre of neurosciences CSU includes; neurology, neurosurgery, stroke, chronic pain, neurorehabilitation and neurophysiology.

LGI provides medical care over 8 medical wards comprising of 144 inpatient beds and 16 day-case beds. The medical wards covered specialities including cardiology, neurology and stroke, including a hyper acute stroke unit. The trust has one of the highest numbers of admissions in the country. Between September 2014 and August 2015 there were 73,896 medical admissions to Leeds Teaching Hospitals NHS Trust, 20,500 were at LGI. Of these admissions, 37% were emergency admissions, 13% were elective admissions and 50% were day cases.

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

During our follow up inspection, we reviewed the safe, effective, responsive and well-led domains. We visited the following ward areas, wards 12, 21, 18, 19, 17, 14, 26 and 20. We spoke with 36 members of staff, including doctors, nurses, healthcare assistants, ward managers, matrons and consultants. We spoke with 7 patients. We looked at the records of 18 patients. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

We rated medical care as good because:

- The service had a strong safety culture that encouraged staff to raise concerns and report incidents and near misses. Lessons were learnt from safety incidents and disseminated to staff. Safety huddles had been implemented to share learning and improve patient safety.
- Staff took steps to raise safeguarding concerns and systems and processes were in place to keep patients safe.
- Staff responded appropriately to changes in risks to people who use services. Observation charts were completed and concerns were escalated.
- Patients' care and treatment was delivered and planned in line with evidence-based guidance. Information about patients' care and treatment, and their outcomes was routinely monitored and collected. The service participated in local and national audits.
- The service responded to complaints and concerns in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safe as good because:

- Staff understood their responsibilities to raise concerns and report incidents and near misses. Nursing staff received feedback about incidents through team meetings, 'safety matters' bulletins and in safety huddles.
- Safety thermometer data showed the service performed well. The service had introduced initiatives to reduce falls and pressure ulcers.
- Staff were compliant with infection prevention and control measures and the service demonstrated good compliance with hand hygiene and cleaning audits.
- Systems and processes for safeguarding were reliable and appropriate to keep patients safe.

However:

- Registered nurse and care support workers staffing levels were below the planned levels in some areas. The service had a clear escalation process for when staffing levels fell below the planned levels.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are in place. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. There were no never events reported in medicine between October 2014 and September 2015.
- Serious incidents are incidents that require reporting and further investigation. LGI reported three serious incidents between March 2015 and February 2016. Falls and pressure ulcers that met serious incident criteria were the most frequently reported serious incidents.
- A root cause analysis (RCA) is a structured method used to analyse serious incidents. The trust held multidisciplinary meetings to analyse the information, identify the root cause and contributory factors, and generate action plans.
- We reviewed three RCAs, two relating to a fall resulting in serious injury and one relating to a category 3 pressure ulcer. All investigations identified the root cause, included recommendations and had a timed action plan. They also identified areas of good practice to be shared. Recommendations made included; ensuring fall bays were supervised at all times, ensuring all staff completed falls prevention training and encouraging the attendance of ward pharmacist at safety huddles.
- Between March 2015 and February 2016 there were 1260 incidents reported within medical services at LGI to the national reporting learning system of these incidents, 997 resulted in no harm, 237 resulted in minor harm and 26 resulted in moderate harm. We reviewed incident data and found slips; trips and falls were the highest number of reported incidents contributing to 336 of incidents reported. Other commonly reported incidents included pressure ulcers (205) and staffing resources (96). Other themes of incidents included medication errors and incidents relating to access, transfer and discharge of patients.
- On the previous inspection there was a mixed response to how well local incidents were reported and learned from. Individuals did not always receive feedback on incidents they reported. During this inspection we found all staff understood their responsibilities to raise concerns and near misses and to report safety incidents using the electronic recording system including junior doctors.
- Staff received feedback on incidents reported. Any lessons learnt from incidents were shared at team meetings, via a 'safety matters' electronic bulletin and in safety huddles. Examples of lessons learnt from incidents included changes to the storage of gel sachets used in urine bottles following a patient safety incident.
- All wards we visited held daily safety huddles. All members of the multidisciplinary team (MDT) attended including medical staff, domestic staff and clinical support workers. The safety huddles were used to share any learning from incidents and identify any patients safety issues including, pressure ulcers, falls, high NEW's score, patients under deprivation of liberty safeguards (DOL's) and any patients with a hospital acquired infection. Staff spoke positively about the safety huddles and felt they had created a sense of ownership amongst staff to improve patient safety.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the duty of candour and spoke about being open and honest.
- Each CSU had monthly mortality and morbidity meetings, individual cases were discussed and required actions were documented with timescales. Any lessons learned from mortality and morbidity meetings were shared via a 'lessons learnt bulletin' and across other specialities.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The trust displayed some aspects of the safety thermometer on all the wards we visited. Wards displayed the number of days since a patient fall and the number of days since a pressure ulcer. They did not display catheter related urinary tract infections and venous thromboembolism. However, the percentage of harm free care was displayed.
- Ward managers recorded and submitted the number of falls, pressure ulcers, urinary tract infections and the percentage of harm free care on to the monthly CSU ward health check. In January 2016; 23 falls were recorded, 2 pressure ulcers were recorded and 0 urinary tract infections were recorded across the wards within the cardio-respiratory CSU and centre for neurosciences CSU. The average percentage of harm free care reported across the wards at LGI was 94%.
- Between March 2016 and May 2016 the average percentage of harm free care on ward 12 was 95%, on ward 17 it was 95%, ward 18 was 94%, ward 19 and 20 was 100%, and ward 21 was 97%.
- Information was displayed on 'how to prevent falls' and certificates were awarded to ward teams for fall-free days.
- We reviewed patient records and saw evidence of falls and pressure ulcer risk assessments. Staff said to reduce the risk of falls they would cohort patients together in to a falls bay and a member of staff would supervise all the patients in the bay.

Cleanliness, infection control and hygiene

- The environment in most of the ward areas we visited appeared clean and well maintained. We saw cleaning books completed for each individual bed space.
- We observed staff complying with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.
- All ward areas had hand sanitising gel and sinks at the entrances to the ward. We saw clear signage encouraging all staff and visitors to wash their hands on entering and exiting the ward.
- The importance of hand washing was clearly communicated to staff and visitors through posters and messages on wards. Ward 17 and 18 displayed a large poster with a message from the chief nurse on the entrance to the ward.
- The number of days since a healthcare-associated infection were displayed on all the wards we visited and recorded on the trust's monthly ward health check. Ward 17 had gone 25 days since a case of Clostridium difficile (C. difficile) and 1462 days since a case of Methicillin-resistant Staphylococcus Aureus (MRSA).
- In the past 12 months there had been 0 cases of MRSA and 13 cases of C. difficile, 3 of these cases were identified as due to lapse in care within medical services at LGI. The trust investigated each individual case to identify any specific themes.
- From February 2015 to February 2016 there had been 10 cases of Methicillin-sensitive Staphylococcus Aureus (MSSA) within medical services across the trust.
- We saw some patients were being barrier nursed. Barrier nursing is used to ensure cross infection is eliminated by the use of personal protective equipment (PPE) and isolation procedures. Patients were nursed in side rooms or allocated bays. We observed staff using PPE, washing their hands or using hand gels when entering and leaving side rooms and allocated bays.
- On ward 21 a deep clean of a bay was taking place as a patient had tested positive for C. difficile.
- At trust level 94% of acute medicine staff had completed their infection prevention and control training, compared to the trust target of 80%.
- Monthly infection control audits were undertaken. Hand hygiene audits showed good compliance. The trust completed 595 audits between July 2015 and February 2016 and medical services were above 95% compliant with hand hygiene. The results of hand hygiene audits

were displayed on wards we visited. Ward 17 results showed the ward was 100% compliant in February, March and April 2016. Ward 18 was 100% compliant in February and March, and 80% compliant in April 2016.
- Monthly cleaning audits were completed by the trust; in February 2016 all patient environments at LGI were above 95% compliant with the exception of ward 17. The audits did not include an action plan.
- Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- Equipment was identified as being clean using cleaning assurance stickers. The label contained the date the equipment had been cleaned.

Environment and equipment

- Some of the wards we visited had a lack of space for the storage of equipment such as hoists, chairs and mattress. This made the ward area appear cluttered. On ward 21 we observed equipment obstructing a fire exit. We informed the ward manager who addressed this immediately.
- We checked the resuscitation trolleys on all the wards we visited and daily checks had been completed by staff. On ward 18 we found a face mask on the resuscitation trolley which had expired in February 2016. We raised this with the ward manager who responded immediately.
- None of the resuscitation trolleys were secured with tamper proof seals. This meant that there was a risk that emergency medications and resuscitation equipment was accessible and staff may not know if the equipment in the trolley had been used.
- We checked the 'safety tested' stickers used on equipment to identify it had been appropriately tested and regularly serviced. All the equipment we checked was in date.
- Bariatric equipment was available and could be ordered. Staff said equipment arrived on the ward within a couple of hours.
- Pressure relieving equipment including mattresses, cushions and gel heel pads were readily available for patients and could be ordered by staff using an electronic ordering system. Staff said equipment arrived within a couple of hours. .
- Ward 21 had a new therapy room and therapy kitchen where patients were taken for their rehabilitation. Therapist said it allowed them to take patients off the ward and into a more suitable rehabilitation environment where patients were not distracted.
- During our previous inspection, concerns were raised about the safety of the environment on ward 26, staff were unable to open windows and thus the ward could get very warm. We visited ward 26 and found it no longer had inpatient beds and was used as a multispecialty assessment area for surgical patients. No concerns were raised by staff about the temperature of the ward.
- Ward 21 was a 33 bedded acute stroke unit and had 8 hyper acute beds. The hyper acute beds were situated near the nurses system and the ward had a central monitoring point at the nurse's station.

Medicines

- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed balance checks in line with the trust policy.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. The room temperature was also monitored and recorded. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range. Staff said if they had any concerns, they would be escalated to the pharmacy team.
- At trust level 80% of acute medicine staff had completed their medicines administration and safety training; this was in line with the trust target of 80%.
- Each CSU completed monthly antimicrobial medicines audits. We reviewed the audit results for the cardio-respiratory CSU. Between July 2015 and February 2016 the percentage of antibiotics reviewed after 3 days were low. Recommendations to improve 3 day review rates included a sticker on the drug chart alerting a review at day 3, an advertising and education campaign and better use of doctors' handover sheets and board-rounds. Results from the monthly antimicrobial

audit showed in November 2015, 50% of antibiotics prescribed were reviewed after 3 days, in December 2016 this improved to 75%, however, in January 2016 this reduced to 65%.

- We reviewed eight prescription charts and found medication had been administered as prescribed and at appropriate times and allergies had been documented.
- During our previous inspection we found oxygen was not routinely prescribed. We reviewed eight prescription charts and found oxygen was appropriately prescribed when applicable.
- On ward 21 we observed nursing staff wearing do not disturb aprons whilst doing medication rounds this aimed to reduce the risk of medication errors.

Records

- On all the wards, records were stored in unlocked trolleys in the doctor's room. Nursing care plans were stored in files and kept at the ends of patients' beds.
- Information governance training was included in the trust's mandatory training programme. Training records showed 86.7% of staff in the cardio-respiratory CSU and 91.9% of staff in the centre for neurosciences CSU had completed the training. This was above the trust target of 80%.
- Patient records were multidisciplinary. All professions involved in a patients care documented in the patient's medical records. Staff felt this improved communication.
- We reviewed 18 sets of paper records. Daily medical reviews were clearly documented along with a working diagnosis and treatment plan. We saw evidence of discussions with families documented in medical records.
- Nursing records were up to date and appropriate risk assessments were completed. We saw evidence of a range of risk assessments including; falls, pressure ulcers and nutrition and hydration.
- The stroke clerking document included a dementia risk assessment tool. Any patients identified as high risk had a dementia care plan in place.
- VTE risk assessments were completed online. We reviewed this on the PPM system and saw it was recorded for 5 sets of notes we reviewed.
- Consultant ward rounds included a checklist to prompt medical staff to document patient's cardiopulmonary resuscitation (CPR) status.
- Patients assessed as having a pressure ulcer were on appropriate care plans and had 'turn charts' to document their position.
- Each CSU completed monthly medical and nursing health record keeping audits. Key findings were summarised along with recommendations. Audit results were feedback to staff via email and at clinical governance meetings. In April 2016 a documentation audit of 20 nursing health records was completed on wards 16, 18, 19 and 20. Key findings included the name of the person was not printed legibly against their signature in 5 sets of notes, in 3 sets the designation of the person was not legible and in three sets not every page had the patient's name and case note number recorded on every page. Recommendations following this included the delivery of documentation master classes for staff if indicated.

Safeguarding

- There were safeguarding policies and procedures available on the trust intranet and staff knew how to access it.
- All staff we spoke to knew how to escalate safeguarding concerns. Staff provided us with examples and were clear about what was seen as a safeguarding concern. Staff said they would complete a safeguarding referral for patients admitted with a pressure ulcer.
- The trust had a dedicated safeguarding team who were available for advice and support. Staff knew who the safeguarding team were and how to contact them.
- The trust used an electronic referral system for all safeguarding referrals.
- The trust collected training data by CSU and not by individual locations. Safeguarding vulnerable adult's Level 1 and 2, and safeguarding children Level 1 were included in the trust mandatory training programme. The trust target for mandatory training was 80%.
- Training records submitted by the trust showed 94.9% of staff within the cardio-respiratory CSU had completed safeguarding vulnerable adult's Level 1 training and safeguarding children Level 1 training. However, only 65.5% of staff had completed safeguarding vulnerable adult's Level 2 training.
- 92.6% of staff within the centre for neurosciences CSU had completed safeguarding vulnerable adult's Level 1

training and 92.4% of staff had competed safeguarding children Level 1 training. However, only 70.4% of staff had completed safeguarding vulnerable adult's Level 2 training.
- Female genital mutilation (FGM) was included as part of safeguarding training. Not all staff we spoke with were aware of the process but knew who to contact if they had concerns.
- All volunteers had a disclosure and barring service (DBS) check. Staff on the wards were given information about the volunteers before they came onto the wards.
- Following the Savile Enquiry volunteers now wore green polo shirts and they were now identifiable on the ward.
- A charity that provided support to the ward had an office at the entrance to the ward. Following the Savile Enquiry all charities now had offices in a non-patient area of the hospital.
- Staff completed risk assessments for visiting clergy and community leaders and they would not be left unattended on the ward.

Mandatory training

- The trust offered comprehensive mandatory training to staff. Modules included; equality and diversity, fire safety, infection, prevention and control, dignity at work, moving and handling, the Mental Capacity Act 2005 and risk and safety training.
- Staff told us they had completed their mandatory training.
- Staff could access their mandatory training record electronically. The training record used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training sessions.
- Staff said training was accessible and they could complete e-learning or attend face to face training. Staff said they were given time to attend mandatory training.
- On the previous inspection the compliance with mandatory training within medicine was 56.2%. Training data from the trust showed mandatory training levels had improved although some training modules remained below the trust target of 80%.
- The trust did not collect mandatory training data by individual location but by CSU. However they had a robust system in place that allowed staff and the trust to know when mandatory training was due to expire.
- Data provided by the trust showed that the cardio-respiratory CSU was above the trust target of 80% for all mandatory training with the exception of fire safety where 71.1% of staff were compliant, adult resuscitation where 77.4% of staff were compliant and resuscitation children where 50% of staff were complaint.
- The centre for neurosciences CSU was above the trust target of 80% for all mandatory training with the exception of fire safety where 62.9% of staff were compliant and adult resuscitation where 66.8% of staff were compliant.

Assessing and responding to patient risk

- Staff knew how to identify and respond if a patient was deteriorating. They told us they used the National Early Warning Score (NEWS) to record patients' observations and to assess if a patient's condition was improving, deteriorating or stable. The score from the NEWS acted as a trigger to escalate concerns to medical staff on the ward.
- Monthly audits of NEWS charts were completed by each CSU. Between April 2015 and February 2016 within the cardio-respiratory CSU, on average 93% of patients had the correct NEWS score, however, 79.4% of referrals for 'at risk' patients were completed. In December 2015, 93.8% of referrals for 'at risk' patients were completed, in January 2016, 77.8% and in February 73.4%. As a response the service had introduced patient safety huddles which allowed the team to identify any patients they were worried about and decide what actions needed to be taken.
- We reviewed 9 observation charts and found that the NEWS scores were completely appropriately and, where necessary, patients had been escalated.
- Patients who had suffered an acute stroke were cared for on the hyper acute stroke unit. The unit had a central monitoring system. This allowed staff to monitor patient's observations from a central point.
- A critical care outreach team was available 24 hours a day, seven days a week to support staff with patients who were at risk of deteriorating and patients whose NEWS score triggered a review. Staff said the team were very responsive and patients could be escalated to Level 3 beds if appropriate.
- From previous inspection, concerns were raised that the frequency of observations was not documented on the nursing handover. We reviewed the handover sheets and saw evidence of frequency of observations was clearly documented.

- Any patients who had a suspected stroke were reviewed by a member of the Brain Attack Team (BAT). They provided a service 24 hours a day, 7 days a week.
- The trust had worked hard to reduce the number of falls. The service had identified steps to reduce falls by discussing falls at daily multidisciplinary safety huddles, educating staff on the importance of footwear and increasing the use of 1:1 nursing for high-risk patients. The trust reported 32% reduction in the number of falls. Wards cohorted high risk patients into a designated falls bay and had a care support worker allocated to the bay to monitor the patients.
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. When a patient was identified as 'at risk' staff had completed the appropriate care plan. Wards used magnetic symbols on patients name boards to identify patients at risk of falls, pressure ulcers.
- If a patient was at significant risk of harm to themselves of others staff would use intramuscular rapid tranquilisation. Staff report variation in the frequency of recording patient observations. Guidance on the use of rapid tranquilisation (2015) states that patient observations should be recorded at least every hour or every 15 minutes if the maximum dose has been exceeded.

Nursing staffing

- The service used the Association of United Kingdom University Hospitals (AUKUH) acuity and dependency tool. The acuity and dependency tool was developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.
- Senior staff said staffing levels were reviewed twice a year and ward managers could access the shared drive to monitor the establishment numbers and keep them information up to date.
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the local and corporate risk register. Controls put in place by the trust to reduce the risk included a clear escalation process and discussion at the daily operational performance (DOP) meetings, use of bank and agency staff, staff deployment from other clinical areas and projects focusing on recruitment, mentorship and retention of staff.
- Staff were clear about the escalation process used if staffing levels fell below the planned number. Ward managers would book agency staff or offer staff additional shifts. Any unfilled shifts would be escalated to the matron and discussed at the DOP meetings. Matrons would review staffing throughout the day and move staff to support wards that were short staffed. Staff understood why this happened and appreciated the help they received from other wards when they were struggling.
- Staffing levels were reviewed three times a day at the DOP meeting.
- We saw evidence of a local induction checklist agency staff completed. This included an introduction and orientation to the ward and ensuring staff had read the trusts induction booklet.
- Wards displayed the planned and actual staffing figures. On some wards, the actual number of staff on duty were lower than the planned number. For example ward 19, had 4 registered nurses and 3 care support workers planned on an early and a late shift and 3 registered nurses and 2 care support workers on a night. The ward actually had 3 registered nurses and 3 care support workers on early and late shift and 3 registered nurses and 2 care support workers on a night.
- On the previous inspection in March 2014 staffing was felt to be a particular concern on wards 17, 18 and 21 due to the number of staffing vacancies. All wards we visited confirmed they had staffing vacancies. We reviewed staffing vacancies and found in January 2016 ward 17 had 5 WTE vacancies, ward 18 had 15 WTE vacancies and ward 21 had 10.1 WTE vacancies.
- We reviewed the planned and actual staffing levels information for all the medical wards. We found that between the 23 March 2016 and 22 May 2016 on the majority of occasions non-qualified staffing levels mitigated for the reduction in qualified nursing levels.
- We did see on a few occasions qualified staffing levels and non-qualified staffing levels were below 100%. For example on ward 18 between the 23 March 2016 and 22 May 2016 there were 18 days when non-qualified staffing levels and qualified staffing levels were below 100%. However, we did not observe an increase in patient safety incidents on these days.
- We reviewed electronic rostering information and found staff that were moved to provide cover on wards not achieving the planned staffing levels were recorded.

However staff that were moved for two to three hours were not always recorded. The trust was looking at enhancing the current electronic rostering system to capture this data for the future.

- Ward 21 had 33 beds for acute stroke patients including an eight bedded hyperacute stroke unit (HASU). Stroke patients were transferred here directly from accident and emergency following diagnosis of a stroke or thrombolysis. Thrombolysis is when patients are treated with a clot-busting drug to try to disperse the clot and return the blood supply to your brain. Planned staffing for the unit was three nurses and two care support workers. The British Association of Stroke Physicians (BASP) stroke services standard 3.4 (2014) confirm that acute stoke patients are managed at a nurse to patient ratio of 1:2 for the first 72 hours. The unit should have 4 registered nurses working in the HASU however; staff said the maximum number of registered nurses working in the HASU would be 3. Therefore, the ward did not have the staffing establishment to meet the recommendation.
- During our inspection the HASU had two nurses and one care support worker. Staff said this was due to the acuity of the patients and staff would be flexed up and moved between the HASU and acute part of the ward depending on the acuity levels of the patients.
- Senior managers were aware of the risks of staffing shortages across the service and were proactively trying to recruit nursing staff. Initiatives included developing band 4 practitioners, recruiting from overseas and a competency programme for band 2 staff to include basic therapy skills.
- The service had introduced advanced care practitioners. Advanced practitioners provided support to medical staff and provided cover until midnight. The trust had nine staff in training and one member of staff had qualified
- Ward managers were not supernumerary and reported finding it challenging to complete management and administrative tasks such as staff appraisals due to short staffing and the need to provide clinical care on the ward.
- We observed a nursing handover on ward 17. The handover was detailed and concise and highlighted any identified patient risks.

Medical staffing

- The medical staffing skill mix showed the trust had a slightly lower proportion of consultants, middle career and junior doctors than the England average, and a higher proportion of registrars. Consultant staff made up 33%, compared to the England average of 34%, middle career doctors (with at least 3 years in a chosen specialty) made up 3%, compared to the England average of 6%. Registrars made up 43%, compared to the England average of 39% and junior doctors were 20%, compared to the England average of 22%.
- There was consultant cover available Monday to Friday for all specialities. Out of hours cover was provided at weekends and at night.
- A medical registrar was available at all times, 7 days a week, 24 hours a day.
- The trust had an on call cardiology consultant 7 days a week including bank holidays. They conducted two ward rounds each day on ward 19 and the coronary care unit. This was supported by senior registrar cover 24 hours a day.
- There was a consultant interventionist 24 hours 7 days providing a primary angioplasty service and acute revascularisation.
- The stroke service provided consultant cover 7 days a week from 8am to 8pm. Out of hours there was a consultant on call rota. Staff also had access to tele-medicine which allowed doctors to assess and treat patients remotely using telecommunication technology and aided with thrombolysis out of hours.
- Junior doctors said they had no concerns about staffing and were encouraged to contact the consultant for advice out of hours. Staff said consultants were accessible and responsive and they could access training.
- We reviewed 5 sets of records and saw evidence of patients being seen on post take ward rounds by a consultant within 12 hours of admission, and were seen on daily ward rounds.
- All out-of-hours junior doctor shifts were paired with a more senior doctor. Junior doctors were not expected to cover wards without direct help.
- All shifts incorporated a full 30 minutes at the start/end to allow full handover to take place, meetings were relocated to dedicated accommodation.
- Junior doctors confirmed that consultants were easily accessible if needed and that training was accessible.

Junior doctors were involved in the rotas and each CSU had a leadership fellow who acted as a liaison between the consultant and junior doctors when making decisions about staff rotas.
- In March 2015 the percentage of locum use within the centre of neurosciences CSU was 4.3% and within the cardio-respiratory CSU it was 3%.

Major incident awareness and training

- The trust had appropriate policies with regard to major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff gave us an example of a recent major incident when a leak put the electrical supply at risk. Patients had to be moved from wards to other areas of the hospital. Staff described a well-coordinated, cross site, organised approach that ensured patient safety.
- Some staff were not clear on their specific role in the event of a major incident but were aware on how to access the major incident policy for guidance via the trust intranet.
- The trust considered seasonal risks when planning medical beds within the trust.

Are medical care services effective?

Good

We rated the service as good for effective because:

- Patient outcomes were monitored through the CSU ward health check. The service participated in local and national audits.
- Staff assessed and managed patients' pain relief. The service scored about the same as other trusts for staff doing all they could to help control pain in the CQC national survey of in-patients.
- Staff appraisal rates were above the trust target. Staff felt the process addressed their learning needs.
- Multidisciplinary teams worked together to understand and meet people's needs

However:

- The trust had an overall score of D (where A is the best and E is the worst) in the Sentinel Stroke National Audit programme (SSNAP).
- Fluid balance charts were not always fully completed.
- Staff were below the trust target for Mental Capacity Act Level 2 training.

Evidence-based care and treatment

- Policies and care pathways were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance.
- Staff demonstrated awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward. We reviewed clinical guidelines on the intranet. Of the three that we reviewed all had identified author/owner and all had review dates.
- Stroke pathways were in line with NICE guidance however, patients did not have access to a Neuropsychologist as recommended in NICE CG162 stroke rehabilitation.
- Each CSU had a yearly audit plan. We reviewed the audit plan for cardiology and found evidence of participation in a range of local audits from the trust's programme including audits of sepsis, consent and VTE thromboprophylaxis. The audit plan also included participation in national audits of guidelines and best practice for example stable angina, smoking and atrial fibrillation.
- The trust audited clinical coding for electrophysiology and device procedures. The trust identified that clinical coding for electrophysiology and device cases were inaccurate and had worked with the coding department to improve accuracy through introducing a tick sheet. The audit found that out of 95 devices, 77 (81%) were coded correctly and out of 76 electrophysiology procedures, 66 (87%) were coded correctly. The audit made recommendations to improve the results; however it did not have a timed action plan.
- All wards participated in the CSU ward health check. Ward managers recorded and submitted data on performance and quality of care using nurse sensitive indicators including, incidents, falls, complaints, pressure ulcers, staffing vacancies, patient experience, healthcare acquired infections and staff sickness. Staff reviewed the data at head of nursing and matrons meetings and at clinical governance meetings and results were shared with ward staff.

Pain relief

- Results from the CQC national survey of in-patients in May 2015 found the trust scored 8 out of 10 which was about the same as other trusts for staff doing all they could to help control pain.
- Pain was assessed and recorded on patients NEWS charts. We reviewed 9 NEWS charts and saw pain scores were appropriately assessed and recorded.
- We observed nurses asking patients about pain and need for pain relief during medication rounds and providing pain relief promptly when requested by patients.
- Patients told us staff were concerned about their pain and assessed it regularly. Patients said that their pain was managed effectively and they did not have to wait to receive pain relief.
- Ward 21 and 12 did not have a specific pain assessment tool for patients who had communication difficulties following their stroke. Staff said they would use non-verbal communication skills to communicate with patients and liaise closely with the speech and language therapist if they were concerned about a patient's pain.

Nutrition and hydration

- Nursing staff used the Malnutrition Universal Screening Tool (MUST) to screen and assess patients' nutritional needs.
- We reviewed 18 sets of records and saw that MUST scores were completed. Patients had food and fluid balance charts. We found five fluid balance charts were not completed correctly. The target balance was not recorded and there were gaps of six to nine hours where the input and output was not recorded. Therefore, staff did not accurately know if the patients were over hydrated or dehydrated.
- Staff said they could refer patients to dieticians if they had concerns about a patient's nutrition. Dieticians were available to produce feeding protocols for patients who required nasogastric (a feeding tube in a patient's nose) or percutaneous endoscopic gastrostomy (a feeding tube in a patient's stomach) feeds.
- Speech and language therapists were available Monday to Friday to provide support for patients who had difficulties swallowing. Patients who were identified as at risk were placed on modified diets and thickened fluids. On a weekend, swallowing assessments for new stroke patients were completed by the Brain Attack Team (BAT); all had completed swallowing assessment competencies.
- The trust had pictorial menus for the older people's menus. The system was used for patients with dementia, learning disabilities, communication difficulties, visual impairment and where written English was not understood.
- Protected meal times were in place. Assistance was offered to patients during mealtimes and safety huddles identified any patients known to require assistance.
- Patients said they were offered a choice of food and regularly offered drinks.

Patient outcomes

- The trusts Summary Hospital-level Mortality Indicator (SHMI) rates and Hospital Standardised Mortality Ratio (HSMR) rates are within the expected range. For the latest reporting period, July 2014 to June 2015 the SHMI rate was 1.006 and the HSMR rate was 96.39.
- The standardised relative risk of readmission for all non-elective admissions was higher than the England average for cardiology and stroke medicine. The risk of readmission was lower than the England average for neurology.
- The standardised relative risk of readmission for elective admission was below the England average for gastroenterology, but above the England average for cardiology and neurology.
- The average length of stay was below the England average for elective admissions, and was below or equal to the England average for non-elective admissions. Stoke medicine was an exception, the average length of stay for patients was 17.2 days, this was higher than the England average of 11.3 days. The trust was planning on implementing an early supported discharge team to reduce the length of stay for stroke medicine.
- The trust took part in the National Diabetes Inpatient Audit in 2015, and performed above the England average in 9 of the 16 scored indicators. The trust scored worse than the England average for visit by specialist diabetes team, able to take control of diabetes care and insulin errors. The trust identified it had an under-developed service for the care of diabetes patients who were admitted with conditions not directly related to their diabetes. The trust identified a range of improvements including education and training for all front line staff, developing an IT system to flag all patients with known diabetes across the trust and introducing a diabetes in-reach service for wards.

Medical care (including older people's care)

- LGI took part in the 2013/14 Heart Failure Audit. The hospital had good results overall and scored above the England average for all but three of the indicators. The trust had the highest number of patients included in the audit (697 patients). 96% of patients had an echocardiography, 71% of patients were cared for on cardiology wards and 77% had input from a consultant cardiologist. The trust wanted to further improve the services and had appointed a third heart failure nurse and a full time consultant cardiologist who specialised in heart failure.
- LGI had good results in the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audit. The audit found that 100% of patients were seen by a cardiologist or member of their team, compared to the 94% England average, 97% of patients were admitted to a cardiac unit or ward, compared to an England average of 56% and 80% of patients were referred for or had an angiography, compared to the England average of 78%.
- In the MINAP audit, the trust was in the lower quartile for delivery of primary percutaneous coronary intervention (PPCI) within 150 minutes of a call for help. This reflected the geographical distribution of patients accessing the service and the complexity of patient's treatment. The trust said work was ongoing with the ambulance service to achieve rapid patient assessment and transfer to LGI.
- The trust took part in the Sentinel Stroke National Audit programme (SSNAP). Between July and September 2015, stroke services at the trust scored an overall score of D (where A is the best and E is the worst). However, during this time the score had varied. One component, speech and language therapy remained at an E.
- Overall SSNAP data had improved from our previous inspection in 2014 when stroke services at the trust scored an overall score of E. Staff felt centralising the service at one site had helped improve the patient journey.
- The trust identified further areas for improvement including, introducing a new data collection tool that would allow for real time uploads of SSNAP data, putting together a business case for a neuro psychologist and implementing an early supported discharge team to improve patient flow and reduce patient's length of stay. A recent business case for an early supported discharge team had been turned down by the CCG's. The trust was meeting to discuss other options for providing the service.
- The trust had a SSNAP user group whose role was to streamline data collection processes to ensure high quality data was submitted. The group discussed and identified any challenges in the collection of SSNAP data, developed practical solutions to gather data whilst patients were still in hospital and aimed to keep up to date with national SSNAP updates.
- The trust took part in the national audit of inpatient falls 2015. The trust scored above average for assessment for the presence or absence of delirium, assessment for medications that increase the falls risk, measurement of lying and standing blood pressure and assessment of vision. The trust scored below the national average for the number of falls and the number of falls that cause harm. The trust had worked hard to reduce the number of falls. The service had identified steps to reduce falls by introducing daily multidisciplinary safety huddles, educating staff on the importance of footwear and increasing the use of 1:1 nursing for high-risk patients. In 2014/15 the trust saw a 32% reduction in the number of falls. The inpatient falls audit identified further areas for improvement including ensuring that all patients over 65 years identified as having continence issues had a care plan.
- The trust achieved JAG accreditation in June 2015 and was due to be reviewed in September 2016. JAG accreditation is a formal recognition that an endoscopy service has demonstrated competence against specific standards.
- All wards participated in the ward health check. Ward managers recorded and submitted data on performance and quality of care using nurse sensitive indicators including, incidents, falls, complaints, pressure ulcers, staffing vacancies, patient experience, healthcare acquired infections and staff sickness. Staff reviewed the data at head of nursing and matrons meetings and at clinical governance meetings.

Competent staff

- Staff received an annual appraisal to facilitate personal development and maintenance of skills and competence. Information submitted by the trust showed 95.6% of staff in the cardio-respiratory CSU and 92.5% of staff in centre for neurosciences CSU had completed an appraisal. This was above the trust target of 75%.

- We saw posters at the nursing station on ward 12 and 21 publicising 'appraisal season' and encouraging staff to book their appraisal with their manager.
- Staff described the appraisal process as a valuable experience and felt that their learning needs were addressed; they were also given the opportunity to attend courses to further their development. We spoke with a physiotherapist who had been supported to do a course to develop their neurological assessment and treatment skills.
- The Brain Attack Team (BAT) held monthly meetings where they identified any learning needs and organised teaching sessions from external speakers and consultants.
- Staff in the BAT had completed dysphagia training to allow them to undertake swallowing assessments. The training was carried out by the speech and language therapists. We saw evidence of a structured competency framework that included both theoretical and practical components. Once deemed competent, the competencies were not reviewed.
- New nursing staff attended a trust induction and received mandatory training. They also completed an introduction to professional practice course. Staff were assigned a preceptor and had a supernumerary period. The supernumerary period varied depending on the competency level of individual staff.
- Nursing staff told us that they had received information and support from the trust regarding Nursing and Midwifery Council (NMC) revalidation.
- Junior medical staff said access to formal and informal training was good and there were various educational forums for medical staff to attend.
- Wards provided placements for student nurses.

Multidisciplinary working

- We saw evidence of close multidisciplinary team (MDT) working on the wards we visited. Staff in the MDT included nurses, doctors, pharmacists, physiotherapist, occupational therapists, speech and language therapists and dieticians. Staff spoke positively about close MDT working.
- We observed a board round on ward 18, therapists, doctors, nurses, ward clerks and pharmacists all attended. Discussions included discharge plans and referrals to ongoing services including mental health teams and community rehabilitation.
- All wards we visited held daily safety huddles. We observed a safety huddle on ward 18. All members of the MDT attended including medical staff, domestic staff and clinical support workers. The safety huddles were used to identify any patients safety issues including, pressure ulcers, falls, high NEW's score, patients under DOL's and any patients with a hospital acquired infection. Staff spoke positively about the safety huddles and felt they had created a sense of ownership amongst staff to improve patient safety.
- Ward 21 and ward 12 had regular MDT meetings with the occupational therapist, physiotherapist, nurses, consultants and speech and language therapists to discuss patients ongoing rehabilitation needs, patient goals and discharge plans. Social workers did not attend the meetings. We saw evidence of MDT meetings documented in patient records.
- Patients on the stroke ward told us they had received input from different professionals during their hospital stay.
- Occupational therapist said they would do joint treatment sessions with speech and language therapists for patients who had communication difficulties.
- Pharmacists were accessible and visited wards daily.
- We saw evidence of referrals made to community services for patients who had ongoing rehabilitation needs.
- Staff had access to an acute psychiatric team. Staff said the team was very responsive and there was an on call psychiatrist available outside of working hours.

Seven-day services

- There was consultant cover available Monday to Friday for all specialities. Out of hours cover was provided at weekends and at night by registrars.
- A medical registrar was available at all times, 7 days a week, 24 hours a day.
- The trust had a consultant interventionist 24 hours 7 days providing the primary angioplasty service and acute revascularisation.
- The cardiac catheter laboratories was open Monday to Friday and there was an on call service provided 7 days a week, 24 hours a day. The service had plans to offer a 7 day service by summer 2016.
- The Brain Attack Team (BAT) were available at all times and provided a service 7 days a week, 24 hours a day.
- Physiotherapy, imaging services and pharmacy provision was available on an out of hour's on-call basis

seven days a week. There was no routine physiotherapy or speech and language therapy on a weekend. Occupational therapist on the stroke unit provided a 6 day service.

Access to information

- On discharge, doctors would complete an electronic discharge summary and send it to the patients GP. This would include details of hospital admission, any relevant tests and investigations and a list of medications. The patient also received a printed copy.
- Staff said if the GP needed they could contact the ward directly to get advice if they had any queries regarding on-going patient care. If a consultant was not available, they could speak to a doctor who had been involved in the patients care.
- All staff were able to access blood test results and diagnostic imaging using electronic systems.
- Staff used the trust intranet to access trust policies and guidelines.
- The trust used an electronic bed management system that shared patient's length of stay and estimated date of discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent audits were included in the CSU's annual audit plan. We reviewed the consent audit completed by cardiology in January 2016 and found all forms included the name, signature, and date and job title of the healthcare professional obtaining consent. All consent forms had evidence that the risks and benefits were discussed with the patient and were signed by the patient however, 70% of consent forms patients did not print their name. Recommendations from the audit included ensuring patient's names are printed but there was no timed action plan included with the audit.
- Mental Capacity Act (MCA) Level 1 and Level 2 was included in the trust's mandatory training programme. Within the cardio-respiratory CSU, 94.3% of staff had completed Level 1 training and 67.5% of staff had completed Level 2, this was below the trust target of 80%. Within the centre of neurosciences CSU, 95.4% of staff had completed Level 1 training and 70.1% of staff had completed Level 2, this was below the trust target of 80%.
- Staff we spoke with had an understanding of DOLS and MCA. Staff were able to tell us the number of patients who had a DOLS in place on the ward and the reasoning for the DOLS. If there was a delay in the DOLS authorisation process staff said they would monitor the patients and the restrictions daily as an MDT, restrictions would be reduced if it was deemed safe and any restrictions amounting to DOLS would be made in the patient's best interest. This was in line with the trusts standard operating procedure.
- We reviewed a DOLS application and saw the document had been completed correctly.
- Staff were able to access a mental health liaison nurse if they had concerns about the mental health of patients. If a patient required a mental health assessment and a section they had access to psychiatrists from the local mental health trust.

Are medical care services responsive?

Good

We rated the service as good for responsive because:

- The service took the needs of people into consideration when planning and delivering services.
- The service consistently met the referral to treatment targets for patients on an incomplete pathway.
- Average length of stay was better than the national average for the majority of elective and non-elective patients.
- People using the service could raise concerns and complaints were investigated and responded to in a timely manner.

However:

- Stroke medicine had challenges around patient flow. The average length of stay for stroke patients was worse than the England average.

Service planning and delivery to meet the needs of local people

- The trust worked closely with local clinical commissioning groups (CCG's), stakeholders, patients and staff to plan and deliver services to meet the needs of local people.
- The trust had worked closely with staff to implement 7 day working in the cardiac catheter laboratories. The trust held three engagement meetings in March, April and May 2015 to provide all staff with an opportunity to

share their views and develop a strategic plan to provide a 7 day service. The service had moved to a 6 day service and was on track to deliver a 7 day service by summer 2016.
- The centre for neurosciences were in discussion to provide an early supported discharge team for stroke patients locally business case submitted to the CCG's had been turned down.

Access and flow

- There are national indicators in the NHS of 18 weeks from referral from general practitioner to treatment time. In February 2016 all but one of the medical specialties was performing at 90% or above for the 18 week national indicator.
- Between September 2014 and August 2015 there were 73,896 medical admissions to the Leeds Teaching Hospitals NHS Trust, approximately 20,500 of these admissions were to LGI. Of these admissions, 37% were emergency admissions, 13% were elective admissions and 50% were day cases.
- Emergency/ non-elective patients were admitted via accident and emergency. Any patients who had a suspected stroke were assessed in accident and emergency by the brain attack team and transferred to the HASU if identified as appropriate.
- Between February 2015 and January 2016. The trust reported on average 72% of patients were not moved during their inpatient stay. 16% of patients were moved once, 9% were moved on two occasions, 2% were moved on three occasions and 2% were moved on four or more occasions.
- We reviewed the number of patients who moved wards after 10pm. In November 2015 70 patients were moved, in December 2015 111 patients were moved and in January 2016 103 patients were moved after 10pm. Over the three months ward 19 (cardiology admissions ward) had the highest number of patients moved after 10pm, 167 patients were moved.
- The trust reported no mixed sex breaches.
- The average length of stay for patients at LGI was shorter (better) than the England average for elective medical patients. For non-elective patients the length of stay was below the England average for cardiology and neurology but significantly above the England average for stroke medicine, 17.2 days compared with 11.3 days.
- Staff within stroke medicine said the length of stay was above the England average because of the challenges around discharging stroke patients. Acute stroke patients who required further rehabilitation as an inpatient were transferred to ward 12 if they were over 65 years or to Chapel Allerton Hospital if they were under 65. Staff said there was a lack of rehabilitation beds in the trust. The service also did not have an early supported discharge team. Staff had raised this with the trust and a business case for an early supported discharge team had recently been turned down by the CCGs. The trust was meeting to discuss other options for providing the service. Staff said other challenges around discharging patients including delays in the provision of care packages and care homes.
- We reviewed patient's length of stay on ward 21. The longest length of stay was 238 days, followed by 75 days and 59 days. Staff said two of these patients were awaiting a rehabilitation bed at Chapel Allerton Hospital and one was waiting repatriation. We reviewed patients' length of stay on ward 12. The length of stay ranged from 10 to 210 days.
- All patients waiting for a rehabilitation bed, package of care or care home were placed on a delayed transfer of care form and discussed at the DOP meeting. Patients continued to get therapy input while they were awaiting transfer to a rehabilitation bed. In March 2016 the centre for neurosciences CSU reported 14 delayed transfers of care. In April this had reduced to 10. The length of stay for stroke patients and delays in discharge due to a lack of social care provision, and early supported discharge team were identified on the CSU risk register.
- The service had stroke patient outlying on other wards. Staff completed a risk assessment and identified at the daily safety huddle patients who were appropriate to be outliers on other wards. Patients would be kept on wards within the centre for neurosciences CSU. The ward kept a list of outliers and had 14 outliers at the time of our inspection. Patients who were outliers were reviewed as part of the daily ward round. We reviewed the medical notes of three outliers and found they all had daily medical reviews and ongoing therapy. Data provided by the trust showed in March 2016 there were 64 medical outliers and in April 2016 there were 52 medical outliers.
- Transient ischemic attack (TIA) clinics were available for high and low risk patients. High risk TIA patients were seen the same or next day, 80% of patients were seen within 24 hours. Low risk patients were seen within 7 days.

- Wards had discharge coordinators to support discharge planning. Staff were proactive in commencing discharge planning and used daily board huddles to discuss patient discharges.

Meeting people's individual needs

- Interpreting services were available for patients whose first language was not English. Staff explained the process of booking an interpreter to us. Interpreters were available via the telephone or could attend the ward. Wards displayed posters informing about interpreting services.
- The trust used the 'Forget Me Not' symbols to identify patients with dementia. A nursing specialist assessments was undertaken when patients with dementia were admitted into hospital, this triggered the completion of 'Know Who I Am' documents. This enabled staff to see the person as an individual and deliver person centred care that was specifically tailored to the person's needs.
- The trust supported John's Campaign, a campaign that was developed in order to allow families and carers to stay on the ward with patients with conditions such as dementia.
- There was a specialist nurse for learning disabilities. Staff described using a 'get me better!' hospital passport, which detailed personal preferences, likes/dislikes, anxiety triggers and interventions.
- We saw a system of magnets in use on boards and by beds, to identify patients living with dementia (forget me not symbol), learning disability (get me better logo) or who were deaf or hearing impaired and patients who had other specific needs, such as falls risk or pressure sores.
- Dementia friendly signage was used to identify the toilets and showers on wards 21 and 12.
- Ward 21 was a stroke rehabilitation ward. Individual communication books were used for stroke patients with communication difficulties. The communication books were developed jointly with families and speech and language therapist. We reviewed a communication book and it identified patient's likes and dislikes and some key phrases.
- Staff explained that they could easily access bariatric equipment, and equipment arrived on the ward within an hour. This included access to special beds, wheelchairs, chairs and hoists. Staff also got support from the moving and handling team.
- Ward 12 had care planning meetings with patients and their families. The meetings discussed stroke patients' progress, goals and discharge plans. We saw evidence of this documented in patient records. Nurses and therapists would attend the meeting.
- Five patients said they felt well informed and involved with discharge plans, they reported that all their preferences had been taken into account and they had been involved in decision making.
- Information leaflets were available to patients and relatives. Staff said they could access leaflets in other languages.
- The trust worked with the Pets as Therapy charity and a therapy dog attended the neurology ward every fortnight, Patients who were well enough would see the dog in the day room.

Learning from complaints and concerns

- Each ward recorded and submitted the number of complaints to the CSU ward health check. In January 2016, no formal complaints were made in the service.
- We reviewed complaint data provided by the trust. Between March 2015 and February 2016 the service received 12 complaints. No common themes were identified. Examples of complaints included, care and communication, communication around hospital discharge and treatment offered and communication with families.
- We saw complaints posters and leaflets available on all wards we visited and 'speak to sister' and 'are you concerned about the number of nurses looking after you?' posters encouraging patients and visitors to raise any concerns or questions.
- The trust had an easy read leaflet on the subject of complaints and complaint leaflets available upon request in the top 10 languages spoken in Leeds.
- Staff were able to describe how they would deal with a complaint, and understood the role of the Patient Advice and Liaison Service (PALS) and formal complaints process.
- We reviewed four complaints letters sent to relatives and found an apology was offered when care fell below the expected standard; the trust was responsive to concerns raised and staff offered to meet with the families concerned.

Medical care (including older people's care)

- The service held fortnightly reviews of all complaints with the patient relations team and key CSU members. Sharing of lessons learnt from complaints was through CSU governance meetings, new letters and individual ward meetings.

Are medical care services well-led?

Good

We rated well-led as good because:

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

- Each CSU held monthly clinical governance meetings. We reviewed minutes from meetings and saw discussions about patient care and safety, complaints, clinical effectiveness and outcomes, a review of RCA's and incidents and any learning to be shared. Any lessons learnt were disseminated to staff via ward managers and CSU newsletters.
- The service had governance processes and systems in place to ensure performance, quality and risk was monitored. Each CSU met weekly and used the ward health check to audit a range of quality indicators including the number of falls, complaints, pressure ulcers, staffing vacancies and staff sickness. This information was reviewed at head of nursing and matrons meetings and at clinical governance meetings.
- Trust wide and CSU risk registers were in place and were regularly reviewed and updated. Risk registers were reviewed quarterly at clinical governance meetings and twice a year by the Trust Board. If any risks were identified outside of the meeting, they were added to the risk register.
- We reviewed the CSUs' risk registers. Risks were categorised using a risk matrix based on the likelihood of the risk occurring and the severity of impact. All risks entered were given a current risk rating. Key controls were put in place to reduce the risk and assurances to assess if the controls were effective.
- The longest standing risk on the centre for neurosciences risk register was from April 2012 and was last reviewed in January 2016. The risk related to issues relating to activity and coding, medical staffing and clinical physiology staffing within neurophysiology and was given a risk score of 9. Controls put in place to mitigate the risk included a coding and counting review, locum and agency consultant in post and the establishment of 4 WTE consultant posts.
- Every three months, each CSU attended the trust risk management meeting chaired by the Chief Executive to discuss the CSU risk register.

Leadership of service

- At ward level staff told us they felt well supported by their ward managers and senior staff. All staff described an open door policy and said ward managers were approachable. Staff spoke positively about the local leadership on ward 21 and said there had been a change in the culture on the ward.

- All ward managers were enthusiastic, and told us they were well supported by their matrons who gave support with day to day operations, including nurse staffing.
- Ward managers all reported that matrons had a 'hands on' approach, were proactive and visited the wards daily. Staff described matrons as approachable and supportive.
- Staff spoke positively about the Chief Executive and senior leadership team and the changes they had made in the organisation. Staff said they did regular walk arounds in clinical area and spoke with staff.
- We saw that the trust had a whistleblowing policy that provided guidance on how to raise concerns. Staff said they know how to raise concerns.
- The ward health check was used on all wards to audit a range of quality indicators. Any wards that were rated red for three consecutive months were placed in escalation and got support from the corporate nursing team. Staff spoke positively about the team and said they supported staff to make changes and drive improvements.

Culture within the service

- Staff told us they felt proud and enjoyed working for the trust. Staff felt part of the team they worked in.
- Staff felt confident to raise any concerns about patient safety and that managers would listen and would take appropriate action. We saw posters displayed on wards providing information about how to speak to the sister or matron if people had concerns.
- Staff gave positive feedback regarding the culture in the organisation and described the trust as a good place to work. They felt the culture encouraged staff to be open and honest and to report incidents and learn from them.
- Staff felt that the senior leadership team had brought about a change in the culture within the organisation.
- The trust and individual CSU held annual award nights to recognise and celebrate staff success.

Public engagement and staff engagement

- Friends and family test results were displayed. On ward 17, 96.9% of people would recommend the service, on ward 18, 98.1% of people would recommend the service and on ward 19, 90.7% of people would recommend he service.
- Staff felt engaged to participate in the ward health check which audited a range of care quality indicators including patient falls, complaints and pressure ulcers. Wards were awarded certificates in recognition of a reduction in the number of falls and pressure ulcers.
- The trust held Schwartz rounds. This was a forum for hospital staff from all backgrounds to come together to talk about the challenges of caring for patients. It offered staff a confidential and safe environment to share patient care issues and to offer support to each other.
- Staff meetings took place regularly on wards. Information was shared with staff via an e-bulletin. Staff felt well informed and up to date with issues within the trust.

Innovation, improvement and sustainability

- Patient safety huddles had been introduced to reduce patient harm and enhance a patient safety culture. The safety huddles enabled staff to share any learning from incidents.
- The cardio-respiratory CSU had made changes to medical staffing rotas, establishing three separate cardiology rotas (general cardiology, ischaemic heart disease and rhythm management). This allowed patients to be under the care of an appropriate specialist for their condition.
- The service had implemented 6 day working in the catheter lab and had plans to move to a 7 day service.
- The service had implemented a physiologist led implantable cardiac monitoring service. The service used a minimally invasive technique and an injectable device in an outpatient setting rather than catheter lab setting. This had improved catheter lab capacity and patient experience.

Surgery

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

Information about the service

The Leeds Leaching Hospitals NHS Trust provides surgical care across four sites. Elective and non-elective surgical services at Leeds General Infirmary (LGI) are managed by three clinical service units (CSU's). They provide a range of services including, major trauma, general trauma, vascular surgery, plastic surgery, neurosurgery, ear, nose and throat, maxillofacial and ophthalmology.

The LGI has 281 inpatient beds and 25 day-case beds spread over 11 surgical wards. There are 19 operating theatres within three theatre suites. The trust has one of the highest numbers of admissions in the country. Between September 2014 and August 2015 there were 63,358 surgical admissions to Leeds Teaching Hospitals NHS Trust. Approximately 32% of these were admitted to LGI. Of these, 38% were day case admissions, 24% were elective admission and 38% were emergency admissions.

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

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

We spoke with 42 staff of various grades including doctors, nurses, support workers, therapy staff, operating department practitioners (OPD's), administration and domestic staff and management. We reviewed 24 sets of patient records, 13 medication charts and spoke with eight patients.

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

Surgery

Summary of findings

We rated surgical services as requires improvement because:

- Two Never Events related to a wrong site anaesthetic block and guidance on this had not been fully adhered to.
- Within Jubilee theatres we found some infection prevention and control practice issues.
- Supporting documentation for Mental Capacity Assessments could not be provided.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- We found from audit data and our observations that not all aspects of the World Health Organisation (WHO) safety checklist took place.
- The audit data provided by the trust did not assure us that national early warning score (NEWS) and escalation was always done correctly.
- Readmission rates for elective and non-elective admissions were higher than the England average.
- Only two specialities were performing above 90% for the 18 week national indicator.

However:

- We saw evidence of the individual needs of patients being met. This included patients with a learning difficulty or living with dementia.
- Service planning was patient focused and collaborative working was in place with other organisations and trusts.
- Projects such as the productive operating theatre were in place to provide data on performance and improve teamwork.
- The trust had a strategy which was patient focused and there was evidence of innovative work to develop services.
- We saw positive leadership at all levels with staff feeling able to escalate concerns and describing a positive change in culture.
- A range of information was collated monthly into dashboards which fed into good governance arrangements.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- We were concerned that the learning from the Never Events was not embedded. The 'stop before you block' guidance was not always adhered to.
- There were aspects of the environment within Jubilee theatres which highlighted infection prevention and safety issues. In particular theatre shoes had not been cleaned and equipment that did not have in date safety testing.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic. Patient copies of consent forms were not always given.
- Despite ongoing work streams, audit data showed that national early warning score (NEWS) and escalation was not always done correctly.
- We were not assured that compliance with all aspects of the World Health Organisation (WHO) safety checklist were consistently taking place.
- There were staffing vacancies and fill rates for nursing staff in theatres and anaesthetics were between 38% and 55% from February 2016 to April 2016. For the surgical wards fill rates for qualified nursing staff were between 77% and 99% from October 2015 to January 2016.

However:

- A number of audits relating to patient safety were carried out and the results were publically available.
- We saw evidence of good medicines management and checking of controlled drugs.
- Emergency equipment was checked daily.

Incidents

- Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Between October 2014 and September 2015 there had been three Never Events within surgery at the trust. None were attributable to the LGI site. Two occurred at the St. James's University Hospital (SJUH) site, one related to a retained swab following surgery and one related to a wrong site anaesthetic block. A second incident of wrong site anaesthetic block occurred within six months at Chapel Allerton Hospital. We reviewed the investigation reports and related action plans for the three Never Events.
- Staff were able to articulate changes in practice in relation to swab counts and using swab boards to record the number of swabs used. This was one of the immediate actions taken in response to the Never Event.
- We reviewed the investigations related to wrong site surgical block. We were concerned that both had identified the 'stop before you block' procedure was not adhered to. The 'stop before you block' patient safety initiative was launched in 2010. It stated what steps should be taken in addition to the World Health Organisation (WHO) safety checklist when a nerve block is being administered. These are, that prior to the insertion of the needle, the surgical site marking is visualised and the consent form is checked. If the patient is awake they can also be asked to confirm which side is being operated on.
- We observed two operations in which nerve block were being administered. 'Stop before you block' information was displayed. During one procedure the check was prompted by a nurse, but was felt to be just in time. We observed a second patient having an anaesthetic block to their shoulder and the necessary safety checks were completed. The stop before you block stage happened but this was again led by the theatre nurse. The guidance states the check should be instigated by a member of the anaesthetic team.
- We asked for further assurance from the senior management team regarding the use of nerve blocks. We were told additional prompt sheets had been placed in theatre and human factors' training was underway. Human factors are the way individual characteristics combined with the work environment and organisation can influence behaviour and affect health and safety.

- We also reviewed audit data from February 2016 to March 2016 where covert observation of 'stop before you block' took place in three theatre suites. Overall compliance was 80%. Recommendations were made to re-audit and consider formal changes to policy as it was identified compliance should be 100%.
- Most staff were aware of the Never Events and managers spoke about them in detail and the learning that had been cascaded.
- Serious incidents are incidents that require further investigation and reporting. Between March 2015 and February 2016 there were nine serious incidents attributable to LGI. Three related to falls and three related to pressure ulcers. The remainder related to an intra-operative incident, infection and treatment. Root cause analysis was undertaken for each of these incidents. Staff were able to articulate changes in practice as a result of learning from serious incidents. For example, clarification of terminology related to mental health disorders. Care plans had also been developed to detect subtle changes in patient's conditions to alert staff their mental health may be deteriorating.
- Incidents were monitored through the trust's CSU governance meetings and we reviewed minutes of these. Information on incidents was shared in a variety of ways. This included a trust wide safety brief which was circulated via email to all trust staff and discussion at senior nurse and team meetings.
- A total of 2,349 incidents had been reported in surgery at this site between March 2015 and February 2016. 75% of these resulted in no harm. Incidents were reviewed by ward managers but also seen by the matrons. Themes of incidents were pressure ulcers and falls. Staff told us about two recent grade two pressure ulcers. The root cause analysis investigation was shared with the team with a focus on documentation.
- With the help of an external agency, quality improvement work was in progress. Part of the work was focused on reducing falls. Audit data showed there had been a significant reduction in the number of patient falls on the orthopaedic wards. In April 2015 there had been 20 falls, from January 2016 to March 2016 there had been none. Despite this patient falls had remained on the trauma and related services risk register since 2014 with a review done in February 2016.
- Discussions with staff highlighted how the twice daily safety huddles had helped with falls reduction. Patients at risk of falls were highlighted and management plans discussed.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014. Staff could explain the duty of candour and spoke about being open and honest.
- The investigation reports we reviewed evidenced the duty of candour requirements being met. For example an apology and reassurance was given to the patient following the wrong site anaesthetic block Never Event.
- We saw evidence of mortality and morbidity reviews by each surgical speciality and we looked at meeting minutes and presentations. Each displayed evidence of discussion and lessons learned.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thromboembolism (blood clots), and catheters and urinary tract infections (UTIs). The data is collected monthly.
- This data was seen displayed in ward areas. The percentage of 'harm free care' for the surgical wards at LGI from January 2016 to May 2016 was between 84% and 100%.
- Between March 2015 and February 2016 there were 68 pressure ulcers, ten falls with harm and eight catheter urinary tract infections recorded by surgical services at LGI.
- The trust was one of 20 hospitals participating in a pilot scheme called 'open and honest care'. The information gathered was available on the trust's website for the public to view and was updated each month. It included data on pressure ulcers, falls, Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile rates. Patient and staff experience surveys and safety thermometer data was also shared.
- Data was collected by each ward and displayed within the ward health check dashboards by each CSU. This information was red, amber and green (RAG) rated to

show areas of improvement and decline. For example, ward L15 had recently won an award for the best improved ward with 105 days without a hospital acquired pressure ulcer and achieving 100% harm free care.
- VTE (blood clots) risk assessments were carried out within the trust. Data showed that from February 2015 to February 2016 each of the surgical CSUs at LGI had achieved above the trust target of 95% for completing these.

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed in clinical areas. The previous report had identified Clostridium difficile rates were higher than expected for the trust. During 2015/2016 110 cases were reported against a trajectory of 119, indicating an improving picture.
- There had been seven cases of MRSA within the trust during 2015/2016, and one case since April 2016. This was above the trajectory of zero.
- Information specific to each CSU was collated in performance dashboards. This included MRSA and Clostridium difficile rates. For example within the centre for neurosciences CSU there had been no reported cases of MRSA between February 2015 and February 2016. However there had been 14 cases of Clostridium difficile.
- Various audits were undertaken in relation to infection prevention and control. This included hand hygiene audits, ward health check data and high impact interventions, such as central line insertion and urinary catheter insertion. High impact interventions are care bundles designed to ensure high quality patient care by means of continuous audit and review.
- We reviewed data in relation to each of these areas for each CSU, which was red, amber and green (RAG) rated to indicate the level of compliance. For example in the trauma and related services CSU hand hygiene compliance was between 66% and 88% between July 2015 and February 2016.
- Infection prevention and control training was mandatory and compliance rates within surgery at LGI were above the trust target of 80%.
- The trust had a policy for MRSA screening for emergency patients. Elective patients were screened at pre assessment. We reviewed compliance rates with screening and noted they were generally above the trust target of 95%.
- Single rooms were available for those patients requiring isolation; signage was in place to advise anyone prior to entering an isolation room. On ward L24 we observed two patients in side rooms who required isolation, however the doors were open. We asked staff about this and were told it was so the patients could be observed.
- In ward areas we observed visitors being prompted to wash hands and alcohol gel and hand wash basins were available at the entrance to wards and departments.
- Bare below the elbows guidance was adhered to by staff in the clinical areas we inspected. We observed good hand hygiene and appropriate use of personal protective equipment (PPE).
- We found ward areas to be visibly clean and generally free from clutter, although some wards, for example L22 did highlight a lack of storage for equipment.
- We observed separation of clinical and non-clinical waste in line with trust policy in ward areas.
- Within the Jubilee theatre suite we observed a broken alcohol dispenser. This was reported to a member of staff. We observed a fridge in the recovery area with what appeared to be blood stained fluid in the bottom. We discussed this with staff who reported the fridge not used, however it was plugged in and temperatures were being recorded.
- In the changing rooms in Jubilee theatres, we observed blood stained clogs in a storage bin and on the floor which were to be used again. We also observed staff walking around theatres in heavily stained clogs. This was raised with the infection prevention and control lead who said it was staff member's individual responsibility to ensure their clogs were clean. From our observations on both the announced and unannounced inspections we were not assured this process was working.
- Surgical site infection surveillance was carried out across Leeds Teaching Hospitals. Each quarter a different speciality was selected. Specific to LGI, surveillance of spinal surgery was audited between April 2015 and June 2015. It was identified that the number of spinal infections was higher than national 90th percentile. We reviewed the action plan in response to this. This included actions such as reviewing skin

preparation with involvement from the microbiology team. A review of patient's records had found mixed documentation with regard the second dose of antibiotics four hours after surgery. A new process was being reviewed for sharing throughout the CSU. Audit meetings were to be used to review any findings.

Environment and equipment

- Within Jubilee theatres a number of cracked electrical sockets were seen, this was reported to the trust at the time of inspection.
- We inspected equipment for evidence of safety testing. Within Jubilee theatres we saw various pieces of equipment with out of date PAT. This included an intravenous contrast perfuser and an operating microscope which had a review date of December 2014.
- In the hands and plastics day unit theatres we found a compact disc player in recovery with a date of 2012, a fan dated January 2014 and a fridge dated 2011. This was raised with the trust at the time of inspection and we were told it would be looked at.
- We were told there was a rolling programme of equipment replacement. However, neurosurgical theatre equipment was on the departmental risk register as a range of equipment had been identified as needed to ensure the continuity of the service. The risk register noted a failure of equipment; this was being managed by a daily review by the neurosurgical bed management team. Incident data from March 2015 to February 2016 showed two incidents relating to equipment failure in theatre. We did not have information as to what level of harm, if any, occurred.
- At the previous inspection concerns had been raised over the quality of the outsourced central sterile services department. A new provider was now being used and staff reported an improved service. We spoke with staff who worked in different theatres and no concerns were raised. Sterilisation of equipment took place off site and was returned the following day.
- Wards reported having sufficient equipment to meet the needs of their patients, for example moving and handling equipment. Bariatric equipment was available from the equipment pool.
- Resuscitation trolleys were easily located on main corridors in ward areas. Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). We inspected resuscitation equipment in four of the wards and were assured that daily checks had been undertaken. It was noted that none of the trolleys had tamper proof seals. This meant the contents of the trolleys were easily accessible so staff could not be assured that equipment was still in situ following checks being completed.
- The resuscitation trolleys in theatre also did not have tamper proof seals; however we saw documented evidence of daily checks being completed. With the exception of one day in April 2016, the difficult intubation trolley had evidence of daily checks being completed.

Medicines

- Medicines administration and safety training was included in the trust's mandatory training. Compliance rates for surgery were above the trust target of 80%.
- We reviewed 13 medication record charts and found them fully completed with any omissions recorded with the reasons why.
- Audits relating to the use and prescribing of antibiotics within each clinical service unit (CSU) were undertaken on a monthly basis. The results were generally positive, with areas such as reason for prescribing and duration being audited. We saw stickers in use to remind staff to review antibiotics on day three of them being prescribed. There were also prompts on the prescription charts.
- Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed the controlled drugs records on surgical wards and in theatres. Accurate records and checks were completed in line with trust policy. Three monthly controlled drug checks were also done by the pharmacy department.
- We observed fridges for storing medications and found these to be locked and temperatures recorded daily.

Records

- We reviewed 24 sets of records across the surgical wards and theatre. We found them to be completed appropriately and each contained completed risk assessments on topics such as skin integrity and falls. We also saw the use of stickers, for example to highlight when a nasogastric tube had been inserted.
- The exception to this was in relation to mental capacity assessments. We reviewed four sets of notes where mental capacity required assessment. Whilst we were assured by staff and other documentation that the

appropriate assessments had been undertaken the actual assessment form could not be located. We asked senior nursing staff who were unclear as to where the form would be kept and could also not locate the form within the patient's medical records.

- We were told mental capacity assessments were undertaken by occupational therapy staff. However training was being put in place to enable band six and seven nurses to complete them.
- We saw completed deprivation of liberty safeguards (DoLs) in four patient records. They had been fully completed and included a family communication care plan.
- Within several of the patient records we saw patients had been consented on the day of their operation and patient copies of consent forms were still attached.
- We reviewed audit data provided by the trust on consent from October 2015 to December 2015 looking at 30 patients across three surgical specialities. It showed that two out of 30 patients were consented in advance of their procedure.
- The General Medical Council (GMC) guidance on consent: Patients and doctors making decisions together, states: "Give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks".
- Consent was discussed with the senior management team. They felt assured that the discussions which took place for elective patients at pre-assessment clinics provided them with sufficient information about their surgery. This was supported by a follow up letter explaining the procedure and associated risks. We were told there was no opportunity to provide a consultant at pre assessment to enable patients to sign their consent form. The trust felt assured that patients were adequately informed prior to surgery. However the trust consent policy of a two stage consent process was not consistently followed.
- We also discussed our observation regarding patients not being given copies of their consent form. The management team agreed this was something to be reviewed.
- On ward L15 there was a doctor's office located on a main corridor. This room was unattended and not locked, medical records were on the desk and accessible to anyone passing.
- Medical and nursing records were found to be stored securely in other clinical areas.

Safeguarding

- Staff received mandatory training in safeguarding of vulnerable adults and children. All staff completed Level 1 safeguarding for adults and children. Adult Level 2 safeguarding training was completed by band six and seven staff. Training was recorded per CSU and was RAG rated with green being above 80%.
- Training for the surgical CSUs at LGI (with the exception of the theatres and anaesthesia and head, neck and ophthalmology, which was cross site) showed compliance rates for adults and children's safeguarding Level 1 were between 92% and 96%. Level 2 training for both adults and children was variable with figures between 40% and 100%. It should be noted these figures were for a small number of staff; on a ward it may have only been three staff members who required such training which would account for the broad variances in compliance.
- Trust protocols and guidance on safeguarding were easily accessible and staff could describe what signs to look for and how they would escalate any safeguarding concerns. On ward L24 we saw an information board for safeguarding with contact details and copies of safeguarding forms.
- There was a safeguarding team who were available for advice.

Mandatory training

- Mandatory training incorporated 23 elements including information governance, dignity at work and equality and diversity. Staff said they liked the training interface as they knew if they were up to date with training.
- Mandatory training was highlighted as an area for improvement at the previous inspection. At this inspection, we noted significant improvements with most areas achieving above 90% compliance.
- Resuscitation training was the exception to this with the CSU at LGI rated red as figures were below 70%. We were told it was difficult to release staff as the training for this took a long time. We were also told the training was provided by the hospital resuscitation team and the volume of people needing training was a challenge.
- Ward managers had oversight of training in their area and received a spreadsheet each month showing RAG rated compliance rates.

- In theatres they had a half day for audit each month so this time was used to complete mandatory training.
- During the inspection, staff were undergoing their annual appraisal. Positive feedback was given from staff on the appraisal process. This was an area of concern highlighted at the previous inspection. Appraisal rates were between 93% and 98% at LGI against a target of 95%. We saw evidence of appraisal meetings being booked for those members of staff yet to have one completed.
- We were told about various additional training available for staff such as a vascular study day and training on acute kidney injury. Care Support workers told us they were being trained in areas such as tissue viability.

Assessing and responding to patient risk

- The national early warning score system (NEWS) was used in each ward area as a tool for identifying deteriorating patients. The documentation we reviewed across all ward areas showed accurate completion of NEWS scores and we saw evidence of raised NEWS scores being escalated appropriately.
- In June 2015 the deteriorating patient intervention bundle was launched following collaborative working with 16 wards utilising the 'Model for Improvement' as a framework for testing new interventions. Following testing of these interventions and making changes in their areas the 'Deteriorating Patient Intervention Bundle' was launched in June 2015. This focused on patients with a serious infection (sepsis) and acute kidney injury. Part of the work with an external agency also focused on reducing the number of avoidable cardiac arrest calls by 70% on the pilot wards. This looked at things such as ensuring correct calculation and escalation of NEWS scores and timely identification of patients approaching end of life care.
- We reviewed audit data on deteriorating patients from April 2015 to February 2016 which looked at eight aspects including a minimum of twice daily observations and correct scoring of NEWS. The data was collated per CSU. Within the centre for neurosciences and trauma and related services CSUs, there were some areas RAG rated amber and red. These related to correct NEWS scoring, 24 hour cumulative fluid balance completed and referrals for 'at risk' patients. The data showed an improvement in December 2015; however in January and February 2016, the percentages dropped (worsened). For example, in neurosciences the percentage of referrals for 'at risk' patients in December was 90%. In January this had dropped to 67%. This meant that not all patients who were deteriorating were referred to the medical team as per hospital policy.
- We discussed deteriorating patients with the senior management team who felt NEWS scoring had improved and the deteriorating adult collaborative was having a positive impact. We were told patients with elevated NEWS were discussed at ward safety huddles and during handover. This was observed by the inspection team.
- We also observed falls prevention being discussed at safety huddles and after a 'board round' had taken place. High risk patients were identified and actions such as cohorting of patients, the use of yellow wristbands and one to one supervision were in place to reduce the risk.
- We also observed boards above patient's beds which identified any individual risk factors.
- A governance presentation by the trauma and related services CSU in January 2016 highlighted safety actions specific to ward L37 which was an orthopaedic trauma ward. This included NEWS escalation stickers, early recognition and escalation and utilisation of the outreach team.
- We also saw the use of the sepsis bundle in patient records. The sepsis bundle is a group of medical interventions to treat patients with a serious infection.
- There was a critical care outreach team who would come and support ward staff if a patient was deteriorating. Since the last inspection the team had increased its provision to provide a 24 hours, seven day service.
- The hospital followed the five steps to safer surgery procedures and WHO safety checklist. We reviewed audit data relating to this which was collected per speciality and per theatre suite. Audits were done monthly and reviewed ten patient records.
- Data from February 2015 to February 2016 showed compliance to be 79.8%-100% for pre brief, 42.5%-100% for post-brief, 98.8%-100% for sign in, 98.2%-100% for time out and 86.4%-100% for sign out.
- Data specific to the specialities at LGI showed compliance rates between 85% and 100% for four out of the five steps to safer surgery. The exception was the post-brief which was completed in 51% to 78% of cases.

- A focused audit took place in plastic surgery between March 2016 and April 2016 looking at ten patients. This found overall good adherence to the checklist but that the surgical team did not attend the de-brief (post brief).
- These findings were further supported by our observations. We observed aspects of six WHO checklists in the Jubilee and hand theatres. We observed team briefs which discussed the operating list. There was clear and appropriate discussion including order of the list, equipment and potential challenges. We observed the 'time out' being completed. We found in each case the post-brief did not take place. We asked staff about this and were told it would be completed if there had been any problems during the list.

Nursing staffing

- The service used staffing acuity tools, including the safer nursing care tool, to review staffing establishments based on patient dependency. Professional judgement also formed an important part of this process. This review took place every six months.
- From the previous inspection nurse staffing levels had improved overall however they remained on the risk registers. In trauma and related services some gaps had been addressed by employing band four staff who took on some of the responsibilities of registered nurses, for example dressing wounds.
- The use of an external agency to support patients who required one to one supervision had also helped with staffing.
- There was a clear escalation process for staffing concerns and staffing was discussed at daily operational performance (DOP) meetings. NHS professionals were used to fill any gaps in staffing as well as redeployment of staff from other areas.
- Most areas we visited had some vacancies, for example ward L15 told us they had agency staff on each shift due to 6.5 whole time equivalent (WTE) vacancies. However, seven new staff were expected in September when student nurses completed their training.
- Data on overall bank and agency fill rates for surgery at LGI from February 2016 to April 2016 was reviewed. They were between 90% and 93% for registered staff and 94% and 95% for unregistered staff.
- We reviewed data relating to staffing fill rates for individual surgical wards at LGI from October 2015 to January 2016. Fill rates for qualified staff were between 77% and 99%, for unregistered staff they ranged from 91% to 171%.
- This data showed where there were gaps with unregistered staff; they were filled with unregistered staff.
- Staffing was co-ordinated by matrons during the day and nurse practitioners at night. We were told staffing was flexible to meet the changing needs of the wards and their patients. Electronic rostering was in use which enabled staff to easily view staffing in other areas. If a ward/department was short of staff or needed some help for a period of increased activity, staff could see if other wards could support them without needing to escalate to a matron. In a focus group we were told by health care support workers they could be moved regularly to support other areas but staff had no issues with this.
- We observed actual staffing levels below the planned levels on wards L24 and L25 on our announced and unannounced inspection. We spoke with staff on both wards who were concerned over the acuity of the patients in relation to the number of nurses on duty. Appropriate escalation had taken place and discussions with senior management demonstrated they had oversight of the situation and further plans to be put in place if the situation continued.
- Ward L24 and L25 were on the neurosciences risk register in relation to staffing for patients with tracheostomies. Staff told us they had a maximum of four patients with tracheostomies but due to reduced staffing numbers this was being reviewed. The assurances around this were reviewed in June 2016; however the risk had been on the register since September 2013.
- Within theatres and anaesthetics there were 63.7 WTE vacancies, this data was for both SJUH and LGI. Data on fill rates for registered staff in theatre from February 2016 to April 2016 was 38%, 90% and 55% respectively.
- Theatres managers reported recruitment and retention was difficult with trying to cover two physically separate sites with reduced staff numbers since adult and paediatric theatres had been separated. There were

recovery staff who were trained to care for Level three patients. A Level three patient is someone who requires advanced respiratory support or a minimum of two organ support.
- We spoke with staff that were new to the trust who reported a good induction programme and that they were encouraged to undertake learning and development.
- Student nurses spoke positively about their mentors and the experience gained on placement.
- We observed nursing handover on the wards and safety briefings in theatre. Informal handovers took place as required throughout the day.
- The nursing handovers were well structured with plans for each patient identified. The reason for admission and medical history was given.

Surgical staffing

- The percentage of middle grade doctor for the trust was below the England average; 1% compared to 11%. The percentage of junior doctors was slightly below the England average 10% compared to 12%.
- However the consultant and registrar group was higher. We discussed gaps in the middle grade rota with the senior management team as it had been highlighted as a concern from discussions with staff. We were assured gaps were covered using locums and some internal cover from consultants.
- We reviewed medical staffing and spoke with consultants, middle grade and junior doctors. Medical cover was available on-site 24 hours a day. Consultants were available 24 hours and were on site between 8am and 6pm. On-call cover was provided at evenings and weekends.
- The on call consultants were supported by on site registrars and foundation level doctors supported the wards. Medical staffing had been on the trauma and related services risk register since 2014, as it was identified there was a risk of insufficient junior doctors to cover the wards, theatre and clinics. This was reviewed in February 2016; mitigating actions had been implemented such as the use of advanced nurse practitioner to cover junior doctor's roles and cohorting patients to specific wards to enable better cover. Eight rotational posts had been advertised to attract overseas doctors.
- Two consultants were on call each week for the major trauma centre. They were also present for wards rounds at weekends with a vascular surgeon.
- Neurosurgical consultant cover for intracranial neurosurgery, spinal surgery and paediatric neurosurgery was provided 24 hours a day. At times one consultant may cover for two specialities. They were supported by a senior registrar and a core trainee doctor.
- On the orthopaedic wards patients over the age of 60 years were reviewed twice a week by the ortho-geriatric team.
- The patients we spoke with reported visibility of doctors and being reviewed at weekends.
- We observed the trauma team; the meeting room was small with people stood in the doorway and sat on tables. However, there was multidisciplinary attendance and participation. We reviewed the handover sheet which was well documented and contained concise information.
- We observed ward rounds in which mobile computers were used to access blood results and view patients x-rays.

Major incident awareness and training

- The trust had a major incident plan and business continuity plans. These were available to staff on the trust intranet.
- The major trauma unit at LGI was an integral part of the major incident plan, with clear pathways and escalation processes.
- Staff reported that there had been good planning and provision by the trust during the recent junior doctor's strikes.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Readmission rates for elective and non-elective admissions were higher than the England average.
- The standardised risk of readmission for elective patients was higher than the England average. In particular neurosurgery which was approximately 1.5 times the England average.

- Only two specialities were performing above 90% for the 18 week national indicators.

However:

- Service planning was collaborative and focused around the needs of patients.
- The productive operating theatre work gave up to date information on performance for individual theatres.
- Systems for managing bed availability had been put in place to try to ensure theatre sessions started on time.
- We saw evidence of practices to meet individual needs of patients, such as those living with dementia or with a learning difficulty.

Service planning and delivery to meet the needs of local people

- For service planning, senior staff worked with local commissioners of services, the local authority, other providers, GPs and patient groups to co-ordinate care pathways.
- Integrated care was one aspect of the trust's five year strategy with a plan to provide more 'joined up' care for patients. This was to be achieved by looking at city-wide working with the Health and Social Care Transformation Board.
- Another aspect of this was developing the Leeds Academic Health Partnership. This focused on collaborative working between NHS trusts, universities and local authority to improve patient outcomes.
- The trust had signed up with NHS England to be an early implementer of seven day services. A seven day service was already provided for acute services. This included a full range of diagnostics, consultant-directed interventions and ward rounds.
- The major trauma centre opened in 2013, this provides specialist treatment for adults in the West Yorkshire region. A purpose built major trauma theatre and ward had also been built with access to a range of specialists, such as maxillofacial and cardiothoracics.
- The trust was building partnership arrangements with other surrounding hospital trusts to be able to offer specialist care to patients closer to home.
- The 'Getting it right first time' work was ongoing focused on improving orthopaedic care. From this an optimised pathway and cohort care for fragility fracture patients was developed.
- One stop Clinics had been developed in trauma and related services which improved efficiency and patient experience. Patients had one attendance at clinic for assessment and diagnostic intervention.

Access and flow

- We reviewed data between November 2015 and January 2016 relating to theatre utilisation at LGI. Theatre utilisation for the major trauma centre was between 67% and 80%. Percentages for the other theatres ranged from 55% to 92% dependent on their speciality.
- Three theatres ran 24 hours a day for all acute operations with one cardiac team on call. This was co-ordinated by a 'bunker system' which was a room with all the patients requiring emergency surgery listed. The theatre list was created by clinical priority. Patients requiring acute spinal surgery had been on the risk register since 2013 stating the 'bunker system' was not actively supported by all specialities. The risk was reviewed in June 2015 with plans to audit and ensure spinal surgeon presence at each meeting.
- The productive operating theatre (TPOT) was in use at LGI. This was a project designed to help theatre teams to work together more effectively and improve the quality of patient experience, as well as the safety and outcomes of surgical services. Data relating to this was updated each week and we saw information displayed within theatres. For example, in the first week of May 2016 for theatre one, which was used for plastic surgery; there was one late start due to their being no critical care bed available.
- To try and deal with the problems of reduced beds and high demand on prompt start times, a rota had been introduced within cardiothoracics. If three theatres were running the theatres take it in turn to start their cases to allow additional time to source a bed.
- Within neurosurgery there was a dedicated bed management team to support a "first start" process in theatres. This had improved start times and theatre utilisation and generated confidence in surgical teams. Spinal surgery was performing the best in theatre session utilisation in the trust.
- At LGI, 553 (1.4%) of the 40,322 scheduled operations between January 2015 and December 2015 were cancelled. Of these, 39 were not treated within 28 days.

Trust wide the percentage of patients whose operations were cancelled and were not treated within 28 days was better than the England average for Q2 and Q3 of 2015/16.

- Data from January 2016 to March 2016 showed 123 operations had been cancelled on the day of surgery. 33 were cancelled due to no ward bed being available, 26 due to running out of theatre time and 19 due to scheduling.
- At LGI the overall standardised risk of readmission for non-elective patients was slightly above the England average.
- The standardised risk of readmission for elective patients was higher than the England average. In particular neurosurgery which was approximately 1.5 times the England average.
- Data related to emergency readmission within 30 days was collected on the CSU performance dashboards.
- LGI performed better than the England average for five of the 10 measures in the Hip Fracture Audit in 2015. They performed worse than the England average for; 'Surgery on the day of or after day of admission' (68% compared to an England average of 72 and 'Mean length of acute stay' (19.3 days compared to 15.7 days nationally).
- At trust level, only two of the surgical specialties (Cardiothoracic Surgery and Ophthalmology) were performing at 90% or above for the 18 weeks national indicators (Complete Admitted) in February 2016. The following specialties were all performing under 70%: Trauma & Orthopaedic Surgery (66%), Ear Nose & Throat (59%) and Oral Surgery (29%) although total number of completed pathways (with a known clock start) were relatively low for both ENT (100) and Oral Surgery (70). Overall trust performance for the surgery core service was 81.3%, which was above the England average of 75.8% in February 2016.
- We were told about challenges in relation to access and flow. These related to repatriating of patients, discharge planning with social services if patients were from an area outside of Leeds and lack of rehabilitation facilities for neurosurgical patients.
- Length of stay for patients was monitored and escalated, it was hoped by working closer with other trusts, repatriation processes would be improved.

Meeting people's individual needs

- The wards were accessible for people who used a wheelchair or walking aids. Disabled toilets and showering facilities were available in the ward areas we visited.
- Translation services were available for people whose first language was not English. We asked staff about translation services and were told it was booked online, and translators would either come in or translate over the phone. We saw a consent form for a person whom English was not the first language, the form was countersigned by an interpreter.
- We saw examples of reasonable adjustments being made for patients. For example, a young female patient being moved in to a single room.
- A flagging system was in place for patients with a learning disability. The hospital also had a specialist nurse for learning disabilities. Staff spoke about 'Get Me Better' which identified personal preferences and any methods which would help reduce anxiety. We also saw patient passports in use, which contain information about an individual such as foods they like.
- We saw 'Know Who I Am' documentation for patients living with dementia. 'Forget Me Not' symbols were also displayed to identify patients to staff.
- Dementia training was provided for staff and most wards and departments had dementia champions.
- Within neurosurgery staff spoke about using independent mental capacity advocates (IMCA's) for specific decisions. We also observed a surgeon liaising with an IMCA.
- Physiotherapy for trauma patients was provided seven days a week and there were dedicated therapy and medical staff for patients with spinal injuries.
- We also saw posters on the wards displaying the discharge goals for lumbar spine patients. These identified patient led goals.

Learning from complaints and concerns

- Data from March 2016 to April 2016 showed there had been 30 complaints relating to surgical services at LGI. Themes of complaints were around communication and attitude and behaviour.
- Data on complaints was also incorporated in the CSU performance dashboards. For example, within the neurosciences CSU between February 2015 and February 2016 there had been 68 complaints. The dashboards also showed what percentage were

responded to within the trusts target time. For example in January 2016, four complaints had been received, 25% or one, of these had been responded to within the trusts time frame.
- We were provided with information that complaint numbers had fallen by 26% over 12 months within the neurosciences CSU. This was due to a restructured complaints handling process with faster response times and more robust responses.
- Posters on how to complain were seen in clinical areas and PALS leaflets were available. However staff said they would always try and resolve any issues at the time.
- There was a pilot ongoing to have PALS services in reception areas to make them more accessible.
- Complaints were discussed at CSU clinical governance meetings. We reviewed a redacted complaint response which showed an explanation of the patient's treatment and why decisions were made. It also showed an acceptance of where improvement could be made as well as an apology.

Are surgery services well-led?

Good

We rated well-led as good because:

- The trust strategy was patient focused and the individual clinical service units (CSU) linked with this.
- We found quality information updated monthly in dashboards which fed in to good governance arrangements.
- Most staff spoke of a positive change in culture. Staff felt engaged and part of the trust.
- We saw positive leadership at ward and department level and staff felt able to escalate concerns.
- Friends and family test data was generally positive with over 90% of patient saying they would recommend the service.
- There was a range of innovative work and research being undertaken by the trust to develop their services.

However:

- In one area within theatres we found a poor culture which was impacting on staffing and having a negative impact on those working in that area.
- A number of risks identified on the risk registers had been present for over two years, despite recent review. This did not assure us that these risks were being managed.

Vision and strategy for this service

- Most of the staff we spoke with made reference to 'The Leeds Way' and felt the trust was patient focused. The five values underpinning this were to be patient centred, fair, collaborative, accountable and empowered.
- We reviewed the trust strategy which focused on collaborative working and integration of services. Patients and people were key to the success of the strategy with recognition of the importance of clear communication and the skills and experience of the workforce.
- We reviewed the CSU's local strategies which were aligned to the overall strategy. There was a focus on quality and patient experience. Each CSU had a clear direction and goals with steps identified in order to achieve them. For example for trauma and related services the focus was on patient pathways specific to their areas and developing them based on patient feedback and performance data.

Governance, risk management and quality measurement

- Corporate and CSU risk registers were in place. We reviewed and discussed the content of the CSU risk registers with the senior management teams. Whilst the risks reflected concerns, several of them had been on the register for more than two years. Mitigating actions had been put in place but for many they were still ongoing. This meant any longer term plans were more difficult to implement and could account for the length of time they remained on the register.
- For example, within neurosciences a risk had been identified that comprehensive patient feedback was not sought. This risk had been added in October 2013 and was still an active risk following review in June 2016.
- In the trauma and related services CSU, it was identified in May 2014 there was a lack of beds. Some actions had been put in place but at review in March 2016 it remained active with an amber rating.
- Surgical services at LGI were in three of the 18 CSUs. Each CSU and clinical speciality held monthly

governance meetings. There were discussions on incidents and clinical issues as well as performance, patient care and finance in the meeting minutes we reviewed.
- We reviewed performance dashboards for each CSU which displayed data for individual wards on a range of areas. The dashboards were RAG rated and indicated an overall direction for each ward. They included patient safety information such as falls, as well as staffing vacancies and sickness rates; this information was discussed at weekly CSU meetings.

Leadership of service

- The hospital was one of five trusts to take part in the NHS Improvement Partnership working with NHS Improvement and an external agency. The programme is about ensuring the trust provides the highest quality care whilst reducing inefficiencies in the service. The five year programme focuses on learning from the experiences of others and empowering clinical teams to have continuous quality improvement across the organisation.
- Staff spoke in a positive way about local leadership. We saw evidence of them having oversight of the concerns and safety performance in their areas.
- We spoke with staff that were transitioning from one role to another or from the community in to the acute site. They reported being well supported and learning needs were identified.
- The senior management team were felt to be visible and staff felt able to escalate any concerns.
- The matrons were present in clinical areas each day and had weekly meetings with the head of nursing to share information.
- Performance dashboards helped inform ward staff and the management team on a number of quality indicators. Any areas rated red for three consecutive months were placed in escalation and additional support was given.

Culture within the service

- We identified some issues in a specific speciality within theatres. This was focused around attitudes and behaviours of some individual staff which was having a negative impact on others.
- We were given examples of staff being shouted at and being discouraged from completing incident forms.
- Overall this was having an impact on recruitment and retention of staff. We raised our concerns with the senior management team who were aware of the situation. We were assured that the appropriate actions were being taken in what was a challenging situation.
- Outside of this staff reported a positive culture and good working relationships between staff groups.
- Staff reported an open culture where they felt concerns were discussed openly with a 'no blame' culture.
- Feedback from student nurses was very positive with comments such as 'I hope I can get a job here when I qualify'.

Public engagement

- Friends and family test (FFT) data was collected and information relating to this was displayed in ward areas.
- Data for surgery at LGI showed a 29% response rate in the FFT which is below the England average of 36%. In most wards, more than 90% of patients responded that they would recommend this service.
- Information relating to FFT was also included in the performance dashboards and provided an overall direction for each ward. For example, wards within the trauma related services CSU had remained consistent in January 2016 with response rates between 34% and 45%.
- The trust conducted compassion in care audits. This data was collected monthly and RAG rated for each area. Patients were asked five questions based on whether their care had been compassionate and if they had felt involved. Data for neurosciences from April 2015 to February 2016 had consistent scores of 100% across all areas.

Staff engagement

- Overall staff felt engaged and involved. For example, junior doctors told us the Chief Executive came to their trust induction which they thought was excellent practice.
- Link nurse roles had been developed to improve staff engagement within clinical issues.
- Staff told us communication had improved and they felt informed about what was happening outside of their immediate work area.

Innovation, improvement and sustainability

Surgery

- There is a consultant led virtual fracture clinic. This allows patients to be assessed without attending the hospital and then have the most appropriate follow up. This reduces unnecessary hospital attendances.
- Revolutionary hand transplant surgery had taken place within plastic surgery.
- The neurophysiology service has been developed with a new department. A review of staffing has enabled the employment of three full time consultants. As a result of this governance and safety has improved and agency costs have reduced.

Critical care

Safe	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

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

The critical care units (CCU) at Leeds General Infirmary (LGI) have a total of 39 beds. They are divided into:

General CCU 10 beds, on wards L2 & L3

Cardiac CCU 15 beds, on wards L4 & L5

Neurology CCU 14 beds, on wards L6 & L7

There are a further 6 high dependency unit (HDU) beds outside of the Clinical Services Unit which accommodated patients having Orthopaedics and Plastics procedures.

We visited all the units and spoke with patients and relatives who were happy to speak with us. We interviewed a range of multidisciplinary staff and managers. We observed staff handover and attended meetings as observers.

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

At the last CQC inspection in 2014 we rated the safe, responsive and well-led domains as requires improvement. We rated the effective and caring domains as good. We identified issues relating to trust leadership, increasing pressure on critical care beds', us and them' culture between the two main hospital sites and the lack of engagement between staff, insufficient medical cover, the quality of the handover and support on the high dependency unit on Ward L39 at Leeds General Infirmary, which was overseen by the surgical services unit rather than the critical care service.

At this inspection we inspected safe, responsive and well-led domains. We did not inspect the effective and caring domains as these were rated as good at the comprehensive inspection in 2014.

Critical care

Summary of findings

We rated critical care services as good because:

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

However:

- LTHT provided specialist critical care service for a large geographical area therefore sometimes the demand for the service exceeded the resources they had causing problems with the access and flow to the critical care units particularly in relation to delayed discharges.
- During our inspection we found equipment had service stickers to show that they had been checked however data supplied by the trust showed that they were not fully compliant and maintenance records indicated there was between 73% and 93% compliant on the units.
- The critical care units could not demonstrate full compliance with GPICS 'safe use of equipment' standard which states that all staff must be appropriately trained, competent and familiar with the use of equipment. Staff we spoke with during the inspection told us they received training on equipment and were confident in using them. However information supplied by the trust on high risk equipment training showed low percentages of staff compliance with equipment training.
- The outreach team did not work out of hours the current arrangements included medical and nursing support from the critical care units to the wards. However there were plans to introduce a 24/7 approach in October 2016 and staff had been recruited to this team.
- Medical staffing did not achieve all of the requirements of the Guidelines for the Provision of Intensive Care Services GPICS (2015). Consultants were all experienced in critical care, however not all were trained as Faculty of Intensive Medicine (FICM).

Critical care

Are critical care services safe?

Good

We rated the service as good for safety because:

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

However:

- Guidelines for the Provision of Intensive Care Service (GPICS) standard for equipment and the Medicines and Healthcare Products Regulatory Agency (MHRA), which is responsible for ensuring that medicines and medical devices are acceptably safe, stipulate that all equipment must conform to the relevant safety standards and be regularly serviced. During our inspection we found equipment had service stickers to show that they had been checked however data supplied by the trust showed that they were not fully compliant and maintenance records indicated there was between 73% and 93% compliant on the units.
- The outreach team did not work out of hours the current arrangements included medical and nursing support from the critical care units to the wards. However there were plans to introduce a 24/7 approach in October 2016 and staff had been recruited to this team.
- Medical staffing did not achieve all of the requirements of the Guidelines for the Provision of Intensive Care Services GPICS (2015). Consultants were all experienced in critical care, however not all were trained as Faculty of Intensive Medicine (FICM).

Incidents

- Staff understood their responsibilities to identify, report and record incidents and near misses. They demonstrated an open and honest culture when responding to incidents. They said when incidents happened there was not a blame culture within the service and the cause of the incident was analysed. Where practices could be improved this was done and staff received training and support to do this.
- Managers were able to verbalise the process for reporting incidents internally and externally and how they investigated and managed the incidents.
- Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- The trust reported that between October 2014 and September 2015 there had been no never events within the critical care units at either site.
- National Reporting and Learning System (NRLS) enables the public including professionals to upload patient safety information. The information for this trust revealed that in twelve months prior to the inspection there was one serious incident; where a patient developed a grade 4 pressure ulcer. A grade four pressure ulcer is the most severe type of pressure ulcer. Staff told us following the incident a root cause analysis took place and as a result staff safety huddle for pressure ulcer was introduced.
- Mortality case Reviews were shared amongst staff to identify good practice and lessons to be learnt. Mortality was discussed at Clinical Governance / Audit meetings on a monthly basis. We reviewed meetings from the meeting on 12 January 2016 and saw evidence of this in the minutes. The emphasis was on reviewing practice and embedding lessons learnt from case reviews in the care and treatment of patients.
- We also found that annual Mortality and Morbidity meetings were held to review themes over the previous year. The last meeting was held on10 February 2015; we saw minutes of this meeting and saw the next meeting was held on Thursday 17 March 2016.
- Matrons and nurses had a good understanding of Duty of Candour. They explained how they applied the regulation when dealing with mistakes and the process for giving written apology to people who used the service.

Safety thermometer

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Critical care

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm. It allows staff teams to measure harm and the proportion of patients that are 'harm free' from the following: - pressure ulcers, falls, urinary tract infections (UTI) in patients with a catheter and venous thromboembolism during their working day.
- We checked the Safety Thermometer data on six units we visited during the inspection where Intensive and/or high dependency care was delivered. They were wards L3, L4, L5, L6, L7 and L8.
- The results of safety thermometer readings were available to staff on most of the units with the exception of L8. Ward L8 a general HDU did not belong to the same clinical services unit (CSU) as the others but patients requiring high dependency Level 2 care were nursed on this unit. The last data submission by this unit was in August 2013 and therefore we were unable to report on their latest performance
- Staff informed us that each month on the same day the data was collected within the units.
- Between September 2014 and September 2015 the annual Safety Thermometer results for both sites at SJUH and LGI disclosed 21 pressure ulcers, four falls with harm and two catheter associated urinary tract infections. There were no apparent trends for all three indicators and there were no incidents of venous thromboembolism reported during this time.
- We saw harm free care on the different wards varied. For example on L7 a neurology HDU the Safety Thermometer records between March 2015 and April 2016 showed 100% harm free care. However on L6 and L5 readings for the same time period was between 68% and 100%. This was due to patients developing pressure ulcers and a pulmonary embolism (PE).
- Senior medical and nursing staff informed us that they discussed the above outcomes and reviewed their practice to make improvements.
- Staff informed us when incidents of pressure sores, UTI and PE were identified they not only reported but also considered the possible actions they needed to take immediately and shared the information at handover sessions. We observed medical and nursing discussing such issues at the beginning of their handover.

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect people from a healthcare-associated infection.
- Staff we spoke with confirmed that they had attended training on infection prevention and control as part of their mandatory training. Information from the trust confirmed 100% of adult critical care staff had completed their Infection Prevention and Control training, compared to the trust target of 80%.
- We found the areas occupied by patients and the clinical areas within the units were clean and free of offensive odour.
- Sharps bins we saw were less than 1/3 full and all bins in use had dates and were signed by a member of staff in line with the local policy.
- Nurses and health care assistants informed us that cleaning within the patient areas and the equipment in use was their responsibility. We observed patients areas to be visibly clean.
- We observed staff adhering to infection control policy and using personal protective equipment (PPE) when delivering personal care. Staff told us there were sufficient PPE and other disposable consumables for their use and our observations during the inspection confirmed this.
- We saw antiseptic wash available to all visitors and staff on the units. We observed people entering and exiting the units, decontaminating their hands by using the wash.
- Eight incidents relating to infection control were reported between October 2014 and September 2015, and they were categorised as 'infection'.
  - On seven occasions, the inability to isolate patients within two hours was stated as the reason. The units had side wards but the main ward areas were open plan with curtains dividing bed areas. Therefore timely isolation of patients had not always been possible.
  - On one occasion there was a delay or failure to order a test for an infection.
- We noted that there wasn't any designated area for the respiratory isolation of patients i.e. providing negative air pressure in a side room. Negative air pressure prevents infection spreading out from the isolation room on to the other areas in the unit.
- Care records showed that patients admitted to the units had their methicillin resistant staphylococcus aureus (MRSA) status checked. Trust information confirmed that during October 2014 and September 2015 there were no patients admitted to the CCUs with MRSA.

- Infection rates for MRSA and Clostridium difficile (C.diff) as reported by ICNARC infection control data showed that Leeds General Infirmary performed within expectations. The results showed that there was no C.diff infection reported during 2013/2014.
- The case mix programme figures from 1 April 2014 to 31 March 2015 indicated that 15% of admissions to the units were high risk sepsis patients. This was similar to other matching units where the patients admitted had 14.7% risk of sepsis.
- Adult Critical Care Antimicrobial Medicines Audits were carried out and reported each month. Between July 2015 and February 2016, these showed on average 90% compliance against the trust policy and professional guidance. The audit included when antibiotics were prescribed, when it was reviewed, how long patients were on antibiotics and if patient allergies were considered.

Environment and equipment

- Guidelines for the Provision of Intensive Care Service (GPICS) standard for equipment and the Medicines and Healthcare Products Regulatory Agency (MHRA), which is responsible for ensuring that medicines and medical devices are acceptably safe, stipulate that all equipment must conform to the relevant safety standards and be regularly serviced. During our inspection we found equipment had service stickers to show that they had been checked however data supplied by the trust showed that they were not fully compliant and maintenance records indicated there was between 73.6% and 93.9% compliant on the units.
- The critical care units could not demonstrate full compliance with GPICS 'safe use of equipment' standard which states that all staff must be appropriately trained, competent and familiar with the use of equipment. Staff we spoke with during the inspection told us they received training on equipment and were confident in using them. However information supplied by the trust on high risk equipment training showed the percentage of staff who had attended from each unit as:
  - General CCU (ward L3) 50.89%,
  - Cardiac CCU(ward L4) 43.41% and
  - Neurosciences CCU ward (L6) was 61.12%.
  - Within the two sites average attendance of training was 65.5%
- We asked for further information from the trust in relation to staff training in the use of equipment in CCU. The trust supplied us information which showed:
  - Each unit across critical care had allocated Key Trainers for each piece of equipment used.
  - Training was delivered by the unit Clinical Educators and Key Trainers and when completed this was recorded on MELVIS (staff training database).
  - Each member of staff had a list of competencies for completion which were logged on MELVIS and reviewed at appraisal and follow up review meetings.
  - Training for new pieces of equipment was delivered by trainers provided by the company in the first instance and followed up by Key Trainers.
  - Competencies were submitted by the company to MELVIS as part of the training contract.
  - Each unit had a dedicated Clinical Educator who was available to work with staff at the bedside to support training if needed.'

Medicines

- A pharmacist visited the units each day and attended ward rounds when possible. They informed us that they checked the prescribing, recording, handling, storage, security and disposal of medicine used in the units.
- Nursing staff were aware of the policies on administration of medicine and disposal of controlled drugs.
- We were informed that 98% of adult critical care staff had completed their Medicines Administration and Safety training, compared to the trust target of 80%.
- Local microbiology protocols for the administration of antibiotics was in use and audits carried out and the compliance was 90%.
- We looked at eight medication administration charts. We found the information was clear, dated and signed. Allergies were noted and when medication was not administered reasons were recorded.
- Ward/unit health checks were carried out each month when medication errors were monitored and action taken to minimise them. We noticed a reduction in the reported errors in January 2016 from December 2015.

Records

- Patient observations charts within the CSU were audited monthly by staff to ensure accurate record keeping. Audit summary reports for 2015/2016 showed that record keeping was timely and accurate and it also

highlighted some shortfalls such as 24hr cumulative fluid charts were not always completed correctly and that sometimes NEWS scores were not correct. Staff told us that monthly results were shared with them at handover.

- Individual care records, of patients and staff were managed in a way that kept people safe. And there were systems, processes in place to communicate to staff and ensure safety of people.
- Staff told us that they had received training on information governance and were able to discuss the importance of maintaining accurate records, confidentiality and adhering to data protection.
- Information about the patients and staff were kept in two formats, paper and electronic. Electronic information was stored securely and access was given through password protection. The paper records were kept securely on the units and in the offices.
- We looked at four medical/multidisciplinary and four nursing records. Records were legible, following each episode staff had updated their records, most signatures were legible however all doctors wrote their personal identification number following their signatures so they could be recognised.
- They knew the process for transferring information to other areas and told us that they followed the local policy.

Safeguarding

- There were arrangements in place to safeguard patients and staff from abuse that reflect relevant legislation and local authority safeguarding requirements.
- Staff understood their responsibilities and told us that they adhered to the trust safeguarding policies and procedures.
- They said safeguarding training was mandatory and they had attended and kept up to date with it. Staff knew the trust lead for safeguarding and informed us that the person was approachable and helpful therefore they were able to discuss matters freely.
- The trust did not collect safeguarding training data by individual location but by CSU. They had a robust system in place that allowed staff and the trust to know when mandatory training was due to expire.
- We were informed that 97% of adult critical care staff had completed their Safeguarding Children Level 1 training, compared to the trust target of 80%.
- 97% of adult critical care staff had completed their Safeguarding Vulnerable Adults Level 1 training, and 69% have completed their Safeguarding Vulnerable Adults Level 2
- Staff informed us of a recent safeguarding referral and the process they followed. There was documentation to support their action. They said that they were kept informed of the progress and the outcome by their safeguarding lead.
- Staff could access their mandatory training record electronically. The training record used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training sessions.
- The training records for medical and allied health professionals were not held within the CSU; however we were informed that they had a system which informed them as well as their line managers.

Mandatory training

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

Critical care

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out during pre-operative visits for patients who came in for elective procedures. All emergency admissions had their risk assessments completed within 12 hours or as soon as possible following admission to the units.
- We saw ten nursing records and five medical notes where we found risk management plans and updated plans as changes happened. We noted patients' risks were managed positively. For example when a patient with severe learning disability is admitted to the unit staff said that they facilitated their carer to stay with them on the unit to reduce the risk of the patient becoming unsettled.
- Within critical care units deteriorating patients were identified promptly and treated. However those on the wards were assessed by the outreach team with the help of NEWS scores. We were informed that the outreach team was accessed by both sites and sometimes staff felt fraught since they were unable to attend the wards promptly. Decisions to transfer patients on to the critical care unit were made by the consultant.
- We were informed, during out of hours the general critical care units were contacted by ward staff to assess patients who were deteriorating. Staff told us that this did not have any negative impact on patient care on the units.
- Consultant reviews of patients took place every 12 hours which helped with responding to the changing needs and the related risks.
- Staff talked to us about how they coped with medical emergencies and patients with challenging behaviour. They said that they had a clear process to follow and there was always a matron available to help if they needed.
- With the safety huddles, all nursing staff within the unit gathered at the nurses' station at a prearranged time and discus how to prevent falls and skin breakdown and resolve patient or relative concerns.
- Staff told us that they had training in the Mental Capacity Act 2005, capacity assessments and the deprivation of liberty safeguards. They explained such assessments were carried out at multidisciplinary meetings where they followed the trust policy.
- They also discussed the pain, agitation, and delirium guidelines (care bundles) they used for adult CCU patients. They were mindful of the complexity when assessing and determining patients whether they were suffering from delirium or whether they had lost capacity to make decisions.
- The trust supplied us with the following clarification on when a patient would remain in Post Anaesthetic Care Unit (PACU). The information clarified that 'in the event that a patient has had a planned (elective) procedure and was managed in PACU following the procedure whilst a bed was made available, the patient was managed by the PACU/anaesthetic team, with support from critical care/outreach if this was required.
- Acute patients awaiting critical care bed were managed in PACU by the staff with additional support provided by critical care nursing staff and the anaesthetist. Patients in PACU that required critical care were discussed and escalated at the daily 8am meeting, which was chaired by a senior member of the clinical management team. Action was actively taken to expedite discharges from critical care, including the review of all elective patients and to prioritise those who were in PACU.'

Nursing staffing

- Over the twelve months between January 2015 and December 2015 the nurse staffing in the critical care units within both sites had been changed to accommodate the needs of the service. This meant there had been an increase in Band 8A, Band 7 nurses and Band 1 health care assistants. However, there was a decrease in Band 2 health care assistants and bands 4 and 5 nurses. This had resulted in the drop of whole time equivalent staff from 387.22 to 379.84 making a 2% reduction overall.
- The CSU supplied us with the planned and actual numbers of staff on duty to cover each unit from October 2015 and January 2016. We were assured that staffing levels were planned using GPICS standards, which specified the staff patient ratios according to the levels of care.
- The data provided showed that during the four months, the general CCU was 95.5%, Cardiac CCU was 93%, Neuro CCU was 94% and outreach staffing was 96% complaint with the expected staffing levels.
- We found arrangements were in place to use bank and agency staff. Agency staff on arrival to the unit

completed a check list with the help of one of the nurses so that they were familiar with the unit. The matrons told us that they used the same agency to ensure the quality and the continuity of staff supplied.
- We observed handover during shift changes. Staff followed a structured approach to shift handover to promote situation awareness. The nurse who was in charge of the unit shared information on any patient safety alerts, quality and safety issues, any key performance updates and staffing capacity with the team of staff who had arrived on duty. They then went over each patient and gave all staff a summary update.

Medical staffing

- The current model for medical staffing at LGI was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- There were eleven consultants in total and nine intensive care consultants (intensivists) however; two consultants who covered the general and neurosciences critical care units were not Faculty of Intensive Care Medicine (FICM) compliant.
- All the consultants led the medical teams and managed the care and treatment of patients within the critical care units. Each unit had a day time consultant and an overnight consultant.
- We were informed by the trust that each consultant had individual days in their job plan to provide CCU cover, with unfilled sessions covered by those consultants who had flexible sessions in their job plans. Discussion regarding movement to block working incorporating time for handover and clinical MDT meetings were on-going and with the view to increasing the number of consultants on the call rota.
- There was insufficient consultant cover for cardiac critical care units. The units were covered by cardiologists and cardiothoracic anaesthetists who also had responsibility for theatres. If they were called to assist in theatres a general or a neuro consultant who was around but not familiar with the patients would be expected to attend to the problems.
- The trust informed us that eight consultants provided cover on the cardiac CCU. They worked in blocks of shifts. There were two blocks Monday to Tuesday and Wednesday to Sunday. Occasional gaps were filled with flexible sessions.
- The Faculty of Intensive Care Medicine (FICM) workforce advisory group recommends that consultant work patterns should deliver continuity of care and that the majority worked 5 day blocks of day shifts on ICU. Such arrangements reduced burn-out in intensivists and maintain the same patient outcomes as 7 day blocks. Within the units consultants were flexible and provided cover for day and night shifts but did not work blocks of day/night shifts.
- At shift change medical staff team including all grades of doctors used a safety handover process to ensure appropriate information was shared and any problems were highlighted and discussed to maintain patient safety.
- We found different grades of locum doctors were employed to cover gaps.

Major incident awareness and training

- Staff verbalised the arrangements in place to respond to emergencies and major incidents. They said this was discussed in their induction. They also told us that the up to date information was kept on the computer and hard copies were held in staff offices.
- The matrons informed us when the policy was reviewed and if changes were made staff were informed of them at staff meetings.
- Managers were aware of the seasonal risks and they said that at the clinical services unit governance meetings they discussed the contingency plans. They told us about two incidents a bus crash and an electrical failure where a major incident plan was applied to manage the situations.

Are critical care services responsive?

Requires improvement

We rated the service as requires improvement for responsive because:

- LTHT provided specialist critical care service for a large geographical area therefore sometimes the demand for the service exceeded the resources they had causing problems with the access and flow to the critical care units. This resulted in cancellations of surgery, delays in admission to CCU when patients were critically ill, discharging patients from the unit out of hours and the

increase in the readmissions to the unit following discharge. Staff and the management teams held three times daily bed meetings within all the sites to enhance the flow and discharge of patients.
- There were monthly formal follow-up clinics for patients who had been discharged from critical care services, however the trust was unable to confirm that these clinics were compliant with the Guidelines for the Provision of Intensive Care Services GPICS (2015).

However:

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

Service planning and delivery to meet the needs of local people

- Planning of the services involved the local health and social service commissioners. There were regular discussions between the trust and the commissioners about the provision of the service and this included the service level agreement for critical care services and the capacity for providing regional specialities.
- We observed patients who had received treatment from the critical care specialist centres such as cardiac and neurosciences critical care units being transferred back to their local hospitals to continue their treatment. Relatives told us that they had been informed that once the patient had received the necessary treatment they would be transferred back to the critical care unit at their local hospital.
- Patients after receiving treatment on critical care units did not have any formal follow-up when they were discharged home. The outreach team supported patients whilst they were in-patients but did not have any formal follow up contact once patients were discharged.
- There were monthly formal follow-up clinics for patients who had been discharged from critical care services, however the trust was unable to confirm that these clinics were compliant with the Guidelines for the Provision of Intensive Care Services GPICS (2015).
- GPICS Core Standards highlight the need for specialised critical care follow up clinics once patients were discharged home. This was due to patients following discharge from critical care showing complex physical and psychological problems that lasted for a long time. These patients benefited from the support offered by a specialised critical care follow-up clinic. Patients requiring rehabilitation and emotional support were referred to The West Yorkshire Adult Critical Care Operational Delivery Network where patients were signposted to different services by the network team and some services were free and the others, patients needed to pay for.

Meeting people's individual needs

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

- Staff told us that the provider of translation services had been changed this year and they had not used them so far.

Access and flow

- The total number of admissions to the critical care units within the LTHT between 1 April 2014 and 31 March 2015 was measured by the ICNARC case mix programme to be 1,153 patients. These numbers did not include all of the critical care units as data was not submitted by them all.
- At the point of discharge into the community following treatment and recovery 797 (89.1%) patients were discharged from the acute hospital and 98(10.9%) died on the wards before discharge. This meant patient survival after 60 days following admission to the unit was 70% and similar units had around 75% survival rate. The data did not consider the complexities of patients' conditions and reported purely on the patient numbers.
- The Intensive Care Society identifies 80% as an average occupancy for critical care to accommodate the frequently changing needs of emergency and elective services. Adult critical care bed occupancy between January 2015 and January 2016 at both sites ranged between 70% and 85%. The national average for this time period was around 80% to 90%.
- Data from ICNARC between 1 July 2015 and 30 September 2015 for general intensive care showed a mixed result compared to other similar units. Some examples were;
  - An out-of-hours discharge of patients from the units to the wards between 10pm and 6:59am was 5% this was higher than other similar units which averaged at 2.8%.
  - Delayed discharges which were more than 4 hours after the reported time when patient was fully ready for discharge on this unit was 20%, which was worse than in similar units which was 5.2%.
- According to GPICS (2015) standards discharges should occur within four hours of the decision being made by a consultant. Between April 2015 and March 2016 information from the trust showed that at LGI between 38% to 78% (3,112 patients in total) waited over four hours to be discharged from the critical care units. Of these between 3%-14% (473 patients in total) were out of hours discharges.
- Data showed between January 2015 and December 2015 there had been one ventilated patient care for outside of the critical care units. Some staff within recovery had been trained to care for level three patients.
- A peer review audit of the service identified patient flow to be a key challenge for the service operationally as well as in relation to compliance with the D16 specifications. D16 specifications underpin the NHS standard contract for adult critical care.
- Key areas of non-compliance were identified as admission and discharge from Critical Care Units.
  - Admissions to Critical Care: - where elective cancellations rates particularly in Cardiac surgery at the LGI were problematic and the delay in admission to a Critical Care unit within 4hr of decision was an issue.
  - Re-admissions within 48hrs to Neurology ward remained a concern.

Learning from complaints and concerns

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

Are critical care services well-led?

Good

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

- Staff members and managers were fully conversant with 'The Leeds Way' which encapsulated their values. The

values underpin patient-centred approach, fairness, collaborative working, being held accountable for their action and empowering staff to carry out their responsibilities.
- We found a number of work streams underway to ensure effective governance to support the trust strategy and deliver good patient care. A risk register was maintained by the critical care CSU and were reviewed during quality assurance meetings. The register highlighted the ongoing risks with details of action taken to mitigate the risks.
- Monthly 'Ward Health check' measurements of the key performances helped staff and management identify trends and take action in a timely manner. There was a criterion for escalation, if a unit /ward scored worse in three areas.
- Staff said the managers were visible and approachable. They said the board members often shared the same transport between the hospitals and were accessible to staff and people who used the services.
- Staff commented that they felt valued by their line managers and colleagues.
- A volume sensor which was referred to as the 'Big Ear' was used in some units to monitor and sense the sound levels. Neurology HDU at LGI used it to help staff control the levels of noise so patients were able to rest.

However:

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

- We found a number of work streams underway to ensure effective governance to support the trust strategy and deliver good patient care.
- A risk register was maintained by the critical care CSU and reviewed during quality assurance meetings by the CSU leads including the clinical quality leads. The register highlighted the ongoing risks with details of action taken to mitigate the risks.
- The director of quality for trust informed us that all risks were weighted and scored during the three monthly CSU meetings on the projected harm. If a CSU risk scoring was 10 or above, they said it would be reviewed twice a year by the Risk Management Committee, which was chaired by the Chief Executive.
- We saw work that was in progress in developing Clinical Audit Programmes during 2015/16; we were informed that the intention was to ensure clinical audits within clinical teams would address both local and trust priorities, facilitate service improvement and provide assurance that agreed clinical standards were being met.
- Leeds General Infirmary was not fully compliant with data collection for ICNARC as wards L2, L3, L6 and L7 only took part. We were informed by staff that the lack of data submission was due to insufficient staff allocated to data collection. They also told us that they were late submitting data due to the lack of

coordination between the electronic systems used in the hospital. This is a key reason for the self-assessment of some standards not being possible in the absence of ICNARC benchmarking data. All core Critical Care units are required to participate in this under the D16 standards.

- There were gaps in compliance with GPICS standards 2015, instead of expected 50% of critical care nursing staff only 37% had a post-registration qualification.
- A monthly 'Ward Health check' was carried out to monitor key performances. The areas audited included patient safety issues, staffing, staff attendance and incidents. The audit helped to identify the direction of travel for each key performance within each unit. For example in the general intensive care there were two medication administration errors reported in December 2015 but in January 2016 there was one error reported. In December 2015 the neuro CCU reported as 100% harm free care; due to incidents in January 2016 it reduced to 88.1%.
- Managers said the key performances measurements for each month helped them identify trends and take action in a timely manner. There was also a criterion for escalation, if a unit /ward scored worse in three areas.
- As part of quality measurement in November 2015, the West Yorkshire Critical Care Operational Delivery Network (WYCCODN) undertook a peer review process to assess the compliance of LTHT's core critical care units against the D16 service specification. The trust and the CSU were asked to consider the following recommendations:

- A significant trust-wide focus on patient flow, particularly in relation to step-downs from critical care. This would support not just D16 compliance, but CQUIN compliance, elective throughput, timely admissions from emergency departments.
- Development of a clear time-line for the integration of Thoracic HDU and Orthopaedic HDU into core adult critical care (ACC) units.
- Negotiation with commissioners for an appropriate tariff payment.
- Development of the consultant establishment in ACC to support ward-round and on-call requirements.
- Business plan proposals in Adult Therapies are supported around additional physiotherapy posts to support 7-day working in ACC.
- Critical care nursing staff to be supported through a new post-registration academic module at Leeds Beckett University, commencing in Sept 2016.
- Progression of a business case to support ICNARC data collection on outstanding Critical Care units (J81 and L04/05). Work was in progress to address the above.

Leadership of service

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

Culture within the service

- It was identified by staff and the managers within the two separate hospitals' critical care units that the staff culture was different. Therefore, to help with integration an external facilitator was sought. Staff told us that they had one to one and/ or group conversations where they received directions on how to work together as a team and not lose their identity, expertise and enthusiasm in what they did. Staff gave positive comments about the external facilitator who had worked to narrow the gap in the culture between staff from the two sites.
- Staff said the managers were visible and approachable. They said the board members often shared the same transport between the hospitals and were accessible to staff and people who used the services.
- Staff commented that they felt valued by their line managers and colleagues.
- Matrons and the head of nursing for the CSU told us they supported staff with behaviour or performance issues with the help of their human resource team. They avoided a blame culture and helped staff overcome their issues. This was supported by staff comments.
- Multidisciplinary staff we came into contact with worked collaboratively and shared responsibilities to deliver good quality care.
- Multidisciplinary staff we spoke with understood what Duty of Candour meant. They said it is all about sharing

accurate and factual information with patients and/or their representatives to help them understand what had happened. Offering verbal and written apologies and maintain integrity and transparency.

Public engagement

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

Staff engagement

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

Innovation, improvement and sustainability

- Introduction of Band 1 health care assistants who have taken over the cleaning around the bed areas, stocking up of disposable items in patient areas. This has given Band 2 staff the chance to assist nurses when delivering personal care to patients.
- A volume sensor which was referred to as the 'Big Ear' was used in some units to monitor and sense the sound levels. Neuro HTU at LGI used it to help staff control the levels of noise so patients were able to rest.
- At each medical handover, a team brief was completed which included staff introduction, staffing and capacity, infection control, coroner's referrals and death certification, training and education, audit data collection and communication points such as patients safety alerts, quality safety issues and performance update. This was observed by us during our inspection.
- To pursue patients' progress in the community and get feedback from patients who had received care in the critical care units a Coffee morning was held with ex-patients in May 2016. Staff said it was a success and they were planning on having a get together three to four monthly meetings. This is to empower patients and listen to their suggestions to improve their practices and to ensure the service was influenced by patients who are the service users.

Maternity and gynaecology

Safe	Good
Overall	Good

Information about the service

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

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

The service at Leeds General Infirmary included pre conceptual care, early pregnancy care, antenatal, intra partum, postnatal care and a home birth service for low risk pregnancies.

The maternity service at LGI delivered 5,014 babies between April 2014 and March 2015.

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

The service offered both medical and surgical termination of pregnancy (TOP). Between April 2014 and March 2015, there were 22 medical and 2 surgical terminations carried out. There were processes in place to ensure the sensitive disposal of pregnancy remains.

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

This inspection took place on the 10, 11, 12 and 13 May 2016. It was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection. We inspected the antenatal clinic, antenatal day unit, maternity assessment centre (MAC), antenatal and postnatal wards, delivery suite and obstetric theatres.

We spoke with three women who used the service and their partners, and 29 staff. This included midwives and community midwives, midwifery support workers, student midwives, ward domestics, doctors, anaesthetists, consultants and senior managers. We also held staff focus group meetings to hear their views of the service they provide. We observed care and treatment, inspected five sets of care records and we reviewed the trust's audits and performance data.

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

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as good because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Records relating to women's care were of a good standard and were kept secure in line with the data protection procedures.
- There was a 'Safe Staffing Levels and Escalation Protocol' for staff to follow.
- Women's privacy, dignity and independence was maintained wherever possible. For example, in antenatal clinic staff asked for chaperones in line with the trust's policy when carrying out intimate procedures.
- Staff within the CSU spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.

However:

- Medical staffing levels did not meet national guidelines.
- Not all staff were up to date with mandatory training.
- Due to insufficient dedicated theatre staff to 'scrub' and recover patients, midwives were taken away from their duties when a second theatre team was needed; this occurred an average of twice a week.

Are maternity and gynaecology services safe?

Good

We rated the service as good for safe because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Records relating to women's care were of a good standard and kept secure in line with the data protection procedures.
- Systems were in place to protect patients from abuse and staff were aware of the procedures to follow.
- There was a 'Safe Staffing Levels and Escalation Protocol' for staff to follow.

However:

- Medical staffing levels did not meet the national guidelines of 98 hours a week labour ward cover.
- The trust was not meeting its 80% target, for mandatory training. For example, for children and adult resuscitation.
- Due to insufficient dedicated theatre staff to 'scrub' and recover patients, midwives were taken away from their duties when a second theatre team was needed; this occurred an average of twice a week.

Incidents

- Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Between March 2015 and February 2016, there were 1246 incidents reported in gynaecology and maternity services. Of these, 1201 were reported as no harm caused, 37 reported as minor injury, seven as moderate harm and one was reported as severe harm caused. Common themes were not identified in the injuries reported as moderate harm

- Between October 2014 and September 2015, there were four serious incidents reported at LGI: one intrauterine and two neonatal deaths. The fourth incidents investigation had not been completed at the time of our inspection.
- A root cause analysis (RCA) had taken place in all three cases, which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons be learnt, to prevent the same incident occurring again. Action plans and recommendation summaries were shared with staff and commissioners.
- Lessons learned had been shared with all staff via email, monthly and quarterly risk maternity management reports and discussed at the monthly perinatal morbidity meeting. Actions and feedback was also provided to staff via the weekly team bulletin and displayed on the staff noticeboards.
- Staff were able to give examples of feedback received from the incidents; recommendations and the lessons learnt. These included the recommendation for the development of a rolling maintenance and repair process for the cardiotocography (CTG) machines. CTG is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The replacement of the machines had taken place.
- Perinatal mortality meetings were held. We saw a Safeguarding Children's Board, Child Death Overview panel met where they discussed neonatal deaths. This was attended by a multidisciplinary team of staff, including a consultant in public heath, consultant neonatologists, obstetricians, the head of midwifery, the risk management midwife, bereavement support midwife and safeguarding midwife.

Duty of Candour

- The duty of candour (DOC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014. Staff could explain the duty of candour and spoke about being open and honest.
- Prior to the introduction of the DOC regulation , communications were sent out by the trust explaining the DOC and included presentations to raise awareness. This was supported by a trust wide Quality and Safety Matters briefing, which was circulated in April 2015 and recirculated again in March 2016.
- An e-learning tool was available for all staff to complete on the trust intranet.
- The DOC had been included as part of the Being Open, and the 'Serious Incident procedures. It was also being included as part of the Root Cause Analysis training and Lead Investigator training.
- Staff told us, they understood the need to be open and honest with families, when things went wrong.
- We saw an example of DOC, where a women's care had not gone according to plan. They had received an explanation from the consultant involved in their care and the Risk Midwife. A letter of apology was sent from the Chief Executive of the trust. This showed the trust was open and transparent with patients about their care and treatment when things went wrong.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at patient harms such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The trust had started to use the maternity safety thermometer towards the end of 2015. Data showed that between October and November 2015, they had 95.7% harm free care. In January 2016, they had 100% harm free care across all services.
- All areas inspected displayed information collated from the previous month. It showed patients had received harm free care in April 2016.

Cleanliness, infection control and hygiene

- The patient led assessment of the care environment showed the trust scored 99% for cleanliness against an England average of 98% in 2015.
- The areas we visited were visibly clean and equipment had stickers on them, which showed they were clean.
- Monthly cleaning audits were completed and displayed in all wards and departments. For example in April 2016, the antenatal/fetal assessment department scored overall, 97.83%.
- On the delivery suite and wards, we saw carbonated books, which reflected the cleaning of each room and

equipment once a patient had vacated. We saw a copy of the record was put into the patients notes who next occupied the room. This provided evidence the room and equipment had been cleaned and by whom.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of wards and departments. There was clear signage encouraging visitor and staff to wash their hands.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- The trust completed a monthly audit of staff hand hygiene. Within women's services, between April 2015 and February 2016, the audit showed the antenatal ward and delivery suite achieved 100% compliance. Whilst the postnatal ward achieved 100% compliance from September 2015 to February 2016. All areas we inspected had achieved 100% compliance in April 2016.

Departments and wards displayed 'Open and honest care boards. For example, on delivery suite we saw how there had been no cases of either Methicillin-resistant Staphylococcus Aureus (MRSA) bacteria, or Clostridium difficile infections for 365 days.

Environment and equipment

- Access to the wards and delivery suite was via an intercom system. All staff needed swipe cards to access the unit.
- Delivery rooms had en-suite facilities and a shower.
- Several of the wooden doors on delivery suite were showing signs of wear. The management team and staff informed us that an environmental audit had taken place and a business case for a programme of refurbishment had been made.
- Resuscitation and emergency equipment checks were taking place in each area we inspected. This meant the equipment would be available in an emergency.
- In one of the theatres, there were several disposable instruments out of date. This was brought to the attention of the theatre staff who removed them immediately.
- Equipment was available to meet people's needs. For example, oxygen and CTG machines. Fifty CTG's were reported to have been recently purchased and these were to replace those, which were likely to fail and not fit for purpose.
- Safety testing of electrical equipment was taking place and had dated stickers on the equipment to show when it had been tested.

Medicines

- Medicines were stored in locked cupboards and trolleys in clinical areas. However, during our visit one of the wards had an emergency trolley stored in a patient accessible area. The trolley contained medicines. This was brought to the attention of the staff at the time and the trolley was moved to a clinical secure area. The medicines were stored correctly.
- We also brought to the attention of the delivery suite staff, the sharps waste disposal bin, which was located on the main corridor. The bin was open and there was a risk of someone being able to put their hand in and remove the contents.
- Medicines that required storage at a low temperature were stored in a specific medicines refrigerator. All fridge temperatures were checked and recorded daily. We found there were no gaps in recording. Nurses and midwives told us they received support from the pharmacist, when necessary.
- Records showed controlled drugs were stored and checked in line with hospital policy.

Records

- An audit was carried out on the record keeping of women's care during labour in October 2015. The results were encouraging for general observations of maternal wellbeing during labour for example, temperature, pulse and blood pressure. However, more specific observations, such as abdominal palpation, contractions and the third stage of labour were not well documented. An action plan had been written to address the shortfalls. A repeat audit would take place in July 2016. One of the themes of the week in the risk management team newsletter, dated March 2016, referred to the audit and the action to be taken by all staff. This included following the maternal observation guidelines during labour.
- Record keeping audits in each unit and ward area took place each month. The information audited included, documentation, twice daily recording, risk assessment monitoring, referral for at risk patients and recording fluid balance where appropriate. For example, between April 2015 to February 2016 antenatal had a score of between 81 to 100%

- We inspected five sets of women's clinical records and medical notes. Records showed each woman had a named midwife or consultant if a high risk patient, responsible for their care. Each record contained antenatal assessments and screening, and a clear pathway of care, which described what women should expect at each stage of their labour.
- The documentation included, a situation, background, assessment, recommendation (SBAR) transfer record; which was used when handing over care between staff. The tool was used in maternity services where there may be multiple handovers between staff. It assists in improving communication, therefore helps in keeping patients safe.
- Risk assessments were fully completed in four out of the five records inspected.

Safeguarding

- Access to the delivery suite and wards was via an intercom system which enabled staff to monitor people visiting these areas. There were environmental systems and procedures in place to protect the security of newborn babies.
- The trust had a safeguarding adult policy and a child abduction procedure, which linked into the children's safeguarding policy.
- Risk assessments and pathways of care were in place to identify women and children at risk.
- The trust had a named midwife for safeguarding who was a resource for staff and who provided support for vulnerable women. They were responsible for managing child protection and domestic violence issues.
- Staff we spoke with told us they understood their responsibilities for identifying and reporting any concerns.
- Safeguarding training was mandatory. The trust was not able to easily provide a separate breakdown of their safeguarding training statistics for each site. However, they confirmed 95.15% of maternity and gynaecology services had received Level 1 training and 74.8% had received Level 2/3 by the 9 May 2016.
- Relevant staff had face to face safeguarding training which met both the requirements of the Level 2 and 3 training. Child and infant abduction training was included as part of the safeguarding training. 75% percent of staff had received this training. Most midwives we spoke with confirmed they had received Level 3 safeguarding training.
- The trust also confirmed midwives participated in initial case conference meetings with social care; follow up review meetings from case conferences; pre -birth planning meetings and strategy meetings on the wards. This participation contributed to the staffs Level 3 safeguarding competencies.
- The trust's safeguarding adults at risk policy identified female genital mutilation (FGM) and guidance in relation to the mandatory process of both reporting and recording newly identified cases of FGM.
- Staff had training and were aware of the procedure and action they would take in reporting.
- The policy directed staff to contact the safeguarding children team, social care and the police where they were concerned about the risk of FGM for a child. The trust had developed a Standard Operating Procedure that provided guidance to staff with regard to FGM. The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. It is mandatory for all acute trusts to report to the Department of Health, on the number of patients who have a family history, or had FGM.

Mandatory training

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

recognised in the training statistics. This could have meant that some of the training statistics were shown on the trust data to be lower in compliance, than the actual training attended by staff.

Assessing and responding to patient risk:

- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Modified Obstetrics Early Warning System (MOEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. All care records we inspected contained completed MOEWS tools. The trust had carried out an audit of the medical staff handovers on delivery suite, between January and February 2016. The audit showed that where applicable, the MOEWS score/deteriorating patient risks had been discussed at each handover during the audited period.
- Trust data showed between April and September 2015, and January to February 2016, there was 100% compliance for referrals of 'at risk' patients and 85.7% compliance across the trust in women's services for October 2015. There were no 'at risk' patients in November and December 2015.
- The World Health Organisation (WHO) devised a safer surgery checklist, which included five steps that should be taken when a patient had an operation. A checklist was used in gynaecology and had been adapted for obstetric procedures.
- An audit of the maternity checklist was carried out from October to December 2015 of five elective section lists. It included 12 cases split over the LGI and SJUH sites. The results for the LGI site, showed 33% of the checklist had been completed. The low result was mainly attributed to staff not signing out at the end of the procedure. The learning and action for staff had been recorded and this included a timescale for completion.
- Staff we spoke with were aware of how to use the checklist. The three notes we inspected, where women had a caesarean section, the surgical checklist had been completed.
- There were clear processes in the event of maternal transfer by ambulance; including, transfer from homebirth to hospital.
- We saw evidence the unit used the 'fresh eyes approach' a system that required two members of staff to review foetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation. In October 2015, 20 records were audited for compliance with fetal monitoring guidelines. Although staff were not always meeting the recommendation of hourly recording relating to CTG monitoring, they were meeting the guidelines standard of two hourly. One of the themes of the week in the risk management team newsletter, dated March 2016, referred to the audit and the action to be taken by staff. This included the hourly recording of the fresh eyes approach to CTG monitoring.

Midwifery staffing

- The midwife to birth ratio had improved since our last inspection to a ratio of 1:29. This was slightly below the nationally recommended Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007) ratio of 1:28.
- The maternity staffing levels were based on the birth rate-plus methodology and factored in the complex case mix of women in Leeds. Between November 2015 and December 2016, an annual review of the staffing was carried out by the Women's service Clinical Governance and Risk Management Forum. The Head of Midwifery presented it to the Maternity Services Clinical Governance, Governance and Risk Management Forum. Six monthly further reviews were to take place in line with the National Institute for Health and Care Excellence (NICE) guidance and staffing levels remained on the risk register.
- The data factored in the corporate guidance in terms of leadership, annual leave and study. The recommendations supported an increased establishment to 359 midwives and an increase of 10.8 maternity support workers to support a midwife to birth ratio of 1:28. Information provided by the trust stated the Trust Board had an agreed investment plan to support the midwifery staffing numbers incrementally, from a ratio of 1:33 in 2014, to the current average of 1:29.
- All of the women we spoke with confirmed they had received 1:1 care throughout their labour and women always have a named midwife responsible for their care.
- We did not receive any concerns from women who had received treatment or care.
- Between June and September 2015, the vacancy rate was 15 whole time equivalent staff. In October 2015, the maternity dashboard showed no vacancies and in

November 2015, the vacancy rate was seven against the trust target of less than five. From August to December 2015, both qualified and unqualified agency staff were used and the amount of staff was recorded as a positive; below the trust target of five.

- We heard how the 'bed manager' midwife established the bed status twice daily and had an overview of the unit, including the work of the hospital based, homebirth team. The day to day management was in collaboration with this manager, team leaders and the 'consultant of the week.' Out of hours, a delivery suite coordinator carried out this role.
- There was a 'Safe Staffing Levels and Escalation Protocol' to assist staff address staffing shortfalls. Changes were made where needed to ensure sufficient staff and maintain safety. A risk assessment form was used prior to the movement of staff. This meant staffing levels were monitored, better organised and staff allocated appropriately.
- Staffing levels of planned versus actual were displayed in the delivery suite and wards and department. On the day of our visit we inspected the duty rotas for March and April 2016. The information showed 129 shifts not covered.
- On the postnatal ward for March 2016, there were 42 'unfilled' shifts on the rota; 54 in April and 42 for May 2016.
- Information provided by the trust, showed in January 2016, the delivery suite actual qualified staffing achieved was 90.5% and unqualified 106.6%. On the postnatal ward for the same period, they achieved 85% actual qualified staffing and 84.1% non-qualified.
- Information also provided showed in February 2016, 8.6 Whole Time Equivalent (WTE) qualified agency staff, 3.5 WTE unqualified staff covered vacant shifts in maternity services across the trust. In March 2016, 10.3 WTE agency qualified staff and 0.10 qualified bank staff were used and 4.3 WTE unqualified agency staff. In April 2016, 9.10WTE qualified and 3.8WTE unqualified agency staff covered vacant shifts.
- Staff reported, on occasions when areas were busy or staff had phoned in sick at short notice, they had been moved to help. They confirmed that the majority of the time, vacant shifts were covered. Staff also told us that the trust had their own secure intranet, staff social network site. They were able to send out an SOS at short notice for staff to cover shifts; they reported how effective this was. They said there was usually someone who could cover the shift and this included managers and supervisors of midwives (SOM's).
- The staff told us the trust were advertising for staff, but were struggling to recruit.
- We heard how new staff had been recruited. Some had not yet started work at the hospital as they were working through the recruitment checks.
- On one of the days of our inspection, we saw five staff on delivery suite were supernumerary. There was new staff in post and staff 'shadowing other staff.' Although the staff on shift may have appeared to be good as far as numbers were concerned, as staff had not completed their induction, they were supernumerary and therefore this showed a deficit in the actual against the planned figures.
- All staff was aware of the 'Safe Staffing Levels and Escalation Protocol' to assist staff address staffing shortfalls and this was monitored through the incident reporting system.
- The Board Assurance Framework May 2016, showed the Trust Board had agreed and had in place, a five year investment plan for nurse staffing. They had identified the risks and had assurance and action plans to address the shortfalls.
- The trust was working with the universities in the sponsoring of staff, with a view to the encouragement of more staff to work at the Leeds hospitals.

Handover meetings

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

Specialist staff/lead roles across the trust included

- A lead midwife for the maternity strategy and matron leads for risk, safeguarding and public health.
- Specialist midwives for fetal medicine, diabetes, FGM support and teenage pregnancies including Family Nurse Practitioner (FNP) links.
- Midwifery leads for peri-mental health, bereavement and substance misuse.

- A specialist "Hammla" team for supporting vulnerable women, including women from black and minority back grounds and travelling communities.
- Two community teams, Leopold and Malvern supported women in the deprived areas of Leeds.
- Gynaecology services had nurse practitioners; colposcopy, hysteroscopy and uro- gynaecology specialists.

Staffing of the second obstetric theatre

- Records showed this theatre was used for 22 cases in a 12 week period; approximately twice a week. There were always midwives on delivery suite who were able to 'scrub' for operations when required and therefore had maintained their competencies.
- The annual review of staffing, carried out by the Women's Service Clinical Governance and Risk Management Forum confirmed the trust did not have a full theatre team to support services. Midwives undertake scrub duties and recovered women post anaesthetic. This had been added to the risk register and monitored.
- A business case had been made to support the provision of theatre staff to meet the needs of the service on both LGI and SJUH sites. The project was being led by the Head of Nursing for theatres.

Medical staffing

- The CQC data pack showed there were 38% (82 WTE) consultants employed by the trust, compared to the England average of 35%. Three percent, middle carer (at least 3 years at Senior House Officer (SHO) or a higher grade within their chosen specialty), 55% registrars and 4% junior doctors (foundation year 1-2). This compared with the England average of 8% middle grade doctors, 50% registrars and 7% junior doctors.
- From April 2014 to June 2015, the average number of hours per week consultant presence on delivery suite was 60hours.
- At inspection consultants, doctors and midwifery staff confirmed there was 60 hours consultant presence on delivery suite each week.
- Cover was provided from Monday - Friday 8.30am to 6pm and an on-call consultant was present until 7pm each week day evening.
- Weekend consultant presence was from 8.30am until 12.30 mid-day. Outside of these hours, the consultants were non-resident on-call. However, the consultants told us that when on-call, several of them chose to provide onsite cover. They said this was not included in the staffing figures.
- Insufficient consultant obstetric staffing levels had been recorded on the risk register. The risk register identified there should have been 98 hours cover. This was in line with the size of unit and the Royal College of Obstetricians & Gynaecologists (RCOG) best practice standard for consultant labour ward cover. The trust had identified there was a deficit of 3.5 WTE consultants.
- Appointments had been made for two consultants and following the inspection the trust notified CQC that the two consultants were now in post. They told us the consultant's job plans were being reviewed and the rotas redesigned to improve consultant cover; this was in the process of consultation. They said these changes would achieve 83 hours planned consultant presence per week from January 2017.
- Additionally, consultant support was provided through the on-call cover arrangements over and above this to further increase consultant presence at the service.
- A business case for a further two consultants was being developed to achieve 98 hour labour ward consultant presence and the trust were in discussions with commissioners about this.
- Staff reported they had no issues speaking with a consultant when needed and they were always contactable.
- Daily antenatal, postnatal and ward rounds took place in line with current guidance and staff reported consultants were supportive and contactable when required.
- Junior doctor worked a shift system and had a first and second on call arrangement. For example, the shifts were blocks of 8.30am to 9pm and 8.30pm to 9am Mon-Thurs, or blocks of Fridays to Sunday; and worked 'normal' days in between.
- The junior doctors told us they were supported by the consultants and staff. The doctors held breakfast 'club' meetings, where they reviewed, discussed, and were supported in medical case discussions.
- The risk register showed there was a gap of 40 unfilled junior doctor shifts each month (identified 1 September 2015 and reviewed 2 February 2016). Recruitment,

training and monitoring of staff was taking place. The new recruits were supplementing the middle grade roles until competent to work on the registrar staffing rota.

Anaesthetist cover

- A resident consultant anaesthetist was based on the delivery suite, Monday to Friday 8am to 6pm.
- In addition to the consultant anaesthetist, a middle grade trainee was resident 24 hours a day, 7 days a week. This grade of staff was dedicated to maternity services and allowed to be on call once assessed as competent.
- Out of hours, a resident consultant supported the trainee anaesthetist. This could also be another trainee anaesthetist should (the consultant be in theatre and) a second theatre be needed, or additional assistance required.
- A further on call consultant anaesthetist was available for advice or practical help, when required.
- Trainee anaesthetists told us they always received excellent support. They told us the consultants were supportive and where able to obtain additional help from another anaesthetist, when required.

Major incident awareness and training

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

Services for children and young people

Safe	Requires improvement
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Services for children and young people were provided by the children's hospital at Leeds General Infirmary (LGI). There was a neonatal unit and transitional care ward at St. James's University Hospital (SJUH).

The hospital provided a range of paediatric services including medicine, general surgery and paediatric intensive care; providing care from Level 1 (high dependency) to Level 4 (highly specialised intensive care). In addition, tertiary level services were provided including paediatric cardiology, paediatric neurosciences, paediatric oncology, paediatric gastroenterology, paediatric liver and transplantation, paediatric cystic fibrosis and paediatric nephrology. There was a range of outpatient clinics covering all specialities.

There were 19 paediatric wards and departments across the trust, including inpatient, day cases and intensive care, with a total of 279 beds. This included 27 beds within the neonatal unit and transitional care ward at SJUH.

The trust had 18,868 episodes of care for children between July 2014 and July 2015, of which 42% were emergency admissions.

We conducted a comprehensive inspection of services for children and young people in 2014. We rated the service as requires improvement for the safe, responsive and well-led domains. This was due to nurse staffing levels regularly falling below expected minimum levels and gaps at middle grade and junior doctor level. The learning from incidents was not shared between units, there were no dedicated areas for young people, there were inconsistent approaches to transition, there was no executive at board level and staff were not aware of the vision of the children's hospital.

During our inspection we visited wards L9, which also had the children's assessment and treatment (CAT) unit, wards L10, L11, L31, L32, L33, L36, L41, L42, L43, L47, L48, L49, L51 and children's outpatients. We also visited the neonatal unit and transitional care ward at SJUH.

We spoke to 55 members of staff including consultants, junior doctors, ward sisters, staff nurses, healthcare assistants, play staff and the management team. We spoke to 20 parents and 15 children and young people. We reviewed 17 sets of records. We held a focus group with staff from the children's hospital during our inspection.

Services for children and young people

Summary of findings

We rated services for children and young people as good because:

- Staff were encouraged to report incidents and learning was shared.
- Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding. However, although the appropriate level training was given, the service was not meeting their target for safeguarding training for staff training and regular safeguarding supervision did not take place.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition.
- Plans were in place for the development of the children's hospital to centralise all children's services. The youth forum provided input into how services were developed. Transition arrangements were good with a lead transition nurse appointed to ensure consistency.
- The CAT unit improved patient access to the hospital and avoided unnecessary admissions; however, the wait in the CAT unit for admission to the ward could be long at times. Some specialities had long referral to treatment times.
- Families knew how to make a complaint and appropriate information was available.
- Children's services had a clear vision and strategy. Staff were aware of the service and trust vision and values. There was an executive lead at board level for children's services. Staff spoke highly of their leaders and were proud to work for the children's hospital.

However:

- Neonatal consultants were covering both St. James's University Hospital and Leeds General Infirmary neonatal units out of hours on a weekend. There was not always sufficient nursing staff on every ward to meet the Royal College of Nursing (RCN) guidance and British Association of Perinatal Medicine (BAPM) guidelines. On five wards, the actual number of staff on duty did not meet the planned number on a regular basis. There were gaps in the junior doctors rotas, which were being filled with locum shifts or consultants were covering.
- We were not assured that all equipment had been safety tested.
- Staff were not meeting expected targets for safeguarding Level 2 and Level 3 training

Services for children and young people

Are services for children and young people safe?

Requires improvement 

We rated safe as requires improvement because:

- Neonatal consultants were providing out of hours cover at weekends to two geographically separate sites simultaneously. This meant that cover during an emergency may be limited and staff felt there was inequality of care between the two sites.
- There were gaps in the junior doctor rotas, which meant there was a risk of the service not providing adequate clinical care. These gaps were filled with locum doctor shifts or by consultants covering.
- Royal College of Nursing (RCN) standards and British Association of Perinatal Medicine (BAPM) guidelines for staffing were not always met. Data provided by the trust showed that planned and actual staffing levels varied between wards, with some wards consistently having less staff than the planned number. Recommended nurse to patient ratios were not met on a number of occasions.
- Assurance could not be given that all electrical equipment had been safety tested.
- Staff were not meeting expected levels for safeguarding Level 2 and 3 training. Staff had achieved 82.9% against a trust target of 85%. Nursing staff did not receive regular safeguarding supervision.
- The safeguarding policy did not contain any information regarding child sexual exploitation (CSE) or female genital mutilation (FGM). Staff told us they had not received training in FGM and it was unclear how much knowledge staff had about their responsibilities concerning FGM.

However:

- Incidents were discussed and learning shared.
- Staff assessed, monitored and managed risks to children and young people.
- Safeguarding procedures were understood and followed.

Incidents

- Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Children's services reported no never events between March 2015 and February 2016.
- There was one serious incident between March 2015 and February 2016. We reviewed the root cause analysis for this incident.
- We saw evidence of learning from this incident. Staff were aware of the incident and could describe what had changed as a result including new systems in to manage difficult airways such as an extubation checklist, individualised plans for difficult intubations and individual equipment available in a difficult intubation box.
- Children's services reported 1,333 incidents between March 2015 and February 2016.
- Systems were in place to ensure incidents were reported and investigated. Staff told us they understood their responsibilities and reported incidents via the electronic reporting system.
- Staff told us and we saw evidence in team meeting minutes that they received feedback and learning from incidents via email and at team meetings. Staff also received a children's hospital newsletter 'The Kite' that contained learning from incidents.
- We reviewed governance meeting minutes. Incidents were a standing agenda item. Key points of discussion and actions agreed were documented. Speciality governance meetings fed in to the children's hospital governance meetings.
- Regular morbidity and mortality meetings took place. We saw minutes from different speciality morbidity and mortality meetings. These minutes were held on the trust computer system for staff to access. A cross-speciality mortality review process had been set up to ensure lessons learned were shared across the children's hospital.
- Staff we spoke with had varying degrees of understanding of the term 'duty of candour'. However all staff could tell us of the need to be open and honest with families. We saw evidence that staff had been provided with information regarding duty of candour in a quality and safety matters briefing.

Services for children and young people

Cleanliness, infection control and hygiene

- All areas that we visited were visibly clean. Handwashing facilities were available at the entrance to the wards. Alcohol hand gel was available with notices informing patients and visitors to use the gel on entrance to and exit from the departments. We saw staff washing their hands appropriately.
- We spoke to 20 parents during our inspection. All said they thought the wards were clean.
- We reviewed ward health check data that showed that in December 2015 children's services were rated green (achieving above 90%) for decontamination of hands by staff (92.3%), patients with an invasive devices care plan (94.9%) and patients requiring source isolation (96.8%).
- Data provided by the trust showed that 87.8% of staff had infection prevention and control training. This was within the trust target of 80%.
- Equipment looked visibly clean. Equipment not in use had stickers on to indicate cleaning had taken place.
- Staff adhered to the bare below the elbows policy and were seen wearing appropriate protective equipment to carry out procedures and personal care.
- Regular cleaning of toys took place. We saw records to indicate this cleaning had taken place.
- Wards displayed their most recent hand hygiene audit results, which showed good results, and information as to how long it had been since they had a case of Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.difficile).
- There had been one case of MRSA and one case of C.difficile between July 2015 and December 2015 within children's services.
- On ward L49, an old shower room was being used as a storeroom. Regular flushing of the shower could not take place, as staff could not access it. Regular flushing of showers reduces Legionella, but Legionella can significantly increase in number if regular flushing does not occur. We brought this to the attention of the trust during the inspection.
- There was only one isolation cubicle available on the children's assessment and treatment unit (CAT). There was therefore a risk that children requiring isolation may be in contact with others.

Environment and equipment

- The children's assessment and treatment unit (CAT) was based on ward L9. This meant that space on both ward L9 and the CAT was limited. Triage of patients took place in the corridor within the entrance to the unit, which meant there was no privacy. Equipment was being stored in one of the bed bays of the assessment unit, as there was a lack of storage space. Intravenous fluids were stored in an unlocked cupboard in the urgent medical assessment room. The ward manager told us they were aware they should be locked away and that lack of space was an issue on the unit. We raised this with the service leads at the time of our inspection.
- We saw that appropriate equipment, such as hoists, was available for children with extra needs.
- Resuscitation equipment was available in every area and daily checks took place. We saw completed records to indicate this. However, the resuscitation trolleys were not locked with a seal. This meant that anyone could access the contents, including the emergency drugs. Good practice would be for trolleys to be locked with a tamper proof seal.
- On a number of wards we saw items of equipment had stickers indicating that their electronic testing was overdue.
- In the neonatal unit at SJUH, 15 pieces of equipment had no indication of any testing having taken place at all. We could not be assured that testing had taken place. This was brought to the attention of staff and managers at the time of our inspection.
- Children undergoing surgery were cared for in dedicated paediatric theatres. This meant that recovery took place in a specifically designed unit away from adult patients.

Medicines

- Staff checked fridge minimum and maximum temperatures daily. We saw checklists to confirm this. Temperatures were within the required range. Staff could tell us of the process to follow if the temperature fell outside the required range.
- Staff handled, stored and recorded medicines, including controlled drugs, in line with national guidance from the Royal Pharmaceutical Society of Great Britain. We observed medicines being stored safely and controlled drugs kept in separate locked cupboards with appropriate checks recorded.
- Pharmacy support was available and staff told us that a pharmacist made daily visits to the wards.

- We reviewed 17 prescription charts. All prescription charts seen had a weight recorded. This allowed for proper prescribing of medication based on weight. All charts had any known allergies documented and reasons for omission of any medication were recorded.

Records

- We reviewed 17 sets of records. Overall, they were clear, accurate and legible. However, there were three sets where it was not clear what grade of doctor was reviewing the child. Nursing and medical records were not integrated. The Department of Health (2010) suggested that best practice was for a single multi-professional record which supports integrated care.
- The electronic patient administration system used a flag system to indicate if a child was subject to a child protection plan, was looked after or had learning disabilities.
- The World Health Organisation (WHO) surgical safety checklist is a tool to improve the safety of surgery by reducing deaths and complications. We saw that those children who were surgical patients had completed WHO checklists within the records.
- GP's received electronic discharge letters, in line with the Royal College of Paediatrics and Child Health (RCPCH) guidance. Copies of the letter were sent to school nurses and health visitors.
- Care plans contained within the nursing records were pre-printed care plans that were not individualised. Best practice would be for the care plans to be individualised and reviewed regularly.
- The safeguarding team audit of records showed that in October to December 2015 90% of records had captured the voice of the child

Safeguarding

- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015. The safeguarding children policy had been written in 2013 and was due to be reviewed in September 2016 Therefore, there was a risk that staff were not working to current guidance.
- There was no specific mention of Female Genital Mutilation (FGM) or Child Sexual Exploitation (CSE) in the safeguarding children policy. In October 2015 a mandatory reporting duty was introduced which requires health professionals to report known cases of FGM in under 18 year olds to the police. The Department of Health (DH) had produced updated statutory guidance on FGM in April 2016. This should therefore be incorporated in to the safeguarding policy.
- All staff we spoke with told us they received some training on CSE in their safeguarding training but did not receive any on FGM. However, information provided by the trust suggested that FGM was included in the safeguarding training. It is unclear therefore how much knowledge staff had about their responsibilities with regards to FGM.
- We saw a standard operating procedure (SOP) that the trust had recently developed for recording and reporting FGM. The SOP had not had an executive review and sign off prior to our inspection so was not in use at the time of the inspection. Procedures relating to FGM appeared to have been slow to develop.
- The trust safeguarding team were notified of any cases where staff suspected that a child was at risk of CSE. From April 2015 to April 2016 there were seven cases identified by the Trust and multiagency procedures were followed, resulting in those children receiving support by children's social care services.
- The trust had dedicated intranet pages for safeguarding accessible to all staff. These intranet pages included multi-agency documentation and links to the Local Safeguarding Children's Board (LSCB) internet pages.
- The trust had in place a named doctor and named nurse for safeguarding. The chief nurse was the executive lead for safeguarding who represented the trust at the LSCB meetings.
- Staff were able to tell us the procedure they would follow if they had a safeguarding concern.
- Staff told us the safeguarding team were accessible and they would discuss any safeguarding concerns they had with the team.
- The Royal College of Nursing Guidance: Safeguarding children and young people – every nurse's responsibility, 2014 states that regular high-quality safeguarding supervision is an essential element of effective arrangements to safeguard children .The trust child protection supervision policy stated that staff should access supervision once every three months. However, nursing staff told us that they did not receive regular safeguarding supervision but would access supervision if they were involved with a safeguarding case.

- Consultant paediatricians had access to weekly safeguarding case peer review. Consultants that we spoke with told us they attended this.
- Figures provided by the trust showed that 95.3% of children's services staff had completed safeguarding children Level 1 training. The trust target was 80%.
- The intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to Level 3 in safeguarding. Figures provided by the trust showed that 82.9% of staff had attended Level 2 and 3 training. The trust target was 85%. The trust wide safeguarding children steering group quarterly report for October to December 2015 identified that the safeguarding team were working with clinical service units in order to reach the required level of training. A full training needs analysis was conducted to ensure staff were being offered the most appropriate level of training in line with the Intercollegiate Document (RCPCH, 2014). The safeguarding team told us that a range of education and activities that provide Level 3 competencies were now available to staff. Evidence for attendance at these events was not recorded centrally, but we were told that it would be in future.
- There was a child abduction procedure available to staff. Access to the children's wards was secure with swipe card access for staff and entry intercoms for patients and visitors.

Mandatory training

- Mandatory training was available in subjects such as fire safety, equality and diversity, the Mental Capacity Act 2005 and infection prevention and control.
- Data provided by the trust showed that children's services had achieved an average of 91%, above the trust target of 80% for mandatory training.
- Staff told us that new staff members completed an induction programme. An induction policy was available.

Assessing and responding to patient risk

- Daily handovers between medical and nursing staff took place that included information sharing about each child and discussions about patient safety.
- Children's services used the paediatric advanced warning score (PAWS) tool, an early warning assessment and clinical observation tool. The charts, PAWS guidelines and deteriorating patient policy included information to assist nursing and medical staff as to the action to take in response to deteriorating scores. We saw evidence of appropriate action taken in response to changing scores.
- The neonatal units did not use the Newborn Early Warning Trigger & Track (NEWTT) assessment tool. Staff told us there was a plan to introduce NEWTT in the surgical new born unit located within the neonatal unit. When asked how they were assured that deteriorating patients are identified at the earliest opportunity we were told that safety huddles were used as a method of recognising deterioration. Staff identified which patients they were most concerned about to ensure that clinical review focused on these patients and the whole team was aware of staff concerns.
- We saw evidence of risk assessments completed on admission. These included infection risk, care needs, pressure ulcer risk, pain, and falls assessments.
- Figures provided by the trust showed that 102 members of staff had current APLS training. There were also 116 doctors, anaesthetists, emergency department staff and resuscitation practitioners trained. Not every ward had a nurse trained in advanced life support on every shift as recommended by the Paediatric Intensive Care Society (PICS) 2015.
- Some of the wards had introduced safety huddles, a quick five to ten minute get together of staff to discuss sick and deteriorating patients, beds, safeguarding issues, admissions /discharges and staffing and pressures. The aim was to decrease avoidable and unanticipated deterioration by increasing situation awareness. The plan was for these to be introduced on all wards.
- The neonatal unit had started to introduce a safety huddle with the ward pharmacist, doctors and nurses.
- Ward L51 had central monitoring so that staff could see patients observations even when not at the bedside.
- From our review of records we identified that patients were seen by a consultant within 14 hours of admission in line with national guidance.

Nursing staffing

- A paediatric safer nursing care assessment tool was used to produce an overall recommended whole time

equivalent for each area. However, service leads acknowledged that acuity and dependencies needed to be looked at again and staffing requirements reconsidered.

- Staffing levels were reviewed bi-annually and more frequently in response to seasonal activity and increased acuity.
- The RCN (2013) recommend a ratio of one nurse to three patients for under two's and one nurse to four patients for over two's. These ratios were not achieved on every shift for some wards. For example, on ward L9 there were 14 beds and it was often staffed by three qualified members of staff, this meant that recommended ratios would not be met. From data provided by the trust it is unclear how many staff were on ward L9 during a shift as the staffing numbers covered ward L9 and the CAT unit. For example, bed occupancy rates showed that for nurse to patient ratios to be met on one day they would need five staff members. Data showed that there were five staff members on a long day but these would cover ward L9 and the CAT unit. There was one member of staff on a late shift and one member of staff on a twilight shift. Therefore, on this day the nurse to patient ratios would not have been met. Ward L10 had 16 beds and was often staffed with four members of staff. Data provided by the trust showed that for 11 days out of 27 during April 2016 recommended nurse to patient ratios would not have been met.
- Data provided by the trust showed that out of 27 days in April 2016 10 days did not have the correct nurse to patient ratio on ward L42 (surgery).
- Staff on wards L9 and L10 told us that it was normal for them to have one less staff member than planned. They said they felt pressured but did not feel that it was unsafe.
- Staff told us they followed an escalation process when short staffed. Bed management meetings took place twice a day to discuss staffing levels and dependencies for each ward. Staff could be moved within the clinical support unit (CSU) at times to help in other areas after an assessment of required skills and competencies.
- On wards L9 and L10, there was no senior nurse (Band 6) on duty on every shift, particularly at night. Royal College of Nursing (2013) guidance says that a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team. We were told that plans were in place to increase the nursing establishment on ward L10 to ensure night time cover was enhanced.
- Data provided by the trust showed that out of 14 days from the 18 April 2016 to 1 May 2016, the neonatal unit at SJUH did not have enough staff on duty for six days to meet nurse to patient ratios as set out in the DH toolkit for Neonatal Services (2009) and the British Association of Perinatal Medicine (BAPM) guidelines. For example on 1 May 2016 there were 18 cots occupied; two intensive care babies, three high dependency and 13 special care. BAPM recommends nursing ratios of 1:1 for intensive care, 1:2 for high dependency and 1:4 for special care. This would therefore have required seven staff on shift, which is what the planned number was; however, the actual number of staff on duty was six.
- Data provided by the trust showed that planned and actual staffing levels varied between wards. For example, over a four week period in April the fill rate for L52 (neurosciences) was 70%, L9 (medical admission and CAT unit) was 88.1%, L10 (transplant surgery) was 83.7%, L31, 32, 33 (oncology) was 91.6%, L51 (cardiac surgery) was 93%, L43 (neonates) was 72.9%, L48 (HDU) was 98.1% and L40 (medicine) was 109%.
- Data showed that over 28 days in April 2016, ward L52 (neurosciences) should have had four trained staff on a long day each day. This establishment was only met on three days. For 19 days there were three trained staff and for six days there were two trained staff. However, bed occupancy rates for ward L52 showed that despite not meeting establishment requirements for staffing, nurse to patient ratios were met for all but one day during April 2016.
- Ward L9 and the CAT unit should have had an establishment of six trained staff on long days for 28 days in April 2016. This was achieved on one occasion. For 21 days there were five trained staff on a long day, for six days there were four qualified staff on a long day and for one day there was three qualified staff on a long day. However, some staff had done early, late or twilight shifts during this time to make up the numbers for part of the shift. For example, on one day when there were five trained staff on a long day there was also one trained member of staff on a late shift and one member of staff on a twilight shift. On the day there were three trained staff on a long day there was a trained member of staff on a twilight shift.

- Staff on L9 covered the ward and the CAT unit. Staff told us that staffing levels meant that two nurses usually staffed the CAT unit, which saw on average 40 patients in 24 hours. The shift coordinator for ward L9 and the CAT unit often had to work on the CAT unit. Staff told us that the patient flow coordinator would help clinically if needed.
- The CAT unit had six beds for those patients that needed fluid challenges or regular nebulisers. Staff told us that if there were a shortage of medical inpatient beds these beds were used for medical patients and extra staff were sent to help, but this did not always happen. However, when we requested information from the trust we were told that the CAT unit had did not have medical outliers.
- Wards 31,32 and 33 should have had an establishment of three trained staff on an early and a late and two trained staff on nights. For April 2016 this establishment was met for 45 shifts. 17 shifts were one staff member below and 21 shifts were one staff member above the establishment.
- The paediatric intensive care unit (PICU) and High dependency unit (HDU) had the required ratio of staff to patients as set out by the Paediatric Intensive Care Society (PICS 2015).
- Ward L42 (surgery) had seven beds that cared for children with higher dependencies. Staff cared for a mixture of higher and low dependency patients. The ward had an establishment of five trained staff. Managers had recognised that the dependency of patients was increasing and accepted that there was a need for an increased number of staff. Plans were in place to recruit new staff and increase the establishment.
- Ward 51 (cardiology) had six high dependency beds. These beds were staffed to a ratio of one nurse to three patients, therefore not meeting recommended ratios for high dependency care of one nurse to two patients. However, recruitment had taken place and new staff were due to start in October to enable ratios of one nurse to two patients to be met.
- The risk register highlighted nurse staffing on some wards as a risk. Activities were ongoing to encourage retention and recruitment. Recruitment had resulted in 14 whole time equivalent (WTE) staff from April 2016 and a further 61 WTE staff due to start in September/October 2016.
- Data showed that paediatric theatre staffing requirements were not being met with a fill rate in April 2016 of 87.3%. Medical staff told us that this had an impact on theatre capacity and staff morale.
- The NHS staff survey 2015 showed that from 224 responses of nurses working in children's services 85% were working extra hours.

Medical staffing

- Medical staffing had been identified as a risk on the risk register, with gaps in junior doctor rotas. Data provided by the trust showed a 0.5% vacancy rate in children's medical staff.
- Medical staff we spoke to said that doctors were feeling the pressure with the difficulties in staffing. Registrars were offered the opportunity for locum shifts, but if those were not covered then consultants were covering. Consultants were doing more work but were unsure how long this was sustainable.
- Data provided by the trust showed that in January 2016 for general paediatrics, bank locums covered higher specialist trainee shifts (HST) 15 times and agency registrars covered 17 shifts. In February 2016, 13 shifts were covered by bank HST's, seven by a consultant covering and five by agency registrars. In March 2016, 18 shifts were covered by bank HST's, 17 by a consultant covering and four by an agency registrar. In April 2016, 28 shifts were covered by bank HST's, eight by a consultant covering and seven by an agency registrar.
- Data provided showed that for the paediatric intensive care unit (PICU) in January 2016, bank registrars covered 10 registrar shifts. In February 2016, bank registrars covered eight shifts and agency registrars covered six shifts. In March 2016, bank registrars covered seven shifts and agency registrars covered 13 shifts. In April 2016, bank registrars covered nine shifts and agency registrars covered 14 shifts.
- For the paediatric surgery registrar rota, data showed that in January 2016, bank registrars covered seven shifts. February 2016, bank registrars covered four shifts. March 2016, bank registrars covered six shifts and April 2016, bank registrars covered eight shifts.
- New and sustainable ways of working were being looked at by a task and finish group. This had resulted in advertising for two non- training grade posts. There were plans to increase this further.

Services for children and young people

- Each speciality had consultants available on site between 8am and 6pm. The CAT unit had consultant cover until 9pm.
- Every child admitted with an acute medical problem was seen by a healthcare professional on the tier two paediatric rota within four hours of admission and a consultant paediatrician within 14 hours.
- Medical staff told us they often missed teaching sessions that they should have attended due to lack of cover. They were limited as to how many clinics they could observe in order to further their development.
- There were two rotas, general paediatrics and speciality paediatrics. Some medical staff felt positive about their speciality during the nine to five period but when they were on call they could be asked to cover other specialities that they were not so confident with. Staff told us that they were able to contact the consultant out of hours if required.
- One of the medical staff told us that two speciality senior house officers (SHO) should cover the wards at LGI at night but if there was a gap in the rota or sickness then sometimes one SHO may have to hold both bleeps. Two specialist registrars would be available for support during this time.
- Eight and a half whole time equivalent (WTE) consultant neonatologists covering both sites staffed the neonatal units at LGI and SJUH. Each site had consultant cover Monday to Friday. One consultant covered both units on a weekend, on site at Leeds General Infirmary until 1pm and on call after that. BAPM standards (2010) say that for all levels of unit it is not appropriate for a consultant to provide out of hours cover to two geographically separate sites simultaneously. The separate neonatal units had been identified as a risk on the risk register with plans to ensure that there were no planned deliveries under 27 weeks gestation and for no long term/complex care to be delivered at SJUH.
- Medical staffing on PICU met the standards set by the Paediatric Intensive Care Society (PICS) (2015).

Major incident awareness and training

- A major incident policy was available. This set out the responsibilities of key staff when dealing with a major incident.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Plans were in place to bring all of the children's services together in one location within the trust.
- A youth forum had been formed that promoted change within children's services. A teenage area was due to be opened shortly after our inspection.
- The CAT unit ensured that children could be assessed by a paediatrician without the need for admission. The Paediatric Ambulatory Near Discharge Area (PANDA) was an area that children and their families could wait, after discharge, for test results or medication. These units improved access and flow through the hospital.
- Arrangements for transition had been improved with the appointment of a lead nurse to ensure there was a consistent approach to transition across the services.

However:

- Some specialities had long waiting times for treatment.
- Some children requiring admission from the CAT unit waited a long time for an inpatient bed.

Service planning and delivery to meet the needs of local people

- Plans were in place for the development of a new children's hospital that would bring together all the children's services in one location by 2021. At the time of our inspection, the different wards and departments were still spread across the trust site at LGI, which meant there was no defined children's hospital. Although staff felt part of the children's hospital, children and families still did not feel as if it was a definite separate children's hospital.
- The trust had a youth forum. Feedback from this forum had promoted change, such as access to Wi-Fi and changes to the menus.
- The trust had developed a teenage area that was due to open shortly after our inspection. The youth forum had input in to the design of this.
- A teenage oncology unit took teenagers from 13-19 years old. Those aged 17-19 were given a choice as to where they would like to be nursed, including at the young adult ward at SJUH.

- The trust was aware of the need to ensure all young people had access to age appropriate services which were responsive to their specific needs and were in the process of developing guidelines to give 16-18 year olds a choice in whether they were nursed on a children's ward or adult ward. At the time of our inspection, those aged over 16 years who were not previously under the care of a consultant were nursed on an adult ward.
- Neonatal community nurses attended the weekly 'board' round which looked at long term planning for babies, immunisations, discussing medication, feeding and allocating a community nurse. This was useful to provide continuity of care to the babies and families.

Access and flow

- Children were seen on the CAT unit for an assessment by a paediatrician without the need for admission. Staff triaged children on arrival to the unit to ensure those requiring more urgent treatment were seen first.
- Those children needing admission from the CAT unit sometimes had a long wait for transfer to a ward. Staff told us that at times this could be 10 or 11 hours. We were unable to obtain any data about waiting times on the unit, as this information was not collected by the trust.
- Flow through the CAT unit could sometimes be difficult due to nurse staffing issues. Medical staff told us that the workload on the unit had been increasing over the past 18 months. Steps were taken to increase medical staff presence on the unit at peak times. However, nursing staff told us that increasing the number of doctors on the CAT unit increased the demand on the nurses. When there were only two nurses covering the unit it was difficult to manage the throughput at times and children had to wait longer.
- Managers told us that the patient flow coordinator could be clinically based on the CAT unit at peak times to support patient flow. They told us that the CAT unit escalation policy was based on a 'traffic light' Resource Escalation Action Plan (REAP) system. The system had four levels: (C)REAP Level Green - Normal, (C)REAP Level Amber - Concern, (C)REAP Level Red - Moderate Pressure and (C)REAP Level Black - Severe Pressure. Each level outlined the pressures faced on the CAT unit in the form of "Core Triggers" and gave multidisciplinary solutions to those pressures in the form of actions and escalation strategies. The core triggers were: Number of patients in the CAT unit , anticipated / expected attendances, number of patients requiring 1:1 or higher level care, number of patients allocated to assessment beds, triage waiting time, minimum staffing levels (as assessed by the nurse in charge), length of time taken from triage to initial medical/surgical review, in-patient bed availability / allocation, transfer time (CAT - Wards)
- The Paediatric Ambulatory Near Discharge Area (PANDA) was an area on ward L40 where children could wait for test results or medication after they had been discharged. Children discharged home but needing daily intravenous antibiotics could be seen on PANDA. This improved patient flow as children who were well could be moved out of beds needed for children who were ill.
- Between January 2016 and March 2016 there had been 35 cancelled operations. Reasons for cancellation included: critical care capacity, ward bed capacity, failure of equipment, theatres, scheduling and ran out of time.
- Every child admitted with an acute medical problem was seen by a consultant paediatrician within 24 hours in line with the Royal College of Paediatrics and Child Health (RCPCH) standards (2015).
- Staff in the outpatients department told us that sometimes clinics ran over and patients had long waits. We spoke to nine families in the outpatients department. Two families said that sometimes there were long waits.
- The NHS constitution (2010) states that people with a referral from a GP should start their treatment within 18 weeks. The target is that at least 92% of people should spend less than 18 weeks waiting for treatment. Data provided by the trust showed that for January to March 2016 five specialities were not meeting this target. For example, in March 2016 surgery was 89.9%, urology 76.3%, immunology and allergy 83.3%, endocrinology 87.2% and cardiology 88.5%.
- Data provided by the trust showed that for urology the longest wait had been 40 weeks, surgery had been 49 weeks, endocrinology 27 weeks, cardiology 29 weeks and immunology and allergy 30 weeks
- The general manager told us that they were looking at ways to reduce the waiting lists and deliver additional capacity. They had recently appointed two new part time endocrinologists and an additional immunology and allergy consultant. They were developing a business case for an additional nurse practitioner in immunology

and allergy. With regard to surgery and urology, additional weekend operating lists were arranged when theatre teams could support this. The service was looking at the possibility of outreach operating.
- The median length of stay was in line with the England average for both elective and non-elective care of children aged one to 17 years. It was higher than the England average for children aged less than one.

Meeting people's individual needs

- Play specialists and youth workers were trained to be learning disability champions. They were able to provide support to staff around patients with learning disabilities.
- Children's services staff facilitated 'get me better' workshops. Children from local special needs schools attended in order to become familiar with hospital and to reduce their anxieties. Learning disability patients had a 'get me better' passport, which informed staff of their needs.
- Staff had access to interpreter services if needed either over the phone or face to face.
- There was a lead nurse to help young people transition into adult services. Her role was to ensure that there was a generic consistent approach to transition across the trust for all services. The nurse had been in post around a year and was looking at 37 different services. All services will eventually use the same documentation to ensure consistency.
- Specialist nurses were available in areas such as renal, bowel, oncology, cystic fibrosis, diabetes, pain and epilepsy.
- Since our last inspection, a paediatric orthopaedic clinic had been opened so that paediatric patients were not seen in the same clinic as adults.
- Facilities were available for parents to stay overnight. Most wards had fold up beds available and there were an additional 11 bedrooms located away from the wards. Parents could also be accommodated in Eckersley House, a 22-bedroom facility funded by the Sick Children's Trust. The PICU had two parents rooms located off the ward. The majority of wards had parent sitting rooms. All wards had facilities for parents to make hot drinks.

Learning from complaints and concerns

- Wards and departments displayed information advising people how to make a complaint.
- Posters encouraged families to speak to matron so that concerns were resolved at an early stage.
- Parents we spoke to said they would feel confident raising concerns if they needed to.
- Data provided by the trust showed that between March 2015 and February 2016 there had been 52 complaints. There was no particular theme or trend noted.
- Staff could tell us of changes made as result of complaints. For example, parents had complained about not being able to have hot drinks on the ward so the ward had introduced cups with lids to ensure parents could have hot drinks at the bedside.

Are services for children and young people well-led?

Good

We rated well led as good because:

- The children's service had a clear vision and strategy.
- Overall, staff spoke positively about the leadership of the children's service and of the trust as a whole. Staff felt proud to work as part of the Leeds Children's Hospital.
- The development of Leeds Children's Hospital TV allowed children and families to explore the wards at the hospital. Children using the services gave feedback.
- Staff felt that there had been positive changes in the two years since the last inspection.

However:

- The risk register did not contain some of the key issues that staff members had identified, such as lack of space on the CAT unit.

Vision and strategy for this service

- The children's hospital had a clear vision and strategy to be the leading provider of healthcare for children and young people in the North of England. The vision was to become a national leader in clinical research and innovation in order to achieve the best clinical outcomes.
- Staff knew the vision and values for the children's hospital and the wider trust.

Services for children and young people

- There was a vision to bring all children's services together in one building as the children's hospital by 2021.
- Some medical staff we spoke to felt that the neonatal services needed centralising and that there was a sense of isolation and inequality of care between the two sites. Service leads told us that they were keen to centralise services on one site. They said that the trust management team recognised this need but it was not a priority for them.
- Service leads told us that there needed to be a bigger focus on general paediatrics. They had a vision of the children's accident and emergency department becoming part of the children's clinical service unit and were working on new pathways of care.

Governance, risk management and quality measurement

- There was an executive lead at board level for children's services.
- The children's service quality lead was also the lead for governance. Different specialities held governance meetings monthly, which fed in to the wider children's hospital governance meetings. We saw evidence from meeting minutes that discussions took place around patient care and safety, clinical effectiveness, risk management, patient experience and public engagement.
- Matrons attended the governance meetings and staff received feedback in team meetings and via email. We saw evidence of this from team meeting minutes.
- The head of children's nursing told us she had an open door policy for staff to raise any suggestions or concerns.
- A risk register was in place. Any member of staff could access the register and place a risk. However, we saw that service leads had raised the majority of issues on the risk register.
- Staff we spoke to on the wards that had identified risks, such as lack of space, had not raised it as a risk on the register.
- Service leads identified their top three risks as the split site neonatal service, nurse staffing and medical staffing. The risk register identified actions to mitigate these risks and were regularly reviewed.
- Service leads were looking at other alternatives to recruitment such as training more advanced nurse practitioners, having paediatric pharmacy prescribers and arranging for an increased intake in the number of paediatric nursing students for 2016/2017.
- A new children's hospital workforce steering group had been established which looked at the functionality of the hospital during the day and during the night. It also had a rota redesign group to address workforce challenges.
- The children's hospital had started a quality improvement forum from January 2016 to share good practice and provide support for ongoing projects. This forum had introduced the safety huddles to the children's hospital.

Leadership of service

- There was a clear management structure within children's services.
- Staff spoke positively about the executive team. They told us that there had been positive changes and they felt there was stronger leadership now than there had been three years ago. They felt communication from the executive team had improved, they were more visible and it was a good trust to work for.
- Staff said there was more evidence of board to ward management.
- Attendance at a leadership and management course was encouraged and we spoke to staff that had attended. Staff felt it had increased their confidence and junior members of staff were encouraged to take charge of the ward on a shift.
- Staff told us that managers were approachable and visible.
- However, the NHS staff survey 2015 showed that out of 224 nurses in children's services, 25% thought there was good communication between senior management and staff.

Culture within the service

- Staff told us they were proud to work as part of the Leeds Children's Hospital. They identified as a children's hospital and felt part of a team.
- Staff told us they felt respected and valued.
- Staff we spoke to appeared to have a focus on improving child health outcomes.
- The NHS staff survey 2015 showed that out of 224 nurses 79% felt able to contribute to improvements at work.

- During the inspection, staff told us that there was a culture of bullying in theatres concerning one speciality. The trust executive team were aware of this and processes were in place to deal with it.

Public engagement

- Children and young people were encouraged to share their views on some wards by the use of a 'washing line'. The children and young people were encouraged to give their feedback by putting tops (positives) and pants (negatives) on the washing line.
- The ward manager on L51 told us that they had purchased televisions in response to feedback received.
- Friends and Family Test (FTT) questionnaires were given to families in a child friendly format.
- Leeds Children's Hospital TV provided an opportunity for children to give their opinions and feedback via a video booth.
- The youth forum had been established to provide feedback on hospital services from the teenagers.

Staff engagement

- Staff told us that participation in the staff survey was encouraged. Results from the 2015 showed that there were 224 responses from nurses within children's services.
- Staff told us they were encouraged to provide feedback and suggest new things. Junior doctors told us that managers were engaging with them to try to find solutions to staffing problems and a workforce steering group had been set up.

Innovation, improvement and sustainability

- Paediatric theatres had developed a parent pager to inform parents when their child was in recovery.
- The development of Leeds Children's Hospital TV allowed families to explore the wards and meet the teams.

End of life care

Safe	Good
Overall	Good

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. All these services were involved in end of life care at Leeds General infirmary.

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

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

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

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

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

As part of our inspection, we specifically observed end of life care and treatment on wards and other clinical areas. We looked at nine sets of patient care records, including medical notes, nursing notes and medicine charts, and 11 do not attempt cardio pulmonary resuscitation orders (DNACPR). We visited the bereavement service, chapel and prayer room, and mortuary. We spoke with 15 staff including ward nurses, bereavement office staff, the mortuary team, allied health professionals, doctors, the SPCT, and senior managers. We also spoke with two relatives and two patients who were receiving care. Before our inspection, we reviewed performance information from, and about the trust.

End of life care

Summary of findings

We rated end of life care as good because:

- Safety incidents were investigated when things went wrong and lessons learned were widely shared among staff to reduce the risk of re-occurrence. Staff were open and honest when they spoke with patients and families about incidents.
- There was clear guidance for staff to follow within the care of the dying person individual care plan when prescribing medicines at end of life.
- There was enough equipment including syringe pumps to support safe care of end of life patients.

Are end of life care services safe?

Good

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

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

However:

- Bereavement office staff could be at risk due to the lack of a safety alarm in their office; they had been previously threatened.

Incidents

- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are in place. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. There were no never events reported in end of life care between October 2015 and February 2016.
- The electronic incident reporting system included a prompt asking staff if the incident was in relation to an end of life patient. This enabled reporting and analysis of incidents to take place.
- There had been 29 incidents reported between April 2015 and February 2016 in end of life care at the trust. It was not clear exactly how many had occurred at the hospital due to the way incidents were collated.

End of life care

- Examples of incidents which occurred at LGI included communication problems between hospital departments, medical notes not being 'tracked' to the correct location and a flood in the basement of the mortuary.
- Staff we spoke with understood their responsibilities to raise concerns and report safety incidents. They told us they learned about incidents which had occurred in other areas by reading weekly 'lessons learned' bulletins.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of duty of candour and told us of the need to be open and honest if something went wrong.

Cleanliness, infection control and hygiene

- We observed staff complying with the 'bare below the elbows' policy, using correct handwashing techniques and also the use of sanitising hand gels. Staff wore personal protective equipment such as gloves, aprons and theatre 'scrubs' (in the mortuary) as required by the trust policy.
- Areas we visited looked clean and tidy.
- Mortuary staff told us porters were responsible for cleaning the concealment trolley once a day. (The trolley was used to bring deceased patients from the ward to mortuary). We told staff the trolley was cleaned after each use at SJUH and queried which of these the correct procedure was; staff were unable to tell us.

Environment and equipment

- The mortuary had a secure access and exit by electronically locked doors. The entrance for funeral directors was screened from public view, and was secure.
- McKinley syringe pumps with safety features were supplied by the equipment 'pool' and maintained by staff in the medical physics department. (Syringe pumps are used to administer subcutaneous medications to patients). Staff told us there were no problems in obtaining syringe pumps.
- Other equipment for end of life patients such as pressure relieving mattresses and electric profiling beds were in use on the wards

Medicines

- We saw medicines in wards and clinical areas were stored safely. Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.
- Patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of pain and other symptoms.
- We looked at five medicine charts and saw anticipatory medicines had been prescribed appropriately. Prescriptions and administration records were completed accurately and clearly.
- There was clear guidance for medical staff to follow when prescribing medicines at end of life. The guidance was within the care of the dying person individual care plan, and included pain and symptom management guidance, the use of anticipatory medicines and the use of syringe drivers.

Records

- We looked at nine sets of patient records and 11 do not attempt cardiopulmonary resuscitation (DNACPR) forms.
- We found that the standard of record keeping in the care of the dying person booklet was good. This multidisciplinary booklet prompted staff to record sensitive issues in a clear comprehensive way to enable safe care to be given.
- Records showed timely interventions had taken place and documentation was contemporaneous (written as soon as possible after care interventions).
- When a patient was identified as nearing the end of life, this personal care plan was commenced. Staff could record discussions they had with patients and their families, the care which had been given and could evaluate key issues. The care booklet also contained

symptom management guidance and visual guides for staff on the safe use of syringe pumps. This meant that safe practices could be communicated to staff and carried out.
- The specialist palliative care team and end of life care teams kept electronic records which meant risks to patients could be handed over effectively and communicated to colleagues.
- There was some duplication of electronic and paper records. This had been reviewed at the end of life care group April 2016. It was too soon to say if changes put in place would reduce the duplication.
- We saw one set of care records for an end of life patient who had artificial feeding still in progress. The dietary pathway booklet had no space for an ID sticker or patient name on the front sheet; there were 16 loose pages with no ID stickers or patient name written on. We spoke with a member of the dietician team who said they would escalate the design of the form to a senior colleague. We also spoke with the ward manager who said they would remind staff about safe documentation.
- All of the 11 DNACPR forms we reviewed were stored correctly at the front of the notes, 90% of them (10 forms) were legible, 10% (one form) had handwriting which was difficult to read.
- In all of the situations where the patients did not have the mental capacity to participate in discussions about resuscitation, there was evidence a conversation had taken place with family members. Ten of the 11 forms had been countersigned by a consultant; this meant safe decision making had taken place.

Safeguarding

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

Mandatory training

- Mandatory training was provided to all staff and the type and level of training was identified as part of individual job roles. Examples of training included; priorities for care at end of life, fire safety, infection, prevention and control, resuscitation, dignity at work, moving and handling, mental capacity act, equality and diversity, and risk and safety training.
- Staff could access their own electronic mandatory training record. The system used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training or were overdue the sessions.
- We did not know the level of compliance for the SPCT or end of life teams as this was not broken down to team level by the trust.

Assessing and responding to patient risk

- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.
- Changes to a patient's condition were recorded in medical and nursing notes and in the care of the dying person care plan. We saw advice and support from the SPCT regarding deteriorating patients had been sought where appropriate.
- Specialist palliative care was provided from 8.30am to 5pm from Monday to Friday, and 9am to 5 pm at weekends. There was also 24 hour access to palliative care advice. At the weekend, one clinical nurse specialist worked across the trust reviewing patients face to face and giving telephone advice. There was also an on call palliative care consultant out of hours who gave medical advice and support.
- We saw evidence in care plans that when patient's needs increased, staff had assessed and monitored their safety. For example when someone could no longer swallow medication.

End of life care

- A graded response observation chart and National Early Warning System (NEWS) scores were used to monitor for patient deterioration. This was a scoring system in which a score was allocated to physical measurements such as blood pressure, temperature, respiratory rate and level of consciousness. The score from the NEWS acted as a trigger so staff could to escalate concerns about patient risk.
- One ward used an acronym to remind staff of steps to take when managing a deteriorating patient who had sepsis.

Nursing staffing

- The trust wide specialist palliative care team had a clinical and educational role and there was a whole time equivalent (WTE) team leader, and six clinical nurse specialists who worked across a rota which provided cover seven days a week. This totalled 8.4 WTE nursing staff.
- Staffing levels had been reviewed and there were plans to employ a further clinical nurse specialist to allow for two staff to work on a weekend.
- The trust wide end of life care team consisted of one WTE lead nurse, two WTE band 6 end of life nurses (and also another WTE band 6 in a seconded post), and a WTE discharge facilitator. Together they totalled 5 WTE nurses. In addition, there was a 0.4 WTE organisational learning facilitator and 1.6 WTE admin support to the team.
- There was a plan for end of life care discharge facilitators to work seven days a week in order to achieve safe discharge at end of life. This would be funded by the 'Better Care Fund' (an NHS England funding programme).
- Specialist nurse staffing in end of life care met the minimum recommended levels (Commissioning Guidance for Specialist Palliative Care 2012, this is the most recent commissioning guidance
- Clinical leadership was provided by the lead nurse for end of life care and the lead clinician.

Medical staffing

- Medical staffing for end of life care included a consultant who was the trust wide clinical lead; there were also four other consultants who supported both palliative care and end of life care, who together provided 31 sessions, or PAs a week, (Programmed Activities). A full time doctor works 10 PAs a week; this meant there was the equivalent of just over three full time consultants. Two of the consultants worked full time providing direct clinical care and supporting professional activities such as teaching and research.
- There were also two other middle grade (staff grade) doctors, who together provided 13 PAs a week.
- The medical staffing was slightly below the national minimum recommendations for hospital specialist palliative care (Commissioning Guidance for Specialist Palliative Care 2012), which recommends a full time doctor per 250 hospital beds. The LGI had around 1100 beds.
- Face to face cover and telephone advice was available seven days a week by doctors on an on call medical rota.

Other staffing

- There was a team of two bereavement liaison officers and a clerical officer. They told us they felt unsafe as they were alone in the small room when giving out death certificates to bereaved relatives. There was no alarm in the room to use in case of a safety incident. They told us a distraught angry relative had threatened a staff member with a knife some time ago. They had felt very vulnerable. This incident was escalated this but no panic alarm had since been installed.
- The bereavement office staff had not received any conflict resolution or personal safety training.
- We raised this with senior managers during the inspection; they had not been aware of the incident or lack of an alarm and told us they would look into this as a matter of urgency.
- There was a team of five mortuary staff at the hospital; we saw that staff had to be regularly borrowed from the mortuary team at LGI to cover busy periods, holidays and sickness at SJUH. There had been an additional locum staff member for two years at SJUH; however they were no longer employed by the trust, which left a vacancy for an anatomical pathology technologist. Staff told us this was a cost saving measure. We could not corroborate this was the case.
- We spoke with senior managers about this; it had already been discussed at the monthly clinical support unit meetings. We did not find out if there were plans to increase the staffing at SJUH.

Major incident awareness and training

End of life care

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

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

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

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Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Medicines were not always managed appropriately. In some services there was inconsistent monitoring of medicines requiring refrigeration and second signatures for checking of controlled drugs. For example out of range fridge temperatures were not always acted upon. Within surgical services audit data showed that national early warning score (NEWS) and escalation was not always correctly implemented. Routine operations were regularly taking place out of hours. Within the Jubilee theatre suite we observed a broken alcohol dispenser. We observed a fridge in the recovery area with what appeared to be blood stained fluid in the bottom. In the changing rooms in Jubilee theatres, we observed blood stained clogs in a storage bin and on the floor which were to be used again. We also observed staff walking around theatres in heavily stained clogs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) Systems and processes must be established and operated effectively to: (2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and

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Requirement notices

contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

How the regulation was not being met:

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

During our inspection, within the ED department at LGI we saw that patient identifiable information was left on display on monitors in patients' bays on four occasions. The information on display did not relate to the patient in the cubicle at the time. This was a breach of patient confidentiality.

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

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

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How the regulation was not being met:

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

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

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

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

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

How the regulation was not being met:

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

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

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