This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Leeds Teaching Hospitals NHS Trust was established as an NHS trust in 1998, bringing together two NHS trusts to form one trust under a single management structure. The trust is one of the largest in England; it employs around 17,900 people and provides in-patient care by having over 2100 beds located within 105 wards.

The trust provides acute hospital services to a population of more than 780,000 people across Leeds and up to 5.4 million people in the surrounding area. The trust is a regional major trauma centre and also provides specialist services on a regional national basis for a number of services such as cancer care, liver disease care and cardiac care.

Trust services were commissioned by Leeds clinical commissioning group (CCG). The trust balanced its budget in 2017-2018, reporting an overall adjusted financial position of a surplus of £18.9 million.

A list of the acute hospitals at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds General Infirmary</td>
<td>Great George Street, Leeds, West Yorkshire LS1 3EX</td>
<td>Acute medicine, major trauma unit, urgent and emergency services, surgery, maternity, outpatients and services for children and young people</td>
<td>Leeds</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>Beckett Street, Leeds, West Yorkshire S9 7TF</td>
<td>Acute medicine, urgent and emergency services, surgery, maternity, outpatients and services for children and young people</td>
<td>Leeds</td>
</tr>
<tr>
<td>Hospital</td>
<td>Address</td>
<td>Services</td>
<td>Location</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>Chapeltown Road, Leeds, West Yorkshire LS7 4SA</td>
<td>Rehabilitation services, dermatology, rheumatology, gastroenterology, trauma and orthopaedics, outpatients and diagnostics</td>
<td>Leeds</td>
</tr>
<tr>
<td>Seacroft Hospital</td>
<td>York Road, Leeds, West Yorkshire LS14 6UH.</td>
<td>Breast services, reproductive medicine, maternity care, oral and maxillofacial surgery, outpatients, motor neurone disease care centre, renal services and ophthalmology</td>
<td>Leeds</td>
</tr>
<tr>
<td>Wharfedale Hospital</td>
<td>Newall Carr Road, Otley, West Yorkshire LS21 2LY</td>
<td>Abdominal medicine and surgery (day ward), oncology (day treatment), outpatients and diagnostics</td>
<td>Otley</td>
</tr>
</tbody>
</table>

(Source: Trust website)

### Is this organisation well-led?

#### Leadership

The trust was led by the board of directors who were responsible for the day to day running and management of the trust.

The board structure comprised of the chair, the chief executive, six executive directors, and eight non-executive directors.

- Chief executive (CEO) had been in since 2013
- Trust chair had been in post since 2013
- Chief medical officer had been in post since 2013
- Chief nurse was appointed in 2013 also appointed as deputy chief executive and chief operating officer in 2015
- Director of strategy and planning, had been in post since 2014
- Director of finance was appointed in 2017
- Chief digital and information officer was appointed in 2017
- Director of human resources and organisational development had been in post since August 2018.

#### Board members

There was a stable board team with the majority being in post for over five years. Four new non-executive directors had joined the board in 2018. The non-executives told us they had confidence in the executive leadership and were kept up-to-date and well-informed.

Of the executive board members at the trust, there were none who were of a British minority ethnic background (BME); 43% were female.
Of the non-executive board members there were 11% from a BME background, this meant that BME groups were under represented at board level. Female non executives made up 22% of the board.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.%</td>
<td>43%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>All board members</td>
<td>6.2%</td>
<td>31.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

We saw a clear distinction between the executive and non-executive roles and functions of the board. The non-executive directors chaired the four board sub-committees and each committee had an executive lead. The committees included finance and performance, quality assurance, audit and the remuneration/nomination committee; these committees provided support, oversight and insight around performance and goals.

The chief executive undertook formal appraisals of the executive board, and the chair undertook appraisals of the chief executive and non-executive directors. The chief executive and chair’s appraisal was carried out by NHS Improvement, these appraisals were linked to objectives, and we saw evidence of this within the personnel files we reviewed.

We found during our inspection and from monitoring the trust throughout the year that the board was forward thinking. It considered matters which were vital to the success and strategic direction of the trust. There was continued focus on strategy, the culture, talent management and succession, and investment for the business of the trust.

**Leadership**

We found that leaders had an appropriate range of experience, skills, and knowledge to perform their roles, both at the time of the appointment and on an ongoing basis. We found that leaders were visible, approachable and worked well together. There was a strong sense that leaders worked collectively and collaboratively. Front line staff recognised most of the board team, and told us they thought highly of the chief executive and the team. We saw, and staff told us there was a planned leadership ‘walk around’ programme across the year, the board and senior managers visited clinical areas across the trust locations. The walk arounds increased visibility and provided opportunities for staff to discuss issues with leaders. Following the walk around, a leadership walk round a summary was provided to the CSU triumvirate and an annual report of key themes reported to the quality assurance committee, which was a formal committee of the board.

The leadership team described how they monitored patient safety, quality and performance. Senior leaders demonstrated an understanding of the priorities and challenges facing the trust, for example, financial and operational performance, quality and patient safety.

The trust had 19 clinical service units (CSUs) delivering services. Eighteen CSUs provided services for patients; these CSUs were as below.

<table>
<thead>
<tr>
<th>Abdominal medicine and surgery</th>
<th>Leeds children’s hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult critical care</td>
<td>Leeds dental institute</td>
</tr>
<tr>
<td>Adult therapies</td>
<td>Medicines management</td>
</tr>
</tbody>
</table>
The corporate CSU supported the smooth running of the trust and those services encompassed:

<table>
<thead>
<tr>
<th>Corporate operations</th>
<th>Human resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate nursing</td>
<td>Informatics</td>
</tr>
<tr>
<td>Estates and facilities</td>
<td>Medical directorate</td>
</tr>
<tr>
<td>Finance</td>
<td></td>
</tr>
</tbody>
</table>

We saw evidence of collective leadership and collaboration across job roles. Each CSU (apart from the corporate unit) was led by a triumvirate team; each triumvirate was clinically led by a clinical director, who was supported by a head of nursing and a general manager.

Each clinical support unit was responsible for delivery of performance, quality, safety and financial standards. The board reviewed the CSU strategy and performance at least once a year, the trust used a devolved accountability model which meant each triumvirate had the authority to make decisions.

We saw there were clear priorities for ensuring sustainable, compassionate, and effective leadership. There was a talent and leadership development strategy which contributed towards succession planning. The people strategy outlined leadership development methods used at the trust, this included medical and clinical leadership courses at introductory, foundation and advanced levels. The trust also had management and leadership apprenticeships. Applications were encouraged from staff irrespective of age, ethnicity or other protected characteristics.

The Leeds improvement method (LIM, see the next section below) supported senior clinicians and managers to undertake the leadership programmes. The trust also supported staff to join the regional and national aspiring director of nursing and chief operating officer programme. There was support available for future non-executive directors via the ‘Insight’ programme.

In the period April 2017 to March 18;
- 429 staff participated in leadership development programmes

In the period May 2017 to May 2018;
- 423 staff accessed leadership and management development programmes (including the shadow board programme)
- 206 staff participated in lean for leaders
- 25 staff participated in advance lean training

In 2018-2019 the trust planned to deliver the ‘moving forward’ programme to target BME staff in bands 5, 6 and 7 to participate in leadership programmes.
(Source; RPIR)

In 2017-2018 the trust ran a shadow board programme with an aim of identifying and supporting aspirant directors in the organisation. In addition, a recent non-executive appointment had made from the ‘Insight’ programme.
During the inspection, we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Person Requirements (FPPR) (Regulation 5, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This regulation ensures that directors of healthcare providers are fit and proper to carry out this important role.

We checked six director’s files and found that all six files were compliant with the FPPR regulation. We also saw that the trust carried out fit and proper person checks on senior staff who contributed to the board, for example service managers. The files we reviewed generally showed appropriate evidence of robust pre-employment checks for both executive and non-executive directors; however, we noted that disclosure and barring service (DBS) checks were out of date in four of the six files that we reviewed. We noted the local policy was not to have retrospective DBS checks for staff unless they change roles. All new staff had DBS checks. The trust had a clear process for checking that directors were fit and proper on an on-going basis.

**Vision and strategy**

The trust’s vision was ‘to be the best for specialist and integrated care.’ This was supported by five goals:

- To be the best for patient safety, quality and experience
- To be the best place to work
- To be a centre of excellence for specialist services, research, education and innovation
- To offer seamless, integrated care
- To be financially sustainable

Front line staff could articulate the vision to us and most people we spoke with knew that patient safety and good care were at the heart of the trust goals. They could explain to us how the work they did contributed to achieving the goals.

In 2014 the trust published their five year strategy. It set out how a shared set of goals and values called ‘the Leeds Way’ would be achieved. The strategy was updated in 2016 following the publication of the NHS Five Year Forward View. We saw that the strategy had been co-ordinated with stakeholders, local patient involvement groups, public consultation meetings, and aligned to local system wide sustainability and transformation plans.

The trust had been successful in being selected as one of the first five trusts to take part in the NHS Improvement partnership working with the Virginia Mason Institute in Seattle. The trust implemented the Leeds Improvement Method (LIM) because of this work; the trust aim was to empower staff to ensure they had continuous quality improvement across the organisation. Over 7000 staff had been trained in the LIM. The trust told us benefits of this methodology were efficient use of resources and improved patient experiences and outcomes. Staff told us about lean management, improving patient flow through the organisation, and quality and safety improvements.

Senior leaders told us the key to achieving the strategy, goals and transformation was dependent upon engaging doctors, nurses, allied health professionals and other staff in improvement programmes that demonstrated results. Staff understood the quality improvement methods, values, goals and vision were interconnected to improving patient experiences and outcomes. We saw front line teams were supported and empowered to improve care for patients by being part of improvement collaborative groups. There were strategies to support the care of vulnerable groups of patients such as those living with dementia or learning disabilities.
Recent and ongoing work to improve care for patients included:

- Reducing the number of cardiac arrests; the trust incidence of cardiac arrests per 1000 admissions at St James’ hospital was 25% lower than the national average
- More timely administration of medication for people with Parkinson’s disease; the average percentage of late or omitted Parkinson’s medications on wards dropped from 15% to 3.7%.
- Reducing the incidence of pressure ulcers; wards such as J43, J21 and L7 went over 440 days, 300 days and 200 days respectively without pressure ulcers occurring during 2017.

The trust used a strategic framework which had been built on over a number of years. The intention of the framework was to provide a structure to guide the organisation’s long term planning decisions. It focussed on the vision for the trust and was supported by layers of goals, strategies, and objectives.

During our inspection we saw there were clinical business strategies for each of the CSUs. These local strategies provided a ‘bottom up’ perspective through the involvement of trust clinicians and front line staff. We saw from board papers that the strategies had been discussed and agreed with the board.

We saw CSU business strategies which had been updated with the board in 2017. Examples of such strategies included the emergency and specialty medicine CSU clinical business strategy; this clearly demonstrated facts and figures such as bed base, resources and capacity, budget and spending plans, development needs, and staff involvements. Each CSU strategy summarised the CSU’s ambition for the next five years; it included key objectives and the approach to achieving them.

The strategic framework also used strategic developments which were major initiatives to support the trusts goals. The developments were developed partly from discussions with the CSUs yet also reflected the local, regional and national ‘top down’ planning agenda. Examples included the development of the Leeds children’s hospital, and the new configuration of genomics in the region.

We saw strategic ‘enablers’ were used to enable teams to deliver their parts of the strategic framework. These enablers were approved by the board and included:

- The Estate Strategy (2015-20)
- The Informatics Strategy (2015-20)
- The People Strategy (2015-20)
- Research and Innovation Strategy (2015-2020)
- The Quality Improvement Strategy (2017-2020)
- The Five Year Finance Plan (2018-23)

There was a medicines optimisation strategy which promoted safer use of medicines and a collaborative city-wide approach to improving patients experience in using medicines. Some of the work from the strategy included ‘connect with pharmacy’; this was referral from the trust to community pharmacies in order to support improvements to medicines-related transfer of care, and to reduce medicines reconciliation errors in the community.

In line with strategic framework, the trust set specific objectives to underpin the strategies, so it could measure its performance. The objectives were used in annual appraisals and accountability meetings. The objectives were to;
Act on feedback received from patients to deliver patient centred care and improve services.

Ensure the trust provided a leading range of specialist services to the patient communities it served.

Achieve high standards of care for patients.

Seek out complementary business development growth opportunities to benefit the trust, patients and the Leeds city region.

Empower staff to drive continuous improvement and become the safest healthcare organisation in the country.

Be a nationally recognised organisation for research, innovation and education.

Work with commissioners to deliver timely and effective care for patients, in accordance with the NHS Constitution.

Ensure that staff were amongst the most highly engaged and developed in the country.

Work collaboratively to improve care and services both locally and regionally.

Effectively manage resources across the organisation and support investment in the future.

The strategic framework was overseen by the chief executive and the board. We saw evidence of it being monitored by strategy workshops and strategic planning meetings for the CSUs. Board papers showed how progress was reviewed through committees such as the finance and performance committee, the risk management committee, the finance and performance committee, and quality assurance committees.

Board time out days were held, such as one in June 2018 to review the strategic framework. The board held designated workshops throughout the year to consider strategic progress of the regional health economy. These workshops included topics such as progress against national planning priorities, progress with sustainability and transformation plans (STP) and initiatives involving other stakeholders for example, in the development of the ‘health and care academy’ to improve learning opportunities across the city.

In order to support the monitoring of progress towards the strategies a medical director for strategy and planning had been appointed to the chief medical officers team.

The trust contributed to strategic improvements for the region. It was a member of the West Yorkshire Association of Acute Trusts (WYAAT). The chief executive of the trust was the chair of WYAAT and chair of the chief executive forum. This was a collaboration of six NHS trusts who delivered acute hospital services across West Yorkshire and Harrogate. There were strategic system wide priorities to make improvements for patients by the trusts working more closely together.

Culture

We saw that leaders demonstrated and encouraged compassionate and inclusive working relationships among staff so that they felt respected, valued and supported. There were processes in place to support staff and to promote well-being. Staff we spoke with told us they said that they felt appreciated. Front line staff told us, and we saw during the inspection, the strong, open culture within the trust. We saw that leaders within the organisation promoted the vision and values.

During the inspection, we heard that action was taken in a timely way to address performance and behaviours which were not consistent with the trust values. Staff we spoke with felt empowered to
make improvements and raise concerns. Within the organisation there was a strong focus on learning from incidents and sharing good practice, quality improvement and safe innovation.

Staff we spoke with talked positively about the chief executive and how the chief executive had encouraged a change in culture at the trust over recent years. We saw staff were engaged, positive and willing to speak with us. During the core service inspection, staff described feeling well supported by their managers. They described the chief executive and board as being visible, open, and approachable; we also found that the board members and the senior management team worked well together. Front line staff were passionate about providing the best care they could for patients.

The trust had developed a shared set of goals and a collective group of values and behaviours called the ‘Leeds Way’. Senior leaders told us the Leeds way was about listening, being inclusive and taking on board the very best ideas; that it had been developed using engagement with teams and the use of crowdsourcing technology to undertake the largest staff engagement programme. Front line staff told us they had been part of developing the Leeds way. They had been asked in 2014 by the trust to describe the behaviours and leadership they believed were needed to be the very best and to achieve the trust vision. Staff told us the Leeds way was;

- Patient centred
- Fair
- Collaborative
- Accountable
- Empowered

Senior leaders told us the Leeds way had been used to create an open and positive culture. We saw evidence that the Leeds way was driven through staff engagement, creating a sense of community and pride through two-way communication, reward and recognition, and improving employee health and wellbeing. Senior leaders acknowledged that good leadership was central to the Leeds way.

During both the core service and well led inspections, we saw that the elements of the Leeds way were displayed by staff. Staff we spoke with were engaged and able to discuss the Leeds way and where able to provide examples of its use. It was clear from the inspections, that the Leeds way was embedded throughout the organisation as a set of normal staff behaviours linked to delivering positive patient outcomes.

Examples of how the Leeds way was embedded were observed through a number of mechanisms such as:

- Recruitment and interview
- Induction with chief executive for all new starters
- Executive team met new staff with leadership roles each week and encouraged them to hold them to account
- Annual appraisals assessing all staff against Leeds way behaviours
- Board members and senior leaders spend time on the front line, modelling behaviours
- Communications channels so staff were informed, including ‘team brief’, and the chief executive weekly message.
- Year-long campaign for staff to suggest improvements led to ‘dragon’s den’ pitch to executives
- Regular crowdsourcing ‘challenges’ for staff to identify improvements and solutions to problems
- Health and wellbeing activities such as walking challenges, counselling and support
There was a freedom to speak up (FTSU) guardian. Freedom to speak up guardians are appointed to work impartially and objectively, whilst working in partnership with individuals and groups throughout the organisation, including the senior leadership team. The role was supported by a freedom to speak up policy.

We found some barriers in the freedom to speak up processes. There was no FTSU strategy. The guardian worked for two days a week, which meant there were five days a week when they were not available. However, in addition to the guardian, there were 14 FTSU leads and there was a confidential phone line. The guardian told us the FTSU leads were staff who worked at a senior level in the organisation. This meant that staff may not have always felt comfortable raising concerns with them. The equality characteristics of staff who approached the guardian or FTSU leads were not recorded; we were concerned that there was no way to monitor for themes around bullying and harassment. We also had some concerns that the freedom to speak up guardian and leads had enough dedicated time to fulfil their roles. Following our inspection, the trust told us they had begun to monitor the demographic profile of staff and incorporate this into action plans.

The trust had carried out a self-assessment and planned to develop a freedom to speak up strategy. The FTSU guardian formally reported to the board on an annual basis and reported to the audit committee biannually. The guardian told us on average they received two to three contacts a week which they felt was a low number compared to the size of the organisation.

Staff we spoke with were aware of how to raise concerns with the freedom to speak up guardian. During the period April 2016 to March 2017 a total of 22 concerns were raised with the guardian compared with 19 in the previous 12 months.

The table below shows the broad themes of the concerns

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour</td>
<td>10</td>
</tr>
<tr>
<td>Process</td>
<td>1</td>
</tr>
<tr>
<td>Patient Safety / Quality</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

The trust told us key themes arising from freedom to speak up concerns raised were middle managers not listening and acting on concerns that had been raised. There had been a small number of unacceptable management behaviours which had given the trust some concern (Source: RPIR).

We saw historic performance issues had been appropriately addressed in line with the trust vision and values. We reviewed information relating to two cases of disciplinary processes. The disciplinary policy was in date and the cases we reviewed had been followed appropriately in line with best employment practice and due compliance with employment legislation and statutory professional bodies regulations.

The trust had appointed two guardians of safe working hours. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours and to use their powers to impose financial penalties when safe working hours were breached. Junior doctors used a formal mechanism known as exception reporting to register variations from their agreed work schedule. Exception reports were reviewed by the guardians every morning. In line with requirements, a quarterly report was presented to the board. We reviewed the report of September 2018, which showed that 886 exception reports had been made between September 2017 and August 2018, with an average of 73 exception reports per month. The largest number of exception reports related to the neurosciences area; the clinical area with the least exception reports was critical care, with no reports. In the six months before our inspection, we saw 51% of
the reports were due to staff working later than planned hours, on 65% of these occasions staff had been paid for the additional hours worked. Specific interventions had been made as a result of the feedback received from exception reports, including a review of rotas in vascular surgery and a senior doctor now being present at the late afternoon handover in trauma & orthopaedics, which supported junior doctors finishing work on time.

There was emphasis on the well-being of staff; there was access to an occupational health service where staff could be supported with health and well-being needs. Some staff in clinical areas had access to a clinical psychologist who they could approach for support as needed.

There was a strong reporting culture, and staff were encouraged to be open and honest when things went wrong. All the senior leaders we spoke with understood the importance of staff being able to raise concerns without fear of retribution. We saw serious incidents were investigated fully and appropriate learning and actions were put in place as a result.

The trust had a policy in place relating to the duty of candour and staff we spoke with were aware of their requirements in relation to the regulation. The trust had recently undertaken an internal audit and had received significant assurance as part of the review. (Source PIR P31)

The trust monitored duty of candour requirements through the incident reporting system; all incidents rated as moderate or above were reviewed by the risk management team to ensure duty of candour requirements had been met. This was recorded by the CSU using an incident dashboard. Compliance was monitored at the CSU monthly performance meeting, and organisational compliance was reported to the board as part of the quality report.

Equality and diversity
The trust had an equality and diversity strategy (2015 -2020). This described the equality and diversity targeted ambitions. The aim of the strategy was to address inequalities, provide equality information, and articulate the commitment of the trust. The trust had developed an equality and diversity communications plan which was used as a guide to staff for engagement and training. Overall the trust was achieving against each of the four NHS equality and delivery system grades for the nine protected characteristics. (Source- P108 PIR)

The equality and diversity strategic group was led by the chief nurse, and director of human resources and organisational development. Day to day delivery of the equality and diversity objectives were led by the equality and diversity manager who worked closely with the head of patient experience.

The trust had a series of targeted ambition for equality and diversity:

<table>
<thead>
<tr>
<th>Targeted ambitions for equality and diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>we will take positive steps to increase the representation of BAME staff at Band 8b and above and close the gap by at least 50% by 2020</td>
</tr>
</tbody>
</table>
There were a small number of staff networks for those with protected characteristics. Equality leads had worked for some time worked to build LGBT connections outside of the trust, for example participation in LGBT+ Pride, and hosting a Transgender day of remembrance. However, an LGBT+ network had only been established in 2018. (Lesbian, gay, bisexual, transgender; the plus (+) is to ensure inclusion of other groups.

The equal
tity and diversity five year training plan (2015 to 2020) had been reviewed in February 2018 by the equality and diversity strategic group (Source; ‘Equality and Diversity Training Plan Report - January 2018 - Equality and Diversity Strategic Group’ and appendices). There was a comprehensive equality and diversity communications plan (October 2017 to September 2018); this was a plan to engage with, celebrate, or gain feedback from groups of people at certain time of year, for example during black history month or on holocaust memorial day.

The trust had signed up to the West Yorkshire transgender pledge and throughout the year had worked with the Trans community to provide Trans awareness training for staff.

A BME staff network was formed in 2017, senior leaders told us this had around 50 members.

Senior leaders told us a disability staff network was due to be set up in late 2018.

The ethnic background of the local population was;

<table>
<thead>
<tr>
<th>We will take positive steps to increase the staff engagement score for our disabled staff and close the gap by at least 50% by 2020</th>
<th>We will take positive steps to reduce over representation of BAME and men in our conduct procedures and close the gap by at least 50% by 2020</th>
<th>We will review all new consultant appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will undertake a random sample to review of recruitment and selection processes</td>
<td>We will review our approaches to talent management for staff at Bands 6/7 to release potential</td>
<td>We will improve the experience of Trans staff, patients and carers by providing evidence against all five objectives of the Trans Equality Pledge by 2020</td>
</tr>
<tr>
<td>We will improve the experience of staff, patients and carers with mental health problems by working in partnership with external organisations by 2020</td>
<td>We will improve the experience of patients that do not have a religion or belief in the delivery of our care by 2020</td>
<td>We will take steps to ensure the rate of outpatient do not attends, readmissions, referral to treatment breaches and accident and emergency breaches are broadly representative of the patients we serve in relation to BAME, age and religion or belief by 2020</td>
</tr>
<tr>
<td>We will improve the experience of Lesbian, Gay and Bisexual patients and carers by moving from the Top 20 to Top 10 in the Stonewall Healthcare Equality Index by 2020</td>
<td>We will take steps to ensure ready access to hospital services and information from the first point of contact for all patients and carers by 2020</td>
<td>We will improve patient survey results of older inpatients, young patients accessing Maternity Services, Lesbian, Gay and Bisexual patients accessing Accident and Emergency and BAME outpatients by 2020</td>
</tr>
</tbody>
</table>

(Source: Equality and Diversity Strategy 2015 – 2020)
- White 85%
- Asian/ British Asian 7.7%
- Mixed/ multiple ethnic group 2.7%
- Black/ Black British 3.5%
- Other 1%

The chart below shows the percentage of BME staff in the trust workforce. It indicates the largest percentage of BME staff were employed as medical and dental (non-consultant) staff, followed by consultants, then band 5, band 2 and band 1 staff. The percentages were roughly the same as in September 2015. There was less representation of BME staff employed at bands 8-6 and band 4 and 3 than in the local working population.

![Chart showing BME staff distribution by bands](chart.jpg)

<table>
<thead>
<tr>
<th>BAME Senior Workforce</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.94%</td>
<td>2.78%</td>
<td>3.77%</td>
<td>3.45%</td>
<td>3.50%</td>
</tr>
</tbody>
</table>

(Source: Trust equality duty compliance report)

There was an action plan to ensure staff were treated fairly, the actions included;

- Work with the BME staff network to develop and promote learning opportunities to support BME staff to progress in the organisation.
- The resourcing service to review the training provided for recruitment and to work with the BME staff network to ensure all training supported diversity.
- Further analysis into the ‘drop off’ within the recruitment process for all BME groups.
- Build capacity and capability and improve the demographic profile of dignity at work champions and advisors and FTGU leads.
- To continue to use the national leadership academy tool ‘Maximising Potential Conversations’ in training.

The NHS Staff Survey
The NHS staff survey takes place every year and results are used to inform local improvements in staff experience and well-being. The latest results available to us were from the 2017 survey. The results below are broken down to show where the trust was in the top 20% of trusts, better than average, the same or worse than average. The response rate was 30% which put the trust in the bottom 20% of respondents.
The trust had 14 key findings with results in the best 20% of acute trusts in the 2017 NHS staff survey: In the last 3 years, the trust had moved from the bottom 20% of trusts to the top 20%. The results below indicate how the trust compared more favourably than the national average.

<table>
<thead>
<tr>
<th>Key finding</th>
<th>National average</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 11. Percentage of staff appraised in last 12 months</td>
<td>86%</td>
<td>95%</td>
</tr>
<tr>
<td>KF 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>KF 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.73</td>
<td>3.83</td>
</tr>
<tr>
<td>KF 31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.65</td>
<td>3.76</td>
</tr>
<tr>
<td>KF 20. % experiencing discrimination at work in last 12</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>KF 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>85%</td>
<td>89%</td>
</tr>
<tr>
<td>KF 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>KF 9. Effective team working</td>
<td>3.72</td>
<td>3.8</td>
</tr>
<tr>
<td>KF 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>KF 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>45%</td>
<td>49%</td>
</tr>
<tr>
<td>KF 5. Recognition and value of staff by managers and the organisation</td>
<td>3.45</td>
<td>3.54</td>
</tr>
<tr>
<td>KF 6. Percentage of staff reporting good communication between senior management and staff</td>
<td>33%</td>
<td>42%</td>
</tr>
</tbody>
</table>

The trust had nine key findings better than the average for similar trusts in the 2017 NHS staff survey:

<table>
<thead>
<tr>
<th>Key finding</th>
<th>National average</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 12. Quality of appraisals</td>
<td>3.11</td>
<td>3.18</td>
</tr>
<tr>
<td>KF 17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>36%</td>
<td>34%</td>
</tr>
<tr>
<td>KF 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.62</td>
<td>3.7</td>
</tr>
<tr>
<td>KF 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.75</td>
<td>3.86</td>
</tr>
<tr>
<td>KF 7. % able to contribute towards improvements at</td>
<td>70%</td>
<td>71%</td>
</tr>
<tr>
<td>KF 8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.91</td>
<td>3.94</td>
</tr>
<tr>
<td>KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>KF 26. % experiencing harassment, bullying or abuse from staff in last 12 months.</td>
<td>25%</td>
<td>24%</td>
</tr>
</tbody>
</table>
Percentage of staff satisfied with the opportunities for flexible working patterns

<table>
<thead>
<tr>
<th>Key finding</th>
<th>National average</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 4. Staff motivation at work</td>
<td>3.92</td>
<td>3.91</td>
</tr>
<tr>
<td>KF 14. Staff satisfaction with resourcing and support</td>
<td>3.31</td>
<td>3.31</td>
</tr>
<tr>
<td>KF 32. Effective use of patient / service user feedback</td>
<td>3.71</td>
<td>3.70</td>
</tr>
<tr>
<td>KF 16. Percentage of staff working extra hours</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>KF 13. Quality of non-mandatory training, learning or development</td>
<td>4.05</td>
<td>4.06</td>
</tr>
<tr>
<td>KF 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>KF 16. Percentage of staff working extra hours</td>
<td>72%</td>
<td>72%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results similar to acute trusts

The trust had four key findings with results similar to the average for acute trusts in the 2017 NHS staff survey:

<table>
<thead>
<tr>
<th>Key finding</th>
<th>National average</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 4. Staff motivation at work</td>
<td>3.92</td>
<td>3.91</td>
</tr>
<tr>
<td>KF 14. Staff satisfaction with resourcing and support</td>
<td>3.31</td>
<td>3.31</td>
</tr>
<tr>
<td>KF 32. Effective use of patient / service user feedback</td>
<td>3.71</td>
<td>3.70</td>
</tr>
<tr>
<td>KF 16. Percentage of staff working extra hours</td>
<td>72%</td>
<td>72%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results below average of acute trusts

The trust had three key findings with results below the average for acute trusts in the 2017 NHS staff survey:

<table>
<thead>
<tr>
<th>Key finding</th>
<th>National average</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.91</td>
<td>3.86</td>
</tr>
<tr>
<td>KF 3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>KF 24. Percentage of staff / colleagues reporting most recent experience of violence</td>
<td>66%</td>
<td>64%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results in the bottom 20% of acute trusts

<table>
<thead>
<tr>
<th>Key finding</th>
<th>National average</th>
<th>Trust score 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – overall indicator of staff engagement

The figure below shows how Leeds Teaching Hospitals NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff were poorly engaged (with their work, their team and their trust) and 5 indicating that staff were highly engaged.

The trust's score of 3.85 was above average when compared with trusts of a similar type.

The staff recommendation rate of the organisation as a place to work or receive treatment was 3.86, better than the average for acute trusts of 3.75.
The trust had 5,127 staff take part in the survey. This was a response rate of 30% which is in the lowest 20% of acute trusts in England (44%), and compares with a response rate of 46% for this trust in the 2016 survey.

The trust’s staff retention rate is in the second highest (best) quartile nationally at 86.6% against a national median rate of 85.8% in April 2018. (Source: NHS Staff Survey 2017)

**Workforce race equality standard 2017**

There is a requirement for NHS healthcare providers to implement and report on workforce race equality standard (WRES) in the NHS standard contract. WRES is in place to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. NHS providers are expected to show progress against a number of indicators of workforce equality.

Alongside WRES, NHS organisations use the Equality and Diversity system (EDS2) to help in discussion with local partners including local populations, to review and improve their performance for people with characteristics protected by the Equality Act (2010). By using the EDS2 and the WRES, NHS organisations can be helped to deliver on the public-sector equality duty.

There are nine WRES indicators, four of the indicators focus on workforce data, four are based on data from national NHS staff survey questions, and one indicator focuses upon BME representation on boards. The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for key findings 25, 26, and 21, split between white and BME staff, as required for the standard.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Trust 2017</th>
<th>Average (median) for acute trusts</th>
<th>Comparison with all acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White: 24% 27%</td>
<td>White: 24% 27%</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 25% 28%</td>
<td>BME: 25% 28%</td>
<td>Better</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White: 23% 25%</td>
<td>White: 23% 25%</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 30% 27%</td>
<td>BME: 30% 27%</td>
<td>Worse</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White: 90% 87%</td>
<td>White: 90% 87%</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 75% 75%</td>
<td>BME: 75% 75%</td>
<td>Same</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues? (Yes- responses)</td>
<td>White: 5% 7%</td>
<td>White: 5% 7%</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 16% 15%</td>
<td>BME: 16% 15%</td>
<td>Worse</td>
</tr>
</tbody>
</table>

Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

- KF26. The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- KF21. The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
• Q17b. In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The trust had an action plan related to their 2017 staff survey; staff side representatives we spoke with highlighted both positive and negative issues regarding culture within the organisation. It was clear from these discussions that the trust was willing to work in partnership with unions, and staff were positive overall about the senior management team and the changes that had occurred in the trust since the last inspection.

Staff Survey Action Plan 2018/19

The action plan for 2018/19 had two elements, organisational actions and CSU level actions.

Organisational Issues to address and actions

<table>
<thead>
<tr>
<th>Question</th>
<th>2016</th>
<th>2017</th>
<th>% difference / comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>22b+</td>
<td>3.65*</td>
<td>3.43*</td>
<td>-6.13% (reduced since 2016)</td>
</tr>
<tr>
<td>22c+</td>
<td>4.09*</td>
<td>3.54*</td>
<td>-13.58% (reduced since 2016)</td>
</tr>
<tr>
<td>KF3</td>
<td>91%</td>
<td>89%</td>
<td>Reduced since 2016, worse than average acute trusts</td>
</tr>
<tr>
<td>KF2</td>
<td>3.9</td>
<td>3.86</td>
<td>Reduced since 2016, worse than average acute trusts</td>
</tr>
</tbody>
</table>

*Calculated by staff survey provider

The trust received data from the staff survey provider in December 2017, discussions took place with operational managers, senior nursing staff, communications, the staff engagement group and the board to plan the organisational response. The patient centred improvement plan was agreed as in the table below:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Months</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 1       | April, May, June| Awareness raising of projects to support patient recovery: Think drink - project to reduce pre-operative fasting times and improve patient experience  
Sit up, get dressed, keep moving - project to encourage staff to support patients to get dressed and moving |
| 2       | July, August, September | NHS Big 7 tea 2-6 July 2018  
Celebrating the great care that staff deliver to patients through tea parties.  
Three month campaign to share stories of great patient care using the trust’s crowdsourcing platform. Winning 10 stories to be |
Launch of ‘Me and My Medicine’s campaign, designed to encourage patients and staff to discuss medicines.

3 October, November, December

Supporting staff to stay healthy to deliver patient care through health & wellbeing at work week and ‘Schwartz’ rounds.

Christmas Activity to create positive experiences for staff including:

Be a Santa to a Senior
Reverse Advent Calendar
Christmas afternoon tea for ‘medically fit for discharge’ patients

4 January, February, March

Sharing of the great patient care films.

Feedback from:

Sit up, get dressed, keep moving
Think Drink
Me and My Medicines

CSU level actions

Every member of staff had a summary of their CSU results emailed to them in early January which showed:

- three areas of improvement
- three areas where the CSU performed better than the trust average
- three areas for development

In order to target action in areas that would have the most impact, nine of the 88 staff survey questions were used to inform the three areas for development. These nine were chosen as they impact upon the staff engagement score.

(Source PIR - P122)

Gender pay gap

Gender pay gap legislation requires all employers of 250 or more employees to publish their gender pay gap as of 31st March 2017. The trust employed over 17,500 staff in a range of roles, including administrative, medical, allied health and managerial roles. The trust used the national job evaluation framework for agenda for change staff to determine appropriate pay bandings. This meant there was a clear process of paying employees equally for the same or equivalent work.

In March 2018 the trust published their first gender pay report; it was based on data from March 2017. The infographics below are taken from the trusts published report.

This represents the percentage of how many women and men worked in the trust.
The lower quartile represented the lowest salaries in the trust and the upper quartile represented the highest salaries. The trust employed more women than men in every quartile.

The mean gender pay gap for the whole of the public sector economy was 17.7% (Source: Office of National Statistics - October 2017). At 27.9% the trust’s mean gender pay gap was above that for the wider public sector. This was reflective of the pattern with other trusts in line with a larger number of women in the workforce. In line with other NHS trusts, there were more women in lower pay bands, and a predominantly male workforce in the higher banded medical and dental professions.

The Trust had an action plan which included:

- Continue the talent management programme ‘Talent@Leeds’ to support employees to progress.
- Use the female leaders programme to encourage women to progress more quickly into leadership roles.
- Explore how they can attract more men into the organisation at the lower bands, to create a more even gender balance.
- Raise awareness of shared parental leave entitlements and flexible working opportunities through training and communications.
- Take account of gender in the providing of leadership opportunities, including the NHS Insight improvement programme and shadow board programme.
- Continue the commitment to the 50/50 by 2020 initiative, encouraging an even gender split at board level.
- Offer workshop sessions to consultants to encourage clinical excellence pay awards to consultants across the workforce.
Sickness absence rates

The trust’s sickness absence levels were similar to the England average from May 2017 to March 2018. The overall trend followed a similar pattern than the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey 2018
In the national training scheme survey 2018 by the General Medical Council the trust performed the same as expected for all indicators.

(Source: General Medical Council National Training Scheme Survey)

Accessible information standard
From 1st August 2016 onwards, all organisations which provide NHS care have been legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. It covers the needs of people who are blind, d/Deaf, deafblind and/or who have a learning disability. AIS exists also for people who have aphasia, autism or a mental health condition which affects their ability to communicate.

We found that the trust was not wholly complaint with the standard. The trust told us their focus up to the time of our inspection had been on the central patient administration system (PAS) and had involved creating one ‘patient needs’ flag and development of unique codes for 60 disability-related access needs. When the flag appeared, staff were directed to the list of codes and the access needs of the patient or carer could be identified for action.

Before our inspection the trust told us roll out on the PAS system continued and had been reviewed and audited for assurance of implementation and effectiveness. Since 2016, the percentage increase in the flagging of patient access needs had risen. The trust told us this was low compared to the number of patients recorded on PAS, and in comparison to the local population estimated to have disability-related access needs. Plans were in place to improve compliance with the AIS in areas across the trust with a where there were high numbers of patients with sensory impairments.
Provision in meeting each of the 60 disability-related access needs had been reviewed and was supported by an existing contract with an external provider, Leeds Deaf Blind society. We saw some patients were asked about information or communication needs at certain access points, such as in reception areas. There had been a survey of 33 Deaf and hard of hearing patients from December 2017 to March 2018, but there was no action plan following the survey. There had not been any audits carried out on learning disability provision since 2017 as NHS Improvement asked the trust to take part in a data collection programme taking feedback from patients and staff. The trust undertook a separate audit for patients with autism and children with learning disabilities as the NHSI programme did not include them.

However, there was no standard systems for placing alert flags on electronic patient management (EPM) system to make staff aware of patients who might need communication support.

We found good practice in the use of interpreting services. During 2017-2018 there had been:

- 35,613 bookings for face to face and telephone interpreting services, 93.5% of bookings had been fulfilled.
- 1,151 bookings for British sign language and guide interpreters, 98.8% of bookings had been fulfilled.

The trust were in the process of trialling software, with the aim of making it available on the trust website which would enable patients to access and print patient information leaflets in different languages and large print. The software would also speak to the patient in their own language, in cases where someone was unable to read.

We found that maternity services had developed a number of pathways with external organisations across Leeds for:

- Physically disabled women,
- Women with learning disabilities,
- BME women including refugees and asylum seekers,
- Gypsy, Roma and women from travelling communities.

The trust had recently opened a ‘changing places’ facility in Clarendon Wing at the infirmary. This was accessible toilet facilities which provide height adjustable changing bench, a hoist and a centrally placed toilet for use with people with profound and multiple learning and physical disabilities.

We saw the trust bereavement service had worked with local Muslim and Jewish communities to ensure that the early release of deceased patients for burial was consistently delivered. In 2017, deceased Muslim and Jewish patients were released for burial around six hours after death, compared to 24 hours after death which was the average time in 2012.

**Complaints and compliments**

Complaints made to the trust were used to target improvement and compliments were used to celebrate and embed success.

The chief nurse was responsible for the oversight and management of complaints, a non-executive was lead on behalf of the board. The complaints team reported to the patient experience lead and then to the board. CSUs had oversight of complaints performance and that there was an expectation that the CSUs reviewed complaints, timeliness of responses, and any themes at their local governance meetings. We saw there was learning arising from, and good practice identified in complaints investigations and responses were shared within CSUs and across the organisation; however, there was variation in the documented evidence of this from minutes of the governance meetings we reviewed.
The sharing of learning was delivered via a number of routes, for example, the lessons learned group bulletins. The complaints team shared examples of actions taken following a complaint. For example a delayed referral for physiotherapy led to improvements in the service offered to patients and how waiting lists could be reduced further. The physiotherapy team planned to introduce an electronic referral system so reducing the overall waiting time for patients.

**Number of complaints made to the trust**
The trust received 758 complaints from May 2017 to April 2018. Surgery and urgent and emergency care received the most complaints with 185 (24.4%) and 149 (19.7%) respectively.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number</th>
<th>Proportion of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>185</td>
<td>24.4%</td>
</tr>
<tr>
<td>Urgent and emergency</td>
<td>149</td>
<td>19.7%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>140</td>
<td>18.5%</td>
</tr>
<tr>
<td>Medical care</td>
<td>139</td>
<td>18.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>61</td>
<td>8.0%</td>
</tr>
<tr>
<td>Children and young people</td>
<td>39</td>
<td>5.1%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>16</td>
<td>2.1%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>11</td>
<td>1.5%</td>
</tr>
<tr>
<td>Dental</td>
<td>10</td>
<td>1.3%</td>
</tr>
<tr>
<td>Critical care</td>
<td>8</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>758</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Trust Complaints by Subject Code**
The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>40</td>
<td>80%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months? (01/05/2017 – 30/04/2018)</td>
<td>3,926</td>
<td>Not provided</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)

From 1st May 2017 to 30th April 2018, 29 complainants took their complaint to the parliamentary and health service ombudsman (PHSO, which is the second and final stage of the NHS complaints process). This was a slight decrease in the numbers from 2016-2017. If the PHSO upheld or partly upheld a complaint, action plans were developed as a result of PHSO findings. For example, in one clinical area, all registered nurses worked alongside the palliative care team to help them better understand patients the needs of patients at end of life.

(Source: RPIR)
The overall number of PALS contacts (including concerns, advice/enquiries, signposting and compliments) in 2017-2018 was 4468, compared with 5388 in the previous year (17.1% reduction). The most common themes for complaints were communication, care and treatment and administrative issues.

Compliments
From June 2017 to May 2018, the trust received a total of 244 compliments. The trust provided the following breakdown by division:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total compliments</th>
<th>Proportion of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>73</td>
<td>29.9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>53</td>
<td>21.7%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>39</td>
<td>16.0%</td>
</tr>
<tr>
<td>Maternity</td>
<td>21</td>
<td>8.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>20</td>
<td>8.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>15</td>
<td>6.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>8</td>
<td>3.3%</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Dental</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Not core specific</td>
<td>6</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>244</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Governance
Governance in an NHS trust is about the systems, process and lines of accountability used to ensure the trust run themselves efficiently and effectively in order to provide safe high-quality care. The trust worked in partnership with other organisations to improve outcomes for patients.

Within the trust we saw a clear governance structure in place to facilitate quality, performance and risk information to be escalated from ward through to board. Assurance was provided by the structures in place in the form of groups, committees and sub committees. The board was underpinned by the quality assurance committee, which in turn was underpinned by the quality management group. Sub groups and steering groups fed into the quality management group.

We saw that the levels of governance functioned effectively and interacted with each other appropriately. The governance structure is set out below:
Assurance reports were submitted into the groups and sub groups for a wide range of clinical and non-clinical areas as in the structure below;

(Source RPIR)
The ward health check enabled a robust view of medicines management at an operational level; results were fed into action plans at a CSU level and were escalated when needed through the appropriate governance group. The medicines clinical director was part of the management team at a director level and attended regular meetings to provide an overview and update on medicines management within the trust. The drug and therapeutics group was a well-established multidisciplinary group and provided clear terms of reference for its members.

The following committees reported directly to the board:

- Risk management
- Research, educations and training
- Digital and informatics
- Finance and performance
- Quality assurance committee
- Audit
- Remuneration/Nomination

Each of the committees was chaired by an executive or non-executive director and had terms of reference. The quality assurance committee (QAC) received information from the quality management group (QMG), this group had a number of sub committees, and groups escalating information for example, the following committees and sub-groups reported to the QMG:

- Quality monitoring and assurance sub-group
- Patient experience sub-group
- Infection prevention and control committee
- Safety and outcomes sub-group
- Medicines optimisation group
- Mortality improvement group
- Safeguarding steering groups
- Quality improvement steering group
- Cancer board

There were integrated accountability meetings (IAM) which took place on a monthly basis. The CSUs attended on a monthly basis, but this frequency was reduced if they were a high performing CSU. The meeting frequency was based on the CSUs red/amber green rating. The IAMs were the mechanism in place so the trust could be confident it was delivering on quality standards.

Each CSU had a weekly ‘access’ meeting chaired by the general manager to oversee plans for improvement. There were monthly CSU meetings with their clinical director for assurance they were within their financial controls, and a further monthly meeting chaired with the CSU professional lead to review patient experience, safety and service quality. The CSU’s all presented to the board and risk management committee on a six monthly basis, non-executives spoke with us about individual CSU’s attending the board more frequently if they had concerns. For example if there were financial concerns, the CSU would attend the financial stability board.

We saw there was variation in the way some CSUs reported. We reviewed six sets of minutes from CSU governance meetings and found different levels of discussion, documentation, and identification of risk. There was no use of standardised agendas. The chief executive told us there had been a lot of training and work was ongoing to achieve consistency in the reporting mechanisms.
Ward level assurance was provided through audit of a range of ward metrics and a programme of assurance visits by the corporate nursing team. This was also supported by the board leadership walk round programme.

As part of our ongoing monitoring and engagement with the trust, we observed the July 2018 trust board meeting, the August 2018 patient experience committee, and part of the annual general meeting. At the trust board meeting, we saw senior leaders within the organisation present papers to the board for consideration, for example safeguarding and patient experience leads presented their annual reports. During the meeting we observed appropriate challenge and requests for further information from the non-executive directors to other board members.

The trust worked in partnership with a mental health trust and a community healthcare trust to provide access to mental health assessment and care for children, adults and older age adults. Staff we spoke with showed understanding and a non-judgmental attitude when discussing patients with mental health or learning disability needs. This collaborative approach provided a dedicated service in and out of core working hours. The trust were partners in the senior operational group with the mental health provider. The function of the group was to strategic oversight and assurance to the board. There were a number of groups which had oversight of issues and fed these into the senior operational group. We reviewed minutes and reports from some of the meetings and saw the board had been given assurance, for example in relation to the detention of patients under the mental health act (MHA). However, we also reviewed MHA documentation and saw there had been eight invalid detentions over the four quarters of 2017-18. There were incomplete records for over half of the patients who had been detained from 1 Apr-June 2018. This was pointed out to the trust and we were told the MHA team had expanded prior to April 2018. The team now routinely met with detained patients to explain their rights to them and there was a process to review all statutory MHA records.

There was no policy in the trust for rapid tranquilisation of patients with mental health needs. We saw evidence that the trust was not compliant with NICE guidance for ‘physical health after rapid tranquilisation’. Patients’ who had received rapid tranquilisation were not monitored according to the guidance. Front line staff we spoke with were not aware of the NICE guidance. Senior leaders told us the trust were in the process of reviewing the restraint policy and had put a draft protocol in place for use until the end of October 2018. After our inspection, the trust told us the national recommendations were aimed specifically to mental health inpatient settings. Clinicians at the trust had been advised to contact the mental health trust for advice. The restraint and restrictive intervention policy was approved after our inspection. It included reference to monitoring patients after rapid tranquilisation and guidance that all rapid tranquilisation use should be reported using the incident reporting system.

We had some concerns that areas used for the assessment of patients with a mental health condition, were not ligature free. We pointed this out during the inspection and the trust made immediate arrangement to have the environment reviewed. The CSU was working with the planning and estates teams and acute liaison psychiatry service to review and remove the identified potential ligature points.
Board assurance Framework

The board assurance framework (BAF) was the structure used by the board to identify the principal risks to the organisation in meeting its strategic objectives. The BAF identified the main threats to quality and safety across the organisation based on a range of information.

The three risks of 15 and above were workforce, partnership working and financial performance. The table below indicates the risk score and description.

<table>
<thead>
<tr>
<th>Nature of risk</th>
<th>Risk score</th>
<th>Risk Description: There is a risk that the Trust cannot achieve its strategic goals due to;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>15</td>
<td>Due to the failure to have adequate capacity and capability in place across the trust, resulting in possible harm to patients, poor experience and reduction in quality of care, damaged external relations a long term threat to service sustainability, regulatory breach (e.g. CQC)</td>
</tr>
<tr>
<td>Partnership working</td>
<td>20</td>
<td>Due to the absence of effective partnership working, resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability</td>
</tr>
<tr>
<td>Financial performance</td>
<td>20</td>
<td>Due to insufficient revenue and capital resources, resulting in possible harm to patients, poor experience, damaged external relations and a long term threat to service sustainability</td>
</tr>
</tbody>
</table>

We saw the BAF comprehensibly outlined key controls in place to address the issues; it identified gaps in controls and actions to address the gaps. Mechanisms for receiving assurance were identified, and gaps in assurance mechanisms and actions to address the assurance gaps were documented. The BAF also identified measures of success and achievements underneath the key risks for example;

- an increase in the numbers of registered nurses,
- reduced sickness levels,
- achievements in partnership working
- financial achievements.

Management of risk, issues and performance

There were comprehensive assurance systems to manage risk, and we saw performance issues were escalated appropriately through clear structures and processes. Financial pressures were managed so that they did not compromise the quality of care. However we initially found it difficult to understand how risks in relation to nurse staffing were presented to the board in a way which reflected the day to day challenges for staff. Following our inspection, the trust provided us with further detail (see nurse staffing in this section).

The Trust used the ‘datix’ web based reporting system to capture all adverse events, incidents, complaints, PALS queries, and inquest information. The reports on datix were reviewed by the corporate ‘lessons learned’ group. This group identified key learning and produced a number of resources to support learning, such as newsletters, bulletins, videos, and SBAR (situation, background, assessment, recommendation) alerts.

There were patient safety and quality managers who issued quality and safety briefings in response to themes emerging from incident reports and safety alerts that were issued by national bodies. The briefings were circulated trust wide and were available on the trust intranet. The most
common reported incidents related to falls, pressure ulcers and medication incidents. There were quality improvement (QI) programmes in place for each of these themes which were overseen by senior clinical leads.

We saw the governance structure of the CSUs was used to share learning; there was a named patient safety and quality manager who worked between the operational and corporate teams, and they attended the lessons learned group to share learning on a wider basis. A number of different measures were in place to monitor the effectiveness of the QI programmes; for example, monitoring of harm levels and numbers of cardiac arrest calls. The QI programmes were overseen by the quality improvement group and assurance was provided by subcommittees including the quality assurance committee.

Board to ward assurance in relation to risk and performance was provided through the assurance committees and performance management structures. The board received a quality and performance report (QPR) which set out progress against a range of metrics relating to quality, performance and finance. Operational and corporate risks were monitored through the risk management committee; CSUs presented their highest risks to the committee in a rolling programme, in addition to discussing emerging risks that required mitigation. The risk management committee was chaired by the chief executive and focused on all high or significant risks in order to ensure:

- the correct strategy was used to manage the risk
- effective controls were in place
- action plans were robust for risks that remained ‘intolerant’

**Trust corporate risk register**

Corporate risks were calculated using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Any risks entered on to a risk register were assigned a risk rating. Each risk had an initial, current and a target risk rating. The date that risks were added were included, and review dates were seen. Each risk had existing controls, gaps and mitigating actions. Risks at CSU level were reviewed and discussed at the monthly governance meetings; staff we spoke with said that risks were escalated to the risk management committee if the CSU was unable to mitigate the risk to an acceptable level. Some risks had been on the register for over four years, however they had been reviewed regularly by the risk management committee and board, and actions had been taken to reduce the risk.

The corporate risk register contained details on all identified significant risks. These risks were reviewed on a monthly basis and were most recently reviewed in September 2018 by the risk management committee. There was alignment between what senior leaders told us were the top risks, and what was on the risk register. At that time the significant risks related to the following areas:

- National Standards for:
  - 18-week referral to treatment (RTT) standard
  - 62-day cancer target
  - 6-week diagnostic wait
  - 28 day cancelled operations
  - emergency care four hour target
- Finance
  - Aggregate effect of income volatility
  - non-delivery of the waste reduction programme in 2017/18,
The full corporate risk register is below;

We reviewed board papers and saw evidence the risks were being acted upon and addressed, for example following an IT infrastructure failure, a member of the IT integration team was added to the on call rota to provide support out of hours in the event of a system failure. This would be monitored through the informatics directorate.

There was an integrated accountability framework (IAF) which was used to monitor quality performance. From April 2018 the IAF incorporated financial performance management. The purpose of the IAF was to support the CSUs to achieve operational performance, financial performance, and quality standards for patients. The IAF enabled the board to assess the CSUs,
forecast future performance and to prioritise resources for improvement. A red, amber, green (RAG) rating was used to monitor metrics. Senior leaders told us if a CSU was rated amber or red, additional support was provided which enabled closer oversight and increased challenge until improvements were seen.

Service developments and efficiency changes were developed and assessed with input from clinicians so that the impact of changes on the quality of care was understood. For example, following a board time out day in May 2018 the trust consulted with clinical staff in developing the operational plan for subsequent years which included the development of an integrated case system for West Yorkshire.

Medicines optimisation within the trust was well-led. A multidisciplinary team worked within the CSUs to ensure that medicines were managed well at all levels. Key priorities and strategies were approved at the board and clear action plans were in place. Risks were identified and action plans were regularly reviewed. Medicines incidents and audits were reviewed by the multidisciplinary team and actions and learning were shared at all levels.

### Finances overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£1,172.9m</td>
<td>£1,238.3m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£1.9m)</td>
<td>£18.9m</td>
</tr>
<tr>
<td>Full cost</td>
<td>(£1,174.8m)</td>
<td>(£1,219.4m)</td>
</tr>
<tr>
<td>Budget</td>
<td>£1.2m</td>
<td>£9.1m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview)

The trust had a planned turnover of circa £1,282m (2018/19). The trust had a current surplus of £18.9m 2017/18. This included £29.9m of sustainability and transformation fund (STF). The trust's surplus of £18.9m in 2017/18 was the largest ever made, and the first surplus in four years. This included £29.9m of STF, which included a significant bonus element.

CSU financial performance monitoring was carried out at the integrated accountability meeting. There were finance managers in place for each CSU; CSU’s were RAG rated for their financial control and increased support was offered to CSU’s rated amber or red.

The trust used the term ‘waste reduction’ programme instead of cost improvement, senior leaders told us the use of that terminology improved engagement and commitment to the work streams, and made it simpler for staff to identify waste and improve performance.
Nurse staffing

At both the 2014 and the 2016 inspection, we told the trust it must ensure at all times there were sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels. At this inspection we continued to have concerns about nurse staffing.

During this inspection all the senior leaders we spoke with said that nurse staffing remained one of the top risks for the organisation. The board papers we reviewed showed this to be the case and nurse staffing was reviewed on a monthly basis by the board.

The nurse vacancy rate at the time of our inspection was:
- 14% for registered nurses (which was higher than the national average).
- 15% for healthcare assistants.
- 14% for band 5 (staff nurses)
- 9% for senior nurses

The trust was in the fourth year of a five year staffing plan which had been approved in 2014. Since 2014, there has been a net increase of 322 registered nurses in the trust. In 2017 the trust commenced a number of staffing initiatives. These included new roles for nurses in the trust, skill mix changes, and the appointment of assistant practitioners. Pilot projects were also undertaken with a local university.

Nurse staffing was calculated on three levels:

| Minimum level | The minimum level to ensure safe care, This level was based on professional judgement, and was less than the planned number. |
| Current level | The current staffing establishment. Wards could keep recruiting up to the optimum level then ring fenced money would be used |
| Optimum level | Where the ward wants to be when fully recruited The ward manager can work 2 days a week supernumerary. Calculated on what the team think they will need in the future, based on patient need. |

Senior leaders told us they used a range of tools to assess staffing levels on wards and in clinical areas; this included the national quality board (NQB 2018) guidance on safe staffing by using:
- Use of the safer care acuity and dependency tool
- Professional judgement
- Speciality /bed base requirements (tertiary service provider)
- Clinical metrics (known as ‘healthcheck’)
- RAG ratings
- Nursing red flags
- Care hours per patient day (CHPPD)

Actual staffing was also recorded and reported to the board however we found that shortfalls in nurse staffing were not always wholly captured in reports to the board and information provided in reports did not always indicate the full scale of the issue. Monthly care hours figures and other results were presented to the board every month. A number of wards regularly operated at
minimum levels, that is, less than the planned levels. These included wards J14 (where there had been either one or two registered nurses (RNs) for 22 patients); J19, where there was regularly two RNs for 29 patients; and J8 which was regularly staffed by two RNs and had 31 beds for elderly dependent patients.

Front line staff we spoke with told us they were confused about what was minimum and current staffing. They told us they understood that staffing levels were acceptable once minimum was achieved. Senior leaders told us staffing shortfalls were filled by the use of corporate nurses, who worked to supplement areas where there was insufficient staffing, however this was not recorded on any electronic rota’s, so there was no way for the trust to gain assurance to see how often this happened and if it mitigated the shortfalls on the wards. Some frontline staff told us they were not aware of a corporate nursing staff working on wards to support staffing.

We raised concerns with senior leaders during our inspection in relation to our concerns about the monitoring and oversight of nurse staffing and the impact this potentially could have on patient harms and experience. Following our inspection, the trust developed a new standard operating procedure to address the concerns that we had raised. The trust recognised that although there were processes in place to support CSUs in both determining safe staffing levels, including escalation and the movement of staff, the recording of staff availability and movement relied on manual recording. Following our inspection, the trust expanded the manual pilot record of recording staffing to an electronic recording trust wide. The trust also rolled out the process that had been developed and piloted in surgery in line with the procedure for this. Further to the pilot of a RAG system within abdominal medicine and surgery services, which was taking place during our inspection, the RAG system was rolled out to all ward areas to ensure there was a consistency of assessment of the risks in relation to nurse staffing.

The new process included matrons recording staffing status reports every day (see below) and the reports being sent to senior operational staff and the executive team. Daily oversight of staffing was provided by the director of nursing. Any unmitigated staffing concerns were to be escalated to the chief nurse. Senior leaders told us a weekly status report would be provided to the weekly quality meeting, and the weekly executive directors meeting. We saw evidence after the inspection that informatics, HR and nursing services had met to develop an electronic solution in line with the digital strategy. This was planned to be web-form to enable clinical teams to upload staffing levels in real time.

The RAG procedure included the use of a staffing status report against set criteria as below:

<table>
<thead>
<tr>
<th>Color</th>
<th>Staffing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green - Low risk</td>
<td>Staff on duty meet or exceed current staffing levels and skill mix AND All patient care needs are able to be met</td>
</tr>
<tr>
<td>Amber - Moderate Risk (caution)</td>
<td>Staff on duty are below current staffing levels and/or skill mix but not below minimum level AND All patient care needs are able to be met</td>
</tr>
<tr>
<td>Red - High Risk - (depleted)</td>
<td>Staff on duty are below the minimum staffing levels and skill mix Ensure the Matron has followed the “Actions to be taken when the numbers of nurses or midwives are depleted”</td>
</tr>
</tbody>
</table>

These criteria were used to assess the risk level of staffing and ensure that patient care needs could be met safely.
per shift falls short of the agreed roster template” AND mitigated the risks to ensure all patient care needs are able to be met

Black - Not mitigated
Escalate Datix (HoN to investigate and risk assess)

Staffing is below minimum levels and unmitigated safety concerns remain.
OR the staffing levels are at minimum or above and unmitigated safety concerns remain

Nursing ‘red flags’ had not been routinely used at the time of our inspections but following our visit had been put in place, so that staff could escalate under certain circumstances, these included:

- Unplanned omissions in providing patient medications
- Delay of more than 30 minutes in providing pain relief
- Patient vital signs not assessed recorded as prescribed
- Delay or omission of regular checks on patients (intention rounding)
- Delay in repositioning patients.

The daily report would be used to support decision making on trust wide deployment of staff, and to inform the trust wide operational pressure escalation levels (OPEL).

The trust provided us with evidence of a daily report as below which showed the numbers of areas in escalation:

![Nurse Staffing Status Report](image.png)

<table>
<thead>
<tr>
<th>Department</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds Teaching Hospitals Trust</td>
<td>50</td>
<td>31</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>LGI: 40 Units</td>
<td>35</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHU: 48 Units</td>
<td>18</td>
<td>25</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>CAH: 3 Units</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WGH: 1 Unit</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal Medicine and Surgery CSU: 13 Units</td>
<td>5</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adult Critical Care CSU: 3 Units</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardio-Respiratory CSU: 9 Units</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Centre for Neurosciences CSU: 6 Units</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chapel Allerton CSU: 4 Units</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's CSU: 12 Units</td>
<td>10</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency and Specialty Medicine CSU: 18 Units</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck CSU: 1 Unit</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institute of Oncology/Leeds Cancer Centre CSU: 9 Units</td>
<td>5</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma and Related Services CSU: 8 Units</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's CSU: 7 Units</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A twice yearly ward staffing review of nursing acuity and dependency levels was undertaken, which informed changes to skill-mix required and the annual updates to the roster system. At the point of our inspection the trust had concluded the most recent safer care review and rosters were being updated. These were completed after our inspection.

Following our inspection, we saw board papers which confirmed 355 newly qualified RNs would be joining the trust during September-October 2018. Concerns remained for four CSU areas which had high vacancy rates including emergency and speciality medicine.

**Delayed discharges/ delayed transfers of care**

Throughout 2017-2018 the trust experienced unprecedented acute bed pressures. This was in part due to the inability to discharge patients out of hospital who no longer needed hospital care. *(Source: Annual report 2017-2018)*.

This resulted in increased numbers of patients staying unnecessarily longer in hospital when they didn’t need to. This in turn had significant impact on the number of patients in emergency departments who waited to be admitted to a ward. It also impacted on the planned levels of elective care from November 2017 to March 2018. NHS England supported the trust in cancelling all routine operations, other than for cancer or urgent cases, from mid-December 2017 to the end of January 2018.

Performance in the emergency department remained below the 95% standard and on a declining trend throughout the year due to the continuing acute bed pressures. The chart below shows overall performance against the four hour emergency care standard from April 2017 to March 2018.

*(Source: Annual report 2017-2018)*

There were significant levels of congestion in the emergency department despite internal schemes and actions put in place to reduce delays, such as the actions below:

- the use of GPs in emergency department
- opening of a new frailty unit
- establishing more ambulatory care pathways
- Opening three extra ‘Optimised for Discharge’ wards giving a total of 152 additional beds.

The average result for the emergency care standard for the year was 82.8%. There were no trolley waits over 12 hours. The trust recognised that the level of congestion resulted in much longer waits for patients in the emergency department.
The number of patients with a length of stay of seven days or more in the Trust during 2017-2018 was one of the highest within England (Source; annual report 2017-2018).

The trust commissioned an external review in June 2018, to consider ways to improve the flow of patients and reduce delayed discharges. At the time 28% of patients in acute beds in the trust were no longer in need of acute medical care. The charts below are from trust board papers and show the numbers of ‘stranded’ patients on medical and elderly medical wards who were in hospital more than seven days longer than necessary, and ‘super stranded’ patients who had been in hospital more than 21 days longer than necessary.

At the time of our inspection, the trust was working with partner NHS trusts, the local authority, and other agencies to improve timely and safe discharges and transfers.
Across the same time period, the percentage of patients who experienced harm free care was mostly in line with, or better than the national standard, see below:

**Percentage of patients experiencing harm free care**

The cancer waiting times standards (for patients who are urgently referred to a specialist with a suspicion of cancer are seen within two weeks) had been met or exceeded throughout the year apart from January and March 2018, see below;

**Cancer target: urgent GP referrals seen within 2 weeks**

However during 2017-2018 the trust reported 52 week waiting patient breaches for the first time in over two years. The first patients were reported in July 2017, with 153 patients in total reported as having waited over 52 weeks by the end of March 2018. For 2018- 2019 the trust was required to reduce the level of over 52 week waiting patients by 50% throughout the year. Senior leaders told us there had been much collaboration with all system partners across health and social care to make improvements.
Infection prevention and control

There was an Infection prevention and control team, with a dedicated doctor. The infection, prevention and control committee (IPCC), met on a quarterly basis, and reported to the board through the quality assurance committee. The infection prevention and control team (IPCT) also participated in monthly steering group meetings where they reviewed operational issues and provided direction and support to CSUs. Members of the IPCT met with heads of nursing from CSUs on a quarterly basis to review performance. The trust also held fortnightly challenge meetings with the director of infection prevention and control (DIPC) to gain assurance where CSUs had high incidence of health care associated infections. The IPCT had developed a healthcare associated infections faculty, to oversee and promote changes to sustain trust wide improvements in the rates of associated infections. Quality improvement methods were used to minimise the risk of patients acquiring health care associated infections. The trust aimed to achieve the national ambition of a reduction in gram negative bloodstream infections including ‘Escherichia coli’ (E. coli) by 50% by 2021.

Clinicians presented root cause analysis findings at meetings and lessons were shared with other CSUs through newsletters and the use of patient stories. The DIPC met with the IPCT team on a weekly basis, to discuss performance, gain assurance and be aware of any current issues in relation to IPC. The IPC worked in partnership with the estates and facilities team in relation to water safety, decontamination and cleanliness.

The IPCC met regularly with commissioners to conduct reviews following cases of methicillin resistant staphylococcus aureus (MRSA) bloodstream infection. There had been 10 hospital acquired MRSA bloodstream infections in 2016-2017. This was 10 cases higher than the zero target for the trust. In 2015-2016 there had been six cases of MRSA. There had been 115 hospital acquired clostridium difficile cases in the same reporting period. This was four cases lower than the target for the trust; however it was higher than the national average per 100,000 bed days. (The national average was 14.4 per 100,000 bed days; the trust rate was 19.3 days). Around 60% of the reported cases were attributed as being avoidable. The trust had made progress in reducing clostridium difficile case by progress in the antimicrobial stewardship programme and by working collaboratively with GPs and other care providers.

The trust had a collaborative sepsis group; this was a sub group of the IPCC. It comprised of consultants, IPC staff, outreach nurse, sepsis champions, and corporate nurses. In the previous year the trust had implemented a paediatric sepsis screening tool, implemented the electronic adult screening tool and held a ‘sepsis conference’. The sepsis team used the quality improvement methodology within the trust to support them in improvements, for example when examining the barriers affecting prompt prescribing of antibiotics for sepsis treatment.

Mortality

The hospital standardised mortality ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than would be expected. A score of 100 means that the number of deaths is similar to what would be expected; a higher score means more deaths; a lower score means less deaths. For the latest published figures (October 2016 to September 2017) the HSMR at the trust was 100.5. (Source- RPIR)

The standardised hospital mortality index (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die
based on average England figures, given the characteristics of the patients treated there. For the same period, the SHMI was 99.3. (Source RPIR). The HSMR and SHMI were reviewed and reported to the trust mortality improvement group on a regular basis. There was detailed analysis at the diagnosis and procedure group to identify any potential concerns.

The trust had a proactive approach to investigating and improving mortality rates. We met with the mortality leads and heard all deaths were discussed in mortality and morbidity meetings. The trust mortality leads were part of the regional mortality group and shared wider learning. They had developed a comprehensive bereavement information pack for families and presented this to a national conference in October 2018.

All deaths were screened via the electronic mortality screening tool via the electronic patient record. All criteria on the screening tool were based on NHS England guidance. Unexpected deaths triggered a more detailed structured judgement review (SJR). Mortality leads presented those reviews at departmental mortality meetings. Learning from those meetings was fed into CSU governance meetings and to the mortality improvement group to review any themes. The mortality improvement group monitored mortality data, learning from deaths, and reported to the quality assurance committee and trust board. The board received a formal mortality report on a quarterly basis.

Any death which triggered an SJR was reviewed by another independent consultant. The mortality leaders told us over 350 consultants and senior nurses had been trained to carry out mortality reviews. There was a multi-disciplinary approach to reviewing patient deaths. The lead learning disability nurse had been involved in reviews to ensure adjustments had been made in care of patients with learning disabilities who had died. Over 92% training compliance had been achieved in elderly medicine. If after the second review the score remained below ‘3’, both reviews were escalated to the weekly quality meeting held with the chief medical officer and chief nurse to decide the level of further investigation.

All deaths which were reported to the Coroner (including unexpected deaths) were reviewed by the associate medical director for risk management. Post Mortem results, Coroner’s reports and incident investigation findings were used in conjunction with SJRs to inform learning from deaths. We saw learning was also shared through local governance forums and via the regular ‘lessons learned’ bulletins and the chief nurse’s quality and safety matters updates. Learning had been shared around communication and ensuring patients received an early senior review. Learning had also been shared around end of life deaths, in relation to assessing someone’s capacity, and involving independent mental capacity advocates (IMCAs).

Audit
There was a comprehensive programme of clinical and internal audit. The trust participated in a wide range of clinical audits which took account of both national and local priorities as a way of benchmarking itself against national standards and to improve services. The audit programme was managed within CSUs by the clinical director and head of nursing, supported by the clinical audit leads for each area.

The trust contributed audit findings to 97% (74) of the recommended 81 national clinical audits and 100% (five) of the confidential enquiries that it was eligible to participate in. The trust did not participate in some audits (such as inflammatory bowel disease and cardiac rehabilitation) as there had been work to develop IT systems, and technical delays meant it had not been possible to submit data.

Over 670 local clinical audits had taken place in 2016-2017 to improve care for patients. One such example was the audit of advanced hepatitis C therapies where work had been undertaken
to minimise drug interactions by improving processes and involving a specialist pharmacy technician in patient care.

**Information management**

There was evidence of integrated reporting which was used to support decisions made at board level, and performance information was used to hold senior leaders and staff to account. We saw that information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant, with plans to address any weaknesses in performance.

The board received large amounts of information and to aid focus and consideration of key issues they separated reports into summary style documents to read for the board meetings and ‘blue box’ items, which contained the full minutes of meetings should the board or public need more detail.

The trust used performance dashboards to enable appropriate oversight and challenge. These were RAG (red, amber and green) rated. Trends were visible due to the trust using ‘run charts’ to show improvement or decreased performance. We attended a board meeting during the year and saw board members challenge data and information provided on serious incidents.

The trust had invested in information management, with an appointment in November 2017 of a director of information, management and technology. There had been investment in digital programmes including electronic patient records (EPR), electronic prescribing, and patient held records. There was a team of three clinical chief technical and information officers (who all worked in clinical areas), a chief nurse for informatics, five lead project nurses, some allied health professionals and a head of information. We saw robust governance around information quality (IQ); there was an information governance (IG) board, which was chaired by an associate director and fed into the new digital and informatics committee, then to the board assurance framework.

There was a central IQ department whose function was to ensure the accuracy and completeness of data. At the time of our inspection this focused on the core central information systems. The trust had a range of other specialist clinical systems which were managed locally within the CSUs whilst corporate information managed the larger trust systems. Some CSUs had a data manager whose role was to ensure accuracy of the data. Senior leaders told us there were plans to centralise more of these systems. The IQ department was shifting the focus to ensure data quality was right the first time. The trust monitored the accuracy of data from audits. There was a dedicated team (Clinical Information and Outcomes team) whose role was to ensure accuracy and completeness of information before any data was submitted. The digital teams spoke highly about engagement and involvement from clinicians; they told us they had a lot of support from non-executive directors and the chief executive who helped remove barriers to progression.

The trust used a combination of paper and electronic records. The trust was affected by the NHS 2017 cyber-attack and since then had developed a cyber security capability unit to monitor threats and engage with staff about how to protect trust systems. The trust acknowledged that a current weakness of the records management system was the ‘hybrid’ health records system in use. There was an aging IT infrastructure at the trust and this was noted on the corporate risk register as were cyber risks.
Senior leaders told us there were over 300 systems in place and the challenge was to align all of those systems. An electronic health record (EHR) was being rolled out across the trust. In January 2018, the board committed to further develop the EHR for another three years. It was known as PPM+, and was integrated with over 35 systems across health and social care, providing a local integrated care record for 2.8 million patients. Within the trust the electronic system included e-prescribing and digital observations of patients.

IT systems were used effectively to monitor and improve the quality of care. For example there was an electronic ‘recommended summary plan for emergency care and treatment’ (ReSPECT). It formed part of the EHR and was used to record information on advanced care decision and preferences to ensure that patients’ wishes about their care in an emergency were known and respected. There was also a parent led web initiative known as ‘digibete’ which used digital technology and social media to support parents of children with type1 diabetes. A smartphone app was being piloted in the trust to enable clinicians to share patient information in real time; it was designed to reduce the use of pagers and landlines. Electronic prescribing had been rolled out across the trust; the next project was to implement e-meds discharge in outpatients.

During our inspection, progress on the EHR was being made at Chapel Allerton and Wharfedale hospital. There were plans for most of the trust locations to be fully digitalized by December 2019.

The trust was one of six demonstrator sites for the NHS ‘scan4safety’ project which uses scanning barcode technology. The project was used to improve safety and bring efficiency benefits by:

- Tracking products used, for example, during surgical procedures in an operating theatre.
- Tracking patients in each location they go to including which bed they are in on which ward.
- Recording which staff were involved in procedures.
- Rapid identification of the location of products that have been recalled.
- Managing stock more efficiently, reducing stock stored and ensuring all stock is in date

By using scan4safety, the trust reported financial benefits of over £2.3 million and reduced the use of paper in several areas of the trust; it won the ‘Paperlite Project of the Year’ 2018.

There was a senior information risk owner (SIRO) who was accountable for the management of all information assets and any associated risks and incidents, and a Caldicott guardian who was responsible for the management of patient information and patient confidentiality. There were good working relationships between the SIRO and the Caldicott guardian.

There had been an information governance breach in 2017, when paper records were left on a ward and a patient accessed them inappropriately. Following the incident, information governance training was reinforced and the trust carried out the NHS information governance data security and protection toolkit to assure itself. The toolkit is an online system which allows organisations to assess themselves or be assessed against IG policies and standards. The assessment considered the following areas:

- Information governance management,
- Confidentiality and data protection assurance,
- Information security assurance,
- Clinical information assurance,
- Secondary use assurance,
- Corporate information assurance,

The trust self-assessment was reviewed by NHS digital and the scores of ‘satisfactory’ (the highest possible score) was confirmed.

Engagement

**Patient and public engagement**

There were a range of methods in place to engage with patients and the public in order to shape and improve services. Senior leaders had used information from patient experience feedback and the public sector equality duty compliance report to include views from some people with protected characteristics.

There was a patient reference group, which was formed in 2017 with the aim of providing the organisation with a way to access public opinion when discussing issues which have widespread impact for patients. The group met every two months and worked with the trust to produce the patient experience strategy which was launched in May 2018. The patient group produced a series of 'always events'. An always event was an event that should always happen to all patients; the trust theatres team had used some of these ideas and at the time of our inspection, were measuring their impact on improving patient experience. The group also advised on proposals relating to parking for disabled people, which resulted in changes to what had been originally planned. The trusts trained six members of the group to be patient leaders in quality improvement, so they could support and challenge quality improvement initiatives.

There were members of the public on the drug and therapeutics committee and this had brought benefits to the committee. Engagement with external partners, public and staff were embedded in the decision process for formulation of new strategies and innovative practices in relation to medicines, such as ‘it’s ok to ask’ and ‘me and my medicines’.

There was a database of around 3,000 people who have given permission to be contacted to provide their views on topics of interest to them. The database was accessed by CSUs to gather specialty level feedback, and was used for topics that attract broader public interest. Members of the database were consulted on a number of topics including proposed changes to cancer pathways. This involvement supported the CSU to developing plans for patients and helped to highlight considerations which needed to be taken into account. A number of the CSUs had speciality patient forums and these included children’s’ services, neurosciences, critical care, and wheelchair/ orthotic services. There were patient steering groups for people living with dementia, youth forums, and groups for people with learning disabilities or autism. The learning disability and autism steering group was co-chaired by a person with learning disabilities.

The mortality screening tool had been shared across the NHS with a number of trusts and across the Yorkshire regional mortality steering group. The group was part of regional mortality patient and public involvement group, which recruited patients and carers to contribute to the creation of a framework by which carers and families could contribute to mortality review. The work of this group was shortlisted as a finalist for three national awards - the QI category for the Royal college of physician’s excellence award, the health service journal award and the British medical journal awards.

**Friends and Family test**

The Friends and Family Test was launched nationally in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. The trust had recently encouraged patients to use a friends and family app. to undertake the survey; this app also had the ability to translate the survey into different languages. A child friendly version of the app. had recently been developed to enable children’s views to be captured.
The trust scored similar to the England average for recommending the trust as a place to receive care or treatment from July to December 2017 and slightly below the England average from January to June 2018.

(Source: Friends and Family Test)

Staff engagement

The national staff survey (2017) findings showed that the trust scored the most improved trust nationally for staff engagement.

All staff we spoke with said that the senior leadership team were visible and approachable. The executives and non-executives undertook a scheduled programme of walk rounds across different locations and services.

The majority of feedback from CQC focus groups and interviews with staff during the inspection was positive. Staff spoke highly about the level of engagement, and the support they received.

Within the trust staff engagement took place through a variety of methods, including workshops, staff surveys, listening events, social media, bulletins and newsletters. The CEO delivered a personal message to staff in ‘start the week’ a weekly bulletin to staff and within the team brief.

There were a number of initiatives in place to recognise and celebrate staff achievements. This included the time to shine awards, which was the overall trust recognition scheme for teams and individuals. Some individual CSU’s and junior doctors’ groups had developed their own award ceremonies.

The trust had also developed a “walk in my shoes” shadowing programme, this programme aimed to provide opportunities for junior doctors and general managers to learn about one another’s roles, challenges and areas of expertise.

Stakeholder engagement

The trust routinely engaged and collaborated with other healthcare providers such as the community trust and the mental health trust. The trust was a member of the West Yorkshire and
Harrogate STP and worked within the West Yorkshire association of acute trusts (WYATT). The trust engaged with local commissioners, the local authority, NHS improvement, local universities, and local GP service representatives. Feedback we received from stakeholders demonstrated positive engagement with the trust.

The trust was an active member of the patient voices group chaired by Healthwatch with the aim of improving engagement with local people. At a Healthwatch city-wide event, held in February 2018, the trust discussed new plans for ‘building the Leeds way’ with members of the public. Feedback suggested people were keen to ensure good use was made of listed buildings belonging to the trust that would no longer be used for healthcare. This feedback was shared with the planning committee for further consideration. There were regular city-wide engagement events which the trust took part in. We heard that there were established groups supporting deaf and hard of hearing people and blind and partially sighted people, and the trust actively engaged with those groups. There were links to other organisations across Leeds that had access to the patient voice and senior leaders told us they used opportunities for engagement through these groups, including voluntary action Leeds, forum central, the maternity voices partnership and Carers Leeds. There were liaison workers from Carers Leeds who came into the trust as liaison to support cares and patients in discharge planning, and liaison workers from Age UK who worked in the trust to support a hospital to home scheme.

**Learning, continuous improvement and innovation**

There was an embedded and systematic approach to improvement, which made use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. There was a strong focus on learning and improvement throughout the organisation at all levels; the trust participated in a large amount of research and clinical trials to seek improvements to patient care and outcomes.

We saw learning was shared effectively and used to make improvements. There was a lessons learned group which shared lessons learned from serious incidents and never events. Learning points bulletins had been produced covering various topics, including never events, venous thromboembolism prevention and discharge planning. The trust had a lesson learned social media channel and videos were made by the CSUs and uploaded so that other CSU front line staff could learn; a video about serious medication error had been viewed around 3000 times.

The trust had worked with the Yorkshire and Humber improvement academy and had appointed a clinical fellow to lead on human factors training throughout the organisation. There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. The trust was in the process of measuring the impact of their always events; these included improving the night time experience for patients, and improving the anaesthetic / theatre experience for patients. We were told of learning in relation to medicines management, nursing staff received regular medicines management training, a new package had been developed for medical staff to allow a more practical learning environment. Consultant pharmacists were driving improvement through high level clinical input into core CSUs. This included local and national work streams to help drive improvement for the trust.

Safety huddles were in place on 91% of clinical areas. (Safety huddles are short focussed team meetings, which take place at a regular time each day and involve all members of the team. Team members can speak up and jointly act on any safety concerns they have, allowing wards to
continually learn and improve). A member of the portering team had set up porter safety huddles
and won the operational services support worker of the year at the national skills for health
awards.

The trust had a quality improvement strategy 2017-2020; the safety priorities were detailed as;

- Reduction in the incidence of falls and harm sustained by patients following a fall
- Reduction in the number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers
- Care and treatment of patients with sepsis and acute kidney injury
- Improving care for patients with Parkinson’s Disease
- Improvement in the care of patients when their condition deteriorates
- Best use of antibiotic medicines (antimicrobial stewardship)
- Safety huddles - reducing harm and improving patient safety culture by integrating daily
  patient safety huddles on wards

The quality improvement strategy described the trust's approach to improvement, utilising both the
'lean' methodology and the Institute for healthcare improvement model which formed the Leeds
improvement method (LIM). The underpinning philosophy of LIM was everyone working at the
trust was empowered to make improvements in their daily work bringing the benefits of a safe,
high quality experience.

The LIM had identified value streams including the improved use of the Chapel Allerton
orthopaedic centre, improved patient flow in the emergency department and reducing the numbers
of patients in medical and elderly wards who had delayed discharges.

The trust had also developed a 'think drink campaign' aimed at reducing pre-operative fluid fasting
times to improve hydration and recovery. The team at Wharfedale hospital reduced pre-operative
hydration fasting from over 12 hours to just over 5 hours in two weeks which received positive
feedback from patients. The 'sit up, get dressed, keep moving' campaign was in place to promote
patient recovery and to keep patients as active as possible whilst in hospital. We were told the
medicines incident review group provided a multidisciplinary review of incidents to ensure learning
was effectively shared.

Other quality improvement achievements made in the year before our inspection included;

- 60% reduction in patient falls with harm since April 2017,
- 25% reduction in cardiac arrest calls
- 46% wards achieved reduction in harm
- 18% reduction in pressure ulcers since 2017
- Since February 2018, consistently delivered above 90% sepsis screening in emergency
departments
- No patients had been cared for in non-designated bed spaces since May 2018.

Following our inspection in 2017 of non-designated bed space use, the trust had reviewed
arrangements for overseeing the care of patients waiting in non-designated areas to ensure
patients received safe care and privacy and dignity was maintained.

In 2017 the trust was successful in its application to be included within wave 1 of a three year
programme, the national maternal and neonatal health safety collaborative, to improve safety and
quality of care.

We saw and heard of numerous examples of innovative practice. These included;

- The first day-case aortic aneurysm repair (patients are usually in hospital for five to 10
days).
- The neonatal intensive care unit using video updates to connect parents and babies.
- The family integrated care team were named team of the year in the national Bliss neonatal excellence awards.
- The use of scan4safety had saved the trust over £2.3 million and reduced the use of paper in several areas of the trust; the project won the ‘Paperlite Project of the Year’ 2018.
- The maternity team were shortlisted as a finalist in the Health Service Journal (HSJ) patient safety awards for their work on reducing incidents of obstetric anal sphincter injuries. Since the work started there had been a 42% reduction in the incidence of the injuries.
- New orthopaedic joints to give patients greater stability and range of movement,
- Techniques to rapidly stop blood loss after major trauma
- Robot assisted gynaecological, urological and thoracic surgery
- A deep brain stimulator technique for patients with previously unmanageable movement disorders
- A new frailty unit opened providing dedicated care for older people who went into hospital. This was a partnership between the trust, the ambulance service, the community trust, the CCG, and the local authority.
- The Parkinson’s quality improvement collaborative won a UK Parkinson’s excellence network award for their work creating an intervention bundle for patients with Parkinson’s disease. This work involved the multidisciplinary team working closely with carers.
- The trust were one of ten elected to be part of the national ‘building on the best’ programme in conjunction with Hospice UK, Macmillan, NHSE and NHSI. The multidisciplinary team quality improvement project aimed to ensure that all dying patients who experienced terminal agitation had an effective individualised plan of care on an acute stroke ward. This work was led by the palliative care team and was being rolled out to other areas in the trust.

Health promotion
There was a public health steering group which had oversight of a number of health promotion strategies to help people live healthier lives. The trust worked with partner organisations to reduce attendances in the emergency departments for patients with mental health conditions. There was support relating to excessive alcohol and tobacco use.

The trust was the largest solid organ transplant centre in the UK and empowered patients to live healthier lives both pre and post-transplant. A smoking cessation programme was in place for liver transplant candidates, which began at pre-assessment clinic. The liver transplant team had increased their focus on supporting patients to remain well while they were awaiting transplant. Patients were encouraged to exercise in a way that was within their capacity and were provided with an exercise journal to document this.

There was a pilot education programme for patients within the renal service who required weight management support. This was offered at any stage during the renal pathway (from recent diagnosis to dialysis and transplant). Sessions were delivered by a specialist obesity dietician, with renal specialist dietician support both on-site and within a community health centre to improve accessibility for patients. Cognitive behavioural therapy and other talking therapies were offered by clinical psychologists and counsellors to groups of patients who were struggling with their mental health.
Research
The vision and strategy incorporated supporting clinical research activity as a key contributor to best patient care. A new research and innovation centre opened in September 2017. Since then, over 19,000 patients had been recruited to take part in clinical research studies. This meant the trust was second most research active NHS Trust in England. There was a research and innovation manager who led research teams who worked with clinicians across multiple areas of research interest, with particular focus on;
   - Musculoskeletal disease
   - Cardiovascular disease
   - Cancer
   - Medical and surgical technology
   - Infectious disease and antimicrobial resistance
   - Artificial intelligence and service digitisation
   - Real world data (data derived from a number of sources associated with outcomes in patient populations, such as patient surveys, clinical trials/ other studies)

The trust planned to open a clinical research facility in 2019 to allow health industry and academic partners the opportunity to work with senior NHS clinicians and dedicated research delivery staff

Accreditations
NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Scheme Name</th>
<th>Details of latest position for accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy departments at Leeds General Infirmary, Bexley and Wharfedale Hospital</td>
</tr>
</tbody>
</table>
| Clinical Pathology Accreditation and successor Medical Laboratories ISO 15189 | Laboratory Genetics/Cytology - February 2016  
Blood Sciences - January 2018  
Microbiology - October 2017  
Cellular Pathology - November 2017                                      |
| MacMillan Quality Environment Award (MQEM)                                | Radiotherapy service - Oncology - received their MQEM in 2016 for review 2019  
Leeds Cancer Support (Sir Robert Ogden Macmillan Centre) received their MQEM in 2016 for review 2019 |
<p>| UK Rehabilitation Outcomes Collaborative (UKROC)                        | Chapel Allerton Rehabilitation Services since 2011. The trust has been accredited as a Level 2a since 16 December 2016. |
| Strategic Clinical Network external stroke accreditation                 | Accreditation of Hyper Acute Stroke Services 2014                                                         |
| Human Fertilisation &amp; Embryology                                          | Licence renewed 23/05/2017                                                                                  |</p>
<table>
<thead>
<tr>
<th>Authority</th>
<th>Accreditation/Assessment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>National School of Healthcare Science</td>
<td>Accreditation for the cardio respiratory department’s Scientific Training Programme 03/04/2017</td>
</tr>
<tr>
<td>College of Clinical Perfusion Scientists Site Assessment Visit and Accreditation (LGI)</td>
<td>College accreditation assessment 21/02/2017</td>
</tr>
<tr>
<td>BSI Inspection</td>
<td>Purchase, receipt, storage &amp; distribution of meals for patients at RADU ISO9001:2008 / 2015 – 29/08/2017</td>
</tr>
<tr>
<td>NHS England Quality Surveillance Team</td>
<td>Renal and Liver Transplant Peer Review - Paediatrics 08/11/2016</td>
</tr>
<tr>
<td>National Cancer Peer Review</td>
<td>Peer review of Specialist HPB (Pancreas) MDT against Peer Review measure 13-2N-1 03/06/2014</td>
</tr>
<tr>
<td>National Cancer Peer Review</td>
<td>Peer Review of Thyroid MDT against Peer Review measure 14-2I-2 16/10/2014</td>
</tr>
<tr>
<td>National Cancer Peer Review</td>
<td>Peer review of Lung MDT against Peer Review measure 13-2C-1 16/10/2014</td>
</tr>
<tr>
<td>National Cancer Peer Review</td>
<td>To undertake an external review of the trust’s Myeloid and Lymphoid and HMDS services against national haematology peer review standards 15/7/2015</td>
</tr>
<tr>
<td>National Cancer Peer Review</td>
<td>To externally validate the work of the Cancer of Unknown Primary team and assess the service against the national peer review standards 21/4/16</td>
</tr>
<tr>
<td>National Quality Surveillance Team (Previously Peer Review)</td>
<td>To externally validate the work of the Penile Cancer MDT against the QST Indicators</td>
</tr>
<tr>
<td>National Quality Surveillance Team (Previously Peer Review)</td>
<td>To externally validate the work of the Testicular Cancer MDT against the QST Indicators</td>
</tr>
<tr>
<td>National Quality Surveillance Team (Previously Peer Review)</td>
<td>To externally validate the work of the Skull Base Service against the QST Indicators</td>
</tr>
<tr>
<td>JACIE</td>
<td>JACIE reaccreditation 04/06/2015 with successful interim inspection June 2018</td>
</tr>
<tr>
<td>UKAS</td>
<td>UKAS accreditation to ISO 15189:2012 Main visit September 2016; surveillance visit September 2017 HMDS laboratory</td>
</tr>
<tr>
<td>BSI Inspection</td>
<td>Oncology Radiotherapy management system - recertification and confirmation of forward strategic assessment plan. Documented management system with relation to the requirements of ISO 9001:2008 and progress with ISO 9001:2015 – 08/05/2018 &amp; 04/06/2018</td>
</tr>
<tr>
<td>Date Range</td>
<td>Inspection Details</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Accreditations)*
Chapel Allerton Hospital is based in the north of Leeds and in terms of medicine sits within the Chapel Allerton clinical service/support unit (CSU) and provides care in the specialities of dermatology, rheumatology, and neuro rehabilitation. It has 73 beds across four wards. Of these, two wards are day case beds (28 beds), and the other two wards have 45 beds which are open Monday to Sunday.

(Source: Routine Provider Information Request – Sites tab)

The trust had 72,660 medical admissions from March 2017 to February 2018. Emergency admissions accounted for 33,728 (46.4%), 4,577 (6.3%) were elective, and the remaining 34,355 (47.3%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 17,438 (24.0%).
- General medicine: 10,302 (14.2%).
- Cardiology: 9,527 (13.1%).

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

Mandatory training completion was monitored centrally with any staff not on track being flagged
to their line manager for individual follow-up. The trust provided lots of e-learning which supported staff in completing their training. Planning for training of staff was done throughout the year to encourage good compliance.

**Mandatory training completion rates**

The trust set a target of 80.0% for completion of mandatory training.

### Chapel Allerton Hospital

A breakdown of compliance for mandatory training courses as of June 2018 for qualified nursing staff in the medicine department at Chapel Allerton Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous thromboembolism</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training basic awareness</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>23</td>
<td>23</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>50</td>
<td>51</td>
<td>98.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>50</td>
<td>51</td>
<td>98.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>38</td>
<td>39</td>
<td>97.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>48</td>
<td>51</td>
<td>94.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>45</td>
<td>49</td>
<td>91.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Chapel Allerton Hospital medicine department, the 80.0% target was met for all 13 mandatory training modules for which nursing staff were eligible. Eight modules had a completion rate of 100.0%, while the remaining five modules all had completion rates above 90.0%.

A breakdown of compliance for mandatory training courses as of June 2018 for medical staff in the medicine department at Chapel Allerton Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk &amp; safety matters</td>
<td>56</td>
<td>70</td>
<td>80.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>54</td>
<td>70</td>
<td>77.1%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>54</td>
<td>70</td>
<td>77.1%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>53</td>
<td>70</td>
<td>75.7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>40</td>
<td>59</td>
<td>67.8%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>35</td>
<td>52</td>
<td>67.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>45</td>
<td>69</td>
<td>65.2%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>45</td>
<td>70</td>
<td>64.3%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>45</td>
<td>70</td>
<td>64.3%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Chapel Allerton Hospital medicine department, the 80.0% target was met for one of the 16 mandatory training modules for which medical staff were eligible, while a further three modules had completion rates above 70.0%. The remaining 12 modules all had completion rates below 70.0%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

The trust had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone’s business.

We saw that the trust had up to date safeguarding policies for adults and children.

In the period April 2017 to March 2018, trust wide, medicine had made 156 adult safeguarding referrals and zero child safeguarding referrals.

Trust wide, monitoring of safeguarding activity took place through the trust wide child protection steering group and the safeguarding adults and mental health legislation steering group each of which reported to the quality committee and risk and patient safety sub-committee.

Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

Staff had access to safeguarding advice and support from link nurses on the ward, from the trust’s intranet, and the trust’s central safeguarding team.

Any patient considered at risk of female genital mutilation (FGM) or child sexual exploitation was referred to the clinical lead for FGM or children social care.

**Safeguarding training completion rates**

The trust set a target of 80.0% for completion of safeguarding training.

**Chapel Allerton Hospital**

A breakdown of compliance for safeguarding training courses as of June 2018 for qualified nursing staff in the medicine department at Chapel Allerton Hospital is shown below:
At Chapel Allerton Hospital the 80% trust target was met for all seven safeguarding training modules for which qualified nursing staff were eligible. Five modules had 100% completion rates and the remaining two module had completion rates above 85%.

A breakdown of compliance for safeguarding training courses as of June 2018 for medical staff in the medicine department at Chapel Allerton Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent (WRAP)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>39</td>
<td>44</td>
<td>88.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>38</td>
<td>44</td>
<td>86.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Chapel Allerton Hospital the 80% trust target was not met for any of the seven safeguarding training modules for which medical staff were eligible. Four modules had completion rates above 50%, with the highest completion rate of 68.6% for safeguarding vulnerable adults - level 1. The remaining three modules all had completion rates of 41.4%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

With reference to the tables above, we spoke with staff about the compliance rates with training shown regarding medical staff. The trust told us that they were working with the trust’s organisational learning department to ensure that the data was accurate and did not include, say, medical staff on honorary contracts. In addition, staff confirmed that medical staff received reminders. Further, the plan was to undertake a formal review at the relevant speciality governance meetings followed by an updated review at the quarterly governance meeting. With these actions it was expected that compliance rates would improve as the year progressed and so patient safety was not at risk.

Cleanliness, infection control and hygiene

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene.
All patients were swabbed for methicillin resistant staphylococcus aureus (MRSA) when they were admitted to the ward. The MRSA test was re-run for patients who stayed for longer than a month on a four week rolling basis.

In the period August 2017 to August 2018, the wards we visited, C1 and C2, had not had any cases of clostridium difficile (C. diff), MRSA, or methicillin susceptible staphylococcus aureus (MSSA).

When infections occurred, the trust had a system of alerting staff, which led to an investigation by way of a root cause analysis, following which an action plan was produced where necessary. Staff described how they would send samples to the laboratory to check for infection and inform the nurse in charge and the trust’s infection team and notify colleagues at handover.

We saw displayed around the ward information about infection prevention and handwashing.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. On both wards there were side wards available to isolate infectious patients and signs were placed on the doors to alert people to an infection risk. On ward C1 one bay was closed owing to a water leak and we saw infection control notices in place to alert staff, patients and the public.

We observed staff using personal protective equipment when required, and they adhered to ‘bare below the elbow’ guidance. Staff were seen using personal protective equipment (PPE) and handwashing before and after patient contact. Ward audit results for hand hygiene compliance were 100% for August 2018.

To support staff in maintaining levels of infection control, wards benefited from dedicated housekeepers and a central trust domestic cleaning team. Staff cleaned equipment after use and a sticker was used to indicate equipment that had been cleaned. We saw these stickers in use. Housekeepers kept the sluice area clean and tidy and ensured commodes were cleaned and ready for use. We found the sluice area and commodes were clean and tidy.

Infection prevention control audits were done regularly in an unannounced way by a peer from another ward area. Results were submitted electronically to the matron and action plans are generated where necessary.

The wards had a link nurse for infection control. We saw audits for a selection of the wards we visited and all had achieved their target compliance score, scoring either 100% or 95%.

Waste was separated and disposed of in appropriate colour coded bins.

The trust told us it had launched a collaborative for healthcare associated infections (HCAI) which formed part of the quality improvement program.

Environment and equipment

We found the ward environment was clutter free, wheelchair accessible, and with enough equipment for staff to carry out their role, including ceiling track hoists.

Access to ward areas were controlled using magnetic door locks and by use of reception areas staffed by nurses or ward clerks.

We noted patients on ward C1 benefited from an outdoor space which they could use in a supervised way as part of their rehabilitation. Staff told us this area required updating to make it safer, by for example, putting down soft flooring. This was on the risk register and charitable
funding was being sought while plans to make changes were being discussed with the trust’s estates department. Also, there was a dayroom which led to the outdoor space: the dayroom had a television plus equipment to support activities and games.

The trust told us improvements from the annual corporate medicines optimisation audit included the improved local management of airflow meters for piped medical air. The trust told us that it had started a programme to replace airflow meters on the ward environment to support staff in avoiding giving patients air instead of oxygen. We saw on the ward environment on C1 that airflow meters had been removed as part of this programme, and staff were now using nebulisers instead.

We found no gaps in checking of resuscitation trolleys. We found the environment was uncluttered, with storage space, and wide corridors. Sharps bins were used and stored properly.

Staff had access to equipment they needed. In particular, staff had access to computers to view those parts of the patient records that were electronic.

Equipment we saw had been electrical safety checked. The trust told us medical equipment assurance was derived by use of a maintenance performance report based on the medical equipment inventory which was updated daily. Also, datix reports about defective equipment were monitored by a devices safety officer. Corporate oversight of adverse incidents involving equipment were reported six monthly at a safety and outcomes group and action taken as necessary.

**Assessing and responding to patient risk**

Within the medicine service at the site staff used a series of tools and meetings to support them in assessing and responding to risks posed to patient safety.

The trust told us it had a quality improvement strategy 2017/20 which focussed on harm free care around falls reduction, pressure ulcer, acute kidney injury, sepsis, Parkinson’s disease, and care of patients who deteriorate. For example, Ward C1 displayed results that showed it had been free from a fall for 31 days and free from hospital acquired pressure ulcers for 669 days.

Ward C1 provided support to patients requiring acute neurological and complex rehabilitation. Staff used a detailed referral form which was then discussed by a multi-disciplinary team to ensure only appropriate patients were referred to the ward. Once accepted into the ward, patients received a detailed nursing assessment which informed the appropriate care plans that were put in place and monitored by staff, by for example, intentional checks by nurses carried out on a regular basis. One bay on the ward was used to cohort patients who were identified as being at a high risk of falls and a staff tagging system was in place so that the bay was never not staffed.

Ward C2 had criteria in place to ensure that only patients who were low risk, not acutely unwell, and could travel in a patient transport vehicle were referred. The ward paid attention to signage about risk of slipping and fire because the treatments used could make surfaces more slippery or were highly flammable.

Every day staff took part in a safety huddle to support them in assessing and responding to patient risk around, for example, prevention of falls or pressure ulcers. This was separate from the daily nursing handover which was recorded on paper sheets containing key patient details. As part of the handover staff reviewed the medication and care plans and acted on any concerns. We saw notes of staff handovers and saw staff at all levels and grades took part fully in handovers of patient care from one shift to the next. We saw staff used a situation, background, action and result (SBAR) framework to transfer patients between teams. This worked well.
Staff used the national early warning score (NEWS) to assess the health and wellbeing of patients. These assessment tools enabled staff to identify if the clinical condition of a patient was changing for the worse and required early intervention and or escalation to keep the patient safe. For patients who suffered a cardiac arrest staff had access 24/7 to a doctor on site. Staff had a laminated flow diagram to follow which was behind the nurses’ station.

On the records we looked at we found that screening was recorded for the venous thromboembolism check, and assessments were completed, such as for body maps for pressure ulcers and all intentional care checking information was captured on the records we saw. The trust sepsis pathway was in date. There was a link nurse for sepsis. The sepsis pathway was embedded in medicine care and staff used stickers to identify sepsis risks.

The wards we visited did not have or take medical outliers. Trust wide staff could track medical outliers using the trust’s electronic patient record system.

**Nurse staffing**

Medical services had systems and processes in place to provide the required nurse staffing levels so that patients were kept safe.

To support staff in planning staffing levels based on patient needs, the trust used the safer nursing care tool, (and on ward C1, the UK rehabilitation outcomes collaborative guidance (UKROC), plus professional judgment, together with an electronic rostering system, to plan a staffing rota created usually six weeks in advance.

The trust ran a daily bed meeting to support staff in filling any gaps in staffing. Staff reported that this system worked well and kept patients safe.

The matron was available for any escalation and out of hours a clinical site manager held a bleep for this purpose and followed a clear policy of escalation.

A full staffing review was done twice a year. Reports on staffing and quality metrics were discussed through the quality governance processes at each trust board meeting.

The trust reported that many wards and departments had not reached optimum staffing levels in registered nursing posts due to national shortages. But the trust told us the escalation process, combined with ward quality metrics, and weekly meetings, plus use of allied health professionals (AHPs), helped to ensure daily nursing was safe. The trust also told us it had invested in developing the clinical support workers (trained to level three) assistant practitioners (level five foundation degree) and by nursing associates (level five foundation degree).

Regarding wards C1 and C2, the leadership team told us that staffing was reviewed daily. Fortunately, both wards, they told us, benefited from good recruitment and good retention, with use of a core of regular agency staff.

In the last 12 months, they told us there had only been two occasions when ward C2 (which had lower acuity patients than ward C1) had one registered nurse (RN) on overnight. The risk in each case was mitigated by drawing in a RN from another ward.

On ward C1 teams were split into three, and shifts ran on an early, late and night basis, caring for 25 patients. The workforce was made up of registered nurses and care support workers or health care assistants. Planned levels were five RNs and six clinical support workers (CSWs) for the early shift, four RNs and five CSWs for the late shift, and two RNs and two CSWs for the night shift. On the day of our visit actual staffing met planned levels for both types of staff. Staff explained that the staffing model for the ward drew on UKROC guidance which was more
generous recognising the patients on the ward were extremely debilitated although medically stable and fit.

Regarding ward C2, the planned levels were four RNs and four CSWs for the early shift, three RNs and three CSWs for the late shift, and two RNs and one CSW for the night shift. On the day of our visit actual staffing met planned levels apart from two CSWs who were off sick. This gap had been mitigated by moving staff and overtime. Staff reported that they had been given permission to recruit an additional RN.

**Chapel Allerton Hospital**

<table>
<thead>
<tr>
<th>Location</th>
<th>Insert March 2017</th>
<th>Insert March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>44.7</td>
<td>55.5</td>
</tr>
</tbody>
</table>

Chapel Allerton Hospital had a staffing fill rate of 97.2% in March 2018, higher than the fill rate of 80.5% in March 2017, and the trust has decreased planned WTE staff by 1.4 between March 2017 and March 2018. The service had to operate with 10.8 less WTE staff in post than planned in March 2017 and with 1.5 less in March 2018. This site however had 7.9 more WTE staff in post in March 2018 than in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 17.8% in medicine. The trust did not set a trust target for vacancy rates.

The breakdown by site was as follows:
- Chapel Allerton Hospital: 7.4%
  (Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 13.7% in medicine. The trust did not set a trust target for turnover rates.

The breakdown by site was as follows:
- Chapel Allerton Hospital: 10.3%
  (Source: Routine Provider Information Request (RPIR) – Turnover tab)

Staff told us that they had a 3.5 RN vacancy rate but reported no issues in recruiting staff.

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 3.9% in medicine; this was slightly higher than the trust target of 3.5%.

Chapel Allerton Hospital: 3.8%
(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Staff told us that for medicine the sickness rate was running at 3% and this was mainly due to one long term sickness and a recent short-term sickness.

**Bank and agency staff usage**

**Chapel Allerton Hospital**

From April 2017 to March 2018, the trust reported that 3.5% of qualified nursing shifts in medicine at Chapel Allerton Hospital were filled by bank staff and 0.2% were filled by agency staff. In addition, 1.0% of shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 5.4% of nursing assistant staff shifts in medicine at Chapel Allerton Hospital were filled by bank staff, 2.2% of shifts were filled by agency staff and 3.8% of shifts were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing assistant</th>
<th>Qualified nursing staff</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>274</td>
<td>5.4%</td>
<td>213</td>
</tr>
<tr>
<td>Agency</td>
<td>111</td>
<td>2.2%</td>
<td>12</td>
</tr>
<tr>
<td>Not filled</td>
<td>193</td>
<td>3.8%</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,076</strong></td>
<td></td>
<td><strong>6,084</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Staff told us that they were looking to grow their CSW workforce to reduce the reliance on agency staff.

**Medical staffing**

Medicine at the site had systems and processes in place to provide medical staffing levels so that patients were kept safe.

Ward C1 had four consultants and two registrars plus a core trainee level one doctor Monday to Friday 8am to 5pm. The medical staff specialised in neurosciences and rehabilitation. Out of hours and at the weekend there was an on-call rota plus access to a staff grade doctor on site supplied by an agency. Ward C2 had two consultants Monday to Friday 8am to 5pm with a middle grade doctor on call out of hours and at weekends.

The wards we visited had a daily consultant review which varied depending on the speciality. The rota for each service on the site ensured 24/7 consultant cover.

None of the services we visited reported any issues with medical cover. Junior doctors spoken with reported good training and support from consultants.

The trust has reported their staffing numbers below as at March 2017 and from March 2018 for medicine at Chapel Allerton Hospital are shown in the analysis below:
Chapel Allerton Hospital

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>30.3</td>
<td>29.7</td>
</tr>
</tbody>
</table>

Chapel Allerton Hospital had a staffing fill rate of 85.7% in March 2018, lower than the fill rate of 102.0% in March 2017, although the trust had increased planned WTE staff by one between March 2017 and March 2018. The service operated with 0.6 more WTE staff in post than what was planned for in March 2017 and with 4.4 less in March 2018. This site however had 4.0 less WTE staff in post in March 2018 than in March 2017. 

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 4.2% in medicine. The trust did not set a trust target for vacancy rates.

The breakdown by site was as follows:

- Chapel Allerton Hospital: 9.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 37.8% in medicine. However, the inclusion of trainee grades in the data is likely to have inflated the rates. The trust did not set a trust target for turnover rates.

- Chapel Allerton Hospital: 29.3%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 0.9% in medicine; this was much lower than the trust target of 3.5%

- Chapel Allerton Hospital: 0.6%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

Chapel Allerton Hospital

From April 2017 to March 2018 Chapel Allerton Hospital reported that 816 shifts were filled by bank staff and 268 shifts were filled by locum staff in medicine. There were 25 shifts not filled by either bank or locum staff.
A breakdown of bank and locum usage by staff type at Chapel Allerton Hospital is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Shift type</th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>13</td>
<td>801</td>
<td>2</td>
<td>816</td>
</tr>
<tr>
<td>Locum shifts</td>
<td>0</td>
<td>268</td>
<td>0</td>
<td>268</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>0</td>
<td>24</td>
<td>1</td>
<td>25</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

In December 2017, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 550 whole time equivalent staff working in medicine at Leeds Teaching Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/12/2017 - 31/12/2017)

**Records**

We reviewed fifteen sets of records and found them to be legible, detailed, signed and safely stored in locked trolleys when not in use.

Patient records were a mixture of electronic and paper records. For instance, staff used e-observations and electronic medication charts. Most care plans and nursing documentation were paper records. The trust told us it was currently on a digital pathway with the aim to have removed most paper from healthcare delivery processes by December 2019. The trust was in the process of rolling out electronic patient records on a phased basis. For instance, the malnutrition universal screening tool (MUST) was electronic. The aim was for the site to become the first fully electronic site.
On the records we looked at we found that screening was recorded for the venous thromboembolism check, and assessments were completed, such as for MUST, national early warning score (NEWS) (where needed, as most patients were medically fit), pressure care, falls assessment and all care checking information was captured on the records we saw.

Staff told us that records were audited regularly as part of the ward metrics audits and items reviewed included controlled drugs, use of MUST, pressure care and medication.

Information relating to discharge was printed off in hard copy for the patient to keep while the electronic version of the discharge summary was accessible by community staff and GPs.

**Medicines**

We checked the storage of medicines, fluids and gases on the wards we visited. We found that medicines, fluids and gases were stored securely in appropriately locked rooms and fridges were checked and stocks were in date.

The medicine policy we saw was in date.

The wards we visited used an automated drug dispensing cabinet to store and manage medicines, which cabinets were situated in a locked clinical room. Staff would need to use a keypad to gain entry to the clinical room and then either log on or use their fingerprint to access drugs from the automated drug dispensing cabinet, having selected a patient.

Controlled drugs were stored in the automated drug dispensing cabinet and required two members of staff to access them. Staff were tasked to carry out daily checks of controlled drug balances. The trust told us the quarterly controlled drug (CD) audit reviewed varied aspects of the safe and secure handling of medicines designated as controlled drugs. It found the robust storage of the new CD requisition forms was identified as a focus for the next audit cycle as was improving completeness of full documentation in CD record books. We found no gaps in checking in the CD books we reviewed.

For drugs that required refrigeration, the automated drug dispensing cabinet was connected to the fridge which was locked. All fridge temperatures were logged onto a central database and if they went out of range pharmacy would attend following an automated alert. On our inspection we noted the fridge was within its temperature range.

We checked the drugs on the resuscitation trolleys and did a random check for expired drugs in the fridges and automated drug dispensing cabinet and found it all to be in order.

Drugs trolleys we saw were all locked when not in use.

Patient records seen showed patients were receiving medicines promptly and any allergies were clearly recorded.

Chapel Allerton Hospital Pharmacy operated 9am-5pm Monday to Friday with services provided at all other times from a nearby main hospital site. Pharmacy would attend the wards to re-stock the automated drug dispensing cabinet or address replacing stock if the fridge temperature went out of range. A full seven-day service outside the hours indicated above was delivered by an onsite pharmacist, at a nearby main hospital site.

Medicines reconciliation was undertaken by pharmacy staff within 24 hours of inpatient admissions; reconciliation rates for patients admitted to medical and surgical acute care areas was reported at around 90%.
Incidents

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust’s electronic reporting system. The staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.

As can be seen in the table below the medical services at this site reported no never events over the last year.

Staff we spoke with said feedback from incidents was shared in many ways including; handover, safety huddles, and staff meetings. An example of learning from incidents was the introduction of a safety checklist for risk assessing use by patients of the courtyard area on ward C1. The trust also shared learning through weekly bulletins and team briefs plus an annual report.

The trust had a process for ensuring that deaths were reviewed within 24 hours using the structured judgment review method with any learning presented to departmental mortality and morbidity meetings. The trust’s standardised mortality ratio was within the ‘as expected’ range.

We reviewed a root cause analysis report (RCA) from serious incidents and found actions plans and lessons learnt were identified. Actions included providing feedback to staff around the importance of documentation completion.

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 understood the importance of being open and honest with patients. The trust had a process to capture all incidents where duty of candour was triggered which ensured it was adhered to. The trust told us duty of candour processes were recently audited by the trust's internal auditors and were awarded "significant assurance".

Trust wide from April 2017 to March 2018, medical services had incidents where the duty of candour had been applied 201 times.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

The trust told us it had focussed on reducing never events in areas such as retained objects, wrong site surgery, wrong implant, feeding through a misplaced tube, and administration of air instead of oxygen. The trust told us it was reviewing air supply to all its clinical areas considering the national reporting of never events in this area.
Breakdown of serious incidents reported to STEIS

Chapel Allerton Hospital

In accordance with the Serious Incident Framework 2015, Chapel Allerton Hospital reported one serious incident (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018. This was a pressure ulcer meeting the SI criteria.

(Source: Strategic Executive Information System (STEIS))

We saw that staff tackled pressure ulcers by daily monitoring and by flagging any concerns during handover or at the daily safety huddle.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 124 new pressure ulcers, 20 falls with harm and 25 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for medical services.

From May to November 2017 pressure ulcers reported decreased from 17 in May to three in November 2017. From five to seven pressure ulcers were reported for the three-month period from December 2017 to February 2018. After this period pressure ulcers reported increased, reaching its highest point of 18 in April 2018, after which they decreased to 12 in May 2018. The overall trend remained stable although as described above there were variances in numbers reported over the period.

Falls reported remained stable with between one and two falls reported for most months over the period May 2017 to May 2018. The highest numbers of falls (four) were reported in July 2017 and no falls were reported in May 2017 and April 2018.

Reported new urinary tract infections in patients with a catheter increased from two in June 2017 to five in September 2017. No new UTIs were reported in October 2017, after which two CUTIs per month were reported from November 2017 to January 2018. Following three months with no new UTIs, the number increased sharply to six in May 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections in patients with a catheter and at Leeds Teaching Hospitals NHS Trust

![Graph](image)
2 Total Falls (20)

Total CUTIs (25)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Source: Safety thermometer - Safety Thermometer

Staff told us they used the safety thermometer to track safe patient care and displayed headline results for the public to see on the ward safety boards. The matron validated the results and undertook a detailed analysis of any concerns so that lessons could be shared and learning embedded.

For example, the safety thermometer dashboard for ward C2 for July 2018 showed 100% harm free care.

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust’s intranet, guidelines, policies and procedures relevant to their role.

The trust had a procedure for implementing best practice guidance, including all types of NICE guidance. For each piece of guidance, a nominated lead within the clinical service/support unit (CSU) completed an assessment of the trust’s compliance, and actions were put in place to achieve compliance with any recommendations not met.

A six-monthly report giving an overview of the trust’s compliance with NICE guidance provided assurance to the safety and outcomes sub-group that NICE guidance was being implemented. This report was also shared with the trust's commissioners.

The procedure also set out the process to be followed if a decision was taken not to implement specific recommendations from NICE guidance. Any non-compliance had to be presented to the safety and outcomes sub-group, prior to approval by the quality assurance committee.
The leadership team explained that they had a quality manager part of whose role it was to support them in ensuring that the trust process for implementing, say, NICE guidance, was adhered to. This was an item reviewed at the clinical governance meetings.

Staff also used an audit programme to ensure care supplied was evidence based. For example, staff on ward C1 had audited staff reactions to the personal safety training and were due to re-do the questionnaire so results were awaited.

**Nutrition and hydration**

We found that the services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

On admission each patient had a nutritional assessment and staff described how dietitian services could be accessed for complex cases. Where necessary, food charts were used to monitor intake of food.

The medicine service at the site offered patients a full range of meals to meet any needs arising from religion, culture, allergies or personal choice. Staff told us they could go out of menu where necessary and provided snacks outside of mealtimes. Pictures could be used to assist patients in choosing food. Visitors could access snack machines.

Staff described how they tried to encourage patients to be independent when eating but would help where needed, with patients requiring help being noted on handover sheets or by using a red mat system. Water jugs were refilled twice a day.

When we spoke with patients they described food that was of good quality with good food choice.

Water jugs were in reach and replenished regularly. We saw from records of patients that we reviewed that fluids were monitored where necessary.

**Pain relief**

We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients.

In the patient records we saw there were pain assessment charts to support staff in monitoring pain relief for patients. In addition, staff described, when using care rounding documents, they would use their own experience to help them assess pain and use objective markers such as a raised heart rate or blood pressure, and document their findings. For patients who could not verbalise their pain staff could use pictures and a recognised scoring system.

Pain relief was discussed at handover and the safety huddle and any issues noted in addition to analgesics being reviewed on ward rounds.

Staff told us that they had access 24/7 to the trust’s palliative care team who could supply expert advice on pain and its management.

Patients we spoke with had no issues with how their pain was being managed.
**Patient outcomes**

The service had systems and processes in place to monitor patient outcomes including, various trust wide initiatives, and local ward based actions, around early discharge and patient aggression, all with a view to providing effective patient outcomes.

On a trust wide level, the trust told us about many initiatives to help improve patient outcomes. For example, the trust told us it had focused on several measures to further reduce the burden of sepsis. This included a multi-disciplinary collaborative, which oversaw the roll out of many actions. This included provision to staff of a variety of tools and resources, such as, BUFALO bags (which were equipped with all the necessary items to take a sample of blood for culture testing) or the adult sepsis screening tool, with the electronic version within the electronic observations (e-obs) system.

Also, the trust told us it had taken part in all relevant national audits (81 out of 87), external peer reviews and many benchmarking exercises. It was a participant in the get it right first time (GIRFT) program, which was used to improve patient outcomes in clinical services.

Further, its safety and outcomes group received a report on patient outcomes by consultant for each specialty area which showed there were no outliers.

Lastly, by way of example, to support better patient outcomes, all deaths were screened using a tool accessed electronically through the trust's electronic patient record. This showed where a more detailed structured judgement review was required at a departmental mortality meeting. Learning was shared through the local governance forums and through the regular ‘lessons learned’ bulletins and the Chief Nurse’s quality and safety matters updates.

At a local level, staff told us about several initiatives to improve patient outcomes.

For example, on ward C2, the intravenous infusion regime was changed so that instead of running the procedure overnight, it was now run as a day case treatment which was booked in advance. This released more beds on ward C2 allowing them to take more patients.

On ward C1 staff told us they reduced delayed discharges by many days through running a core team of people who worked on removing blocks in the system, such as delayed care packages or delayed financing, thus improving patient outcomes.

Wards gave each patient an estimated date of discharge (EDD) which was reviewed at a goal setting meeting at which the EDD was reset.

The multi-disciplinary team (MDT) had identified with commissioners and community colleagues funding to support an early supported discharge team. This ensured that patients who were physically fit but required ongoing emotional support could be discharged home with this support in place.

Lastly, two RNs were employed to address patient outcomes for patients who had severe challenging behaviour following a brain injury. Previously, staff would use the trust’s security team but this was not considered ideal because it was not therapeutic. So, staff designed physical intervention training for staff to use therapeutic handling for such patients. This involved development of a training schedule, policy and documentation bundle to reduce the need to rely on the trust’s security staff.
Relative risk of readmission

**Chapel Allerton Hospital**

From February 2017 to January 2018, patients at Chapel Allerton Hospital had a like expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective admissions**

- Patients in rheumatology had a like expected risk of readmission for elective admissions
- Patients in dermatology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a much higher than expected risk of readmission for elective admissions. However, this was based on only 18 admissions.

**Non-Elective admissions**

- Patients in dermatology had a higher than expected risk of readmission for non-elective admissions
- Patients in rheumatology had a like expected risk of readmission for non-elective admissions

No other medical specialty reported more than six non-elective admissions at this site over this period.

**Elective Admissions - Chapel Allerton Hospital**

![Graph showing elective admissions](image1)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Non-Elective Admissions - Chapel Allerton Hospital**

![Graph showing non-elective admissions](image2)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

(Source: HES - Readmissions (01/02/2017 - 31/01/2018))
National Diabetes Inpatient Audit

Trust level

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 241 in patients with diabetes at the trust, 78.2% of whom reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this trust in quartile 2. Trust performance deteriorated between 2016 and 2017. In 2016, 90.8% of patients reported they were satisfied or very satisfied with their overall care of diabetes while in hospital and the trust was placed in quartile 4.

(Source: NHS Digital)

National Audit of Inpatient Falls 2017

Trust level

At Leeds Teaching Hospitals NHS Trust the crude proportion of patients who had a vision assessment (if applicable) was 56%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 39%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 10%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 80%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust told us that it had developed an action plan which we saw to try and improve its performance through a trust wide falls group with all CSUs asked to deliver a plan to show how they intend to improve.

Competent staff

Appraisal rates

Chapel Allerton Hospital

As at June 2017 and June 2018, 94.4% and 95.5% respectively of registered nursing and medical and dental staff within medicine at Chapel Allerton Hospital received an appraisal compared to a trust target of 95%.
### June 2017 | June 2018

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Individuals required</th>
<th>Rate</th>
<th>Completed</th>
<th>Individuals required</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery</td>
<td>51</td>
<td>54</td>
<td>94.4%</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>34</td>
<td>36</td>
<td>94.4%</td>
<td>34</td>
<td>38</td>
<td>89.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td><strong>90</strong></td>
<td><strong>94.4%</strong></td>
<td><strong>85</strong></td>
<td><strong>89</strong></td>
<td><strong>95.5%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through sharing information, by email, at team meetings, in a newsletter, and by offering staff additional training.

Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal. The trust operated an annual appraisal season that ended in June each year. As a CSU chapel Allerton were 99% compliant with appraisals.

Senior staff told us they received monthly reports from the organisational learning team and could track individuals to ensure an appraisal was booked and done. Staff who had not yet done an appraisal were booked to receive one.

Staff on ward C1 received training in additional competencies relevant to the patients they cared for. For example, staff did a course run by the neurosciences CSU which gave a background on brain injuries and stroke. Further, because patients on ward C1 could pose a serious risk to themselves, other patients, staff or the public, staff received bespoke personal safety training. On ward C2, staff supplied drugs for treating cancer and received special study days for that. This was supported by practice educators. The trust told us training on the use of insulin fell within the trust’s priority training programme and was delivered to staff through an e-learning package and face to face learning bursts.

Staff were inducted and trained by the trust. Staff told us new nurses completed an introduction to professional practice. This included a one-week induction followed by a daily induction spread over six months.

For students, staff told us there was a clear training pathway and students who had trained on the wards reported a positive experience. For example, in one speciality we spoke with a student nurse who confirmed that they had been allocated a mentor and pre-placement, an associate mentor in readiness for a 12-week placement. The ward supplied them with a student handbook with set learning outcomes.

All wards visited had link nurses for various areas including infection control, safeguarding, learning disability and dementia to support staff in maintaining competence in these areas.

**Multidisciplinary (MDT) working**

To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service.

Ward C1 held a weekly MDT meeting on the ward that was attended by doctors, occupational therapists, physiotherapists, neuro psychologists, dietitians and speech and language therapists.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.
The ward displayed a daily rehabilitation board showing which discipline was due to see the patient that day, including physiotherapists, occupational therapists, speech and language therapists and psychology staff.

The occupational therapy team had visited other providers to look at best practice and bring the learning back into the MDT. The physiotherapy team worked closely with various charities including the stroke association and headway.

Staff told us how they worked with wheelchair services or the orthotics department to create bespoke equipment for their patients.

**Seven-day services**

The medical services ensured there was a seven-day consultant rota providing cover and no services we visited reported issues with seven-day access to diagnostic services.

Medical cover was provided Monday to Friday 8am to 5pm by a team of four consultants, two registrars and a core trainee year one doctor. After 5pm and at weekends, there was a on call rota in place. In addition, there was an out of hours doctor on site.

Staff explained that on a weekend it was possible to obtain access to x ray using a on call radiologist and a CT scan could be obtained using an ambulance to transfer a patient to one of the trust’s main hospital sites. Ultrasound could be supplied on site together with magnetic resonance imaging scans (MRIs) and other scans such as electrocardiogram (ECT) scans.

The occupational therapy team provided cover Monday to Friday on this site with nursing staff providing cover over the weekend.

A dispensing service was available 24/7: the dispensary was open 8am - 8pm Monday to Friday and 9am - 5pm weekends and Bank Holidays with a resident pharmacist onsite outside these hours.

**Health promotion**

The medicine services on site had limited initiatives running to promote healthy lifestyles but patients did benefit from individualised care plans with goals.

Staff told us that they gave patients information about diets to improve nutrition and avoid blood clots and, as part of a trust wide initiative, improved signposting in documentation to support networks.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards.

We saw that the trust had an up to date policy dealing with consent and mental capacity.

Compliance with the consent policy was audited annually using the consent audit tool that CSUs were required to complete. Outcomes of the audits were uploaded to the trust's clinical audit database and reported to the safety and outcomes sub-group by the associate medical director for corporate governance.

Staff spoken with knew about mental capacity and where to access more help, say, to assist them in completing a best interest decision or a deprivation of liberty application. Staff described
how mental capacity was assessed as part of the booking in process and any expiration date for a deprivation of liberty application was noted on handover sheets. We saw that the trust’s intranet was a valuable resource for staff to consult. For instance, there was guidance and leaflets and information on the intranet for the mental health act process as well as a form to confirm rights. In addition, staff had access to a team of three social workers on site who could help with best interest meetings and discharge planning.

On ward C1 there were nine patients on a deprivation of liberty safeguard. We looked at three sets of notes which had a deprivation of liberty safeguard in place. One record showed the application had been extended. In the other two records we looked at, while deprivation of liberty safeguarding applications were made, both had expired, although while on the ward one was being updated by the trust’s best interest assessor who happened to be on the ward. This role supported patients and staff in complying with carrying out best interest decisions for patients and ensuring applications were up to date.

For patients with mental health act rights, the trust had a standard operating procedure which gave the nurse in charge a duty to explain rights to the patient when detained on the ward. The trust told us a member of the trust’s mental capacity act/mental health act team would also visit each detained patient to ensure the process was followed and to repeat the explanation. The trust explained that they made automatic referrals to independent mental health advocates (IMHA) to ensure each patient was given the support of an independent expert mental health advocate.

The trust told us it had continued to work with its partners at a local mental health trust to improve the care of patients with mental health conditions, notably those who displayed aggression towards other patients and staff.

Staff on the site had access to 24/7 neuro psychological services and three social workers.

**Mental Capacity Act and Deprivation of Liberty training completion**

**Chapel Allerton Hospital**

The trust reported that as of June 2018 Mental Capacity Act (MCA) training level 1 and 2 was completed by 96.2% of nursing staff in medicine at Chapel Allerton Hospital compared to the trust target of 80.0%.

The trust reported that as of June 2018 Mental Capacity Act (MCA) training level 2 was completed by 60.0% of medical staff in medicine at Chapel Allerton Hospital compared to the trust target of 80.0%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

As noted above in the ‘safe’ section of this report, the trust told us that it was doing a number of things to ensure medical staff complied with their training.

**Is the service caring?**

**Compassionate care**

We found that patients received compassionate care from staff which supported their privacy and dignity.

We observed staff providing compassionate care to patients. For instance, we saw a nurse
ensure that a patient who was standing was provided with adequate seating while they were calling a relative. Another patient said about the ward staff’s compassionate care that they felt they had been “dropped into heaven”.

Patients we spoke with described no issues with families visiting them, with good information provided at bedside handovers.

Patients described nursing staff introducing themselves on shift changeover.

Patients were content with their meal choices and had no issues with their pain management.

Patients described being kept informed with daily updates and regular goal setting meetings.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 36% which was better than the England average of 25% from June 2017 to May 2018.

A breakdown of the percentage of patients who would recommend the trust for surgery by site is shown below:

**Chapel Allerton Hospital**

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</thead>
<tbody>
<tr>
<td>C01 Neuro Rehabilitation</td>
<td>46</td>
<td>94%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
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<td></td>
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<td>100%</td>
<td>100%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>C02 Dermatology/Rheumatology</td>
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<td>43%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
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<td></td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>94%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>C05 Rheum/Gastro Day Case Unit</td>
<td>2145</td>
<td>22%</td>
<td>95%</td>
<td>99%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
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<td>97%</td>
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</tbody>
</table>

From May 2017 to April 2018 the overall percentage of patients that would recommend the service was over 90% for all three-medicine ward at Chapel Allerton Hospital.

| Highest score to lowest score     | 100% | 50%  | 0%   |

*Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.*

(Source: NHS England Friends and Family Test)

**Emotional support**

We found that staff offered a range of emotional support to patients.

On ward C1 the patients were medically stable and fit but severely debilitated and required specialist psychology support for them and their families to support them to come to terms with their recovery. We saw evidence of how the MDT worked to support the emotional needs of the patients and their families. This included signposting to local charities that could offer further support.
One patient told us how the ward manager arranged for psychology staff to visit the ward to see them plus arranged for a staff member to take time to talk to them.

To support the emotional needs of patients living with a brain injury, staff on ward C1 worked with such patients to create a newsletter that was written by patients for patients, families and friends. One example newsletter we saw set out details about, say, the speech and language therapy team, tips on communication, and a quiz.

Staff had access to chaplaincy services for those patients with a faith or none.

**Understanding and involvement of patients and those close to them**

We found the staff tried to understand patients, involve them and those close to them.

Staff told us about how they had arranged for a patient to get married on site before the patient passed away. Staff managed to decorate an unused ward and arrange a ‘stag’ do in other rooms. This understanding and involvement of patients and those close to them was reported in the trust’s team brief.

Another example of how staff understood and involved patients and those close to them involved helping a patient to make a meal for their family on a special day.

When setting the EDD patients and their families were involved in setting short term, medium and long-term rehabilitation goals.

The trust told us that an always event called ‘Calm at Night’ was being developed in response to feedback that the trust night time environment was not always conducive to restful sleep.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

The leadership team we spoke with described many ways in which the service had been designed to meet the needs of local people.

For example, to avoid patients having to travel unnecessarily to the site for a consultation with the consultant, there was telephonic dermatology service for skin cancer. Patients now saw their GP if they had concerns about any type of mole or lesion. The GP could take a photo and the dermatology consultant on site would review it and supply advice or an urgent appointment.

The rheumatological and dermatological services had set up a patient panel group to help them design the services, including design of the ward environment.

Staff told us about work that had been done on redesigning the musculoskeletal pathway for rheumatological patients. This ensured that when they presented to their GP they were referred to the right place and did not end up being referred to orthopaedics (as happened in the past) thus avoiding a wasted orthopaedic appointment.

We found no mixed sex accommodation breaches.
As shown below the service had average lengths of stay for elective procedures was lower than the England average.

**Average length of stay**

**Chapel Allerton Hospital**

From March 2017 to February 2018 the average length of stay for medical elective patients at Chapel Allerton Hospital was 4.5 days, which was shorter than England average of 5.9 days. For medical non-elective patients, the average length of stay was 23.3 days, which was much longer than England average of 6.4 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in rheumatology was much shorter than the England average.
- Average length of stay for elective patients in dermatology was shorter than the England average.

No other medical specialty reported more than six overnight elective admissions at this site over this period.

**Elective Average Length of Stay - Chapel Allerton Hospital**

![Bar chart showing average length of stay for elective specialties: All, Rheumatology, Dermatology compared to England average.](image)

*Note: Top three specialties for specific site based on count of activity.*

**Average length of stay for non-elective specialties:**

- Average length of stay for non-elective patients in rheumatology was longer than the England average.
- Average length of stay for non-elective patients in dermatology was much longer than the England average.

No other medical specialty reported more than six non-elective admissions at this site over this period.
Non-Elective Average Length of Stay - Chapel Allerton Hospital

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

To seek to reduce the average length of stay which could be between three and six months staff set and agreed EDDs with the patient and worked with the patient and their family with monthly reviews that were tracked on a spreadsheet which the MDT had access to.

Staff told us about changes made to the musculoskeletal pathway which made sure that when a patient with rheumatological conditions presented to their GP they were referred to the right appointment. Also, to help manage the service, staff told us about tele medicine for skin cancer so specialists could view photos of skin moles and advise without the patient having to be admitted.

Meeting people’s individual needs

We saw that staff cared for patients as individuals and strived to meet their individual needs.

On admission to the ward each patient received an individual assessment to support staff in identifying their individual needs.

Staff told us that they could access language interpretation services and leaflets could be produced in different languages. The trust produced a range of materials and services to support staff in meeting the individual needs of patients such as induction loops, British sign language or Makaton interpreters, with written material available in braille and browse aloud. Staff told us of one patient who needed a translation and the translator was brought to the ward.

The trust’s electronic systems permitted staff to flag patients with a learning disability. The trust told us it had a dedicated lead nurse for learning disabilities and autism and older people who oversaw the care of patients with dementia. Patients with these conditions were picked up on a patient assessment and adjustments were made as necessary including working with carers as necessary. We saw a daily rehabilitation board was used by staff to meet individual needs.

The trust had a specialist diabetes team consisting of diabetes specialist nurses, specialist diabetes dietitians, a diabetologist, specialist podiatrists and administrative support. We saw evidence in patient notes of input from the dietitian.

The trust told us examples of reasonable adjustments to meet individual needs may include additional time for consultations, environmental management such as the use of side rooms where
possible, welcoming carers to the ward outside visiting hours, flexible mealtimes, provision of resources such as fiddle boxes or twiddle muffs, and accessible information.

We saw that occupational therapy staff could use the greenhouse in the ward courtyard garden to grow plants with patients which were then sold for ward funds.

The trust told us it had champions to support good practice on the ward. For example, there were now 103 champions for learning disability, hidden disability and autism. Many wards had dementia champions and as part of their role they promoted the use of ‘know who I am’ booklets and a ‘forget me not flower’ symbols at the bedside.

Staff told us about how they had arranged for a patient to get married on site before the patient passed away. Staff managed to decorate an unused ward and arrange a ‘stag’ do in other rooms.

Another example of how staff met individual needs involved helping a patient to make a meal for their family on a special day.

**Access and flow**

The services had systems and processes in place to monitor access and flow and to ensure that they were responsive to the needs of patients.

Ward C1 had a waiting list of seven patients which was monitored by all staff. To improve patient flow into and out of the ward, staff told us recent refurbishment of one area of the ward enabled them to expand the bed base, with five complex beds on ward C2.

Staff explained that bed moves at night and patient moves did not take place on ward C1 because moves could be detrimental to the patients cared for on that ward. Ward C2 sometimes did receive patients at 9pm.

Staff at the service said the process for transfer from other hospitals was robust owing to the referral criteria which ensured only patients who were stable enough to travel from one of the trust’s main hospital sites were accepted into the wards. A multi-disciplinary team approved all referrals into the ward environment.

In terms of delayed discharges, staff told us there were two main causes, the first being agreeing continual healthcare funding packages and the second being delays with social care packages. Staff explained that regarding the first cause of delay, they tried to mitigate the delays by working closely with commissioners to create unique one-off packages. In relation to the second cause of delays, staff met monthly with social work colleagues with a view to building better understanding to iron out any delays.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From June 2017 to May 2018 the trust’s referral to treatment performance for admitted patients (percentage admitted within 18 weeks of referral) was consistently better in comparison to the England average, by an average of 5.3%.

There was a slight deterioration in performance in January 2018, followed by a trend of improvement from February to May 2018.
Referral to treatment (percentage within 18 weeks) – by specialty

Six specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>91.3%</td>
</tr>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.8%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.7%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.7%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>70.4%</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission

The trust did not provide data for ward moves per admission. They provided the following information:

“Currently we do not measure the number of moves for individual patients; we do know that for some patients with complex discharge needs and protracted lengths of stay this can be up to four moves within their admission period. In times of extremis when there is a requirement for speciality acute beds for the most acute and dependent patients a "fit to lodge" risk assessment is actioned and patients may be selected to board on other wards to create capacity and maintain safety for acute demand.”

(Source: Routine Provider Information Request – Ward moves tab)

Patient moving wards at night

Please note that the following analysis excludes ward moves at night from assessment centres and day wards.
Chapel Allerton Hospital

From April 2017 to March 2018 there were 25 patients at Chapel Allerton Hospital moving wards at night within medicine. Dermatology / Rheumatology had the highest number of ward moves with 17 moves at night over the period.

(Source: Routine Provider Information Request – Ward moves at night tab)

Learning from complaints and concerns

The services had a system in place to encourage complaints and compliments with a view to improving services for patients.

Staff told us they would seek to resolve a concern informally first but complaints were dealt with formally if necessary. The governance arrangements in place ensured that lessons from complaints were shared amongst staff.

We saw notices displayed within the services showing how to complain and signposted patients or their carers or relatives to the trust’s patient advisory and liaison service (PALS) for support in making a complaint.

We discussed complaints with staff. All response times for complaints were met with support from the trust’s PALS team.

Staff learnt from complaints and tried to improve the service as a result. For example, arising out of a continual healthcare funding application, because of a complaint, relatives now received a paper copy of the application. Further, within the neurosciences speciality, patients were feeding back that it was very frightening having a stroke and how they would have liked to talk to someone who had been through the experience. In response, the service introduced a programme of volunteer stroke buddies.

Summary of complaints

Chapel Allerton Hospital

From May 2017 to April 2018 there were one complaint about medical services at St James’s University Hospital. This complaint was still under investigation.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From May 2017 to April 2018 there were 73 compliments within medicine. Compliments received for medicine accounted for 29.9% of all compliments received by the trust.

Chapel Allerton Hospital

Chapel Allerton Hospital received five compliments; 6.8% of all compliments received for medicine. The five compliments received were all for dermatology.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The leadership team were made up of a clinical director, general manager, and head of nursing who in turn were supported by a lead clinician, matron, and business manager. The leadership team reported to the nursing and medical director who reported to the chief medical officer and chief nurse who reported to the chief executive.

The trust invested in their leaders: this included access to accredited courses such as lean for leadership. Also, by way of mentorship, the clinical directors met every month as a group with the executive directors.

The leadership team we met for medicine at the site were experienced in commissioning, designing and running their services. It was evident from discussions that their priority was on running a clinically safe service.

The leadership team met with the chief nurse, medical director, and deputy chief executive as necessary and through them had ready and easy access to the trust’s board.

Staff told us their leadership team was approachable and visible and the team told us that they met regularly in different forums to discuss quality, finances and governance.

At ward level the leadership team derived support from senior sisters with whom they met regularly.

Vision and strategy

The vision used by the services we visited was the trust’s vision, which was committed to delivering the highest quality and safest treatment and care to every patient, every time. It was supported by the ‘Leeds Way’ values, (patient centred, fair, collaborative, and accountable).

Each directorate had a strategy and business plan which set out in detail how the directorate intended to contribute towards the trust’s vision and strategy. The trust told us evaluation of the clinical business strategies by Board members took place in 2014 and again in 2017 when the strategies were updated.

Culture

We observed that the services we visited had a positive culture with staff that were proud to provide patient focussed care to patients.

Running throughout the culture was the values known as the ‘Leeds Way’. The trust told us this was embedded through several streams including at recruitment and interview and from weekly messages from the CEO, through to staff and corporate and service level awards events to recognise staff and their work.

Staff we spoke with described good teamwork and multi-disciplinary working with visible leaders who were happy to help and provide support.

Staff had various forums in which they could express their views and be heard including one to ones, team meetings, and safety huddles.
Governance

The services had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

In terms of local governance, the leadership team met every week. At the weekly meeting the leadership team looked at finance, performance, patient safety and quality, governance audits, service development, strategy, the risk register, and staffing. Consultants within the specialities on the site met regularly and their meetings fed into the monthly clinical governance meeting. This was followed by a monthly business meeting at CSU level. In addition, there was a senior nurse meeting and a site meeting.

To bring back knowledge trust wide to the local site, a member of the leadership team attended a speciality clinical governance meeting once a month, and a CSU governance meeting that took place once a quarter.

We saw minutes for a speciality clinical governance meeting. The trust had introduced a standard template which looked at: clinical effectiveness and outcomes; research and innovation including new guidelines; risk management including incidents; patient experience; patient and public engagement; FFT; governance, and any other business.

The business meetings standard agenda items included: looking at delivering the best clinical outcomes, which looked at mandatory training, infection control, the risk register, complaints and incidents; providing patient centred services, which looked at the performance dashboard, staffing, and business cases; spending public money wisely, which looked at finance; employing caring and cared for staff, which looked at recruitment; and any other business.

Senior matrons met as a group and discussed governance issues including learning from incidents or complaints and staffing issues together with issues cascaded to them from the leadership team.

All staff in a leadership role also had access to dashboards looking at performance, finance, governance and staff engagement.

Management of risk, issues and performance

The leadership team received information to support them in managing risk, identifying issues, and assessing performance.

We spoke with members of the leadership team about how they measured quality and performance. The team had access to various sources of information, such as ward metrics, which captured a series of indicators ranging from documentation audits to hand hygiene. This information was examined, discussed and action taken through the meetings noted above.

The trust board had oversight of the operational and corporate risks through the risk management committee. CSUs presented their highest risks to the committee in a rolling programme, in addition to discussing emerging risks that required mitigation. The trust’s long-term strategic risks were set out in the board assurance framework (BAF), under the key headings finance, workforce and partnership working. The trust told us a clear governance framework was in place for CSUs and specialty teams detailing how risks emerging were escalated to the risk management committee.

We discussed with the leadership team the risk register. Risk registers were maintained at CSU level, with a brief description of the risk, control measures, an owner, risk level and a review date.
We spoke to the leadership team about their top three risks. The first risk was patient aggression which had been mitigated by training staff in personal safety while promoting therapeutic handling. The next risk was the outside space on ward C1. The area needed to be safer by replacing flooring with softer floors. This risk was mitigated in the short term by supervised access to the area and risk assessments for use of the area. In the long term charitable funds had been applied for to support the planned renovation works. Lastly, lack of bed space was a risk. This risk had been addressed by opening more beds (eight) and through discussions with commissioners with a view to opening more beds.

Measures and information relating to quality and safety was provided at CSU, specialty and ward level to the leadership team. Ward level assurance was provided through audit of a range of ward metrics.

The trust told us the trust Board received a quality and performance report (QPR) that set out the trust’s progress against a range of metrics relating to quality, performance and finance and a report on the significant risks that had been discussed at the risk management committee. Further detailed assurance was provided to the quality assurance committee, a formal committee of the Board. This was supported by a range of sub-committees, including the safety and outcomes, patient experience and quality improvement.

Further assurance was provided by visits by the corporate nursing team. This was supported by the Board leadership walk round programme, which provided an opportunity for Board members to engage with patients and their families and staff to receive direct assurance on quality and safety.

The trust’s non-executive directors had designated responsibilities such as for safeguarding, quality, audit, finance, performance and business planning.

**Information management**

From speaking with staff and reviewing information supplied in electronic format, it was clear that staff at all levels could access information in a digital format which could be interpreted and rapidly used to help improve the service.

The trust told us that data quality is managed locally by the CSU and centrally by the corporate information team. The CSUs manage the data quality of the locally maintained systems whilst the corporate information team managed the larger trust systems. The trust’s information quality department ensured the accuracy and completeness of data. A clinical information and outcomes team assured data for accuracy and completeness before it left the trust.

The leadership team told us that they received information in electronic format and they found the information robust. For instance, the CSU received a monthly report about staff appraisals from the organisational learning team. Also, the leadership team had access to ward metrics covering a range of indicators from documentation audits to hand hygiene which they could use to monitor performance.

**Engagement**

Staff and the trust gave examples of how they engaged with the public and staff with a view to ensuring their views were used to help to shape the service provided to patients.

The trust told us it used various routes to engage with the public, such as: a patient reference group, with the aim of providing the trust with a way to access the public voice when discussing issues which have a widespread impact for patients. This met every two months; a database of over 3,000 people who had given permission to be contacted remotely to provide their views on topics of interest; participation in the patient voices group with the aim of improving efficiency in engaging with the people of Leeds; taking part in existing specialist groups, such as, the deaf and
hard of hearing and blind and partially sighted and carers Leeds; and through speciality patient forums.

We saw patient information leaflets on stroke, MRSA, diabetes, and complaints: but some of these were beyond their review date.

The trust explained that it had taken recent steps to improve access for the public to provide feedback through the trust’s friends and family test (FFT) programme, including by increasing the use of text messaging and ensuring all wards had access to a FFT app. There was also an opportunity to provide feedback using the trust's external website.

The trust told us the PALS team, as well as providing a feedback route, regularly monitored patient opinion and NHS choices. They also ran outreach activities to promote their service with a variety of local harder to reach groups, including black minority ethnic (BME) communities.

At a ward level we saw that, to engage with the public, each ward visited displayed a safety board which allowed the ward to share with the public key safety information about outcomes in terms of ward performance. This was based on many elements. The elements covered overall ward performance, a spider diagram scoring the ward against key care standards such as patient observations, friends and family test results, key steps staff were working on flowing out of the last audit, staffing levels and harm free care.

The friends and family feedback was positive with a 4.9 out of a five-star rating. Staff told us that work on a patient focus group was ongoing.

To engage with staff, the CSU had run an awards night which staff reported was well attended by a range of staff and helped maintain staff morale.

The trust told us it shared information from the NHS staff survey and staff FFT so it could identify themes and trends and agree actions where needed. It also ran a series of way finder campaigns to engage with staff and seek their views on improvement initiatives.

**Learning, continuous improvement and innovation**

Prior to the inspection, and while on inspection, the specialities shared with us the following examples of learning, continuous improvement and innovation:

Ward C2 were proud of their team of the year nomination for the CSU in April 2018. They were nominated by colleagues. Despite having to take on neurosciences patients (because of the water leak on ward C1) and challenging patients over the winter period, feedback remained positive from staff, patients and relatives.

The site hosted the clinical institute of rheumatology and musculoskeletal science which was a recognised centre of clinical excellence.

### Surgery

**Facts and data about this service**

The trust has 34 wards across three sites:

- Chapel Allerton Hospital: one ward, 32 inpatient beds
- Leeds General Infirmary: 16 wards, 59 day case beds, 263 inpatient beds
- St. James’s University Hospital: 16 wards, 56 day case beds, 226 inpatient beds
- Wharfedale Hospital: day surgery unit and accompanying ward with 23 day case beds.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides surgical care through the abdominal medicine and surgery clinical service unit. Specialties provided include: colorectal surgery, transplant surgery, pancreatic surgery, upper gastro-intestinal surgery and urology.

(Source: Routine Provider Information Request (RPIR) – AC1 Context - description of all acute services)

The trust had 54,616 surgical admissions from March 2017 to February 2018. Emergency admissions accounted for 16,056 admissions (29.4%), 27,080 (49.6%) were day case, and the remaining 11,480 (21.0%) were elective. In total five children were treated at Chapel Allerton for elective surgery during the period August 2017 to August 2018.

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The trust set a target of 80% for completion of mandatory training.

In surgery the trust had an overall training compliance rate of 96.7% for qualified nursing staff at trust level. The 80% target was met for 16 out of 19 mandatory training modules for which qualified nursing staff were eligible. In 13 modules more than 95% of staff had completed the training. The lowest training rates were in PRTD paediatric life support level 1 and level 2 with 66.7% training compliance; however, this equated to six staff not completing the level 1 training and only one member of staff not completing the level 2 training.

**Chapel Allerton Hospital**

A breakdown of compliance for mandatory training courses as of June 2018 at Chapel Allerton Hospital for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>39</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>39</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>39</td>
</tr>
</tbody>
</table>
At Chapel Allerton Hospital the surgery service had an overall training compliance rate of 99.1% for qualified nursing staff. The 80% target was met in all 12 mandatory training modules for which qualified nursing staff were eligible and 100% of staff had completed training in 10 of the modules.

A breakdown of compliance for mandatory training courses as of June 2018 at Chapel Allerton Hospital for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>21</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>20</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>21</td>
</tr>
<tr>
<td>Information governance</td>
<td>21</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>21</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>21</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>21</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>21</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>21</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>19</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>15</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>19</td>
</tr>
<tr>
<td>Resuscitation training advanced update</td>
<td>13</td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>13</td>
</tr>
</tbody>
</table>

At Chapel Allerton Hospital the surgery service had an overall training compliance rate of 73.2% for medical staff. The 80% target was met for two out of 14 mandatory training modules for which medical staff were eligible. Less than 60% of staff had completed the two advanced resuscitation training modules which equated to 14 staff not completing them in each case.

**Safeguarding**

The trust had a safeguarding policy for adults and children. The policies could be accessed by staff through the intranet. Staff completed safeguarding training as part of their mandatory
training, this consisted of e-learning and classroom based training. Staff told us that there had been no safeguarding issues in the last 12 months. If a safeguarding alert was reported on the electronic system, it would send an automatic alert to the safeguarding team based at St. James’s Hospital who covered the whole trust. Band 6 and above staff had completed level 3 training in safeguarding children and band 5 staff had completed level 2 training.

**Safeguarding training completion rates**

The trust set a target of 80% for completion of safeguarding training.

**Chapel Allerton Hospital**

A breakdown of compliance for safeguarding training courses as of June 2018 at Chapel Allerton Hospital for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>38</td>
<td>39</td>
<td>97.4%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>38</td>
<td>39</td>
<td>97.4%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>32</td>
<td>37</td>
<td>86.5%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>32</td>
<td>37</td>
<td>86.5%</td>
<td>80.0%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

At Chapel Allerton Hospital the surgery service had an overall training compliance rate of 92% for qualified nursing staff. The 80% target was met for all seven safeguarding training modules for which qualified nursing staff were eligible. Three modules reported 100% compliance, however this only related to one member of staff in each module.

A breakdown of compliance for safeguarding training courses as of June 2018 at Chapel Allerton Hospital for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>10</td>
<td>19</td>
<td>52.6%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>10</td>
<td>19</td>
<td>52.6%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>7</td>
<td>19</td>
<td>36.8%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>2</td>
<td>6</td>
<td>33.3%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>2</td>
<td>6</td>
<td>33.3%</td>
<td>80.0%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

At Chapel Allerton Hospital the surgery service had an overall training compliance rate of 59% for medical staff. The 80% target was not met in any of the seven safeguarding training modules for which medical staff were eligible. The training compliance target was almost met for the level 1 safeguarding vulnerable adults and level 1 safeguarding children modules with a 78%
completion rate. The lowest training completion rates were reported for level 2 safeguarding children and level 2 safeguarding vulnerable adults with 33% completion rates; however, these related to small numbers of staff with two out of six members of staff completing each module.

Cleanliness, infection control and hygiene

The trust had an infection control policy in place. Staff completed infection control training as part of their mandatory training.

We observed staff wearing standard NHS uniforms and staff were bare below the elbows. Aprons, gloves and antibacterial gels dispensers were available throughout the ward. There was signage near the ward entrances encouraging visitors to use the antibacterial hand gels. The ward was also trialling ‘Give soap a chance’ campaign; that was, encouraging visitors and staff to wash their hands with soap rather than use the antibacterial hand gels in the first instance.

The ward we visited was visibly clean and free from clutter. The admission waiting area was visibly clean with chairs neatly lined against the wall, thus there was no trip hazard for patients or their relatives. There were numerous ‘I am clean’ stickers on various equipment on the ward.

The ward has not had a MRSA report for eight years. The rate for post-operative joint infection was 0.6%, whereas the national average was 6%.

Environment and equipment

The theatres we visited were visibly clean with surgical and resuscitation equipment fit for purpose and checked regularly in line with professional guidance. The theatres contained separate bins for clinical and domestic waste. The bins were clearly labelled with the types of waste that could be disposed within them. There were sharp bins on the floor in the operating room and anaesthetic room. However, the nurse in charge informed us that stands for the sharp bins had been ordered.

The store was visibly clean, well-organised and no items stored on the floor. All items were labelled for ease of identification.

The day rooms and dirty utility rooms we observed were visibly clean and tidy with items neatly lined against the wall so there was no trip hazard. The cleaning cupboards were locked with equipment inside stored neatly on shelves.

Most of the equipment on the ward had undergone safety testing recently and this was evidenced with test stickers displaying the date of the test on each piece of equipment. However, we found that some equipment such as the dishwasher and the hot water dispenser in the pantry did not contain safety testing stickers.

In the pantry, the fridge and freezer had a temperature recording sheet on the door where it had been signed three times by the staff checking the temperature and once by a supervisor. This was for the week commencing 24 September 2018. The member of staff ticked a column against their signature to confirm that the temperature was within the acceptable zone of 0 – 5 C for the fridge and -18C or lower for the freezer. If the temperatures went out of the acceptable zones, the estates and facilities manager who was on-call 24 hours would be informed. The food in the fridge and freezer would be placed in the bin.

The two resuscitation trollies on the ward were examined and they were sealed with tamper proof tags that were numbered. The trollies were examined daily by staff and this was evidenced with signed and dated checklists on the top of each trolley. Inside the trollies, the defibrillators had
been tested, this was evidenced with test stickers on the outside with date of tests. A random examination of equipment inside the trollies showed that none of it was out of date. The resuscitation trollies were approved by the trust’s resuscitation team and thus appropriately equipped to be used on adults and children. The admission and anaesthetic criteria for any patient aged 14 – 16 is that they had to be of adult size; that is, over 50 kilogrammes in weight.

**Assessing and responding to patient risk**

At the time of the inspection staff told us they were moving towards a paperless system on the ward. We were able to review both paper records and computer records. We examined five sets of patient records selected at random and these were all fully completed, signed and dated with no gaps in the information. We also examined these records to verify whether the five steps to safer surgery including the World Health Organisation (WHO) safety checklist was being implemented consistently within surgical services. All of these records contained completed WHO checklists. We observed the WHO checklists being completed during our inspection of the theatres.

The service had a WHO safer procedure checklist and the correct surgical site marking policy and standard operating procedure in place. This was a comprehensive document outlining the procedures that staff should follow when undertaking surgical procedures.

The WHO checklists audits provided were from August 2017 to July 2018. These showed that the performance at Chapel Allerton for surgery was consistently high when compared to trust-wide data. For the team brief the compliance rate was 98% and for the de-brief the compliance rate was 89%. The sign-in compliance was 99%, for the time out the rate was 99% and for sign-out the rate was 99%

For Venous Thromboembolism (VTE) risk assessments conducted within 24 hours of patients being admitted, the data showed there was consistently high compliance; that is greater than 98%, from the data supplied from July 2017 to July 2018. For example, in July 2018 the compliance rate was 99%.

The pre-operative assessment was not carried out on the ward and the pre-assessment notes arrived with the patient. Staff on the ward would go through the assessment with the patient to confirm the information and would make alterations or additions as required. We saw evidence of the ward dashboard for July 2018, the ward had no actions following an audit of patient notes.

The patient records we reviewed showed that the trust was using the national early warning score (NEWS) tool. We examined five patient records and all five records contained NEWS data. Patient NEWS scores were reviewed by clinical support workers, if the score was raised they contacted a doctor or nurse in charge as per the trust’s policy. If the patient was too poorly to be treated on the ward, they were transferred to another ward in the trust.

There was evidence that NEWS data was recorded and reviewed at the monthly clinical governance meeting. The minutes of the meeting for July were reviewed which showed two adult patients had been moved off the ward, one was pre-planned and the other un-planned.

All patients were monitored in-line with the Trust’s policy for the prevention and management of the deteriorating patient, which included the management of both adults and children. Staff monitored children’s physiological observations according to their post-operative plan of care and applied these to a NEWS chart which guided staff on the need for any escalation.

The NEWS chart was appropriate for the patient age group who attended for planned day case surgical procedures at Chapel Allerton Hospital; that is 14 – 16 years.
The ward had a deteriorating patient policy in the form of a flow diagram which separated patients that were acutely unwell and those that required the resuscitation team. The flow diagram clearly described the steps that staff should follow under both of these scenarios. For example, for acutely unwell patients, the first step was for the senior nurse to review if the NEWS was deteriorating. The next steps were for the doctor to review urgently and if the patient was unwell out of hours, then the on-call doctor should be called by the senior nurse. This flow diagram showed that there were clearly established steps in place that staff had to follow for deteriorating patients.

The service treated children under 16 on the ward. However, this was subject to them meeting a strict criteria of height, weight and mental maturity. Children had to be aged 14 – 16 and weigh 50kg or more. The maturity was assessed at the pre-assessment appointment by the anaesthetist and surgeon in consultation with the parent. The surgery only went ahead if the anaesthetist was satisfied that the children had the mental maturity to cope with being treated on an adult ward. Only day case surgery for soft tissue injury was performed on the ward for children, but a bed was booked at Leeds General Infirmary prior to any surgery taking place on children in case of deterioration. If a bed wasn’t booked or not available at Leeds General Infirmary (LGI), then surgery didn’t go ahead for children. Deteriorating children were transferred via ambulance.

Post-operatively, children were initially cared for on the Post-Operative Unit (POC). The children recovered in two side rooms with their parents. From the POC, children were discharged home or if necessary transferred to LGI. The paediatric patient’s anaesthetist and consultant remained in the department until the patient was fit to be discharged home from the POC or transferred to LGI by 5pm.

In the event of transfer from Chapel Allerton Hospital to the Children’s Hospital, the ward would follow the established patient transfer procedure, including nurse escort and the required level of medical observation. Only one child had been transferred in the last year and that was due to pain control.

Patients were cared for by experienced orthopaedic nursing staff and skilled postoperative nurses; this included a band 6 recovery nurse who managed the post-operative recovery of patients. The band seven ward manager for ward C3 and their deputy (band six) had all completed their safeguarding level three children’s safeguarding training. The ward had onsite access to registered children’s nurse specialists for advice and support.

Staff we spoke with were aware of the BUFALO system to identify sepsis and had BUFALO packs. Staff explained if a patient had suffered post-operative complications they would be asked to return to the ward to be seen by the consultant that had operated on them. They would be classified as a ward attender. When they attended the ward, they were assessed for sepsis.

### Nurse staffing

The trust has reported their staffing numbers for March 2017 and March 2018 as shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>33.2</td>
<td>35.2</td>
</tr>
</tbody>
</table>
In March 2018 there were 740.7 WTE nursing staff in post in surgery services compared to a planned WTE establishment of 944.9 WTE staff, giving a fill rate of 78%. This was similar to the previous year's fill rate of 79%.

Staff we spoke with told us they used E roster to book staff on to shifts.

The charge nurse we spoke with told us because the ward had elective surgery patients there was the ability to have the correct number of staff to deal with the planned number of patients. The ward had access to paediatric trained nurses who were based in the dermatology department as they came under the same management structure. They were on the ward when a child was present.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From June 2017 to May 2018 the trust reported a nursing staff vacancy rate of 22% in surgery. The trust does not have a target for vacancy rate. A breakdown by site is shown below:

- Chapel Allerton Hospital: 3.3%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018 the trust reported a nursing staff turnover rate of 11.0% in surgery. The trust does not have a target for turnover rate. A breakdown by site is shown below:

- Chapel Allerton Hospital: 9%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018 the trust reported an annual nursing staff sickness rate of 4.2% in surgery which was higher than the trust’s target of 3.5%. A breakdown by site is shown below:

- Chapel Allerton Hospital: 2.5%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Chapel Allerton Hospital

From April 2017 to March 2018, the trust reported that 3.3% of qualified nursing shifts in surgery at Chapel Allerton Hospital were filled by bank staff and 6.5% of shifts were filled by agency staff. In addition, 4.6% of shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 2.3% of nursing assistant staff shifts in surgery at the hospital were filled by bank staff, 7.5% of shifts were filled by agency staff and 2.0% of shifts were not filled by
either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>107</td>
<td>2.3%</td>
<td>320</td>
</tr>
<tr>
<td>Agency</td>
<td>353</td>
<td>7.5%</td>
<td>618</td>
</tr>
<tr>
<td>Not filled</td>
<td>93</td>
<td>2.0%</td>
<td>439</td>
</tr>
<tr>
<td>Total</td>
<td>4,716</td>
<td></td>
<td>9,564</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The trust has reported their medical staffing numbers for March 2017 and March 2018 as shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
</tbody>
</table>

Chapel Allerton Hospital

27.1 | 21.5 | 125.9% | 21.9 | 21.5 | 101.7%

There was an over-establishment of WTE medical staff at Chapel Allerton in both years; however, the over-establishment had reduced from 126% in March 2017 to 102% in March 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From June 2017 to May 2018 the trust reported a medical staff vacancy rate of 2.2% in surgery. The trust does not have a target for vacancy rate. A breakdown by site is shown below;

- Chapel Allerton Hospital: over-establishment of 7.5%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From June 2017 to May 2018 the trust reported a medical staff turnover rate of 41% in surgery. However, the inclusion of trainee grades in the data is likely to have inflated the rates. The trust does not have a target for turnover rate. A breakdown by site is shown below;

- Chapel Allerton Hospital: 61%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From June 2017 to May 2018 the trust reported an annual medical staff sickness rate of 1.3% in surgery which was lower than the trust’s target of 3.5%. A breakdown by site is shown below:

- Chapel Allerton Hospital: 0.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

Chapel Allerton Hospital

From April 2017 to March 2018 Chapel Allerton Hospital reported that one shift was filled by bank staff in surgery and there was one shift not filled by either bank or locum staff. During out of hours and at the weekend, there was one doctor covering the whole hospital. The doctor, sister and anaesthetist had bleeps, thus there were no concerns about cover. There were no senior doctors in the hospital out of hours or at the weekends, but advice was available via the telephone.

A breakdown of bank and locum usage by staff type at Chapel Allerton Hospital is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Shift type</th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Locum shifts</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

As of December 2017, the proportions of consultant staff and junior (foundation year 1-2) reported to be working at the trust were similar to the England averages.

Staffing skill mix for the whole time equivalent (WTE) staff working at Leeds Teaching Hospitals NHS Trust

Total WTE (674.4)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>38%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Records

We examined five sets of patient records selected at random. At the time of the inspection staff told us they were moving toward a paperless system on the Ward. We were able to review both paper records and computer records.

These were found to be fully completed containing care plans for patients, signed and dated with no gaps in the information. We also examined these records to verify whether the five steps to safer surgery including the World Health Organisation (WHO) safety checklist was being implemented consistently within surgical services. All these records contained completed WHO checklists.

Medicines

The pharmacy consisted of nine members of staff comprising five pharmacists from bands 2 – 6 and a ward pharmacy technician. We observed the pharmacy technician take a patient’s drug history and enter the details on an online recording system. We observed the pharmacist discuss and check medicines with a post-operative patient. The patient was given a leaflet about the medicine being described and the pharmacist explained the possible side effects verbally. We observed two nurses prepare and administer oral morphine solution. This was undertaken as per the trust’s policy and national guidance. The pharmacy had access to a weblink to print patient leaflets in other languages.

The hospital had an automated medicine dispensing system installed where orders placed before 2 pm resulted in next day delivery. However, medicines could also be obtained urgently if there was a patient need. There were two dispensing cabinets; one in ward C3 and the other in the post-operative unit. However, there was no fridge in the post-operative unit.

The pharmacy fridge located on the ward temperature was checked on a daily basis. The records showed that the temperature had been checked daily and all the temperatures recorded were within range. There was stock rotation of medicines but two bottles of insulin stored in the fridge had an expiry date of 16 August 2018. There were no items stored on the floor in the pharmacy store room.

In the anaesthetic room, the fridge contained drugs that were all in date. The fridge was visibly clean and tidy and daily temperature checks had been recorded on to a sheet on the front of the fridge door. Examination of this recording sheet showed that all the recorded temperatures were within range. However, the recording sheet only showed the temperatures for August. Staff informed us that if the temperature went out of the acceptable range of 0 – 5 C they would inform the pharmacy who would examine the drugs inside the fridge and take action. This would consist of either destroying the drugs, reducing their expiry date or no action taken. If the fridge temperature regularly went out of the acceptable range, the fridge would be taken out of action and the drugs placed in another fridge. Staff informed us that the fridges contained antibiotics and insulin.
Controlled drugs were checked twice on a daily basis, there had been no missing checks in 2018. There were signatures against these checks. There was stock rotation in the drugs cupboard and there were no drugs missing.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported four incidents classified as a never event for surgery. The details of the never events are shown below:

- Retained foreign object – reported in June 2017. The incident occurred in April 2017 at Leeds General Infirmary and took 55 days to report.
- Wrong site surgery – reported in June 2017. The incident occurred in May 2017 at St James’s University Hospital and took 30 days to report.
- Wrong site surgery – reported in July 2017. The incident occurred in July 2017 at St James’s University Hospital and took four days to report.
- Unintentional connection of a patient requiring oxygen to an air flowmeter – reported in May 2018. The incident occurred in May 2018 at Leeds General Infirmary and took eight days to report.
- Staff informed us that lessons learned from incidents were shared with staff by the ward manager verbally and via email.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018.

**Trust level**

A breakdown of all incidents reported in surgery is shown below:

- Pressure ulcer meeting SI criteria – 10 (35.7%)
- Slips/trips/falls meeting SI criteria – eight (28.6%)
- Surgical/invasive procedure incident meeting SI criteria – seven (25.0%)
- Treatment delay meeting SI criteria – two (7.1%)
- Sub-optimal care of the deteriorating patient meeting SI criteria – one (3.6%)

**Chapel Allerton Hospital**

At Chapel Allerton Hospital there was one serious incident reported from June 2017 to May 2018 which was categorised as a surgical/invasive procedure incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

The trust had an electronic reporting system in place and staff we spoke with could confidently describe how they would report incidents by completing the online system. Staff we spoke with
informed us they would also report the incident verbally to a senior nurse or the ward manager. All members of staff had the authority to report incidents.

The trust had an incident reporting policy which staff could access through the intranet. This policy set out the types of incidents, reporting procedures and responsibilities of managers with regards to reporting and investigation.

Most of the staff we spoke with could recollect the top incident for their ward; that is falls. However, they could not recollect the most recent incident they had reported.

Staff informed us that learning from incidents was shared verbally by the ward manager each morning during the handover meetings and later circulated via email to all staff. Staff could also enter their email address in to the online reporting system in order to receive feedback from reported incidents.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 84 new pressure ulcers, eight falls with harm and 13 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Leeds Teaching Hospitals NHS Trust**

1. Total Pressure ulcers (84)
2. Total Falls (8)
3. Total UTIs (13)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter
The prevalence rate of pressure ulcers in patients surveyed generally remained similar over time, except in June 2017 when a higher prevalence rate was recorded. Trends in total falls and CUTIs cannot be commented on due to the small numbers reported.

(Source: NHS Digital)

The safety thermometer data was displayed on a noticeboard in the main corridor of the ward. This dashboard showed the number of pressure ulcers, falls, MRSA and C.Difficile cases. We examined the dashboard and found it to be displaying the most recent information and the date of the last update. The data showed that it had been five days since a patient had a fall, 91 days since a patient developed a pressure ulcer, over two years since a patient had C.Difficile and over eight years since a patient had MRSA.

**Is the service effective?**

**Evidence-based care and treatment**

Policies were stored on the intranet and staff we spoke with explained how they could access these policies. We examined policies such as medicines management, discharge and final consent policy. All of these policies were comprehensive and had review dates in the future.

Staff told us it would be unlikely to have a patient with sepsis on the ward as the surgery carried out there was elective. However, staff we spoke with were aware of the BUFALO system to identify sepsis and had BUFALO packs.

**Nutrition and hydration**

Staff we spoke with informed us that patients could be referred to a dietitian if there was a need. Patients were cared for under the ‘Think Drink’ campaign which allowed them to drink clear liquids up to four hours prior to their surgery. These were individual fasting times. This helped to speed up their recovery post-operatively. However, there were no audits in place to confirm these fasting times.

Protected meal times were in place and during our inspection we observed that patients were provided with their meals on time. Drinks were provided at meal times and in between meals. We saw that drinks were placed within patients’ reach.

We examined five fluid balance charts and noted these were completed fully.

**Pain relief**

Medical records examined showed that patients were administered pain relief drugs. This was clearly documented with signatures and dates. Staff monitored the effectiveness of the pain relief drugs by asking patients about their pain at regular intervals. Staff used pain management plans to effectively manage pain relief of patients.

**Patient outcomes**

From February 2017 to January 2018, all patients at Chapel Allerton Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Trauma & orthopaedics was the only specialty to report readmissions following elective admission at this site over this time period. This specialty had a higher than expected risk of readmission.
Elective Admissions - Chapel Allerton Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

There were no readmissions reported following non-elective admission at this site over this time period.

(Source: Hospital Episode Statistics)

National Hip Fracture Audit

Chapel Allerton Hospital

Chapel Allerton Hospital did not participate in this audit.

(Source: National Hip Fracture Database 2017)

Patient Reported Outcome Measures

In the patient reported outcomes measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance was similar to the England performance for all metrics relating to hip replacement, knee replacement and varicose vein.

Performance on groin hernias was about the same as the England average for improvement in patient outcomes. Performance was better for the proportion of patients who had reported worsened outcomes for groin hernia according to the EQ VAS indicator.

(Source: NHS Digital)

**Competent staff**

As well as completing the mandatory training, staff had the opportunity to complete additional training. Staff told us that managers were supported if they identified a course that they wanted to complete which would be beneficial to their career development.

**Appraisal rates**

**Trust level**

At trust level, all staff in surgery had an appraisal completion rate of 89% as at June 2017 and 98% as at June 2018. The trust target was 95%. A breakdown of appraisal completion rates for nursing and medical staff is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Required</td>
<td>Rate</td>
<td>Completed</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>652</td>
<td>748</td>
<td>87.2%</td>
<td>733</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>370</td>
<td>384</td>
<td>96.4%</td>
<td>409</td>
</tr>
</tbody>
</table>

Both nursing staff and medical staff met the trust target for appraisal rate as at June 2018. Nursing staff had a higher appraisal completion rate as at June 2018 compared to the previous year, as at June 2017. The appraisal completion rate for medical staff remained similar between the two years.

**Chapel Allerton Hospital**

At Chapel Allerton Hospital surgery had an appraisal completion rate of 86% as at June 2017 and 99% as at June 2018. A breakdown of appraisal completion rate for nursing and medical staff is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Required</td>
<td>Rate</td>
<td>Completed</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>31</td>
<td>35</td>
<td>88.6%</td>
<td>38</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>23</td>
<td>24</td>
<td>95.8%</td>
<td>20</td>
</tr>
</tbody>
</table>

Both nursing staff and medical staff met the trust target for appraisal rate as at June 2018 with 100% of eligible medical staff having completed an appraisal. Both nursing staff and medical staff had a higher appraisal completion rate as at June 2018 compared to the previous year, as at June 2017. Staff found the appraisals beneficial as it helped them to focus on their career development. Also, managers were supportive if staff identified training that they wanted to complete and which would help them in their jobs.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Multidisciplinary working
There were multidisciplinary team (MDT) meetings held each morning attended by doctors, senior physiotherapists, senior occupational therapists and the nurse in charge. The ward held safety huddles each morning and evening during the shift changeovers.

The ward had their own physiotherapy team seven-days a week and the occupational therapy team were on the ward five-days a week 9 am – 5 pm.

Staff we spoke with informed us that all colleagues irrespective of grade worked together effectively and supported each other.

Seven-day services
The ward had their own physiotherapy team seven-days a week from 9 am – 5 pm and an occupational therapy team five-days a week from 9 am – 5 pm.

Health promotion
Health promotion information was available on the ward. This included display boards and information leaflets. Staff we spoke with informed us that patients could utilise support groups such as smoking cessation, drugs and alcohol services and chaplaincy services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Chapel Allerton Hospital
Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. There was a consent policy in place which was issued in April 2018 with a review date of March 2020. The policy clearly explained the roles and responsibilities of staff when obtaining consent, the situations where oral consent would be sufficient and where written consent would be necessary. It also explained the need for two or more stage consent process in elective cases. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

The Mental Capacity act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests.

Staff we spoke with informed us that they had completed Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLs) training either as part of their mandatory training or separately upon commencing their role.

Deprivation of Liberty Safeguards (DoLs) can only be used if a person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.

There were no DoLs patients on any of the wards that we visited.
The trust reported that as of June 2018 Mental Capacity Act (MCA) training was completed by 89% of staff in surgical care at Chapel Allerton Hospital compared to the trust target of 80%.

MCA training was completed by 100.0% of nursing and midwifery staff in surgery services. A breakdown of MCA training modules for nursing and midwifery staff at Chapel Allerton Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Mental capacity act level 1</td>
<td>31</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>8</td>
</tr>
</tbody>
</table>

MCA training level 2 training was completed by 59.3% of medical staff in surgery services. Only level 2 MCA training was completed by medical staff as shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>16</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Friends and Family test performance

We observed staff speaking with patients in a polite and friendly manner. At mealtimes, staff ensured that the food and drinks were placed within easy reach of the patients and no visitors were on the ward to ensure that patients could eat their meals without disturbance.

We spoke with seven patients during our inspection. The majority of patients were satisfied with the level of care they were receiving. Patients we spoke with informed us that all staff were very friendly and they were kept informed about any changes to their care plans. One patient we spoke with stated “Honestly, can’t praise them high enough.” Another patient stated “Marvellous, everything done punctually and I like the place.” A third patient stated, “All been lovely, couldn’t have had a better service if I had gone private.” However, two patients told us that the meal choices were repetitive. Another patient stated, “Food not good, poor quality.”

The friends and family test (FFT) response rate for surgery at Leeds Teaching Hospitals NHS Trust was 40% which was better than the England average of 28%.
A breakdown of response rate by site can be viewed below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total responses</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapel Allerton</td>
<td>1,233</td>
<td>34%</td>
</tr>
</tbody>
</table>

Breakdowns of the percentages of patients who would recommend the trust for surgery by site and ward/unit are shown below:

Chapel Allerton Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>C03 Elective Orthopaedics</td>
<td>1,233</td>
<td>34%</td>
<td>99% 98% 100% 98% 98% 96% 100% 99% 98% 98% 97% 98% 98%</td>
</tr>
</tbody>
</table>

Highest score to lowest score

- 100%
- 50%
- 0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

A multi-faith chaplaincy service was available for patients to access during their stay. Staff from the chaplaincy team could visit patients on the wards to provide emotional and spiritual support. A multi-faith prayer room was located in the hospital.

We observed that ward managers and senior nursing staff were visible on the wards and that patients and relatives could speak to them if they had any concerns.

Understanding and involvement of patients and those close to them

Patients we spoke with told us that staff involved them in their care decisions. This included asking them about their full medical history, including allergies and staff informing them about the risks and benefits of their surgery.

Patients we spoke with told us that staff answered their questions fully and explained things in simple language so that it was easy to understand.

Is the service responsive?

Service delivery to meet the needs of local people

The hospital provided elective surgical treatments for patients. The ward conducted all types of surgery apart from spinal surgery.

Patients were seen at pre-assessment appointments where they were assessed whether they were suitable for surgery. This also gave patients an opportunity to ask questions about their surgery.
Average length of stay

Chapel Allerton Hospital - elective patients

From March 2017 to February 2018 the average length of stay for elective patients at Chapel Allerton Hospital was 4.2 days, which was similar to the England average of 3.9 days.

The average length of stay for trauma & orthopaedics elective patients was similar to the England average.

No other surgical specialty reported more than six elective admissions at this site over this period.

Elective average length of stay - Chapel Allerton Hospital

Note: Top three specialties for specific site based on count of activity.

Chapel Allerton Hospital – non-elective patients

The average length of stay for all non-elective patients at Chapel Allerton Hospital was 48.3 days, which was much longer than the England average of 4.9 days. However, this was based on only 28 non-elective admissions at this site over this time period.

The average length of stay for trauma & orthopaedic patients was much longer than the England average. However, this was based on only 25 non-elective admissions to trauma & orthopaedics at this site over this period.

No other surgical specialty reported more than six non-elective admissions at this site over this period.

Non-elective average length of stay - Chapel Allerton Hospital

Note: Top three specialties for specific site based on count of activity. (Source: Hospital Episode Statistics)
Meeting people’s individual needs

The ward had access to interpretation services. The interpreters were booked by the nurses and the ward preferred the interpreters to attend in person so that there was no misunderstanding in communication. Staff informed us that there were information leaflets available online in other languages which could be printed at the patients’ request. For people that could not read or write, there were picture leaflets available. Staff we spoke with were competent and confident in accessing these services. However, these services were not advertised on posters in the ward corridors.

Staff completed Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS) training as part of their mandatory training. Staff informed us that there were no DoLS patients on the ward as it was a planned elective orthopaedic unit. Sometimes dementia patients were admitted on the ward. For these patients, the ward had dementia champions and dementia passport. The ward ensured that carers and family members were involved in the care plan of such patients.

The hospital had a multi-faith prayer room located on the ground and also a chaplaincy service which provided spiritual support to patients. The chaplaincy team could visit patients on the wards.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

From June 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average and from January 2018 to May 2018 was better than the England average.

The trust’s performance was generally consistent over time. In the most recently reported month (May 2018) 76% of patients were treated within 18 weeks compared to the England average of 67%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of RTT rates for surgery broken down by specialty is below. Of these, five specialties were above the England average:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>93.7%</td>
<td>80.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>88.3%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Specialty</td>
<td>Trust</td>
<td>England average</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>79.3%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.8%</td>
<td>76.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.3%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>58.3%</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Leeds Teaching Hospitals NHS Trust

The percentage of patients whose operation was cancelled and were not treated within 28 days was consistently higher than the England average from April 2016 to March 2018. Performance deteriorated over time with particularly poor performance reported from October 2016 to March 2017 and from January to March 2018.

Cancelled Operations as a percentage of elective admissions - Leeds Teaching Hospitals NHS Trust
Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust was consistently above the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

For the period August 2017 to July 2018, there had been 3151 operations completed and 1151 operations (26.8%) had been cancelled. The trust told us the figures represented the total number of non-clinical cancellations by the trust either on the day of the operation, or before the day of planned admission not just for this site. The numbers included patients who were admitted but not treated. We were told most cancelled operations were attributable to scheduling and ward bed capacity issues.

Learning from complaints and concerns

Summary of complaints

From May 2017 to April 2018 there were 185 complaints about surgical care. Where the complaint had been closed the trust took an average of 60 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 40 days.

Chapel Allerton Hospital

From May 2017 to April 2018 there were no complaints about surgical care at Chapel Allerton Hospital. On the noticeboard in the main corridor of the ward, there was a poster explaining to patients what they should do if they had a problem, concern or complaint. This poster mentioned the PALS service and a phone number and email address of the hospital to raise any complaints. The poster also stated that patients could ask for a leaflet called “What to do if you have a problem, concern or complaint.”

During the inspection we reviewed two complaints made in the previous 12 months, one was concluded the other was still under investigation. The concluded complaint had evidence of the investigation, lessons learned an action plan. It had been responded in line with the trust’s complaints policy.

The charge nurse we spoke with explained the action could only be signed off as completed after it had been signed off by the Clinical Governance Group.

The complaint still under investigation showed the trust policy in relation to the timescales to conclude the investigation and provide responses were being met.

Individual feedback was provided through an e mail. The information was also shared through the safety huddles.

Any concerns raised by the patient while on the ward or following discharge which did not constitute a complaint were recorded on the PPM+ record system. The charge nurse we spoke with explained the information was used to identify any themes which needed to be addressed.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From May 2017 to April 2018 there were 53 compliments within surgery. A breakdown by location is shown below:

Chapel Allerton Hospital

There were four compliments within surgery, all of which related to elective orthopaedics.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The ward sits under the Clinical Services Unit (CSU). The CSU is led by a triumvirate team consisting of a clinical director, general manager and head of nursing. This triumvirate team reported to the chief nurse/deputy chief executive.

Staff we spoke with told us they saw someone from the management team every day. Staff described the leaders as being very supportive. They provided up to date information such as the bed state across the trust, incidents, current estates maintenance and it was an opportunity to raise issues in a non-formal setting.

Staff we spoke with told us they could do the “Leeds Improvement Method” which was a quality improvement tool available to all staff.

Staff also told us they had been given time to develop leadership skills. The charge nurse and senior sister we spoke with told us they had been given time away from work to contribute to the Quality Improvement Surgical Team (QUIST). They had also attend a conference in Amsterdam in relation to enhanced recovery and reduced time of hospital stay.

Courses were available on line and the staff we spoke with told us funding could be applied for to complete university courses. The charge nurse told us their time was spilt 80% management and 20% clinical. The Sister we spoke with told us their time was split 50% management and 50% clinical.

Vision and strategy

Staff we spoke with told us the trust was in the second year of a five-year plan to increase the number of operating theatres and to increase the wards to take more day cases. Chapel Allerton was aiming to be the first hospital in the trust to be digital and paperless. The ward was working toward reducing the length of stay and reduce the level of delayed discharges.

Culture

Staff we spoke with said they said they felt valued by their patients, ward leaders and the trust and had not witnessed or experienced bullying or harassment. Staff told us if they witnessed or experienced bullying or harassment, they would either confront the perpetrator or inform their line manager.
Staff we spoke with enjoyed working on the surgical wards as they felt supported by their colleagues and line managers. One staff member told us “I love my job and I love orthopaedics.” Another member of staff told us “Love coming to work.”

Two out of the eight staff we spoke with had heard of the trust’s pride and respect project and could name the trust’s freedom to speak up guardian.

All the staff we spoke with were aware of the trust values “The Leeds Way” and could explain them. The values were displayed on computer home screens and in prominent places around the ward for staff and public to see. The values of the trust were patient-centred, accountable, fair, collaborative and empowered.

**Governance**

The service had a clear governance framework and there was a governance structure in place for all specialities. The governance Clinical Services Unit (CSU) meeting took place each quarter which was attended by the quality and assurance manager who looked at the issues relating to their CSU. The service held weekly triumvirate meetings each Monday where issues were discussed. If they couldn’t be solved at these meetings, they were escalated to the next level in the governance structure. We examined minutes of these meetings and these confirmed that they were taking place weekly.

All incidents were recorded on an online system. We saw evidence of this in the minutes from the Health and Safety/ Risk Management meeting. The ward Matron attended this meeting and is challenged during it.

**Management of risk, issues and performance**

The service had a risk register which was discussed at the governance meetings. The risks had mitigating factors with scores and the service pro-actively monitored these scores to ensure that the scores were reducing. The senior management also attended the trust’s risk management board where risks were discussed. The risks that had been on the register for longer than a year were junior doctor cover and finance.

The service monitored performance and this was evidenced through a ward audit dashboard which contained rated scores for various elements of care delivery such as cleanliness and infection control. We examined the ward dashboard for July 2018 and saw that the ward had no actions following an audit of patient notes. Staff we spoke with told us that they conducted an infection control audit every month. The ward had not had a MRSA incident for the last eight years. The rate for post-operative joint infection was 0.6%, whereas the national average was 6%.

Staff also told us the results of the clinical dashboard were also subject to scrutiny. If any actions resulted from the audit activity, they had to be finalised within a month and signed off by the matron.

If the action plan was taking more than a month to finalise, the matron had to explain the reasons behind the delay to the Head of Nursing. If the action plan was taking more than two months to finalise, the matron had to explain the reasons for the delay to the trust board.

If the actions plans were finalised they could only be signed off by the Matron, Head of Nursing or the trust board dependent upon completion time. We saw evidence on notice boards the governance information was displayed for staff and public to see.
Information management

At the time of the inspection staff told us they were moving toward a paperless system on the ward. We were able to review both paper records and computer records. Staff could access the patient records using an online system which was password protected and staff had different levels of access according to their grades. Also, staff had access to policies and procedures via the intranet. Nurses could access blood tests results for patients through the electronic system whereas doctors and consultants could access x-ray and scan results through this same system.

Engagement

Staff we spoke with told us there was an annual award scheme called ‘Shining Star Award’ which had seven different awards such as compassionate care, piece of research. Anyone in the trust could nominate who they liked. The management triumphant chose the winners. The winners received certificates at an award ceremony and their names were displayed on a plaque in Leeds General Infirmary.

Staff we spoke with told us the ward had come out very well from the recent staff survey with no action to be taken. The trust had recently carried out an internal survey to check if improvements had been made. The results were not available at the time of the inspection.

The service was on Twitter and any compliments for staff were tweeted as were photos related to dermatology. The last staff survey had resulted in a 97.7 % satisfaction rate.

Staff we spoke with felt valued by their ward and by the trust as a whole. Staff were encouraged to develop professionally by being supported to complete training courses additional to mandatory training.

Patients were given information about support groups such as smoking cessation, drugs and alcohol, housing needs.

Patients were provided with information leaflets on topics such as blood transfusion, preventing falls, caring for plaster casts and preventing blood clots. The leaflets were in English and staff informed us they were available in other languages online and these could be printed for patients if they requested. However, this service was not advertised anywhere on posters in the ward.

Learning, continuous improvement and innovation

The ward manager communicated the lessons learned verbally at the morning safety huddles and via email for those staff not present at these huddles.

Staff we spoke with told us of the following innovations and changes to working practices to improve the service:

- **Think Drink** – to encourage all staff to ensure patients remained hydrated. This is accomplished by allowing patients to drink clear liquids up to four hours prior to their surgery from previously 12 hours. This aids patients’ recovery after surgery as they are less dehydrated.
- **Safety Huddles** – these enable staff to share information about patients when changing shifts and during the ward round attended by doctors, senior physiotherapists, senior occupational therapists and nurse in charge.
- **The Leeds improvement method** – a course for managers to manage change.
Leeds General Infirmary
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services.

In addition to regular urgent care the trust also has the Leeds major trauma centre. The service has a rooftop helicopter pad able to receive direct transfer of multiple-injured patients. The unit can accommodate up to ten bays during a major incident. All specialties are covered and the unit has quick access to specialist cross sectional imaging, including a hybrid endovascular suite which is co-located with A&E.

(Source: Routine Provider Information Request (RPIR- Acute) – Context tab)

- Leeds General Infirmary – type 1 A&E department (including paediatrics), clinical decisions unit, minor injuries unit.
- St James’s University Hospital – type 1 A&E department, clinical decisions unit, minor injuries unit.

(Source: Routine Provider Information Request (RPIR- Universal) – Sites tab)

Activity and patient throughput

Total number of urgent and emergency care attendances at Leeds Teaching Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017

From April 2016 to March 2017 there were 236,564 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2016/17 compared to 2015/16. In both years, the proportions were higher than the England averages.

Updated analysis for March 2017 to February 2018 showed that 34.1% of attendances at the trust resulted in admission which placed the trust in the highest quantile in comparison to national rates.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2017 to February 2018

*Admitted to hospital includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 80.0% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses as at June 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and safety matters</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity general</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling lower risk</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>235</td>
<td>236</td>
<td>99.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control specialist clinical</td>
<td>234</td>
<td>235</td>
<td>99.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>234</td>
<td>236</td>
<td>99.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>230</td>
<td>233</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>231</td>
<td>236</td>
<td>97.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>223</td>
<td>236</td>
<td>94.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2</td>
<td>131</td>
<td>154</td>
<td>85.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 1</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>160</td>
<td>209</td>
<td>76.6%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2 update</td>
<td>103</td>
<td>154</td>
<td>66.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 80.0% target was met for 14 of the 17 mandatory training modules for which qualified nursing staff were eligible.

The service had a 100% completion rate for seven training modules and a further six modules had completion rates above 90%. Nursing staff had an overall mandatory training completion rate of 95.2%, exceeding the trust target of 80.0%.
Paediatric life support level 2 update had the lowest completion rate at 66.9%, while resuscitation training level 2 and PRTD paediatric life support level 1 had completion rates of 76.6% and 76.9%, respectively.

A breakdown of compliance for mandatory training courses as at June 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling lower risk</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk and safety matters</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality at diversity general</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>86</td>
<td>96</td>
<td>89.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>55</td>
<td>62</td>
<td>88.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thrombembolism</td>
<td>109</td>
<td>124</td>
<td>87.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>115</td>
<td>135</td>
<td>85.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>specialist clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>103</td>
<td>123</td>
<td>83.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>111</td>
<td>136</td>
<td>81.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>110</td>
<td>136</td>
<td>80.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>109</td>
<td>136</td>
<td>80.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 3 ALS</td>
<td>12</td>
<td>19</td>
<td>63.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2 ILS</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>33</td>
<td>114</td>
<td>28.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>(update)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>33</td>
<td>114</td>
<td>28.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2 PMST</td>
<td>13</td>
<td>100</td>
<td>13.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 80.0% target was met for 12 of the 17 mandatory training modules for which medical staff were eligible. Eight training modules had completion rates above 85.0%. Medical staff had an overall mandatory training completion rate of 75.0%, lower than the trust target of 80.0%.

The trust target was not met for five training modules, with the lowest completion rate of 13.0% for resuscitation training level 2. Resuscitation training advanced and resuscitation training advanced (update) both had a completion rate of only 28.9%. Resuscitation training level 2 ILS had a completion rate of 50%, although this equates to only one eligible staff member not completing the training.

Resuscitation training had been affected by staff shortages within the Resuscitation Training Officer role in the Trust. The reduction of training officers by 50% had led to this shortfall which had caused a reduction in capacity and reduced availability for resuscitation training.
A breakdown of compliance for mandatory training courses as at June 2018 for qualified nursing staff in the urgent and emergency care department at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous thromboembolism</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling lower risk</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity general</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control specialist clinical</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk and safety matters</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>146</td>
<td>147</td>
<td>99.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>143</td>
<td>144</td>
<td>99.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>144</td>
<td>147</td>
<td>98.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>137</td>
<td>147</td>
<td>93.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2</td>
<td>83</td>
<td>90</td>
<td>92.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2 (update)</td>
<td>74</td>
<td>90</td>
<td>82.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>96</td>
<td>120</td>
<td>80.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 1</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary urgent and emergency care department the 80.0% target was met for 15 of the 16 mandatory training modules for which qualified nursing staff were eligible. Nursing staff had an overall mandatory training completion rate of 96.6%, exceeding the trust target of 80.0%.

Eight training modules had a 100% completion rate and a further five modules had completion rates above 90%. PRTD paediatric life support level 1 had the lowest completion rate of 76.9%, although this equates to only three eligible staff members not completing the training.

A breakdown of compliance for mandatory training courses as at June 2018 at Leeds General Infirmary for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling lower risk</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk and safety matters</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity general</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>86</td>
<td>96</td>
<td>89.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>55</td>
<td>62</td>
<td>88.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>109</td>
<td>124</td>
<td>87.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control specialist clinical</td>
<td>115</td>
<td>135</td>
<td>85.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Safer blood transfusion | 103 | 123 | 83.7% | 80.0% | Yes
Fire safety - all staff | 111 | 136 | 81.6% | 80.0% | Yes
Personal safety - lower risk | 110 | 136 | 80.9% | 80.0% | Yes
Information governance | 109 | 136 | 80.1% | 80.0% | Yes
Resuscitation training level 3 ALS | 12 | 19 | 63.2% | 80.0% | No
Resuscitation training level 2 ILS | 1 | 2 | 50.0% | 80.0% | No
Resuscitation training advanced (update) | 33 | 114 | 28.9% | 80.0% | No
Resuscitation training advanced | 33 | 114 | 28.9% | 80.0% | No
Resuscitation training level 2 PMST | 13 | 100 | 13.0% | 80.0% | No

Six training modules had a 100% completion rate and a further six modules had completion rates above 90%.

The 80.0% trust target was not met for three modules. PRTD paediatric life support level 2 (update) had the lowest completion rate of 45.3%, while resuscitation training level 2 and PRTD paediatric life support level 2 had completion rates of 71.9% and 75.0% respectively.

We spoke with 15 members of staff on site at Leeds General Infirmary (LGI) who confirmed that their mandatory training was up to date.

The senior staff within the department at LGI confirmed that compliance for paediatric life support was worse than the required compliance rate and was attributed to vacancies within the resuscitation training department. We were assured by senior departmental staff that these vacancies have now been filled and we saw evidence of a roll out of paediatric life support courses to ensure all staff had completed the required training.

We reviewed 5 mandatory training evaluation forms which had been completed in 2018 which demonstrated that meaningful feedback was obtained from staff attending mandatory training sessions.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 80.0% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as at June 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>233</td>
<td>236</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In urgent and emergency care, the 80.0% target was met for six of the seven safeguarding training modules for which qualified nursing staff was eligible. Nursing staff had an overall mandatory training completion rate of 90.8%, exceeding the trust target of 80.0%.

Two training modules had a 100% completion rate and a further two modules had completion rates above 90%.

One training module, Prevent (WRAP), had a completion rate of 77.8%, although this equates to only two eligible staff members not completing the training.

A breakdown of compliance for safeguarding training courses as at June 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
<td>28</td>
<td>31</td>
<td>90.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>121</td>
<td>136</td>
<td>89.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>53</td>
<td>68</td>
<td>77.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>23</td>
<td>31</td>
<td>74.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>22</td>
<td>31</td>
<td>71.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>89</td>
<td>136</td>
<td>65.4%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>24</td>
<td>67</td>
<td>35.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 80.0% target was met for two of the seven safeguarding training modules for which medical staff was eligible. Medical staff had an overall safeguarding training completion rate of 72.0%, not meeting the 80.0% trust target.

Five modules had completion rates lower than the trust target. Safeguarding children level 2 had the lowest completion rate of 35.8%, followed by safeguarding children level 1 with a completion rate of 65.4%.

**Leeds General Infirmary urgent and emergency care department**

A breakdown of compliance for safeguarding training courses as at June 2018 for qualified nursing staff in the urgent and emergency care department at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
At Leeds General Infirmary Hospital urgent and emergency care department the 80.0% target was met for six of the seven safeguarding training modules for which qualified nursing staff was eligible. Nursing staff had an overall safeguarding training completion rate of 94.3%, meeting and exceeding the trust target.

Four modules had a 100% completion rate and a further two modules had completion rates of 88.7%. One module, prevent (WRAP) had a completion rate of 66.7%, below the trust target of 80.0%. This however equates to only two eligible staff members not completing the training.

A breakdown of compliance for safeguarding training courses as at June 2018 at Leeds General Infirmary for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>125</td>
<td>141</td>
<td>88.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>125</td>
<td>141</td>
<td>88.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 80.0% target was met for two of the seven safeguarding training modules for which medical staff was eligible. Medical staff had an overall safeguarding training completion rate of 72.0%, not meeting the 80.0% trust target.

Five modules had completion rates lower than the trust target. Safeguarding children level 2 had the lowest completion rate of 35.8%, followed by safeguarding children level 1 with a completion rate of 65.4%.

Of the 15 members of staff we spoke with each was conversant with the safeguarding referral processes for adult and children. Within the paediatric department band 6 nurses reviewed all notes from the previous 24 hours to assess for any safeguarding concerns.

All staff that we spoke with were aware how to manage patients presenting with complex safeguarding needs, for example involving their mental health, domestic violence, learning difficulties, and female genital mutilation (FGM).

Staff we spoke with knew how to recognise safeguarding concerns, they were able to make safeguarding referral and they could describe the types of incidents that they would refer to the safeguarding team. Staff were able to describe examples of safeguarding concerns they had been involved with, including what actions they had taken and the outcomes. The examples included support for victims of domestic violence.
The electronic patient record would identify children who were known to social services including those on the ‘At Risk Register’. The patient record would generate specific questions in relation to safeguarding which would require a response before it would allow the user to move on.

The IT system would flag multiple attendances and would give a figure in days since the last attendance to the department.

**Cleanliness, infection control and hygiene**

The emergency department was visibly clean, including the patient cubicles and toilet areas. Disposable curtains were clearly labelled to show the dates of when they were last changed and when they would routinely require changing. Domestic staff followed a cleaning schedule which was observed to be fully completed with the date and the staff member’s signature. Care staff were responsible for cleaning equipment and trolleys which was observed during the inspection.

The department participated in routine infection control audits and it was reported by senior nursing staff that they scored highly in these audits. The staff reported that the purpose of infection control audits was to set standards for infection prevention and control practice. The aim was to optimise and assess infection prevention and control practices in clinical teams throughout the hospital to reduce infection rates.

We observed staff adhering to trust policy and national standards for infection prevention and control. It was observed that all staff cleaned their hands between patient contact and we also observed all equipment being cleaned between patient use.

Patient assessment areas were cleaned after each patient use. The cleaning records were completed regularly and fully. Hand basins were appropriately sited; soap and alcohol gel dispensers were working and well stocked. Paper towels were available for drying hands. Sharps bins were available and were not over filled.

Mandatory training in Infection Control and Prevention (IPC) for all staff was 85.2% which exceeded the Trust target of 80%

Staff had access to personal, protective, equipment (PPE) and staff were observed to use it as appropriate

All staff were noted to be bare below the elbow in line with good practice and guideline

**Environment and equipment**

The department was comprised of areas for resuscitation majors, minors and paediatric assessment and treatment. The paediatric department was separate from the adult department and had its own waiting area.

We found that equipment in the department had been safety checked. All of the electrical equipment we checked had up to date tests. All areas were well stocked with equipment appropriate for the treatment of patients within those areas. All equipment was stored appropriately and securely.

All equipment for major incidents including decontamination were stored separately, securely and were appropriate for their purpose.

All resuscitation trolleys had checklists attached which were completed daily and signed by staff checking them. All equipment and other items such as medicines within the trolleys were in date.
There were designated mental health assessments rooms available within the department, however, at inspection they were found to not be ‘ligature free’. This was raised at inspection and immediate action was taken by the Trust

**Assessing and responding to patient risk**

All patients would be seen by a ‘streaming nurse’ once the reception staff had booked them onto the electronic system. The streaming nurse sat alongside receptionist and would identify where they would be required to attend best for their needs.

We observed the nurse streaming at the front of the department for a period of time. The nurse observed patients over the reception desk and advised where they would receive their care and were referred to for their treatment.

Patients were triaged using the Manchester triage assessment tool into four priorities streams. Priority four was the longest triage time of two hours. Experienced nurses at a band 6 level provided the initial streaming assessment. This allowed staff with experience to triage patients to the correct place on the first time.

A designated nurse has been introduced on each shift to accept and coordinate ambulance handovers which has been reported as decreasing both handover times and time from attending to being assess

We reviewed 22 sets of patient notes and found National Early Warning Systems (NEWS) for recognition of deteriorating patients to be included when appropriate.

The paediatric unit was noted to use an appropriate paediatric early warning system (PEWS) to manage the deteriorating patient. We observed three sets of documentation which held evidence of completed PEWS scores

We observed and reviewed the departmental sepsis care pathways including for both adult and paediatrics.

All nursing staff from Band 5 were trained in Immediate Life Support (ILS) and all non-registered staff were training in Basic Life Support (BLS)

All nurses at Band 6 and above were trained in Advanced Paediatric Life Support (APLS)

All qualified paediatric nursing staff are trained in Paediatric Immediate Life Support (PILS) and Advanced Paediatic Life Support (APLS)

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
department, did you feel threatened by other patients or visitors?

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median from June 2017 to February 2018.

Arrival to initial assessment times were on average 2.4 minutes better than the England average from June 2017 to February 2018. Over this period the overall trend remained static with a slight increase during the winter months of January and February 2018.

Ambulance – Time to initial assessment from June 2017 to February 2018 at Leeds Teaching Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Leeds General Infirmary

From July 2017 to February 2018 the percentage of turnaround times over 30 minutes generally decreased, from 54% in July 2017 to the lowest percentage of 50% in February 2018. From April 2018 onwards there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Leeds General Infirmary. The management team when asked were not able to explain the upward trend.

Following the inspection, the trust provided ambulance handover data for both main hospital sites which showed:

<table>
<thead>
<tr>
<th>Month</th>
<th>LGI % &gt; 30 minutes</th>
<th>SJUH % &gt; 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2017</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>August 2017</td>
<td>0.7%</td>
<td>0.2%</td>
</tr>
<tr>
<td>September 2017</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>October 2017</td>
<td>2.4%</td>
<td>0.7%</td>
</tr>
<tr>
<td>November 2017</td>
<td>0.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>December 2017</td>
<td>2.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>January 2018</td>
<td>1.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td>February 2018</td>
<td>March 2018</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>Number of journeys with turnaround times over 30 minutes - Leeds General Infirmary</td>
<td>1.1%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Number of journeys with turnaround times over 30 minutes - Leeds General Infirmary</td>
<td>1.5%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

**Ambulance: Number of journeys with turnaround times over 30 minutes - Leeds General Infirmary**

Between 30 and 60 minutes
Over 60 minutes

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Leeds General Infirmary**

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From May 2017 to April 2018 the trust reported 29 black breaches, with a decreasing trend over the period.

Six black breaches were reported in May 2017, after which numbers decreased to zero in August 2017. Although numbers increased again to four in October 2017 no “black breaches” were reported in November 2017. Six “black breaches” were reported during January 2018 before decreasing once again to two in April 2018.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
Nurse staffing

The trust reported the following qualified nursing staff numbers as at March 2017 and March 2018 for urgent and emergency care by site:

Leeds General Infirmary

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>141.5</td>
<td>146.7</td>
</tr>
</tbody>
</table>

Leeds General infirmary had a staffing fill rate of 100.0% as at March 2018, in spite of the fact that the trust had increased planned staff figures by 5.8 whole time equivalent (WTE) staff members between March 2017 and March 2018. In March 2018 the site had 11.1 more WTE staff members in post than what they had in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The paediatric unit was staffed solely with Registered Sick Children’s Nurses (RSCN)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 6.5% for qualified nursing staff in urgent and emergency care. The trust did not set a target for vacancy rates.

The breakdown by site was as follows:

- Leeds General Infirmary: -3.2% (indicating that this site was overstaffed)
- St James’s University Hospital: 20.2%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 19.3% for qualified nursing staff in urgent and emergency care. The trust did not set a target for turnover rates.

The breakdown by site was as follows:

- Leeds General Infirmary: 17.9%
- St James’s University Hospital: 21.6%

At Leeds General Infirmary 28.0 WTE staff members have left the trust over the period and at St James’s University Hospital 18.6.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 3.1% for qualified nursing staff in urgent and emergency care. This was slightly lower than the trust target of 3.5%

The breakdown by site was as follows:

- Leeds General Infirmary: 2.7%
- St James’s University Hospital: 3.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and agency staff usage

Trust Level

From April 2017 to March 2018, the trust reported that 5.0% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 0.3% of shifts were filled by agency staff. In addition 4.7% of shifts were not filled by bank and agency staff to cover staff absence.

Over the same period, 11.2% of nursing assistant shifts in urgent and emergency care were filled by bank staff. We saw 2.4% of shifts were filled by agency staff and 5.6% of shifts were not filled by bank and agency staff to cover staff absence.

Please note that the trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James's Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Bank</td>
<td>1,393</td>
<td>11.2%</td>
<td>1,858</td>
<td>5.0%</td>
</tr>
<tr>
<td>Agency</td>
<td>300</td>
<td>2.4%</td>
<td>109</td>
<td>0.3%</td>
</tr>
<tr>
<td>Not filled</td>
<td>700</td>
<td>5.6%</td>
<td>1,662</td>
<td>4.4%</td>
</tr>
<tr>
<td>Total shifts</td>
<td>12,456</td>
<td></td>
<td>37,360</td>
<td></td>
</tr>
</tbody>
</table>

Leeds General Infirmary

From April 2017 to March 2018, Leeds General Infirmary reported that 3.2% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 0.1% of shifts were filled by agency staff. In addition 2.6% of shifts were not filled by bank and agency staff to cover staff absence.

Over the same period, 5.3% of nursing assistant shifts in urgent and emergency care were filled by bank staff, 0.6% of shifts were filled by agency staff and 3.4% of shifts were not filled by bank and agency staff to cover staff absence.

Please note that the trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James's Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing assistant</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Bank</td>
<td>324</td>
<td>5.3%</td>
<td>624</td>
<td>3.2%</td>
</tr>
<tr>
<td>Agency</td>
<td>36</td>
<td>0.6%</td>
<td>11</td>
<td>0.1%</td>
</tr>
<tr>
<td>Not filled</td>
<td>206</td>
<td>3.4%</td>
<td>496</td>
<td>2.6%</td>
</tr>
<tr>
<td>Total shifts</td>
<td>6,120</td>
<td></td>
<td>19,220</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)
Medical staffing

The trust reported the below medical staffing numbers as at March 2017 and March 2018 for urgent and emergency care.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
</tr>
<tr>
<td></td>
<td>WTE staff</td>
<td>WTE staff</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>115.9</td>
<td>115.3</td>
</tr>
</tbody>
</table>

Leeds General infirmary had a staffing fill rate of 112.8% as at March 2018, indicating that the site had 15.6 more WTE staff in post than planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Due to LGI being a Trauma Centre there is 24 hour per day, 7 day per week consultant cover

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of -8.8% for medical staff in urgent and emergency care at Leeds General Infirmary, indicating that this service was over staffed. The trust did not set a target for vacancy rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 52.3% for medical staff in urgent and emergency care at Leeds General Infirmary. The trust did not set a target for turnover rates. Over the period 69.6 WTE staff members left the trust. However, the inclusion of trainee grades in the data is likely to have inflated the rates.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 1.8% for medical staff in urgent and emergency care at Leeds General Infirmary. This was lower than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018, Leeds General Infirmary reported 4,065 shifts filled by bank staff and 621 shifts filled by locum staff in urgent and emergency care. There were 200 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.
<table>
<thead>
<tr>
<th></th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>444</td>
<td>3,063</td>
<td>558</td>
<td>4,065</td>
</tr>
<tr>
<td>Locum staff</td>
<td>328</td>
<td>293</td>
<td>0</td>
<td>621</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>20</td>
<td>179</td>
<td>1</td>
<td>200</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As of December 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower. The trust had 11% less middle career doctors and 17% more registrars working at the trust when compared to the England averages.

**Staffing skill mix for the 117 whole time equivalent staff working in urgent and emergency care at Leeds Teaching Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

We reviewed 22 sets of patients notes—all were completed without error or omission. Each record was predominantly electronic based but there were some paper based notes utilised. Each record contained all relevant patient specific data. Safeguarding issues were flagged within the patient notes. Appropriate risk assessments were noted to have been completed when appropriate, we observed 3 falls assessments within the notes that we reviewed. The patient records alerted staff to specific patient needs such as learning disability or dementia.
Medicines

All medicines including intravenous fluids were checked and were found to be stored appropriately, all were in date and all documentation that we reviewed regarding medicines were completed fully and without error or omission.

There was regular pharmacy involvement within the department.

We found that all fridges within the department had a daily temperature checklist which was completed and signed without omission. There was evidence on the daily checklists of action being taken when a temperature was out of range.

All controlled drugs were stored securely, we observed two staff checking the controlled drugs whilst we were on inspection.

There were Nurse Prescribers working within the Minors area of the department who would prescribe medication as necessary.

We observed that there were local antimicrobial protocols.

In all patient notes that we reviewed the patient’s allergy status was recorded as appropriate.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported two incidents classified as never events for urgent and emergency care. Both incidents occurred at St James’s University Hospital.

The first incident took place in March 2018, when a patient required oxygen to be administered and the tubing was connected to the wall air outlet instead of the wall oxygen outlet. No harm came to the patient as a result of this error.

The second incident took place in May 2018. The patient was put on air instead of oxygen by the paramedic crew. This was noticed by staff and was corrected. No harm came to the patient as a result of this error.

(Source: NHS Improvement - STEIS)

All medical and nursing staff we spoke with were aware of incident reporting. Staff could describe what an incident was, how they would report one and told us they received feedback from incidents they had reported.

We saw evidence of learning from incidents in the form of staff newsletters and as part of the appraisal process.

Feedback was shared in a variety of methods, there were daily huddles, shift handovers, newsletters and ongoing appraisal and 1 to 1 sessions.

Staff understood the duty of candour and when it needed to be applied. At a senior nursing level letters to patients and their relatives would be sent acknowledging the duty of candour following incidents or complaints.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs), including the two never events, in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018.

A breakdown of all incidents reported in urgent and emergency care is shown below.

- Slips, trips and falls meeting SI criteria: Five incidents (41.7%)
- Treatment delay meeting SI criteria: Two incidents (16.7%)
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident (8.3%)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident (8.3%)
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident (8.3%)
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this included foetus, neonate and infant): one incident (8.3%)
- Medical equipment/ devices/disposables incident meeting SI criteria: One incident (8.3%)

(Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

Safety thermometer

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within ten days of the suggested data collection date.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

We observed evidence based clinical guidance on the trust intranet which included Standard Operating Procedures (SOPs) and clinical pathways. Staff reported being able to access the intranet without issue.

We also observed staff using NICE guidelines to assist with decision making.

Medical and nursing staff across the urgent and emergency care service, including the minor injuries unit (MIU) followed clinical guidance as used in the main emergency department. Staff gave examples of National Institute for Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines which they used, for example the Ottawa foot ankle and knee rules.

Clinical governance meetings were used as an approach to monitor outcomes and ensure use of evidence based care and treatment.

Nutrition and hydration

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

We observed within the department that they utilised band 2 non clinical support workers and volunteers to provide nutrition and hydration to patients within the department.

We spoke with 10 patients who reported that they had been offered drinks whilst in department. No patients that we spoke with had been in the department long enough to require food.

There were vending machines available within the waiting areas offering a selection of hot and cold drinks and cold snacks. We noted there were healthy options available. The department was situated to the main entrance where there were additional opportunities to purchase food and drink.

Fluid balance charts were included within the nursing notes for patients requiring fluid management.

The department was able to access food that was specific for cultural or dietary needs.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “how many minutes after you requested pain relief medication did it take before you got it?” This was the about same as other trusts.

The trust scored 7.4 for the question “do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
We reviewed 22 sets of patient notes and all had pain scores and analgesia prescribed and administered if required. We spoke with 15 patients who reported having been offered pain relief.

**Patient outcomes**

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Leeds General Infirmary**

In the 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma audit, Leeds General Infirmary emergency department failed to meet any of the standards. The department submitted 50 records to this audit.

The department was in the upper UK quartile for two standards:

- **Standard 4** (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 90.5%; UK: 77.0%.

- **Standard 5**: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - **Standard 5b** (fundamental): within 4 hours (moderate). This department: 44.0%; UK: 28.0%.

The department was in the lower UK quartile for one standard:

- **Standard 2a** (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 4.0%; UK: 26.0%.

The department’s results for the remaining four standards were all between the upper and lower UK quartiles:

- **Standard 1a** (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 18.0%; UK: 19.0%.

- **Standard 3** (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 14.0%; UK: 25.0%.

- **Standard 5**: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - **Standard 5a** (fundamental): within 60 minutes of arrival (acute severe). This department: 20.0%; UK: 19.0%.

- **Standard 9** (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
    - This department: 55.0%; UK: 52.0%.
RCEM Audit: Consultant sign-off 2016/17

Leeds General Infirmary

In the 2016/17 Consultant sign-off audit, Leeds General Infirmary emergency department failed to meet any of the standards. The department submitted 50 records to this audit.

The department was in the upper UK quartile for three standards:

Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 30.0%; UK: 11%.

Standard 2 (developmental): Consultant reviewed: fever in children under one year of age. This department: 30.0%; UK: 8.0%.

Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 60.0%; UK: 12%.

The department’s results for the remaining one standard were between the upper and lower UK quartiles:

Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 10.0%; UK: 10.0%.

RCEM Audit: Severe sepsis and septic shock 2016/17

Leeds General Infirmary

In the 2016/17 severe sepsis and septic shock audit, Leeds General Infirmary emergency department failed to meet any of the standards. The department submitted 37 records to this audit.

The department was in the upper UK quartile for one standard:

Standard 3: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 64.3%; UK: 30.4%.

The department was in the lower UK quartile for two standards:

Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 5.4%; UK: 69.1%.

Standard 7: Antibiotics administered: Within one hour of arrival. This department: 16.7%; UK: 44.4%.

The department’s results for the remaining five standards were all between the upper and lower UK quartiles.

Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 59.5%; UK: 64.6%.

Standard 4: Serum lactate measured within one hour of arrival. This department: 56.8%; UK: 60.0%.
Standard 5: Blood cultures obtained within one hour of arrival. This department: 35.1%; UK: 44.9%.

Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 43.2%; UK: 43.2%.

Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 8.1%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

Leeds General Infirmary

In the 2015/16 Vital signs in children audit, Leeds General Infirmary failed to meet any of the standards.

The department was in the upper England quartile for one fundamental standard and one developmental standard:

Standard 3 (developmental). There should be explicit evidence in the emergency department record that the clinician recognised the abnormal vital signs (if present). This department: 96.1%; England: 69.7%.

Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. This department: 96.1%; England: 73.2%.

The department was in the lower England quartile for one fundamental standard and one developmental standard:

Standard 1. All children attending the emergency department with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:

- Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU scores. This department: 25.0%; England: 37.6%.
- Standard 1b (developmental). Capillary refill time. This department: 7.0%; England: 22.5%.

The department’s results for the remaining two standards were all between the upper and lower England quartiles.

Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. This department: 2.0%; England: 4.4%.

Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). This department: 62.5%; England: 60.0%.

(Source: Royal College of Emergency Medicine)
RCEM Audit: Procedural sedation in adults 2015/16

Leeds General Infirmary

In the 2015/16 Procedural sedation in adult’s audit, Leeds General Infirmary failed to meet any of the audit standards (which were all 100%).

The department was not in the upper England quartile for any fundamental standards or developmental standards:

The department was in the lower England quartile for three fundamental standards and one developmental standard:

Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. This department: 66.0%; England: 90.0%.

Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
- Standard 4a. A doctor as sedationist
- Standard 4b. A second doctor, ENP or ANP as procedurist
- Standard 4c. A nurse
This department: 4.0%; England: 40.8%.

Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. This department: 14.0%; England: 41.0%.

Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
- Standard 7a. (Fundamental): Return to baseline level of consciousness.
- Standard 7b. (Fundamental): Vital signs within normal limits for the patient.
- Standard 7c. (Fundamental): Absence of respiratory compromise.
- Standard 7d. (Fundamental): Absence of significant pain and discomfort.
- Standard 7e. (Developmental): Written advice on discharge for all patients.
This Department: 0.0%; England 2.6%

The department’s results for the remaining three standards were all between the upper and lower England quartiles.

Standard 1 (fundamental): Patients undergoing procedural sedation in the emergency department should have documented evidence of pre-procedural assessment, including:
- Standard 1a. ASA grading
- Standard 1b. Prediction of difficulty in airway management
- Standard 1c. Pre-procedural fasting status
This department: 26.0%; England: 7.6%.

Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. This department: 68.0%; England: 51.8%.

Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
- Standard 5a. Non-invasive blood pressure
- Standard 5b. Pulse oximetry
- Standard 5c. Capnography
- Standard 5d. ECG
This department: 36.0%; England: 23.9%.
RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

Leeds General Infirmary

In the 2015/16 Venous thrombo-embolism risk in lower limb immobilisation in plaster cast audit Leeds General Infirmary failed to meet any of the audit standards (which were all 100%).

The department was in the upper England quartile for one of the two standards:

Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. This department: 43.7%; England: 2.0%.

The department was in the lower England quartile for one of the two standards.

Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. This department: 83.3%; England: 100.0%.

(Source: Royal College of Emergency Medicine)

Whilst the department failed to achieve the required percentage in each RCEM audit, it was noted that the percentage awarded was higher than the results achieved by comparable Trusts.

We spoke with senior consultants who assured us that action was being taken to address the issues raised by the audit results

Unplanned re-attendance rate within seven days

From June 2017 and May 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and slightly worse than the England average.

With the exception of October 2017, when percentages were 0.5% better, figures were marginally worse than the England figures by an average of 0.6% per month. Although there were some variances month on month, a slight decrease in trend can be seen, from 9.3% in June 2017 to 8.8% in May 2018.

Unplanned re-attendance rate within seven days - Leeds Teaching Hospitals NHS Trust

(Source: NHS Digital - A&E quality)
Competent staff

A structured induction programme was in place for new staff. All nursing staff new to the department received a four-week induction, when they were not counted as part of the staff rota. Staff we spoke with who had recently joined the department told us they felt well supported, which included preceptorship and mentorship. When staff felt ready (usually after six months) they attended an initial assessment training day to enable them to work in the triage area.

Senior nurse managers told us that personal development reviews included interaction to support the staff member’s development and an action log was completed and signed within two weeks of the appraisal. A planned career progression plan was available for all staff. Planned training opportunities within the emergency department included the multi-disciplinary team.

If poor performance is identified, the staff member is supported by being allocated as supernumerary and having a senior member of staff to work alongside to provide support and guidance. If performance fails to improve then there are other routes to follow to address this.

Staff we spoke with had each received an appraisal in the last 12 months. Learning needs were identified in annual appraisals, one to one meetings and development meetings.

Each member of staff we spoke with was satisfied with the quality, availability, support and appropriateness of training they received. Staff we spoke with said support from the head of the unit was excellent.

Education and training was considered a high priority within the department, and staff were encouraged and given time to complete training in areas of interest relevant to the role such as mentorship training. When staff were in training, they were directly supervised by qualified staff.

Appraisal rates

Trust wide

As at June 2017 and June 2018 respectively, 98.2% and 99.0% of nursing and medical staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
</tr>
<tr>
<td>Nursing and midwifery staff</td>
<td>235</td>
<td>238</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>42</td>
<td>44</td>
</tr>
</tbody>
</table>

Leeds General Infirmary

As at June 2017 and June 2018, 98.7% and 99.3% of nursing staff within urgent and emergency care at the Leeds General Infirmary received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
</tr>
<tr>
<td>Nursing and midwifery staff</td>
<td>152</td>
<td>154</td>
</tr>
</tbody>
</table>
Multidisciplinary working

We observed multiple examples of excellent multidisciplinary working. We noted that the department utilised a designated ambulance handover nurse who was responsible for the organisation of all ambulance patients attending the main department. We spoke with six paramedics/ambulance staff who spoke positively about the impact this role had the time they spent in department waiting to handover their patients

We observed very effective communication between staff as they prepared for the arrival of a trauma patient. Each of the team worked during handover to stabilise the patient, and to maintain the patient’s dignity and to preserve confidentiality.

We observed the mental health team travelling from across sites to assess patients within the department.

There was an obvious positive culture within the department and that effective team working was apparent

Seven-day services

Leeds General Infirmary emergency department operated 24 hours a day, seven days a week.

There was 7 day consultant cover within the department

Health promotion

We observed multiple examples of health promotion displayed throughout the department covering a diverse range of topics such as domestic violence, excess alcohol, drugs awareness and healthy eating

We observed patient information leaflets being readily available

Staff were observed to give health promotion advice though we noted that health promotion literature was only available in English.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Trust wide

The trust reported that, as of June 2018, Mental Capacity Act (MCA) training level 1 and 2 was completed by 99.1% of nursing staff in urgent and emergency care compared to the trust target of 80.0%.

The trust reported that as of June 2018 MCA training level 2 was completed by 79.1% of medical staff in urgent and emergency care compared to the trust target of 80.0%.

Leeds General Infirmary

The trust reported that, as of June 2018, Mental Capacity Act (MCA) training level 1 and 2 was completed by 100% of nursing staff in urgent and emergency care at Leeds General Infirmary,
compared to the trust target of 80.0%.

The trust reported that as from June 2018 MCA training level 2 was completed by 79.1% of medical staff in urgent and emergency care at Leeds General Infirmary compared to the trust target of 80.0%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

We spoke with 15 members of staff about Mental Capacity Act and deprivation of liberty training and each confirmed they had completed mandatory training covering these areas.

We found that staff understood how and when to obtain consent. We observed staff as they obtained informed consent prior to assessment and treatment and documented this appropriately. Assessment and treatment was explained to the patient.

Staff we spoke with were aware of the rights of patients and their role in protecting the rights of patients in relation to the Mental Health Act. The requirements of legislation and guidance relating to mental capacity were understood by the staff we spoke with. Staff were able to explain assessment and treatment in several ways and stated that where they felt a patient lacked capacity they would act in the best interests of the patient and make safeguarding or GP referrals, as appropriate.

Staff on the paediatric unit were very conversant around the issues of consent in children and young people. We observed staff obtaining consent from the young person on the unit as well as involving parents in the conversation.

Is the service caring?

Compassionate care

Friends and Family test performance

The trust’s urgent and emergency care friends and family test performance (% recommended) was slightly worse than the England average from June 2017 to March 2018 before improving in the most recent two months, April and May 2018.

Recommendation rates were consistently slightly lower than England rates, by an average of 2.3% per month from June 2017 to March 2018. The lowest recommendation rates of 82.4% and 78.8% were reported in January and March 2018, 4% and 5.5% lower than the England average respectively. Percentages improved to one percent better in April 2018 and 2.4% better than the England average in May 2018.

A&E Friends and Family Test performance - Leeds Teaching Hospitals NHS Trust

(Source: NHS England Friends and Family Test)
We observed documentation and other promotional material within the department regarding the Friends and Family test.

**Emotional support**

We observed staff working with patients who were distressed, to provide reassurance. Staff understood the impact illness or injuries may have on people’s physical and emotional wellbeing. They offered emotional support in the department and provided onward referral when required.

There were two rooms available for use by relatives or those accompanying patients who required private space; these were equipped with telephones and tea/coffee making facilities.

Bereavement services were available and staff were able to describe how to access this

**Understanding and involvement of patients and those close to them**

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examine and treating you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>Comparison</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------------</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

We observed staff communicating effectively with patients, to ensure that care, treatment and conditions were understood. Staff gave a clear explanation to the patient about their condition. Staff checked that patients had fully understood their care and treatment by asking whether they had any further questions at the end of a treatment.

We observed staff communicating effectively with patients’ relatives and including them as appropriate.

Staff gave patients advice about the services available and how to access them. Where a patient required further advice or support after treatment they were advised to contact their GP or facilitated referrals as required. Patients were encouraged to manage their own health care and wellbeing and self-care advice was given on discharge.

Is the service responsive?

Service delivery to meet the needs of local people

Staff stated that they understood the cultural needs of the diverse population of Leeds and went to great lengths to meet those needs, including liaising with members of staff from those communities to establish cultural, social and religious needs.
Meeting people’s individual needs

Emergency Department Survey 2016

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

We found services were delivered in a way that accommodated the specific needs of patients. Where a patient was living with dementia or learning disability, they were prioritised to minimise distress and anxiety. Patients who were profoundly deaf were communicated with by text messages, or pad and pen to ask questions.

Respect was shown to patients of different faiths or cultures and staff had investigated how to best meet the needs of the multicultural population of Leeds, for example through the use of chaperones. The department had access to an interpreter's service by telephone.

We discussed the care of patients with a learning disability with nursing staff. We were informed that patients usually arrived at the unit with a carer to support them and this made communication more effective. We observed the care of a patient with a learning disability. The patient was asked if they had a learning disability and was supported appropriately with their care and treatment.

Patients with mobility needs or disabilities were treated, where possible, in the most comfortable position for them. Bariatric equipment was available on the hospital site.

Access and flow

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for any of the months over the 12 month period from June 2017 to May 2018.

From June 2017 to May 2018 performance was consistently much higher than the 60 minutes standard by. Patients at the trust had to wait a median time average of 57 minutes longer from arrival to treatment than the England median. Median waiting times increased month on month during the winter months from December 2017 to February 2018, reaching the longest median waiting time of 171 minutes in February 2018. Median waiting times decreased from March to May 2018 although remained well above the standard and England median waiting times by a median time average of 58 minutes.
Median time from arrival to treatment from June 2017 to May 2018 at Leeds Teaching Hospitals NHS Trust

- This Trust
- England Avg.
- Standard

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From July 2017 to June 2018 the trust failed to meet the standard and performed generally worse than the England average.

From July 2017 to October 2017 performance against this metric was slightly lower than the England average. The percentage of patients admitted, transferred or discharge within four hours decreased to well below the England average during the winter months from November 2017 to March 2018. The lowest percentage of 69% of patients, admitted, transferred or discharged within four hours, was reported in January 2018. Percentages however improved to similar to the England average in May and to slightly below in June 2018.

Four hour target performance - Leeds Teaching Hospitals NHS Trust

- This Trust
- England Avg.
- Standard

(Source: NHS England - A&E Waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From July 2017 to April 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average before improving to better than the England average in the most recent two months, May and June 2018.
From July 2017 to January 2018 performance against this metric increased sharply to well above the England average. Percentages improved to lower than the England average in May 2018 and similar to the England average in June 2018.

The trust performance followed roughly the same trend as the England average, with the highest percentages reported during the winter period from December 2017 to April 2018. Trust performance however was worse than the England average for the majority of months over the period.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Leeds Teaching Hospitals NHS Trust

The table below shows the numbers of patients waiting more than four hours to admission by month:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2017</td>
<td>589</td>
</tr>
<tr>
<td>August 2017</td>
<td>602</td>
</tr>
<tr>
<td>September 2017</td>
<td>740</td>
</tr>
<tr>
<td>October 2017</td>
<td>937</td>
</tr>
<tr>
<td>November 2017</td>
<td>1,136</td>
</tr>
<tr>
<td>December 2017</td>
<td>1,512</td>
</tr>
<tr>
<td>January 2018</td>
<td>1,773</td>
</tr>
<tr>
<td>February 2018</td>
<td>1,499</td>
</tr>
<tr>
<td>March 2018</td>
<td>1,713</td>
</tr>
<tr>
<td>April 2018</td>
<td>1,038</td>
</tr>
<tr>
<td>May 2018</td>
<td>305</td>
</tr>
<tr>
<td>June 2018</td>
<td>383</td>
</tr>
</tbody>
</table>


Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from July 2017 to June 2018, no patients waited more than 12 hours from the decision to admit until being admitted. (Source: NHS England - A&E Waiting times)
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From June 2017 to January 2018 the monthly median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently worse than the England average.

From June to September 2017 patients that left the trust before being seen were on average 2% higher than the England average. In October and the winter months of November and December 2017 trust performance deteriorated and percentages were on average 3% higher than the England rates.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Leeds Teaching Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From June 2017 to May 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Over this time period, patients at the trust spent on average 41 minutes longer in A&E than the England average.

During the winter months of December 2017 to March 2018, patients spent an average of 52 minutes longer in A&E than the England average. Trust performance however improved in April and May 2018, although total time spends in A&E remained longer than the England average.
Learning from complaints and concerns

Summary of complaints

Trust level

From May 2017 to April 2018 there were 149 complaints about urgent and emergency care services. The service took an average of 47 working days to investigate and close complaints. This is not in line with the trust’s complaints policy, which states complaints should be closed within 40 days.

Twelve complaints (8.1%) were not upheld, 55 (36.9%) were partially upheld, 48 (32.2%) were fully upheld and 34 (22.8%) were still under investigation.

The trust has allocated multiple subjects for each complaint received. It is therefore not possible to provide number of complaints per subject.

Leeds General Infirmary

From May 2017 to April 2018 there were 35 complaints about urgent and emergency care services at Leeds General Infirmary. The service took an average of 47 working days to investigate and close complaints. This is not in line with the trust’s complaints policy, which states complaints should be closed within 40 days.

Two complaints (5.7%) were not upheld, 14 (40.0%) were partially upheld, 11 (31.4%) were fully upheld and eight (22.6%) were still under investigation.

The trust has allocated multiple subjects for each complaint received. It is therefore not possible to provide a breakdown of the number of complaints by subject.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From May 2017 to April 2018 there were 39 compliments in urgent and emergency care. Compliments received for urgent and emergency care accounted for 16.0% of all compliments received by the trust.

Leeds General Infirmary

Leeds General infirmary received 17 compliments; 43.6% of all compliments received for urgent and emergency care.

A breakdown is shown in the table below:

<table>
<thead>
<tr>
<th>Team/Unit/Ward</th>
<th>Compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency (A&amp;E)</td>
<td>16</td>
</tr>
<tr>
<td>Clinical Decisions Unit (CDU)</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We saw evidence of learning from complaints which was shared with clinical governance and is consultant led to prepare clinical case examples for feedback to staff to embed learning. Complaints received via PALS were handled by a band 7 nurse. Formal complaints went to the matron and had a specified response date. Compliance reports were received and monitored each month. The matron and a consultant would try and meet with the complainant; the meeting would be recorded and a transcript sent to the complainant along with an action plan.

We saw active participation with seeking feedback as part of friends and family-staff were observed to give patients the opportunity to provide feedback, there were posters and other documentation within the department regarding feedback and recently received feedback was displayed prominently within the department.

Is the service well-led?

Leadership

The care group leadership team included the nurse director, an operations director and clinical director which formed a clinical delivery leadership triumvirate. Medical and nursing staff spoke positively about the functioning of the leadership triumvirate for the emergency department.

All staff we spoke with told us that department leads were approachable, supportive and well respected, and that there was regularly a visible management presence in the department.

The nursing team in the department was led by experienced staff who provided clinical and professional supervision. We observed that staff were encouraged to develop their skills and knowledge. At the time of our inspection, a change in senior nursing leadership was taking place in the department.

Vision and strategy

A clear vision and operational plan was in place for the continued development of the department. The trust’s vision was ‘to be the best for specialist and integrated care’ and this was supported by a five-year strategy based on a set of values and behaviours referred to as ‘The
Leeds Way’.
These values were described as patient-centred, fair, collaborative, accountable and empowered; we were told that staff were involved in developing the values and those we spoke with in the ED said their impact on the culture had been very positive.

**Culture**

The emergency department’s culture was clearly positive, which a visitor could sense and which staff told us about. Staff we spoke with felt valued, appeared happy and enthusiastic and spoke positively about working in the department.

The department had a psychologist for staff to access; confidential sessions were available weekly on a ‘drop-in’ basis.

There was an anonymous/confidential telephone helpline which operated across both EDs to provide support for colleagues. ‘Listening Ears’ was developed following an incident that occurred the previous year and had an impact on all staff. It was set up and run by staff from both sites who had received training from a clinical psychologist. The service was originally specific to ED but other areas were becoming involved due to the success of the service.

**Governance**

Governance meetings for ED took place monthly and were done in conjunction with SJUH. The department had a designated governance lead. The meetings were attended by clinical/nursing leads, business manager, quality governance manager and pharmacy.

Information was used to monitor and manage the operational performance of the department, and to measure improvement. Service performance measures were monitored and reported.

ESM governance meetings were attended by matrons, deputy head of nursing, clinical leads from the specialities and business managers.

**Management of risk, issues and performance**

Managers told us that the risk register was regularly reviewed and discussed at monthly clinical governance meetings. Risks were also reviewed twice yearly at executive level. There was a nominated clinical lead for risk and learning in the ED.

Safety incidents and learning were shared and discussed with the clinical team.

**Information management**

The department collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. Information was used to monitor the performance of the department, and performance data was shared with staff through the CEM Books computer application.

Information governance training was part of the trust’s mandatory training programme, with a compliance target of 80%. Data provided by the trust showed that compliance in urgent and emergency care at LGI was 99.2% for nursing staff and 80.1% for medical staff.

**Engagement**

Medical and nursing staff we spoke with told us that engagement with staff and feedback to staff following engagement is continually improving. Staff consultation took place through a variety of forums including a multidisciplinary improvement forum and new ideas were progressed through an improvement group.
Staff told us about the ‘commending excellence in the emergency department’ (CEED) awards; staff could nominate their colleagues to receive an award in recognition of their achievements and contribution to the department. Information and examples were displayed on a notice board in the main corridor.

Learning, continuous improvement and innovation

We spoke with staff who reported that they were encouraged to undertake non mandatory training in order to improve professionally. We were told of a member of staff who had successfully applied to undertake an enhanced training role on secondment from the department.

Staff described having the opportunities to work with different specialties to improve their skill set. There are opportunities for development within the department with advanced care practitioner roles.
Medical care (including older people’s care)

Facts and data about this service

Leeds General Infirmary was based in the centre of Leeds and had ten wards with 194 beds delivering medical care across a range of specialties such as emergency medicine, cardiology, respiratory, and neurology including stroke. Clinical service/support units (CSUs) based on this site relevant to medicine were abdominal medicine and surgery, emergency and speciality medicine, cardio-respiratory and the centre for neurosciences.

(Source: Routine Provider Information Request – Sites tab)

The trust had 72,660 medical admissions from March 2017 to February 2018. Emergency admissions accounted for 33,728 (46.4%), 4,577 (6.3%) were elective, and the remaining 34,355 (47.3%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 17,438 (24.0%).
- General medicine: 10,302 (14.2%).
- Cardiology: 9,527 (13.1%).

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

Mandatory training completion was monitored centrally with any staff not on track being flagged to their line manager for individual follow-up. The trust provided lots of e-learning which supported staff in completing their training. Planning for training of staff was done throughout the year to encourage good compliance.

Mandatory training completion rates

The trust set a target of 80.0% for completion of mandatory training.
Leeds General Infirmary

A breakdown of compliance for mandatory training courses as of June 2018 for qualified nursing staff in the medicine department at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation training basic awareness</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>250</td>
<td>250</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>250</td>
<td>250</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>250</td>
<td>250</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>250</td>
<td>250</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>249</td>
<td>250</td>
<td>99.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>238</td>
<td>241</td>
<td>98.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>236</td>
<td>239</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>181</td>
<td>184</td>
<td>98.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>239</td>
<td>243</td>
<td>98.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>241</td>
<td>250</td>
<td>96.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>228</td>
<td>250</td>
<td>91.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>207</td>
<td>244</td>
<td>84.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 1</td>
<td>17</td>
<td>23</td>
<td>73.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary medicine department, the 80.0% target was met for 13 of the 15 mandatory training modules for which qualified nursing staff were eligible. Five training modules had 100% completion rates and a further seven modules had completion rates above 90.0%. Infection prevention and control had the lowest completion rate of 66.7%, although this equates to only one eligible staff member not completing the training.

A breakdown of compliance for mandatory training courses as of June 2018 for medical staff in the medicine department at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention and control</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2 intensive life support</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 3 advanced life support</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training basic awareness</td>
<td>59</td>
<td>64</td>
<td>92.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>174</td>
<td>193</td>
<td>90.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>120</td>
<td>138</td>
<td>87.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>254</td>
<td>299</td>
<td>84.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>254</td>
<td>299</td>
<td>84.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>252</td>
<td>299</td>
<td>84.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>252</td>
<td>299</td>
<td>84.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Venous thromboembolism

<table>
<thead>
<tr>
<th>Venous thromboembolism</th>
<th>184</th>
<th>229</th>
<th>80.3%</th>
<th>80.0%</th>
<th>Yes</th>
</tr>
</thead>
</table>

### Safer blood transfusion

<table>
<thead>
<tr>
<th>Safer blood transfusion</th>
<th>165</th>
<th>207</th>
<th>79.7%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Infection prevention & control specialist clinical

<table>
<thead>
<tr>
<th>Infection prevention &amp; control specialist clinical</th>
<th>234</th>
<th>294</th>
<th>79.6%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Personal safety - lower risk

<table>
<thead>
<tr>
<th>Personal safety - lower risk</th>
<th>235</th>
<th>299</th>
<th>78.6%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Information governance

<table>
<thead>
<tr>
<th>Information governance</th>
<th>221</th>
<th>299</th>
<th>73.9%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Fire safety - all staff

<table>
<thead>
<tr>
<th>Fire safety - all staff</th>
<th>212</th>
<th>299</th>
<th>70.9%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Resuscitation training advanced

<table>
<thead>
<tr>
<th>Resuscitation training advanced</th>
<th>104</th>
<th>220</th>
<th>47.3%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Resuscitation training advanced update

<table>
<thead>
<tr>
<th>Resuscitation training advanced update</th>
<th>103</th>
<th>220</th>
<th>46.8%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

### Resuscitation training level 2 PMST

<table>
<thead>
<tr>
<th>Resuscitation training level 2 PMST</th>
<th>14</th>
<th>31</th>
<th>45.2%</th>
<th>80.0%</th>
<th>No</th>
</tr>
</thead>
</table>

At Leeds General Infirmary medicine department, the 80.0% target was met for 11 of the 19 mandatory training modules for which medical staff were eligible.

Medical staff had 100% completion rates for three modules, although for one of these only one staff member was eligible to complete the training. A further two modules had completion rates above 90%. The 80% trust target was not met for eight modules, although three of these had completion rates of 79.7%, 79.6% and 78.6%, just below the trust target of 80%. Three modules had completion rates below 50% with the lowest completion rate of 45.2% for the module resuscitation training level 2 pharmaceutical medicine speciality training (PMST).

(Source: Routine Provider Information Request (RPIR) – Training tab)

### Safeguarding

The trust had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone’s business.

We saw that the trust had up to date safeguarding policies for adults and children.

In the period April 2017 to March 2018, trust wide, medicine had made 156 adult safeguarding referrals and no child safeguarding referrals.

Trust wide, monitoring of safeguarding activity took place through the trust wide child protection steering group and the safeguarding adults and mental health legislation steering group each of which reported to the quality committee and risk and patient safety sub-committee.

Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

Staff had access to safeguarding advice and support from link nurses on the ward, from the trust’s intranet, and the trust’s central safeguarding team. For example, one staff member described how they contacted the trust’s safeguarding team and domestic abuse team to safeguard a young patient that they were caring for.

Any patient considered at risk of female genital mutilation (FGM) or child sexual exploitation was referred to the clinical lead for FGM or children social care.

### Safeguarding training completion rates

A breakdown of compliance for safeguarding training courses as of June 2018 for qualified nursing staff in the medicine department at Leeds General Infirmary is shown below:
### Name of course | Number of staff trained | Number of eligible staff | Completion rate | Trust target (%) | Met (Yes/No)
---|---|---|---|---|---
Safeguarding children level 1 | 243 | 250 | 97.2% | 80.0% | Yes
Safeguarding vulnerable adults - level 1 | 243 | 250 | 97.2% | 80.0% | Yes
Prevent (WRAP) | 27 | 28 | 96.4% | 80.0% | Yes
Safeguarding children level 3 | 22 | 28 | 78.6% | 80.0% | No
Safeguarding vulnerable adults - level 3 | 22 | 28 | 78.6% | 80.0% | No
Safeguarding children level 2 | 161 | 210 | 76.7% | 80.0% | No
Safeguarding vulnerable adults - level 2 | 161 | 210 | 76.7% | 80.0% | No

At Leeds General Infirmary medicine department, the 80% target was met for three of the seven safeguarding training modules for which qualified nursing staff were eligible, with all three training modules with completion rates above 96%. The trust target was not met for four training modules, although two of these had completion rates of 78.6%, just below the trust target and the remaining two modules both had completion rates of 76.7%.

A breakdown of compliance for safeguarding training courses as of June 2018 for medical staff in the medicine department at Leeds General Infirmary is shown below:

### Name of course | Number of staff trained | Number of eligible staff | Completion rate | Trust target (%) | Met (Yes/No)
---|---|---|---|---|---
Safeguarding vulnerable adults - level 1 | 240 | 299 | 80.3% | 80.0% | Yes
Safeguarding children level 3 | 67 | 90 | 74.4% | 80.0% | No
Safeguarding vulnerable adults - level 3 | 67 | 90 | 74.4% | 80.0% | No
Safeguarding children level 1 | 222 | 299 | 74.2% | 80.0% | No
Prevent (WRAP) | 52 | 90 | 57.8% | 80.0% | No
Safeguarding vulnerable adults - level 2 | 56 | 112 | 50.0% | 80.0% | No
Safeguarding children level 2 | 40 | 112 | 35.7% | 80.0% | No

At Leeds General Infirmary medicine department, the 80% target was met for one of the seven safeguarding training modules for which medical staff were eligible. Six modules had completion rates below the trust target, three of which had completion rates just below 75.0%. Three modules had completion rates below 60%; of these the module safeguarding children level 2 had the lowest completion rate of 35.7%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

With reference to the tables above, we spoke with staff about the compliance rates with mandatory training shown regarding staff. The trust told us a training needs analysis had been updated and was currently being measured against a trajectory to achieve the trust target, so that compliance figures would improve as the year progressed and so patient safety was not at risk.

**Cleanliness, infection control and hygiene**

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene.
The trust told us it had launched a collaborative for healthcare associated infections (HCAI) which formed part of a quality improvement program.

All patients were swabbed for methicillin resistant staphylococcus aureus (MRSA) when they were admitted to the ward. The MRSA test was re-run for patients who stayed for longer than a month.

Wards we visited reported low or no cases of clostridium difficile (C. diff), MRSA, and methicillin susceptible staphylococcus aureus (MSSA). Staff described how they worked with the trust’s infection prevention control team on a programme of refresher training on catheter care, changing bags, and cannula care.

When infections occurred, the trust had a system of investigation, including a root cause analysis, following which an action plan was produced. Staff described how they would send samples to the laboratory to check for infection and inform the nurse in charge and the trust’s infection team and notify colleagues at handover.

We saw posters displayed around the ward about infection prevention and handwashing.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors or at the end of beds. Services had access to isolation rooms for infectious patients and signs were placed on the doors to alert people to an infection risk. A patient was placed in an isolation room on the ward if they came from abroad or from a hospital that was known to have had an outbreak.

We observed staff using personal protective equipment when required, and they adhered to ‘bare below the elbow’ guidance. Staff were seen using personal protective equipment (PPE) and handwashing before and after patient contact. Patients we spoke with confirmed staff were washing their hands before and after treating them. Hand hygiene audits were completed. For instance, ward J21 (hyper acute stroke and stroke) had scored 100% for hand hygiene for June, July and August 2018.

To support staff in maintaining levels of infection control, wards benefited from dedicated housekeepers and a central trust domestic team. Staff cleaned equipment after use and a sticker was used to indicate equipment that had been cleaned. Housekeepers kept the sluice area clean and tidy and ensured commodes were cleaned and ready for use.

Infection prevention control audits were done regularly in an unannounced way by a peer from another ward area. Results were submitted electronically to the matron and action plans were generated where necessary.

The wards had a link nurse for infection control. We saw audits for a selection of the wards we visited and all had achieved their target compliance score, scoring either 100% or 95%.

Waste was separated and disposed of in appropriate colour coded bins.

**Environment and equipment**

We found the ward environments were clutter free overall, wheelchair accessible, and with enough equipment for staff to carry out their role.

Access to ward areas were controlled using magnetic door locks and by use of reception areas staffed by nurses or ward clerks.

The trust told us improvements from the annual corporate medicines optimisation audit included the improved local management of airflow meters for piped medical air. The trust told us that it had
started a programme to replace air flow meters on the ward environment to support staff in avoiding giving patients air instead of oxygen.

The wards had an environment which was dementia friendly, for instance, with coloured toilet seats, contrasting colours on the walls and floors, and clear signage to the toilets.

With one exception where a few days were missed, we found no gaps in checking of resuscitation trolleys. We found the environment was, overall, uncluttered, with storage space, and wide corridors. Sharps bins were used and stored properly.

Staff had access to equipment they needed. Staff had access to computers to view electronic patient records. Equipment we saw had been electrical safety checked.

We found on ward L18 (cardiology) a cardiac monitor and defibrillator that were past their service date. This was reported to staff and medical physics attended immediately and a new sticker was put in place. On some wards we found made up cleaning fluid or tablets in an unlocked room.

The trust told us for medical equipment, assurance was derived by use of a maintenance performance report based on the medical equipment inventory which was updated daily. Monitoring of datix reports was done by a devices safety officer, and corporate oversight of adverse incidents involving equipment were reported six monthly at a safety and outcomes group.

**Assessing and responding to patient risk**

Within the medicine service at the site, staff used a series of tools and meetings to support them in assessing and responding to risks posed to patient safety.

The trust told us it had a quality improvement strategy 2017/20 which focussed on harm free care around falls reduction, pressure ulcer, acute kidney injury, sepsis, Parkinson’s disease, and care of patients who deteriorate. For example, ward L12 (stroke medicine) provided 1:1 patient care and cohorted patients at a high risk of falls. Ward L17 (neurology) was part of a falls collaborative which consisted of monthly meetings about preventing falls that was attended by representatives from multiple CSUs.

Staff at ward level took part in a safety huddle to support them in assessing and responding to patient risk around for example prevention of falls or pressure ulcers. This was separate from the daily nursing handover which was recorded on paper sheets containing key patient details. As part of the handover staff reviewed the medication and care plans and acted on any concerns.

We observed a morning handover and saw notes of staff handovers and saw staff at all levels and grades took part fully in handovers of patient care from one shift to the next. We saw staff used a situation, background, action and result (SBAR) framework to transfer patients between teams. This worked well.

Staff used the national early warning score (NEWS) to assess the health and wellbeing of patients. These assessment tools enabled staff to identify if the clinical condition of a patient was changing for the worse and required early intervention and or escalation to keep the patient safe. For patients who suffered a cardiac arrest staff had 24/7 access to a site crash team.

Staff used other tools to help them monitor patient well-being. For instance, on ward L20 (coronary care unit) staff had access to an electronic cardiac trace monitoring board so that all staff could see traces of their patients and act where needed. Other wards had electronic whiteboards that displayed details of which patients were at risk of falls or pressure ulcers.

On the records we looked at we found that screening was recorded for the venous thromboembolism check, and assessments were completed, such as for body maps for pressure ulcers and all intentional care checking information was captured.
The trust sepsis pathway was in date. There was a link nurse for sepsis. The sepsis pathway was embedded in medicine care. For example, staff spoken with could describe what they would do if they suspected sepsis. Staff used stickers to identify sepsis risks.

For medical outliers (a medical patient temporarily boarded on a non-medicine ward), staff could track medical outliers using the trust’s electronic patient record system. Staff told us outliers were seen daily by a doctor for the speciality concerned and one doctor usually carried an outlier bleep. We saw from records of outliers reviewed that this was so. We also noted outliers were covered during MDT meetings which took place on the wards.

**Nurse staffing**

Medical services had systems and processes in place to provide the required nurse staffing levels so that patients were kept safe.

To support staff in planning staffing levels based on patient needs, the trust used the safer nursing care tool, and professional judgment, together with an electronic rostering system. This was used alongside a daily bed meeting to fill any gaps in staffing. Staff reported that this system worked well and kept patients safe. The matron was available for any escalation and, out of hours, a duty matron held a bleep for this purpose and followed a clear policy of escalation. A full staffing review was done twice a year.

To mitigate against nurse staffing vacancies, wards used care support workers (CSWs) or rotated staff, say from critical care. Nurse staffing and skills mix was reviewed daily through an operations meeting working with matrons and heads of nursing.

The trust reported that many wards and departments had not reached optimum staffing levels in registered nursing posts due to national shortages. But the escalation process, combined with ward quality metrics, and weekly meetings, plus use of CSWs or staff rotation, helped to ensure daily nursing was safe. The trust also told us it had invested in developing the clinical support workers (trained to level three) assistant practitioners (level five foundation degree) and by nursing associates (level five foundation degree).

Most wards we visited were short of one registered nurse (RN) on the shift. For example, L20 (coronary care unit) aimed to have four RNs and one care support worker but most days worked with three RNs and either one CSW or none. This unit also offered non-invasive ventilation. Staff explained that, if for example, they had one unwell patient on a valve transplant, two unwell patients requiring non-invasive ventilation and some patients on balloon pumps, the staffing could be challenging. However, staff said they managed by rotating staff from intensive care or by acquiring extra staff from the daily staff meeting. Staff described the long-term plan was to train up band three and four staff who could look after more stable patients.

The neurosciences speciality had a hyper acute stoke unit (HASU) that consisted of eight beds split across two bays. The nurse staffing for the HASU was either two RNs or one RN with one band four nurse and a healthcare assistant for each shift, early, late and night. While staff we spoke with recognised that this did not comply with national guidelines for staffing a HASU, staff explained it was safe because, depending on the acuity of a patient, staff were able to draw on staff from another area. For instance, the brain attack team (which was part of the stroke pathway), were situated in the emergency department.

The trust has reported their staffing numbers below as at March 2017 and March 2018 for medicine.
Leeds General infirmary

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>209.6</td>
<td>230.8</td>
</tr>
</tbody>
</table>

Leeds General Infirmary had a staffing fill rate of 86.5% in March 2018, lower than the fill rate of 90.8% in March 2017, although the trust has increased planned (whole time equivalent) WTE staff by 15.4 between March 2017 and March 2018. The service had to operate with 21.2 less WTE staff in post than planned in March 2017 and with 33.3 less in March 2018. The service however had 3.3 more WTE staff in post in March 2018 than in March 2017.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 17.8% in medicine. The trust did not set a trust target for vacancy rates.

The breakdown by site was as follows:

- Leeds General Infirmary: 15.3%

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 13.7% in medicine. The trust did not set a trust target for turnover rates.

The breakdown by site was as follows:

- Leeds General Infirmary: 15.1%

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 3.9% in medicine; this was slightly higher than the trust target of 3.5%.

- Leeds General Infirmary: 3.7%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and agency staff usage**

**Leeds General Infirmary**

From April 2017 to March 2018, the trust reported that 3.5% of qualified nursing shifts in medicine at Leeds General Infirmary were filled by bank staff and 1.7% of shifts were filled by agency staff. In addition, 8.2% of shifts were not filled by bank or agency staff to cover staff absence.
Over the same period, 15.5% of nursing assistant staff shifts in medicine at Leeds General Infirmary were filled by bank staff, 6.9% of shifts were filled by agency staff and 5.4% of shifts were not filled by either bank or agency staff to cover staff absence.

Please note that the trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James's Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>4,060</td>
<td>15.5%</td>
<td>1,367</td>
</tr>
<tr>
<td>Agency</td>
<td>1,815</td>
<td>6.9%</td>
<td>647</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,409</td>
<td>5.4%</td>
<td>3,216</td>
</tr>
<tr>
<td>Total</td>
<td>26,124</td>
<td></td>
<td>39,204</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Medical services had systems and processes in place to provide medical staffing levels so that patients were kept safe.

All specialities we visited had medicine consultant cover 8am to 5pm Monday to Sunday, with consultant cover over the same period out of hours from 5pm to 8pm with on-call consultant cover outside of these times.

The services we visited had a daily consultant review.

None of the services we visited reported any issues with medical cover. Junior doctors spoken with reported good training and support from consultants.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>199.9</td>
<td>213.5</td>
</tr>
</tbody>
</table>

Leeds General Infirmary had a staffing fill rate of 93.9% in March 2018, marginally higher than the fill rate of 93.6% in March 2017, although the trust had increased planned WTE staff by 7.7 between March 2017 and March 2018. The service had to operate with 13.6 less WTE staff in post than what was planned for in March 2017 and with 13.4 less in March 2018. This site however had 7.9 more WTE staff in post in March 2018 than in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 4.2% in medicine. The trust did not set a trust target for vacancy rates.
The breakdown by site was as follows:

- Leeds General Infirmary: 5.3%
  
  *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 37.8% in medicine. However, the inclusion of trainee grades in the data is likely to have inflated the rates. The trust did not set a trust target for turnover rates.

- Leeds General Infirmary: 30.8%
  
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 0.9% in medicine; this was much lower than the trust target of 3.5%

- Leeds General Infirmary: 1.1%
  
  *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

**Leeds General Infirmary**

From April 2017 to March 2018, Leeds General Infirmary reported that 4,703 shifts were filled by bank staff and 311 shifts were filled by locum staff in medicine. There were 211 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type at Leeds General Infirmary is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Shift type</th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>335</td>
<td>4,363</td>
<td>5</td>
<td>4,703</td>
</tr>
<tr>
<td>Locum shifts</td>
<td>249</td>
<td>62</td>
<td>0</td>
<td>311</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>3</td>
<td>197</td>
<td>11</td>
<td>211</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)*

**Staffing skill mix**

In December 2017, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 550 whole time equivalent staff working in medicine at Leeds Teaching Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/12/2017 - 31/12/2017)

Records

We reviewed 33 sets of records (including medication charts) and found them to be legible, detailed, signed and safely stored in locked trolleys when not in use.

Patient records were a mixture of electronic and paper records. For instance, staff used e-observations and electronic medication charts. Most care plans and nursing documentation were paper records. The trust told us it was currently on a digital pathway with the aim to have removed most paper from healthcare delivery processes by December 2019. The trust was in the process of rolling out electronic patient records on a phased basis. For instance, the malnutrition universal screening tool (MUST) was electronic.

On the records we looked at we found that screening was recorded for the venous thromboembolism check and assessments were completed, such as for MUST, national early warning score (NEWS), pressure care, falls assessment and all care checking information was captured on the records we saw.

Staff told us that records were audited regularly as part of the ward metrics audits and items reviewed included controlled drugs, use of MUST, pressure care and medication.

We reviewed five records for compliance with do not attempt cardio pulmonary resuscitation forms completion and found them all to be compliant.

Information relating to discharge was printed off in hard copy for the patient to keep while the electronic version of the discharge summary was accessible by community staff and GPs.

Medicines

We checked the storage of medicines, fluids and gases on the wards we visited. We found that, overall, medicines, fluids and gases were stored securely in appropriately locked rooms and fridges were checked and stocks were in date.

The medicine policy we saw was in date.
Some of the wards we visited used an automated drug dispensing cabinet to store and manage medicines while others used a traditional locked cabinet, both of which cabinets were situated in a locked clinical room. Staff would need to use a keypad to gain entry to the clinical room and then either log on or use their fingerprint to access drugs from the automated drug dispensing cabinet, having selected a patient.

Where controlled drugs were stored in the automated drug dispensing cabinet two members of staff were required to access them. Staff told us the automated drug dispensing cabinets improved efficiency including waste reduction and freeing up more time for patient contact.

The trust told us the quarterly controlled drug (CD) audit reviewed varied aspects of the safe and secure handling of medicines designated as controlled drugs. It found the robust storage of the new CD requisition forms was identified as a focus for the next audit cycle as was improving completeness of full documentation in CD record books.

Staff were tasked to carry out daily checks of controlled drug balances. We found no gaps in checking in the CD record books we reviewed.

For drugs that required refrigeration, staff told us that if the fridge temperature went out of range, pharmacy would be called to advise on whether any of the drugs had to be replaced. Many wards we visited benefited from daily cover by assistant technical officers from pharmacy who would check fridge temperatures and take appropriate action with the stored drugs if the temperature went out of range. Also, the trust intranet had guidance for staff to follow if a fridge containing drugs went out of temperature range.

We checked the drugs on the resuscitation trolleys and did a random check for expired drugs in the fridges and automated drug dispensing cabinet and found it all to be in order.

Drugs trolleys we saw were all locked when not in use.

Patient records seen showed patients were receiving medicines promptly and any allergies were clearly recorded. Staff reported that the roll out of e-prescribing had supported staff in efficient administration of medicines.

On some wards we visited (such as L19 and L14 and catheter laboratory) we found on each ward one drug that was out of date. We also found an example of two free standing medical gas cylinders on the catheter laboratory: this posed a health and safety risk. Other medical gas cylinders seen were chained to the wall. We pointed out to staff that storage of anaesthetics on the catheter laboratory were insecure and were told this would be followed-up.

Medicines reconciliation was undertaken by pharmacy staff within 24 hours of inpatient admissions; reconciliation rates for patients admitted to medical and surgical acute care areas was reported at around 90%.

Incidents

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust’s electronic reporting system. The staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses. However, staff told us they tended not to report staffing shortages because this had become normal, so that shortages were reported as part of the daily review instead.

As can be seen in the table below the medical services at this site reported no never events over the last year.

Staff we spoke with said feedback from incidents was shared in many ways including; handover,
safety huddles and staff meetings. An example of learning from incidents was the introduction of ‘hypo boxes’ in each clinical area, the use of which was audited. Some medical staff said they did not receive feedback from incidents they had reported.

The trust had a process for ensuring that deaths were reviewed within 24 hours using the structured judgment review method with any learning presented to departmental mortality and morbidity meetings. The trust’s standardised mortality ratio was within the ‘as expected’ range.

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 understood the importance of being open and honest with patients. The trust had a process to capture all incidents where duty of candour was triggered which ensured it was adhered to. The trust told us duty of candour processes were recently audited by the trust's internal auditors and were awarded "significant assurance.”

Trust wide from April 2017 to March 2018, medical services had incidents where the duty of candour had been applied 201 times.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for medicine.

*Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)*

The trust told us it had focussed on reducing never events in areas such as retained objects, wrong site surgery, wrong implant, feeding through a misplaced tube, and administration of air instead of oxygen. The trust told us it was reviewing air supply to all its clinical areas considering the national reporting of never events in this area.

**Breakdown of serious incidents reported to STEIS**

**Leeds General Infirmary**

In accordance with the Serious Incident Framework 2015, Leeds General Infirmary reported three serious incidents (SIs), in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

Incidents per type is shown below:
- Pressure ulcer meeting SI criteria: one incident
- Treatment delay meeting SI criteria: one incident
- Slips/trips/falls meeting SI criteria with: one incident

(Source: Strategic Executive Information System (STEIS))

We reviewed a root cause analysis report (RCA) for one of the serious incidents above and found actions plans and lessons learnt were identified. Actions included providing feedback to staff.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 124 new pressure ulcers, 20 falls with harm and 25 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for medical services.

From May to November 2017, pressure ulcers reported decreased from 17 in May to three in November 2017. From five to seven pressure ulcers were reported for the three-month period from December 2017 to February 2018. After this period pressure ulcers reported increased, reaching its highest point of 18 in April 2018, after which they decreased to 12 in May 2018. The overall trend remained stable although as described above there were variances in numbers reported over the period.

Falls reported remained stable with between one and two falls reported for most months over the period May 2017 to May 2018. The highest numbers of falls (four) were reported in July 2017 and no falls were reported in May 2017 and April 2018.

Reported new urinary tract infections in patients with a catheter increased from two in June 2017 to five in September 2017. No new UTIs were reported in October 2017, after which two catheter acquired urinary tract infection level 3 only (CUTIs) per month were reported from November 2017 to January 2018. Following three months with no new UTIs, the number increased sharply to six in May 2018.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections in patients with a catheter and at Leeds Teaching Hospitals NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Source: Safety thermometer - Safety Thermometer

Staff told us they used the safety thermometer to track safe patient care and displayed headline results for the public to see on the ward safety boards. The matron validated the results and undertook a detailed analysis of any concerns so that lessons could be shared and learning embedded.

For example, on one ward we visited, because of a slight increase in grade two pressure ulcers, the ward team organised a ‘stop the pressure ulcer’ week, working closely with the tissue viability nurse team.

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust’s intranet, guidelines, policies and procedures relevant to their role.

The trust had a procedure for implementing best practice guidance, including all types of NICE guidance. For each piece of guidance, a nominated lead within the CSU completed an
assessment of the trust’s compliance, and actions were put in place to achieve compliance with any recommendations not met.

The safety and outcomes sub-group received a six-monthly report giving an overview of the trust’s compliance with NICE guidance. The trust told us, it shared the report with the trust's commissioners.

The trust’s procedure also set out the process to be followed if a decision was taken not to implement specific recommendations from NICE guidance. Any non-compliance had to be presented to the safety and outcomes sub-group, prior to approval by the quality assurance committee.

The leadership team we spoke with explained that they had a quality manager part of whose role it was to support them in ensuring that the trust process for implementing, say, NICE guidance, was adhered to. This was an item reviewed at the clinical governance meetings.

Staff also used an audit programme to ensure care supplied was evidence based. For example, neurosciences did a nasogastric tube audit which showed actions such as ensuring that patients were given a leaflet but otherwise that care and insertion were excellent.

Another example was the venous thrombo-embolism (VTE) audit which showed 90% of assessments were being done but actions included improving VTE assessment at 48 hours.

**Nutrition and hydration**

We found that the services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

On admission each patient had a nutritional assessment and staff described how dietitian services could be accessed for complex cases. Where necessary, food charts were used to monitor intake of food.

The medicine service at the site offered patients a full range of meals to meet any needs arising from religion, culture, allergies or personal choice. Staff told us they could go out of menu where necessary and provided snacks outside of mealtimes. Pictures could be used to assist patients in choosing food. Visitors could access snack machines.

Staff described how they tried to encourage patients to be independent when eating but would help where needed, with patients requiring help being noted on handover sheets or by using a red mat system.

When we spoke with patients they described food that was of good quality with good food choice. Water jugs were in reach and staff told us were replenished regularly. We saw from records of patients that we reviewed that fluids were monitored where necessary.

**Pain relief**

We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients.

In the patient records we saw there were pain assessment charts to support staff in monitoring pain relief for patients. In addition, staff described, when using intentional care documents, they would use their own experience to help them assess pain and use objective markers such as a
raised heart rate or blood pressure, and document their findings. For patients who could not verbalise their pain staff could use pictures and a recognised scoring system.

Pain relief was discussed at handover and any issues noted in addition to analgesics being reviewed on ward rounds.

Staff told us that they had access 24/7 to the trust’s palliative care team who could supply expert advice on pain and its management.

Patients we spoke with had no issues with how their pain was being managed. For example, one patient told us pain relief was available whenever they needed it.

**Patient outcomes**

The service had systems and processes in place to monitor patient outcomes including, various trust wide initiatives, and local ward based actions, around reducing pressure ulcers, and redesigning services, all with a view to providing effective patient outcomes.

On a trust wide level, the trust told us about many initiatives to help improve patient outcomes. For example, the trust told us it had focused on several measures to further reduce the burden of sepsis. This included a multi-disciplinary collaborative, which oversaw the roll out of many actions. This included provision to staff of a variety of tools and resources, such as, BUFALO bags (which were equipped with all the necessary items to take a sample of blood for culture testing) or the adult sepsis screening tool, with the electronic version within the electronic observations (e-obs) system.

Also, the trust told us it had taken part in all relevant national audits (81 out of 87), external peer reviews and many benchmarking exercises. It was a participant in the get it right first time (GIRFT) program, which was used to improve patient outcomes in clinical services.

Further, the trust’s safety and outcomes group received a report on patient outcomes by consultant for each specialty area which showed whether there were any outliers. This helped the trust monitor patient outcomes at consultant level.

Lastly, by way of example, to support better patient outcomes, all deaths were screened using a tool accessed electronically through the trust's electronic patient record. This showed where a more detailed structured judgement review was required at a departmental mortality meeting. Learning was shared through the local governance forums and through the regular 'lessons learned' bulletins and the chief nurse's quality and safety matters updates.

At a local level, staff told us about several initiatives to improve patient outcomes.

For example, on ward L12 (stroke medicine), staff told us about a care support worker project to reduce pressure ulcers. This involved care support workers supporting registered nurses with patient pressure ulcer care. While not yet audited, staff told us that prior to the project starting there were nine grade two pressure ulcers whereas a year into the project there was one grade two pressure ulcer.

On ward L14 (cardiology) a cardiac suite (which inserts heart valves into patients thus avoiding open heart surgery) had been opened in February 2018. Prior to opening, there was not enough room on the ward, long waiting times and general anaesthetic was used. Following opening of the suite, staff told us waiting times reduced from six months to six to eight weeks, there was more room to treat patients, and local anaesthetic was used.
We met a diabetes research nurse who had successfully recruited a patient to a trial into monitoring devices. Staff told us the devices would support staff in receiving live results which would support prompt intervention from the consultant.

Lastly, the neurosciences speciality was successful in setting up a regional centre for removing blood clots. Prior to this there was no regional service which meant patients had to wait longer for a bed to become available. The service had done five regional procedures since April and was active in a clinical advisory group to work with local district general hospitals to improve the referral system.

**Relative risk of readmission**

*Leeds General Infirmary*

From February 2017 to January 2018, patients at Leeds General Infirmary had a slightly higher than expected risk of readmission for elective admissions and a slightly higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective admissions**
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in cardiology had a higher than expected risk of readmission for elective admissions
- Patients in hepatology had a higher than expected risk of readmission for elective admissions

**Non-Elective admissions**
- Patients in cardiology had a like expected risk of readmission for non-elective admissions
- Patients in stroke medicine had a like expected risk of readmission for non-elective admissions
- Patients in neurology had a slightly higher than expected risk of readmission for non-elective admissions

**Elective Admissions - Leeds General Infirmary**

![Elective Admissions Chart]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*

**Non-Elective Admissions - Leeds General Infirmary**

![Non-Elective Admissions Chart]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*
Sentinel Stroke National Audit Programme (SSNAP)

Leeds General Infirmary

Leeds General Infirmary takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved an overall SSNAP level of grade B in the latest audit, April to July 2017. The hospital’s SSNAP performance was adequate and improving up to November 2016.

The hospital performed well in relation to thrombolysis, speech and language therapy and standards by discharge. However, performance in relation to the stroke unit, physiotherapy and multidisciplinary team working was poor.

As of July 2016, the hospital’s acute organisation Audit Key Indicator score was four out of 10, compared to the national aspirational target of eight or above. The ratio of nurses on duty at 10 am weekends to 10 stroke unit beds was 2.5. The national aspirational target is three or more nurses per 10 beds.

(Source: Royal College of Physicians London, SSNAP audit)

The trust told us it was pleased with its results but was currently working with commissioners and the trust to address bed capacity issues within stroke care so that the score it received for discharge improved which would then improve the overall result further. In relation to team working, data to November 2017, shows that physiotherapy and multi-disciplinary teamwork had improved from “poor”.

Heart Failure Audit

Leeds General Infirmary

In-hospital Care Scores

Results for Leeds General Infirmary in the 2015/16 Heart Failure Audit were better than the England and Wales average for three of the four standards relating to in-hospital care.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Leeds General Infirmary</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology inpatient (%)</td>
<td>48.5%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Input from consultant cardiologist (%)</td>
<td>61.8%</td>
<td>56.9%</td>
</tr>
<tr>
<td>Input from specialist (%)</td>
<td>71.7%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Received echo (%)</td>
<td>98.5%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>
Discharge Scores

Results for Leeds General Infirmary were better than the England and Wales average for five of the nine standards relating to discharge. The percentage of patients receiving an MRA on discharge was 22% higher than the England and Wales average, while the percentage of patients referred to a heart failure nurse for follow up were 16.8% higher. In contrast, the percentage of patients receiving ACEI or ARB on discharge and ACEI on discharge were 20.8% and 17.4%, respectively, lower than the England and Wales average.

\[
\begin{array}{l|c|c}
 & Leeds General Infirmary & England and Wales \\
ACEI on discharge (%) & 43.7% & 61.1% \\
ACEI/ ARB on discharge (%) & 52.9% & 73.7% \\
Beta blocker on discharge (%) & 81.8% & 80.4% \\
MRA on discharge (%) & 67.4% & 45.4% \\
Received discharge planning (%) & 81.8% & 87.3% \\
Referral to HF nurse follow up (%) & 71.6% & 54.8% \\
Referral to HF nurse follow up (LVSD only) & 75.0% & 70.8% \\
Referral to cardiology follow-up & 51.0% & 47.2% \\
Referral to cardiac rehabilitation (%) & 6.1% & 12.1% \\
\end{array}
\]

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

The trust told us it was pleased with the overall results but was doing work to understand the 52.9% score for ACEI or ARB on discharge as it was felt this was a coding error.

National Diabetes Inpatient Audit

Trust level

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 241 in patients with diabetes at the trust, 78.2% of whom reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this trust in quartile 2. Trust performance deteriorated between 2016 and 2017. In 2016, 90.8% of patients reported they were satisfied or very satisfied with their overall care of diabetes while in hospital and the trust was placed in quartile 4.

(Source: NHS Digital)
Myocardial Ischaemia National Audit Project (MINAP)

Leeds General Infirmary

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 80.8% of patients received all the secondary prevention medications for which they were eligible, compared to an England average of 88.4%. The proportion in the 2014/15 report was 96.4%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

Trust level

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 83.0%, which did not meet the audit minimum standard of 90%. The 2016 figure was 54.1%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 14.6%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 64.9%. This is within the expected range. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The case mix adjusted one-year relative survival rate for the trust in 2016 is 42.0%. This shows good practice. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

The trust told us it was focussing on improving the proportion of patients receiving treatment within 62 days by new appointments to the oncology team and surgical team so that hopefully time to treatment or scans would improve and by having regular pathway meetings to identify solutions.

National Audit of Inpatient Falls 2017

Trust level

At Leeds Teaching Hospitals NHS Trust the crude proportion of patients who had a vision assessment (if applicable) was 56%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 39%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 10%. This did not meet the national aspirational standard of 100%.
The crude proportion of patients with a call bell in reach (if applicable) was 80%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust told us that it had developed an action plan which we saw to try and improve its performance through a trust wide falls group with all CSUs asked to deliver a plan to show how they intend to improve.

Competent staff

Appraisal rates

Leeds General Infirmary

As at June 2017 and June 2018, 91.3% and 99.0% respectively of registered nursing and medical and dental staff within medicine at Leeds General Infirmary received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
<td>Rate</td>
<td>Completed</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>226</td>
<td>258</td>
<td>87.6%</td>
<td>247</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>139</td>
<td>142</td>
<td>97.9%</td>
<td>149</td>
</tr>
<tr>
<td>Total</td>
<td>365</td>
<td>400</td>
<td>91.3%</td>
<td>396</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through sharing information, by email, at team meetings, in a newsletter, and by offering staff additional training.

Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal. The trust operated an annual appraisal season that ended in June each year.

Senior staff told us they received monthly reports from the organisational learning team and could track individuals to ensure an appraisal was booked and done. Staff who had not yet done an appraisal were booked to receive one.

Staff explained that they received additional training relevant to their role. For example, on ward L20 (the coronary care unit) staff received additional training on how to use new non-invasive ventilation machinery, or removing temporary pacing wires or balloon pumps. Staff on this ward told us they also did scenario training for the nurse in charge because the ward accepted critically ill patients. On ward L21 staff told us about training for placement of nasogastric tubes. On the hyper acute stroke unit (HASU), staff received additional training in giving blood clot treatment to patients and use of the Glasgow coma scale and use of relevant equipment, such as monitors.

Training for staff competencies was supported by practice educators.

The trust told us training on the use of insulin fell within the trust’s priority training programme and was delivered to staff through an e-learning package and face to face learning bursts.

Staff were inducted and trained by the trust. Staff told us new nurses completed an introduction to professional practice. This included a one-week induction followed by a daily induction spread over six months. We saw some examples of the preceptorship packs used by staff.
For students, staff told us there was a clear training pathway and students who had trained on the wards reported a positive experience. For example, in one speciality we spoke with several student nurses who confirmed that they had been allocated a mentor and pre-placement and an associate mentor in readiness for a 12-week placement. The ward supplied them with a student handbook with set learning outcomes.

All wards visited had link nurses for various areas including infection control, safeguarding, learning disability and dementia to support staff in maintaining competence in these areas.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision with regular meetings.

**Multidisciplinary working**

To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multi-disciplinary team (MDT).

Ward L21 (stroke) had occupational therapists, physiotherapists, dietitians and speech therapists on the ward all the time and we saw the team communicating and working with other staff.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.

We observed an MDT board round. This was attended by a physiotherapist, a discharge coordinator, an occupational therapist, a dietitian, consultants and junior doctors. All patients were discussed and actions agreed to benefit the patients.

**Seven-day services**

The medical services ensured there was a seven-day consultant rota providing cover and no services we visited reported issues with seven-day access to diagnostic services.

Consultant cover was provided over seven days 8am to 5pm. Out of hours there was a consultant on call over seven days 5pm to 8pm, with a consultant on-call outside of these times. All specialities we visited operated daily ward rounds.

The speech and language therapy team worked Monday to Friday 8:30am to 4:30pm but there was no cover at weekends. Where physiotherapy or occupational therapy services were not available 24/7, those teams worked with care support workers on the wards who would continue rehabilitation over the weekend.

Staff had 24/7 access to a full range of diagnostic services such as, x ray, computed tomography (CT) scans or magnetic resonance imaging (MRIs).

A dispensing service was available 24/7: the dispensary was open 8am - 8pm Monday to Friday and outside of these hours orders were sent to a nearby main hospital site up to 10pm with a bleep pharmacist outside these hours.

**Health promotion**

The services, with patient consent, used a healthy living interventions assessment to promote health. We saw that as part of the individual patient assessment process used by the wards, with patient consent, a healthy living interventions assessment was used. This collected patient
responses around lifestyle issues such as smoking, weight and alcohol. Once complete, the form
was sent to the patient’s GP so that they could signpost patients to further help if appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew the importance of gaining consent to treatment and had received training in consent,
mental capacity and deprivation of liberty safeguards.

We saw that the trust had an up to date policy dealing with consent and mental capacity.

Compliance with the consent policy was audited annually using the consent audit tool that CSUs
were required to complete. Outcomes of the audits were uploaded to the trust's clinical audit
database and reported to the safety and outcomes sub-group by the associate medical director
for corporate governance.

Staff spoken with knew about mental capacity and where to access more help, say, to assist
them in completing a best interest decision or a deprivation of liberty application. Staff described
how mental capacity was assessed as part of the booking in process and any expiration date for
a deprivation of liberty application was noted on handover sheets. We saw that the trust’s intranet
was a valuable resource for staff to consult. For instance, there was guidance and leaflets and
information on the intranet for the mental health act process as well as a form to confirm rights.

For patients with mental health act rights, the trust had a standard operating procedure which
gave the nurse in charge a duty to explain rights to the patient when detained on the ward. The
trust told us a member of the trust’s mental capacity act/mental health act (MCA/MHA) team
would also visit each detained patient to ensure the process was followed and to repeat the
explanation. The trust explained that they made automatic referrals to independent mental health
advocates (IMHA) to ensure each patient was given the support of an independent expert mental
health advocate.

The trust told us it had continued to work with its partners at a local mental health trust to improve
the care of patients with mental health conditions, notably those who displayed aggression
towards other patients and staff.

Staff reported that psychiatric liaison was available 24/7.

Mental Capacity Act and Deprivation of Liberty training completion

Leeds General Infirmary

The trust reported that as of June 2018 Mental Capacity Act (MCA) training level 1 and 2 was
completed by 95.8% of nursing staff in medicine at Leeds General Infirmary compared to the trust
target of 80.0%.

The trust reported that as of June 2018 Mental Capacity Act (MCA) training level 2 was
completed by 76.1% of medical staff in medicine at Leeds General Infirmary compared to the
trust target of 80.0%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)
Is the service caring?

Compassionate care

We found that patients received compassionate care from staff which supported their privacy and dignity.

Several interactions we observed between staff, both nursing and medical, demonstrated how staff maintained confidentiality and supported patient dignity and provided compassionate care. For instance, we spoke with a patient who told us staff pulled the curtain around them and doctors spoke with them in a way they could understand.

One patient said the care was “10 out of 10” and “wonderful”, and another patient told us the nursing staff were “fantastic” while another told us staff were “caring”, “sensitive”, and “brilliant”. Another said they could not “praise staff highly enough.” All staff seen spoke with patients in a kind and compassionate way, encouraging the patients.

One patient described how in the early hours of the morning staff went to find them something to eat and drink because they felt hungry.

Patients said that nurses were responsive to call bells and kept them informed about their care.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 36% which was better than the England average of 25% from June 2017 to May 2018.

A breakdown of response rate by site can be viewed below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Total responses</th>
<th>Response rate (Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds General Infirmary</td>
<td>8,556</td>
<td>33%</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>13,136</td>
<td>35%</td>
</tr>
<tr>
<td>Chapel Allerton</td>
<td>2,465</td>
<td>11%</td>
</tr>
</tbody>
</table>
A breakdown of the percentage of patients who would recommend the trust for surgery by site is shown below:

**Leeds General Infirmary**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>L14 Cardiology Day Case Ward</td>
<td>2708</td>
<td>67%</td>
<td>97%</td>
</tr>
<tr>
<td>L17 Neurology</td>
<td>222</td>
<td>36%</td>
<td>88%</td>
</tr>
<tr>
<td>L18 Cardiology Ward</td>
<td>430</td>
<td>52%</td>
<td>100%</td>
</tr>
<tr>
<td>L19 Cardiology Admission Ward</td>
<td>1248</td>
<td>38%</td>
<td>99%</td>
</tr>
<tr>
<td>L20 Coronary Care Ward</td>
<td>579</td>
<td>45%</td>
<td>100%</td>
</tr>
<tr>
<td>L21 Stroke Ward</td>
<td>101</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>L26D Neurology Day Case Ward</td>
<td>198</td>
<td>13%</td>
<td>100%</td>
</tr>
<tr>
<td>LDWE Endoscopy Unit</td>
<td>2789</td>
<td>35%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Highest score to lowest score

100% 50% 0%

**Note** - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

From May 2017 to April 2018 the overall percentage of patients that would recommend the service was over 90% on every medicine ward at Leeds General Infirmary.

(Source: NHS England Friends and Family Test)

**Emotional support**

We found that staff offered a range of emotional support to patients.

Staff described how they would spend time chatting to patients or their family to provide emotional support or offer to signpost patients to support organisations. A patient described the emotional support staff gave when they had gone outside and the staff came to them and stayed with them to chat to them. Another patient spoke about how reassuring doctors and nurses had been which supported them in deciding to go ahead with the procedure.

One patient mentioned how staff introduced themselves and this helped them to relate to the staff and made a big difference to them giving them confidence.

Carers of patients we spoke with described being impressed with the emotional support they and their relative had received, with regular updates provided by staff about the care their relative had received.

Carers and relatives described how impressed they were on seeing their relative up and dressed and out of bed, which raised their spirits.
Some wards operated protected visiting times to support patients and their families in having protected time together.

Staff described how they supported the emotional needs of patients living with dementia by ensuring they were not left alone and always had people around them.

Staff had access to chaplaincy services for those patients with a faith or none.

**Understanding and involvement of patients and those close to them**

We found the staff tried to understand patients, involve them and those close to them.

Staff described how they involved patients in the choice of food or clothing to wear and involved families in the MDT discussions.

One patient told us how staff had arranged special visiting rights for their relative which considered the cultural needs of the family.

We observed staff attending to a family who had phoned the ward for an update about their relative and noted how advice and reassurance was supplied to keep the family involved.

One ward we visited employed a nurse whose role was to support patients undergoing a procedure and their families by explaining the procedure and answering their questions so that they all felt involved.

The trust told us a process known as ‘calm at night’ was being developed in response to feedback from patients that the night time environment in hospital was not always conducive to restful sleep.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

The leadership team we spoke with described many ways in which the service had been designed to meet the needs of local people following discussions with local commissioners.

For example, staff told us the cardiology speciality belonged to a cardiac benchmarking collaborative. Information was shared around length of stay, mortality, friends and family test results, complaints, infection rates, falls, and pressure ulcers. The information was used to inform how the service was planned and where changes needed to be made.

Staff in the cardiology speciality spoke about how the creation of the day case cardiac suite was a direct response to the needs of local people for a less congested, more responsive, and better patient experience.

Another example concerned the cardio respiratory speciality where staff told us they met with partners in the local health economy to look at respiratory care in Leeds with a view to bringing care closer to home and to avoid admissions. This had led to a pilot virtual ward where community nursing staff visited patients with a virtual ward round led by a respiratory consultant. The pilot virtual wards focussed on those areas in Leeds with the highest levels of chronic pulmonary obstructive disease.

We found no mixed sex accommodation breaches.
As shown below the service had average lengths of stay for elective procedures lower than the England average.

**Average length of stay**

From March 2017 to February 2018 the average length of stay for medical elective patients at Leeds General Infirmary was 2.6 days, which was shorter than England average of 5.9 days. For medical non-elective patients, the average length of stay was 7.1 days, which was longer than England average of 6.4 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in cardiology was slightly shorter than the England average.
- Average length of stay for elective patients in hepatology was shorter than the England average.
- Average length of stay for elective patients in neurology was shorter than the England average.

**Elective Average Length of Stay - Leeds General Infirmary**

![Bar chart showing elective average length of stay](chart_elective.jpg)

*Note: Top three specialties for specific site based on count of activity.*

**Average length of stay for non-elective specialties:**

- Average length of stay for non-elective patients in cardiology was shorter than the England average.
- Average length of stay for non-elective patients in stroke medicine was much longer than the England average.
- Average length of stay for non-elective patients in neurology was longer than the England average.

**Non-Elective Average Length of Stay - Leeds General Infirmary**

![Bar chart showing non-elective average length of stay](chart_non_elective.jpg)

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)
Meeting people’s individual needs

We saw that staff cared for patients as individuals and strived to meet their individual needs. On admission to the ward each patient received an individual assessment to support staff in identifying their individual needs.

Some wards had activity trolleys so that patients could paint, do crosswords, colour, do jigsaws, read books or watch DVDs.

Staff told us that they could access language interpretation services and leaflets could be produced in different languages. The trust produced a range of materials and services to support staff in meeting the individual needs of patients such as induction loops, British sign language or Makaton interpreters, with written material available in braille and browse aloud.

The trust’s electronic systems permitted staff to flag patients living with a learning disability. The trust told us it had a dedicated lead nurse for learning disabilities and autism and older people who oversaw the care of such patients. Patients with these conditions were picked up on a patient assessment and adjustments were made as necessary including working with carers.

For instance, on ward L20 (coronary care unit) staff told us how patients living with dementia would be placed in beds opposite the nursing station so that staff could attend to their additional needs. Staff told us on one ward they continued funding the carer’s package to ensure patients with a learning disability felt supported and comfortable.

The trust had a specialist diabetes team consisting of diabetes specialist nurses, specialist diabetes dietitians, a diabetologist, specialist podiatrists and administrative support.

The trust told us examples of the sort of reasonable adjustments they would make to meet individual needs such as additional time for consultations, environmental management such as the use of side rooms where possible, welcoming carers to the ward outside visiting hours, flexible mealtimes, provision of resources such as fiddle boxes or twiddle muffs, and accessible information.

The trust told us it had champions to support good practice on the ward. For example, there were 103 champions to support people with for learning disability, less obvious disabilities, and people with autism. We saw on ward L21 (stroke) that details of the learning disability and autism lead (including a photo) were on display.

Many wards had dementia champions and as part of their role they promoted the use of ‘know who I am’ booklets and a ‘forget me not flower’ symbols at the bedside.

Access and flow

The services had systems and processes in place to monitor access and flow and to ensure that they were responsive to the needs of patients.

Several services used patient flow coordinators to help manage the flow through the wards. For instance, the cardiology service employed a flow coordinator who went around the wards to check on the bed situation with a view to putting a plan in place.

Staff told us about a multi-agency discharge event which led to several actions to support access and flow. For example, patients were given an estimated date of discharge (EDD) on admission, and patients were reviewed before midday. For patients whose stay reached seven days or 21 days senior staff did a deep dive working with the trust’s operations team to understand what was preventing the discharge and to try and resolve it. For example, staff described some learning flowing from the deep dive involved looking at whether some of the patients would be better situated being cared for in a local hospice rather than on the hospital ward. This has led to work on setting the correct ceiling of care for such patients to keep their stay on the ward environment appropriate.
The stroke pathway made use of a brain attack team which sat in the emergency department. The team could triage patients who may be at risk of a stroke and carry out telemetry and CT scans so avoiding unnecessary admissions to the hyper acute stroke unit (HASU).

A number of wards took part in a regional repatriation programme so that patients referred in to Leeds, for example for treatment of their heart condition, would be transferred back to their referring district general hospital once they were stable.

Referral to treatment (percentage within 18 weeks) - admitted performance

From June 2017 to May 2018 the trust’s referral to treatment performance for admitted patients (percentage admitted within 18 weeks of referral) was consistently better in comparison to the England average, by an average of 5.3%.

There was a slight deterioration in performance in January 2018, followed by a trend of improvement from February to May 2018.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Six specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>91.3%</td>
</tr>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.8%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.7%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.7%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>70.4%</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
Patient moving wards per admission

The trust did not provide data for ward moves per admission. They told us they did not measure the number of moves for individual patients. They were aware for some patients with complex discharge needs and protracted lengths of stay this could be up to four moves within their admission period. Where there was a requirement for speciality acute beds for the most acute and dependent patients a ‘fit to lodge’ risk assessment was actioned and patients may be selected to board on other wards to create capacity and maintain safety for acute demand.

(Source: Routine Provider Information Request – Ward moves tab)

Patient moving wards at night

The following analysis excludes ward moves at night from assessment centres and day wards.

Trust level

From April 2017 to March 2018 there were 2,884 patient moving wards at night within medicine. On average there were 240 moves per month. Higher numbers were reported during the winter months of November (323) and December 2017 (372).

Leeds General Infirmary

From April 2017 to March 2018 there were 708 patients at Leeds General Infirmary moving wards at night within medicine. The hyper acute stroke unit had the highest number of 280 moves, followed by the acute stroke unit (171) and the Cardiology ward with 151 bed moves at night. On average there were 59 bed moves at night per month. Much higher numbers, were reported during the winter months of December 2017(83) and February 2018 (81).

(Source: Routine Provider Information Request – Ward moves at night tab)

This was an improvement in average bed moves since the last inspection which ran at 94.6 compared to 59 now.

Learning from complaints and concerns

The services had a system in place to encourage complaints and compliments with a view to improving services for patients.

Staff told us they would seek to resolve a concern informally first but complaints were dealt with formally if necessary. The governance arrangements in place ensured that lessons from complaints were shared amongst staff.

We saw notices displayed within the services showing how to complain and signposted patients or their carers or relatives to the trust’s patient advisory and liaison service (PALS) for support in making a complaint.

We discussed complaints with staff. Staff told us all response times for complaints were met with support from the trust’s PALS team.

Staff learnt from complaints and tried to improve the service as a result. For example, within the neurosciences speciality, patients were feeding back that it was very frightening having a stroke and how they would have liked to talk to someone who had been through the experience. In response, the service introduced a programme known as ‘volunteer stroke buddies’.
Summary of complaints

From May 2017 to April 2018 there were 78 complaints about medical services at Leeds General Infirmary. The service took an average of 45.2 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 40 days.

Thirteen complaints (16.7%) were not upheld, 36 (46.2%) were partially upheld, 17 (21.8%) were fully upheld and 12 (15.4%) were still under investigation.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From May 2017 to April 2018 there were 73 compliments within medicine. Compliments received for medicine accounted for 29.9% of all compliments received by the trust.

Leeds General Infirmary

Leeds General infirmary received 19 compliments; 26.0% of all compliments received for medicine.

A breakdown by team is shown in the table below:

<table>
<thead>
<tr>
<th>Team/Unit/Ward</th>
<th>Compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>14</td>
</tr>
<tr>
<td>Neurology</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory physiology</td>
<td>1</td>
</tr>
<tr>
<td>Stroke medicine</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Leadership

The leadership team were made up of a clinical director, general manager, and head of nursing who in turn were supported by a lead clinician, matron and business manager. The leadership team reported to the nursing and medical director who reported to the chief medical officer and chief nurse who reported to the chief executive.

The trust invested in their leaders: this included access to accredited courses such as lean for leadership. Also, by way of mentorship, the clinical directors met every month as a group with the executive directors.

The leadership team we met for medicine at the site were experienced in commissioning, designing and running their services. It was evident from discussions that their priority was on running a clinically safe service.

The leadership team met with the chief nurse, medical director, and deputy chief executive as necessary and through them had ready and easy access to the trust’s board.

Staff told us their leadership team was approachable and visible and the team told us that they met regularly in different forums to discuss quality, finances and governance.
At ward level the leadership team derived support from senior sisters with whom they met regularly.

**Vision and strategy**

The vision used by the services we visited was the trust’s vision, which was committed to delivering the highest quality and safest treatment and care to every patient, every time. It was supported by the ‘Leeds Way’ values, (patient centered, fair, collaborative, and accountable).

Each directorate had a strategy and business plan which set out in detail how the directorate intended to contribute towards the trust’s vision and strategy. The trust told us evaluation of the clinical business strategies by board members took place in 2014 and again in 2017 when the strategies were updated.

**Culture**

We observed that the services we visited had a positive culture with staff that were proud to provide patient focussed care to patients.

Running throughout the culture was the values known as the ‘Leeds Way’. The trust told us this was embedded through many streams including recruitment, interview and on boarding through to a CEO weekly messages to staff and corporate and service level awards events to recognise staff and their work. Staff we spoke with spoke about the Leeds Way.

Staff we spoke with described good teamwork and multi-disciplinary working with visible leaders who were happy to help and provide support.

Staff had various forums in which they could express their views and be heard including one to ones, team meetings and safety huddles.

**Governance**

The services had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

In terms of local governance, the leadership team met every week. Consultants within the specialities on the site met regularly and their meetings fed into the monthly clinical governance meeting. This was followed by a monthly business meeting at CSU level. In addition, there was a senior nurse meeting and a site meeting.

We saw minutes for a variety of speciality clinical governance meetings. The trust had introduced a standard template which looked at: patient safety, including incidents and medicine management; complaints and friends and family test; clinical audits; best practice and NICE guidance; mortality; lessons learned; health and safety; risk register; mandatory training; and any other business.

The business meetings standard agenda items included: looking at delivering the best clinical outcomes, which looked at mandatory training, infection control, the risk register, complaints and incidents; providing patient centred services, which looked at the performance dashboard, staffing, and business cases; spending public money wisely, which looked at finance; employing caring and cared for staff, which looked at recruitment; and any other business.
Senior matrons met as a group and discussed governance issues including learning from incidents or complaints and staffing issues together with issues cascaded to them from the leadership team.

All staff in a leadership role also had access to dashboards looking at performance, finance, governance and staff engagement.

Management of risk, issues and performance

The leadership team received information to support them in managing risk, identifying issues and assessing performance.

We spoke with members of the leadership team about how they measured quality and performance. The team had access to various sources of information, such as ward metrics, which captured a series of indicators ranging from documentation audits to hand hygiene. This information was examined, discussed and action taken through the meetings noted above.

The trust board had oversight of the operational and corporate risks through the risk management committee. CSUs presented their highest risks to the committee in a rolling programme, in addition to discussing emerging risks that required mitigation. The trust's long-term strategic risks were set out in the board assurance framework (BAF), under the key headings of finance, workforce and partnership working. The trust told us a clear governance framework was in place for CSUs and specialty teams, detailing how risks emerging were escalated to the risk management committee.

We discussed with the leadership team the risk register. Risk registers were maintained at CSU level, with a brief description of the risk, control measures, an owner, risk level and a review date.

We spoke with the leadership team about their risks and they could identify their risks and explain how they were mitigating them. For example, across the different CSUs that medicine covered staffing was a risk. Each CSU had adopted the same methods to mitigate the risk of staffing by, for instance, trying to grow a non-registered nurse workforce to support the national shortage of registered nurses, continued recruitment into registered nursing posts, plus use of the therapy team as part of the ward team. Other risks were specific to the speciality concerned. For instance, in cardiology there was a risk regarding ageing equipment in the catheter laboratory. This was addressed in the short term by maintenance to keep the equipment safe. In the long term, consideration was being given to entering into a managed service arrangement with a supplier of the equipment.

Measures and information relating to quality and safety was provided at CSU, specialty and ward level to the leadership team. We saw examples of the performance summaries the leadership team had access to. Ward level assurance was provided through audit of a range of ward metrics.

The trust told us the trust board received a quality and performance report (QPR) that set out the trust’s progress against a range of metrics relating to quality, performance and finance and a report on the significant risks that had been discussed at the risk management committee. Further detailed assurance was provided to the quality assurance committee, a formal committee of the board. This was supported by a range of sub-committees, including the safety and outcomes, patient experience and quality improvement.

Further assurance was provided by visits by the corporate nursing team. This was supported by the board leadership walk round programme, which provided an opportunity for board members to engage with patients and their families and staff to receive direct assurance on quality and safety. Many staff we spoke with told us that they had seen these walkarounds.
The trust’s non-executive directors had designated responsibilities such as for safeguarding, quality, audit, finance, performance and business planning.

**Information management**

From speaking with staff and reviewing information supplied in electronic format, it was clear that staff at all levels could access information in a digital format which could be interpreted and rapidly used to help improve the service.

The trust told us that data quality was managed locally by the CSU and centrally by the corporate information team. The CSUs manage the data quality of the locally maintained systems whilst the corporate information team managed the larger trust systems. The trust’s information quality department ensured the accuracy and completeness of data. A clinical information and outcomes team assured data for accuracy and completeness before it left the trust.

The leadership team told us that they received information in electronic format and they found the information robust. For instance, the CSU received a monthly report about staff appraisals from the organisational learning team. Also, the leadership team had access to ward metrics covering a range of indicators from documentation audits to hand hygiene which they could use to monitor performance.

**Engagement**

Staff and the trust gave examples of how they engaged with the public and staff with a view to ensuring their views were used to help to shape the service provided to patients.

The trust told us it used various routes to engage with the public, such as: a patient reference group, with the aim of providing the trust with a way to access the public voice when discussing issues which had a widespread impact for patients. This met every two months; a database of over 3,000 people who had given permission to be contacted remotely to provide their views on topics of interest; participation in the patient voices group with the aim of improving efficiency in engaging with the people of Leeds; taking part in existing specialist groups, such as the deaf and hard of hearing and blind and partially sighted and carers Leeds; and through speciality patient forums.

We saw patient information leaflets but some of these were beyond their review date; these included the leaflet about ‘understanding the ward patient safety board.’

The trust explained that it had taken recent steps to improve access for the public to provide feedback through the trust’s friends and family test (FFT) programme; including by increasing the use of text messaging and ensuring all wards had access to a FFT app. There was also an opportunity to provide feedback using the trust’s external website.

The trust told us the PALS team, as well as providing a feedback route, regularly monitored patient opinion and NHS choices. They also ran outreach activities to promote their service with a variety of local harder to reach groups, including black minority ethnic (BME) communities.

At a ward level we saw that, to engage with the public, each ward visited displayed a safety board which allowed the ward to share with the public key safety information about outcomes in terms of ward performance. This was based on many elements. It took the form of a ‘spider’ diagram which scored against key care standards such as patient observations, friends and family test results, staffing levels, and harm free care.
To engage with staff, the CSU had run an awards night which staff reported was well attended by a range of staff and helped maintain staff morale.

The trust told us it shared information from the NHS staff survey and staff FFT so it could identify themes and trends and agree actions where needed. It also ran a series of way finder campaigns to engage with staff and seek their views on improvement initiatives.

Learning, continuous improvement and innovation

Prior to the inspection, and while on inspection, the specialities shared with us the following examples of learning, continuous improvement and innovation:

Staff were proud about the cardiac suite which had improved the patient experience and received positive feedback.

Nurses were leading on sedation for the trans catheter aortic valve implantation clinic.

It had been two years since the cardio respiratory CSU had experienced a MRSA blood stream infection.

A new interventional procedures group was set up to provide the trust with assurance that new procedures involving either an implantable medical device or a new interventional procedure were safe, effective and affordable.
Facts and data about this service

The Leeds Teaching Hospitals NHS Trust (LTHT) provides surgical care across 34 surgical wards at four sites:

- Chapel Allerton Hospital: one ward, 32 inpatient beds
- Leeds General Infirmary: 16 wards, 59 day-case beds, 263 inpatient beds
- St. James’s University Hospital: 16 wards, 56 day-case beds, 226 inpatient beds
- Wharfedale Hospital: day surgery unit and accompanying ward with 23 day-case beds.

Surgical care at Leeds General Infirmary (LGI) comprises 263 inpatient beds and 59 day-case beds spread over 16 surgical wards and a multi-speciality surgical assessment unit. Excluding those used for women’s and paediatric services, there are 19 operating theatres across three theatre suites; most of which (16), are housed within the Jubilee wing.

Elective and non-elective surgical services at LGI are managed by clinical service units (CSUs) and surgical specialities. They provide a range of services including, major trauma, general trauma, vascular surgery, plastic surgery, neurosurgery, ear, nose and throat, maxillofacial and ophthalmology.

The trust hosts the West Yorkshire Major Trauma Network and all patients who suffer a serious injury are admitted to the Major Trauma Centre at LGI, if they can safely be taken there within 60 minutes.

The trust has one of the highest numbers of admissions in the country. The trust had 54,616 surgical admissions from March 2017 to February 2018. Emergency admissions accounted for 16,056 admissions (29.4%), 27,080 (49.6%) were day case, and the remaining 11,480 (21.0%) were elective. From August 2017 to July 2018, a total of 19,269 operations were carried out at LGI.

In May 2016, CQC carried out an announced comprehensive inspection of surgical services at the location; focusing on safe, responsive and well-led domains. We rated safe and responsive as requires improvement and well-led as good. In December 2013, CQC carried out an announced comprehensive inspection, in which we rated effective and caring as good. Ratings were amalgamated, and as of May 2016, surgical services at the location were rated as good overall.

Following our 2016 inspection, we told the trust that they must take the following actions to improve surgical services at the hospital: ensure all aspects of the WHO checklist are followed (in particular, the post brief); ensure best practice and guidelines are followed with regards to consenting patients for surgery; ensure documentation is completed in relation to mental capacity assessments; and ensure raised NEWS are managed appropriately as per trust guidance. We also suggested that the trust should consider ensuring clinical areas in Jubilee theatres adhere to safety and infection control guidance; and the trust should consider the use of tamper proof seals on resuscitation trolleys.

At our most recent unannounced inspection, we followed key lines of enquiry and rated all domains.

During our inspection, we visited the surgical service areas and spoke with 23 patients, and 67
members of staff. These included doctors, nurses, support workers, therapy staff, operating department practitioners (OPD’s), administration and domestic staff and management. We observed care and treatment, looked at 12 complete patient records (and specific documentation in several others) and 12 medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service.

We observed patient care, the environment within wards and theatres, handovers and safety briefings. We also reviewed the hospital’s performance data in respect of surgical services.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion was monitored centrally, and non-compliance was tracked and flagged to individual line managers for individual follow-up. Staff we spoke with reported the trust provided a robust e-learning plan and supported staff in completing training.

A breakdown of compliance for mandatory training courses as of June 2018 at Leeds General Infirmary for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff</td>
</tr>
<tr>
<td></td>
<td>trained</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>260</td>
</tr>
<tr>
<td>Resuscitation training basic awareness</td>
<td>6</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>277</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>277</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>277</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>277</td>
</tr>
<tr>
<td>Personal safety</td>
<td>276</td>
</tr>
<tr>
<td>Medicine safety</td>
<td>249</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>269</td>
</tr>
<tr>
<td>Information governance</td>
<td>273</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>214</td>
</tr>
<tr>
<td>Fire safety</td>
<td>263</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>50</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>13</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>161</td>
</tr>
<tr>
<td>PRTD paediatric life support level 1</td>
<td>12</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2 specialist</td>
<td>2</td>
</tr>
</tbody>
</table>
At Leeds General Infirmary, the surgery service had an overall training compliance rate of 97% for qualified nursing staff. The 80% target was met in 14 out of 17 mandatory training modules for which qualified nursing staff were eligible.

The lowest training rates were reported for PRTD paediatric life support level 1 and 2, with 67% training compliance each. However, this equated to six members of staff not completing the level 1 module, and just one member of staff not completing the level 2 module. Resuscitation training level 2 showed 75% compliance, marginally below the trust target of 80%.

A breakdown of compliance for mandatory training courses as of June 2018 at Leeds General Infirmary for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Prescribing standards</td>
<td>273</td>
<td>312</td>
<td>87.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>432</td>
<td>511</td>
<td>84.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling</td>
<td>432</td>
<td>511</td>
<td>84.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>428</td>
<td>511</td>
<td>83.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>426</td>
<td>511</td>
<td>83.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 3 advanced life support</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety</td>
<td>371</td>
<td>456</td>
<td>81.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>382</td>
<td>476</td>
<td>80.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2 intensive life support</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>396</td>
<td>498</td>
<td>79.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>400</td>
<td>508</td>
<td>78.7%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Personal safety</td>
<td>396</td>
<td>511</td>
<td>77.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>393</td>
<td>511</td>
<td>76.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>388</td>
<td>511</td>
<td>75.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2 PMST</td>
<td>157</td>
<td>236</td>
<td>66.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training advanced update</td>
<td>228</td>
<td>478</td>
<td>47.7%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training advanced update</td>
<td>227</td>
<td>478</td>
<td>47.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary, the surgery service had an overall training compliance rate of 76% for medical staff. The 80% target was met for nine out of 17 mandatory training modules for which medical staff were eligible.

In the two advanced resuscitation training modules, only 48% of staff had completed training. Resuscitation training level 2 showed 76% compliance.

**Safeguarding**

The service had systems in place for the identification and management of adults and children at risk of abuse.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse and which issues staff should report.
There was an established safeguarding team in the trust, led by a head of safeguarding. The safeguarding team reviewed and investigated individual notifications and provided advice, support and training to staff. Staff we spoke with had knowledge of the services available, found the team accessible, and were confident about the referral process.

From April 2017 to March 2018, 36 adult safeguarding referrals were made from surgical services across the trust. No child safeguarding referrals were made in this time frame.

From January 2018, the trust started to record falls and pressure ulcers under specific safeguarding referral domains (neglect/self-neglect), where relevant. Since our last inspection of the service, the safeguarding team had worked closely with the Pressure Ulcer Collaborative, and had introduced a flowchart for staff to define when and how to highlight the development of pressure ulcers as a safeguarding issue. The safeguarding team had also worked alongside the clinical nurse specialist for tissue viability to engage and ensure learning is taken from relevant Local Safeguarding Adult Board (LSAB) reviews.

Safeguarding training completion rates

Following our previous inspection of the service in 2016, the trust was required to ensure that staff had completed safeguard training at the appropriate levels for their role; in line with national recommendations. At the service, we saw that the quality and content of mandatory safeguarding training had been refreshed in July 2017.

A breakdown of compliance for safeguarding training courses as of June 2018 at Leeds General Infirmary for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>272</td>
<td>278</td>
<td>97.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>272</td>
<td>278</td>
<td>97.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>29</td>
<td>30</td>
<td>96.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>190</td>
<td>239</td>
<td>79.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>190</td>
<td>239</td>
<td>79.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>18</td>
<td>28</td>
<td>64.3%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>18</td>
<td>28</td>
<td>64.3%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary the surgery service had an overall training compliance rate of 88% for qualified nursing staff. The 80% target was met for three of seven safeguarding training modules for which qualified nursing staff were eligible.

Two modules almost met the trust target (safeguarding children level 2 and safeguarding vulnerable adults level 2, both with 79.5%). The lowest training compliance was reported for safeguarding vulnerable adults level 3 and safeguarding children level 3; at 64% each. However, this equated to 10 members of staff in each category not completing the module.
A breakdown of compliance for safeguarding training courses as of June 2018 at Leeds General Infirmary for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>413</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>397</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>201</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>198</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>153</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>101</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>81</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary the surgery service had an overall training compliance rate of 69% for medical staff. The 80% target was met in one of the seven safeguarding training modules for which medical staff were eligible.

Training compliance targets were nearly met for safeguarding children level 1 (78%) and safeguarding children level 3 (76%) modules, and compliance for safeguarding vulnerable adults level 3 was 75%.

Training compliance was lower than 60% for three of the seven modules; with 49% compliance for safeguarding vulnerable adults level 2 and 39% compliance for safeguarding children level 2.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Clinical staff in the service also received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or those living with dementia. The service had around the clock access to mental health liaison, and other specialist mental health support if staff were concerned about safeguarding risks associated with a patient’s mental health.

During our inspection, nursing staff we spoke with could describe what signs to look for and how they would escalate any safeguarding concerns. Some staff described using safeguarding control notes/plans, a feature added to the electronic patient record system since our last inspection.

Staff we spoke with could detail the actions they had taken in relation to safeguarding concerns.

During our inspection, we saw staff managing a potential safeguarding concern at the location. A patient had raised a safeguarding concern to the ward sister suggesting that her partner was manipulating/forcing her into marriage. We saw that the safeguarding concern was escalated, documented and communicated as per trust policy and process. The situation was managed sensitively, ensuring patient privacy and dignity was maintained.

**Cleanliness, infection control and hygiene**

The trust had an infection prevention and control (IPC) policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination, and IPC practices. Staff across different wards and theatres told us they had link nurses for infection prevention and control.
During our inspection, we observed staff interactions with patients were compliant with key trust infection control trust guidelines; for example, with respect to hand hygiene and the use of personal protective equipment (PPE).

During our inspection, we observed surgical patients under isolation due to infection and the risks of cross contamination. We also saw isolation rooms were available in PACU Jubilee theatre areas. Signage was adequate and staff were able to explain the reasoning behind the need to isolate.

Equipment cleaning labels were used, and this provided assurance that re-usable patient equipment has been cleaned and was ready for use.

We saw information displayed on cleanliness and infection control on safety information notice boards across surgical wards and units.

Overall, ward environments we visited were visibly clean, tidy and dust free. Hand hygiene points were visible at all ward entrances, main entrance and exit points and staff/patient corridors. Signage was visible regarding infection control across the hospital, and alcohol hand gel was available at every bed space.

We typically observed separation of clinical and non-clinical waste in line with trust policy in most ward areas at the location. However, we saw clinical waste had been placed in a linen basket on a plastics ward (L22). This was escalated to a senior member of ward staff. In addition, we saw some clinical waste bins housed in a storage area opposite ward L34 were left open; increasing the risk of cross contamination and non-adherence to hospital policy. This was reported to senior member of staff and the inspection manager.

During our inspection, we saw daily cleaning schedules for specific areas had been completed and updated. We observed housekeeping staff changing material privacy curtains around patient bed spaces.

At our previous inspection of the service in 2016, we told the trust to ensure that infection prevention and control protocols were consistently followed in theatres.

At our recent inspection, we saw systems and processes were in place to prevent and protect people from health care associated infection, and NICE guidance CG74 was adhered to (the guideline governs protocols in relation to the pre-operative, intraoperative, and post-operative phases).

In most areas visited, we found theatre environments to be clean and generally tidy. Sharps bins in areas visited were secure, dated and signed, and stored off the floor. However, some specific issues were identified, which are discussed in more detail below.

Theatre areas had facilities for safe storage of linen and cleaning equipment. We observed separation of clinical and non-clinical waste in line with trust policy in theatre areas at the location. However, we observed some ‘newer’ clinical waste bins (for example, in the anaesthetic room in theatre 14) were small, and not fit for purpose.

In the hand and plastic theatres (L46), we saw disposable curtains were in use, however, these were not dated so we could not identify when they should be replaced. Staff we spoke with said that housekeeping had changed the curtains at the beginning of May 2018. In addition, we saw the area behind theatre two was cluttered and dusty; for example, around the bio-hazard kit.

The general environment of PACU in the different theatres we visited was clean and uncluttered. Senior staff told us that theatre units had up to do date air unit handling verification. We sampled a section of air handling units and found most air flow units within theatre areas working and within
limits. However, we saw that the door from Jubilee theatre 15 did not close and air was being forced into the theatre room from the storage room on the opposite side; this was the reversed action of the expected flow. We also noted the dampener to the store room between theatres 15 and 16 was broken. This was raised with theatre staff.

We observed there was a ‘twin’ (adjoining) theatre in Clarendon Wing (L46: Hand and plastics theatre 2, A & B). Following our inspection, the trust provided us with an independent engineering report (June 2018) regarding the performance of the ventilation system(s) serving the suite. The verification process was comprised of a series of test and measurements in accordance with the relevant HTM (Health Technical Memorandum) and accompanying scope of works. The report detailed that key measures, such as air volume and change rates, and room pressure differentials, were sufficient in the preoperative area and theatre.

Following our inspection, we reviewed ward health check audit information provided by the trust for the centre for neurosciences CSU, for the period August 2017 to July 2018. Over the period, data showed 93.2% compliance for decontamination of hands by staff at the point of care using five moments for hand hygiene, 88.2% compliance for completion of invasive devices care plans, and 75.7% compliance for patients requiring source isolation. Data for surgical wards, such as L24 and L25 (spinal and cranial surgical wards) largely showed good IPC compliance. Data for L28 (surgical day unit and short stay ward) had only been collected from March 2018, and showed comparatively low levels of compliance for hand hygiene (76.0%) and patients requiring source isolation (58.3%).

We also reviewed ward health check audit information provided by the trust for the trauma and related services CSU, for the period August 2017 to July 2018. Over the period, data showed 95.4% compliance for decontamination of hands by staff at the point of care using five moments for hand hygiene, 85.6% compliance for completion of invasive devices care plans, and 94.0% compliance for patients requiring source isolation. Data for surgical wards, such as L10 (major trauma), L15 (vascular surgery), and L22 (plastic surgery) largely showed good IPC compliance. However, we noted completion of invasive devices care plans compliance was 67.4% on ward L22.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018, and noted that Leeds General Infirmary scored 99.80% for cleanliness.

The trust provided us with theatre and PACU safety audit data, presented at trust level. We analysed a 12-month period of data from August 2017 to July 2018. Data showed 99% compliance for finding theatre and PACU environments clean, tidy and clutter free.

The trust provided health care acquired infection (HCAI) data for the period August 2017 to July 2018. Data showed that within the centre for neurosciences CSU there had been no cases of MRSA, five cases of MSSA, 12 cases of Clostridium difficile, eight cases of E.coli, two cases of Klebsiella, and one case of Pseudomonas. Data for surgical wards, such as L24 and L25 (spinal and cranial surgical wards), showed very few cases of HCAI within this time frame.

Over this period, data showed that within the centre for trauma and related services CSU there had been no cases of MRSA, six cases of MSSA, five cases of Clostridium difficile, 10 cases of E.coli, three cases of Klebsiella, and one case of Pseudomonas. Data for surgical wards, such as L10 (major trauma), L15 (vascular surgery), and L22 (plastic surgery), showed very few cases of HCAI within the time frame.

The trust had a policy for MRSA screening for emergency patients. Elective patients were screened at pre-assessment. The trust provided 2017 to 2018 MRSA audit data that showed across the centre for neurosciences CSU, 100% of eligible patients sampled were screened for
MRSA within 48 hours; and 100% of relevant patients had wounds and lacerations screened. In addition, all patients sampled who required isolation had been isolated in a side room as per the trust’s MRSA pathway and guideline. Trauma and related services CSU data showed 97% of eligible patients sampled were screened for MRSA within 48 hours; however, only 38% of relevant patients had wounds and lacerations screened. All trauma CSU patients sampled who required isolation had been isolated in a side room as per the trust’s MRSA pathway and guideline.

We saw that each CSU had separate action plans for reductions in hospital acquired Clostridium difficile infections and MRSA and MSSA infections for 2018/19 (dated to May 2018).

There was a surgical site infection (SSI) surveillance programme in place at the trust. The trust participated in the PHE SSI surveillance scheme. Each quarter, a different surgical speciality was chosen to participate, determined by a rolling programme, or as a result of identifying higher than average SSI rates in a previous surveillance period. The mandatory orthopaedic SSI programme was carried out by the trauma and related services CSU.

Data provided by the trust showed the vascular surgery SSI rate was 0.7% from April to June 2017; compared to national rate of 2.6%. The SSI rate for breast surgery was 0% from January to March 2017; compared to a national rate of 0.8%.

In July 2017 spinal surgery services at the trust received a notification from PHE relating to outlier status (2.3% SSI rate from January to March 2017; compared to a national rate of 1.2%). The trust provided information that described a meeting was held with the spinal team in September 2017 to discuss both local actions for clinical team/theatres and actions for IPC. They also provided a presentation outlining the SSI rates, delivered by a spinal surgery consultant microbiologist and lead infection control doctor, that was presented to spinal surgery staff. However, this did not include formulated actions, only bullet points for discussion thereof.

We saw data from the Getting It Right First Time (GIRFT) SSI surveillance audit conducted between May and October 2017. Excluding obstetrics and gynaecology, and paediatric surgeries, data showed 120 instances of SSI at the trust between May 2017 and October 2017; of these 20 cases (17%) related to spinal surgery. The SSI surveillance programme showed a spinal surgery SSI audit was ongoing at the time of our inspection (timetabled from July to September 2018).

In October 2017, trauma orthopaedic services at the trust received a notification from PHE relating to outlier status for SSI of patients with fracture neck of femur. The period of interest was April to June 2017, during which there was a 2.8% infection rate. This was compared to a 1.1% infection rate for the previous year (July 2016 to June 2017). The service undertook route cause analysis (RCA) of cases identified in the 2 clusters of infection isolates. As a result of the RCA, the trust clarified and reviewed guidelines for prophylaxis, audited practice regarding indwelling catheters and revised practice aiming to encourage prompt catheter removal, and had standardised wound care practice (for example, dressings to remain in-situ for 14 days). The trust provided a ‘hip governance action tracker plan’, showing measures implemented to reduce the SSI rate (dated May 2018). Data provided by the trust showed repair of neck of femur SSI rates were 1.5% from October to December 2017, and 1.6% from January to March 2018. There was ongoing surveillance of the SSI rate, which was being monitored by PHE.

Data from the Getting It Right First Time (GIRFT) SSI surveillance audit conducted between May and October 2017 showed 120 instances of SSI at the trust between May 2017 and October 2017. Of these: 27 cases related to urological surgery (23%), 20 cases related to spinal surgery (17%), 21 cases related to cranial neurosurgery (17%), 19 cases related to vascular surgery (16%), and 13 cases related to cardiothoracic surgery (11%). Remaining SSI cases related to other
specialities, and amounted to 5% or less each. We did not know the number of corresponding surgeries undertaken during this period, so we were unable to calculate respective SSI rates.

**Environment and equipment**

Access to ward areas was via intercom with security cameras, staff gave access for admission from the main ward reception desk.

Surgical wards and patient areas we visited were spacious and side rooms were available for those who needed them. In main bays, bed spaces were separated by curtains to maintain patients’ privacy and dignity. Toilets for use by staff and visitors were clean and wheelchair accessible. We found wards were accessible to wheelchair users, with clear signage, and call buzzers were available by beds. There were designated areas for those waiting for surgery and post-operative patients.

Ward areas were visibly clean and tidy and generally free from clutter. However, some wards, for example L22, did highlight a lack of storage for equipment; this was found at our last inspection of the service in 2016.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that Leeds General Infirmary scored 97.03% for condition appearance and maintenance.

Staff we spoke with said that they had adequate stocks of equipment to meet the needs of their patients, for example, moving and handling equipment. Bariatric equipment was available from the equipment pool if required; this included theatre trolleys, beds, wheelchairs and commodes.

We were told there was a rolling programme of equipment replacement; and we saw evidence of equipment risks escalated to CSU risk registers where appropriate.

We inspected equipment for evidence of portable appliance testing (PAT). This is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. With few exceptions, we found equipment was electrically safety tested within the review date and serviced in line with manufacturers’ guidelines.

Sterilisation of reusable surgical equipment was performed off-site by an independent company, and returned the next day.

At our previous inspection in 2016, we told the trust they 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.

At our recent inspection, we observed three dirty utility rooms with doors unlocked and accessible (wards L34, L35, and L37). The dirty utility rooms were used to store chemical tablets (chlor-clean), which is a hazardous substance; and we saw this was accessible to patients. We also found an unlocked store room named as CSSD (on ward 37), and an unlocked store/cleaning cupboard on ward L22. Both rooms had acetone stored in them, which are substances hazardous to health. Incidents were reported to senior ward staff at the time of inspection.

In ward areas, resuscitation trolleys were easily located on main corridors. At the 2016 inspection, we said the trust should consider the use of tamper proof seals on resuscitation trolleys. During our recent inspection, we reviewed ten resuscitation trolleys, all of which had a tamper proof, numbered seal. We saw the trolleys were regularly checked, in line with trust policy. Equipment we reviewed was clean, tidy, and ready for use and staff had checked the equipment as per trust policy.
The one exception to this was observed on ward L35, where we found daily trolley checks were sometimes inconsistent; and had not been conducted on 25 July and 18 August 2018. Otherwise, the trolley was found to be in good order. The ward sister was informed and spoke with staff.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 91% compliance for emergency equipment. Over the same period, Centre for Neurosciences CSU data showed 90% compliance for emergency equipment.

We reviewed trolleys used for difficult airway access within theatres and noted these were easy to access, orderly and equipment was in date and ready to use.

Theatres environments were generally found to be adequate; however, we noted storage facilities to be an issue in some areas. We also observed equipment stored along main corridors within the Jubilee theatres, which we felt inhibited thorough cleaning of the area, and placed equipment at risk of damage or loss. We also saw that areas within hands and plastics theatres (L46) were cluttered; staff explained that renovation works were ongoing (due for completion September 2018) and this had caused areas to be temporarily used as storage areas.

We observed that some areas within theatres would benefit from updating; for example, we saw wooden cupboard frames in an anaesthetic room were broken, and trays/racks were damaged; we also saw paint was peeling next to the utility room door (theatre 14).

**Assessing and responding to patient risk**

We saw that the trust had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. A series of prompts were built into the trust’s electronic patient record (electronic observations (e-obs) recording system on PPM whiteboards) to support staff in managing risks posed to individual patients. For example, in relation to allergy alerts, deteriorating patients, national early warning scores (NEWS), and those at risk of falls.

We observed staff handover from a night shift to a day shift. The hand over was robust, incorporating risks, care given overnight, clinical summary, nutrition and hydration (diet), social, pain assessment, observations, consultant plan and next steps with respect to multidisciplinary care planning.

We observed risk factors and mitigating actions, such as falls and pressure ulcer prevention, being discussed at safety huddles and during handovers. We also observed boards above patient’s beds which identified any individual risk factors.

To address patient falls, elective patients were assessed pre-admission and all patients were assessed on admission to assess (or reassess) potential risks surrounding mobility and history of falls. The trust had instigated close observation bays where a clinical support worker was allocated to closely observe patients who were at risk of falls. For example, we observed patients at risk of falls on L35 (male orthopaedic and vascular ward). We saw there was a designated six-bedded bay for patients deemed to be at high risk; which was staffed by two clinical support workers who were present to observe, monitor and assist these patients with daily activities. We saw that wards visited had access to either ward-based physiotherapists and occupational therapists, and could refer to those services.

The National Hip Fracture Database Annual Report 2017 showed that of cases audited at the trust, 98.8% of patients had received a falls assessment, and 92.8% received bone health assessment.

Staff discussed learning from pressure ulcer incidents, and changes to practice. Nurses informed us that all patients are screened for pressure ulcers using the ‘Waterlow’ risk assessment tool.
which considers age, skin type, appetite, mobility, continence and weight. Patients who scored 10 or above were given an individualised care plan which detailed how pressure ulcer prevention or pressure ulcer care would be managed. Immediate care was instigated to address pressure care by ongoing assessment, mobility assessment, turns to alleviate pressure, pressure relieving devices (e.g. air flow tron mattresses) and nutrition and hydration assessment.

Neurosurgery ward staff described additional work undertaken around prevention of pressure ulcers. This had involved inviting specialist tissue viability nurses and dieticians to the ward to discuss patient needs with staff; and the types of enhanced care that might benefit patients on the ward and prevent pressure ulcers from developing.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 97% compliance for falls assessment, and 95% compliance for pressure area care. Over the same period, Centre for Neurosciences CSU data showed 96% compliance for falls assessment, and 94% compliance for pressure area care.

We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling and venous thromboembolism (VTE) compliance in 12 patient records, and found these fully completed with few omissions. For example, we could not identify that a falls risk assessment had not been conducted in one instance. In addition, we could not identify evidence of VTE risk assessment in three cases.

Following our inspection, the trust provided VTE risk assessment audit data for CSUs, and at individual ward level. Data referred to the number of patients who had received a VTE risk assessment within 24 hours of admission. We reviewed data for May 2018 to July 2018, which showed 91% VTE risk assessment compliance on average within the centre for neurosciences CSU, and 86.9% average compliance in the trauma and related services CSU over the period.

However, when we analysed data at ward level, we saw some variable performance across surgical service areas reviewed within the trauma and related services CSU. As shown in the table below, compliance on two surgical service wards within the CSU (L34 and L22) showed less than 60% compliance.

<table>
<thead>
<tr>
<th>Ward Code</th>
<th>Ward Name</th>
<th>May-18</th>
<th>Jun-18</th>
<th>Jul-18</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>L34</td>
<td>Trauma &amp; Orthopaedics Ward</td>
<td>51%</td>
<td>58%</td>
<td>54%</td>
<td>54%</td>
</tr>
<tr>
<td>L22</td>
<td>Major Trauma Ward</td>
<td>57%</td>
<td>65%</td>
<td>49%</td>
<td>57%</td>
</tr>
<tr>
<td>L35</td>
<td>Trauma &amp; Orthopaedics Ward</td>
<td>72%</td>
<td>78%</td>
<td>48%</td>
<td>66%</td>
</tr>
<tr>
<td>L08</td>
<td>Plastic Surgery/Trauma HDU</td>
<td>69%</td>
<td>67%</td>
<td>69%</td>
<td>68%</td>
</tr>
<tr>
<td>L37</td>
<td>Orthopaedic Trauma</td>
<td>89%</td>
<td>76%</td>
<td>73%</td>
<td>79%</td>
</tr>
<tr>
<td>L26</td>
<td>Multi-Specialty Assessment Area</td>
<td>86%</td>
<td>83%</td>
<td>83%</td>
<td>84%</td>
</tr>
<tr>
<td>L15</td>
<td>Vascular Ward</td>
<td>90%</td>
<td>89%</td>
<td>98%</td>
<td>92%</td>
</tr>
<tr>
<td>L10</td>
<td>Trauma &amp; Orthopaedics Ward</td>
<td>100%</td>
<td>98%</td>
<td>88%</td>
<td>96%</td>
</tr>
<tr>
<td>L46</td>
<td>Hand Day Surgery</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

We reviewed Trauma and Related services CSU governance meeting minutes. In the July 2018 minutes we saw discussion of 24-hour VTE assessment compliance rates. We saw discussion of wards struggling to improve compliance figures (such as L22 and L34), and daily chasing by senior staff to improve timescales for completion. Minutes showed that extension of 24 hours to 36 was being considered.
Similarly, when we analysed data at ward level, we saw variable performance across surgical service areas reviewed within the centre for neurosciences CSU. As shown in the table below, 24-hour VTE risk assessment compliance on wards L24 and L25 sometimes fell below 50% during the period examined.

<table>
<thead>
<tr>
<th>Ward Code</th>
<th>Ward Name</th>
<th>May-18</th>
<th>Jun-18</th>
<th>Jul-18</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>L25</td>
<td>Neuro Cranial &amp; Ortho Spine</td>
<td>75%</td>
<td>49%</td>
<td>41%</td>
<td>55%</td>
</tr>
<tr>
<td>L24</td>
<td>Neuro Cranial &amp; Ortho Spine</td>
<td>65%</td>
<td>49%</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>L28</td>
<td>Surgical Day Unit/Same Day Admissions</td>
<td>77%</td>
<td>70%</td>
<td>68%</td>
<td>72%</td>
</tr>
</tbody>
</table>

At trust-level, we saw the Quality Management Group (July 2018) had met to discuss an SBAR Proposal for VTE risk assessment, presented by the VTE Steering Group.

At our inspection of the service in 2016, we told the trust to ensure that all national early warning scores (NEWS) and observations were calculated and escalated in line with trust guidance. At our recent inspection, nursing staff we spoke with were able to articulate the deteriorating patient and were able to describe when they would escalate to senior staff for further review. Staff also told us that they had access to an outreach team if NEWS scores were abnormal and they required additional help and support. Senior staff told us patients with elevated NEWS were discussed at ward safety huddles and during handover. This was observed by the inspection team.

We reviewed 12 sets of patient notes and saw appropriate documentation and evidence of escalation of deteriorating patients in these records; in one record we saw that one NEWS score had not been correctly documented (calculated).

We reviewed NEWS compliance audits conducted from July 2017 to June 2018. Across NEWS audit metrics, we saw 96% compliance within the centre for neurosciences CSU, and a 96% compliance within the trauma and related services CSU. Across both CSUs, prescribing of observations, minimum twice daily recording, correct NEWS Score, and 24h cumulative fluid chart scores were consistently high. Within the trauma and related services CSU, we saw that documentation of interventions of raised NEWS (three or more in one parameter or five) showed 82% compliance, and the trauma and related services CSU showed 74% compliance over the timeframe.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 95% compliance for patient observations. Over the same period, Centre for Neurosciences CSU data showed 96% compliance.

Senior staff informed us that effectively managing patients with suspected and confirmed sepsis was a key focus of the trust. There was a sepsis steering group in place at the trust, and we saw evidence of meeting minutes (July 2018), which included review and monitoring of associated action plans (dated to June 2018). We also saw that the trust had organised a sepsis conference (May 2018), led by local and national sepsis leads. We also evidence of in-depth sepsis learning needs analysis, undertaken by the trust’s improvement academy.

During our inspection, we saw wards displayed posters about the risk of sepsis; which all displayed the ‘BUFALO’ acronym (designed to help clinicians to remember the elements of the sepsis six care bundle) and prompts for putting patients on a sepsis pathway. BUFALO bags were available in the service; which were equipped with all necessary items to take a sample of blood
for culture testing. Staff we spoke with were aware of sepsis escalation policy and processes. Staff could demonstrate use of the both electronic and paper-based (when in use) adult sepsis screening tools (dated to January 2018).

We saw that the trust had made good progress screening patients with suspected sepsis. For the quarter January to March 2018, the trust achieved 92% compliance for screening patients who met the required criteria. For 2017/18, estimated mortality rates for septic patients at national level was 30% on average. The figure at the trust for 2017/18 was around 13%. Audit results for the quarter January to March 2018 showed that 77% of patients received antibiotics within the hour, and antibiotics were reviewed appropriately for 98% of patients.

In theatres, staff used the World Health Organisation’ (WHO) surgical safety checklist. At our last inspection of the service in 2016, we found use of the checklist inconsistent and routine practice not embedded. In addition, two never events involving wrong site surgery had occurred at the trust (though not at this location) in May 2017 and June 2017. At our recent inspection, we saw a WHO Safer Procedure Checklist and the Correct Surgical Site Marking Policy and Standard Operating Procedure was in place (dated to July 2018).

During our inspection, we directly observed a robust WHO safety checklist culture. All staff we spoke with were aware of the importance of safety checks to reduce risk. During observation of procedures, we noted the WHO checklist was appropriately completed on seven occasions at the location. We saw good engagement from the clinical team, which provided assurance that this was an effective process.

In addition, we saw that accountable items were reviewed and recorded on whiteboards. The trust provided us with theatre and PACU safety data for the period August 2017 to August 2018. Data was at trust-wide level and showed use/completion of accountable items whiteboards had been audited from August 2018; with a 92.5% compliance score recorded.

At the service, completion of the safer surgery checks was audited continuously by the theatre management system, and regular reports were produced. The trust provided who safer surgery checklist audit data specific to Leeds General Infirmary, for the period August 2017 to July 2018. We saw that audits were undertaken for one week (Monday to Sunday) of every month, and six key metrics were measured: team brief, team debrief, average staff satisfaction score (with a maximum score of 5), sign in, time out, and sign out.

From August 2017 to July 2018, aggregated data at this location showed:

<table>
<thead>
<tr>
<th>Who safer surgery checklist metric</th>
<th>Average compliance/ result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Brief</td>
<td>58.2%</td>
</tr>
<tr>
<td>De-Brief</td>
<td>46.9%</td>
</tr>
<tr>
<td>Average Staff Satisfaction Score</td>
<td>3.77</td>
</tr>
<tr>
<td>Sign In</td>
<td>98.4%</td>
</tr>
<tr>
<td>Time Out</td>
<td>98.4%</td>
</tr>
<tr>
<td>Sign Out</td>
<td>98.2%</td>
</tr>
</tbody>
</table>

We analysed team brief and de-brief data further and found that average weekday (Monday to Friday) compliance was considerably better than average weekend compliance (Saturday to Sunday), with Sunday showing the lowest scores for compliance; as shown in the table below:
Following our inspection, the trust informed us that the data they provided did not take account of non-elective (acute) surgical lists, which were more likely to be performed on weekends; compared to elective surgery. They said that their electronic theatre management system (TMS) did not allow for individual patient team brief/debrief data to be captured, and that paper records were held. They noted that this was to be addressed by the theatres and anaesthetic CSU.

Nevertheless, we saw that overall compliance with brief and debrief checks was internally recognised to be an issue at the trust. This was reflected in the trust’s 2017/18 WHO safer surgery checklist audit; which was presented to the Clinical Audit and Learning Forum (March 2018), and the Safety and Outcomes Sub-Group (April 2018). Findings described that there had been a decrease in ‘down-tools’ (brief and debrief) checks when compared to 2016/17 data; with the lowest compliance seen in the de-brief check, which had decreased from 76% in 2016/17 to 56% in 2017/18.

The trust provided us with theatre and PACU safety audit data for the period August 2017 to August 2018. Data was presented at trust level. We analysed a 12-month period of data from August 2017 to July 2018. As shown below, high scores were observed across metrics, with a total average score of 90%. The lowest scores were observed for correct information display of patient safety boards as expected standard (82%) and evidence that the team de-brief from the previous theatre list was completed (82%).

<table>
<thead>
<tr>
<th>Theatre and PACU safety metric</th>
<th>Average compliance (%) August 2017 to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence that team brief completed for that day and all team recorded?</td>
<td>96.26%</td>
</tr>
<tr>
<td>Evidence the team de-brief from their previous list was completed?</td>
<td>82.08%</td>
</tr>
<tr>
<td>Is the theatre/PACU environment is clean, tidy and clutter free?</td>
<td>99.38%</td>
</tr>
<tr>
<td>Have four theatre staff members been allocated to the list?</td>
<td>91.14%</td>
</tr>
<tr>
<td>Is the patient safety board is displaying correct information as expected standard?</td>
<td>81.67%</td>
</tr>
<tr>
<td>Is there an identified Practitioner in charge displaying sticker?</td>
<td>88.20%</td>
</tr>
<tr>
<td>Total: average across metrics</td>
<td>89.8%</td>
</tr>
</tbody>
</table>

The trust hosts the West Yorkshire Major Trauma Network and all patients who suffer a serious injury are admitted to the Major Trauma Centre at Leeds General Infirmary, if they can safely be taken there within 60 minutes. Data showed good overall compliance with Trauma Audit and Research Network (TARN) metrics.
Nurse staffing

The trust told us that staffing on each ward or department was assessed using a range of tools, such as safer nursing care tools, and 1:8 ratios, to agree both their safe staffing levels and their optimum staffing levels (as part of a four-year plan). Prior to our inspection, the trust provided us with information that detailed they used the term ‘optimum level’ to denote staffing to establishment level using nationally recognised methodologies, and the term ‘safe level’ to denote staffing to a minimum level to ensure safe care as agreed by members of the senior leadership team at the trust. The trust acknowledged that many wards and departments had not yet achieved ‘optimum’ staffing levels, specifically in registered nursing posts, due to local and national shortages.

However, staff at all levels who we spoke with during our inspection expressed difficulty articulating the difference between ‘optimum’ (establishment) and ‘safe’ (minimum) staffing levels; and how these had been agreed upon.

To mitigate for a shortage of registered nurses, the service described they had adjusted the skill mix to reflect a more diverse range of roles within the ward workforce. This, they said, included investing in the knowledge and skills of the un.registered workforce to ensure patients received high quality care. The trust had expanded the number and increased the skills of senior Clinical Support Workers (trained to level 3) and Assistant Practitioners (Level 5 Foundation Degree), and had introduced Nursing Associates (Level 5 Foundation Degree). We saw evidence of these mitigating actions implemented on surgical wards during our visit.

There was a clear escalation process for staffing concerns (Actions to Be Taken When the Numbers of Nurses or Midwives Per Shift Falls Short of The Agreed Roster Template, updated August 2018); and staffing was discussed at daily operational performance (DOP) meetings.

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.

We reviewed CSU risk registers for surgical service areas and found risks relating to registered nurse staff shortages featured prominently. However, we saw most of these risks had been downgraded over the last 12 to 24 months following mitigating actions being put in place, as described earlier.

During our visit, we saw registered nurse staffing on ward L24 did not meet the planned level by one registered nurse on each (early, late and night) shift. However, we saw there were five clinical support workers rostered for each of these shifts, two of whom were designated to providing enhanced care on each shift.

During our inspection, senior staff told us that they had implemented a programme for critical care CSU staff to be seconded to the Neurosciences CSU, and we were told that seconded staff had been placed for nine-month periods onto wards L24 and L25 (surgical core service wards). In addition, additional band six staff had been appointed. This was also reflected in Centre for Neurosciences CSU Governance Meeting minutes (April and March 2018).

Prior to our recent inspection, the trust provided information about staffing levels on wards and in specific core service areas they were concerned about. Of the four areas described, two related to the surgical core service areas; and at this location included nurse staffing in the trauma and related services CSU; specifically, on trauma and orthopaedic wards.
During our visit, we saw registered nurse staffing on wards L10 and L22 did not meet the planned level on one shift each. On L22 four nurses were planned for the early shift, but three were on duty. On ward L10, three nurses were planned for the night shift, but two were on duty. However, we saw that planned nurse staffing levels on other shifts were met. In addition, there were three clinical support workers on duty for each shift (early, late, night) on both wards, as planned.

On ward L35 we saw planned registered nurse shifts were not met on the early and late shifts (three planned, two on duty for each); however, clinical support worker shifts were met on the late shift (four), and over filled on the early shift (four planned, five on duty).

On ward L37 planned registered nurse shifts were met on the early and late shifts (three planned, three on duty for each) and the night shift (two planned, two on duty). However, clinical support worker shifts were not met on the early shift or late shift (six planned, four on duty in both instances); yet we saw these were over filled on the night shift (four planned, five on duty).

Despite our observations during inspection, several nursing and clinical support worker ward staff we spoke with (predominantly on orthopaedic surgical wards) remarked that although mitigating staffing actions had made a positive difference in some respects (for example, with the monitoring of patients at risk of falls), they felt the shortage of registered nurses within the service had a detrimental impact on staff wellbeing and patient care. For example, they told us: there was “not enough staff which makes it uncomfortable for safety.”

The trust reported their staffing numbers for March 2017 and March 2018 as shown in the table below. These refer to optimum (establishment) staffing levels:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th></th>
<th>March 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>33.2</td>
<td>35.2</td>
<td>94.4%</td>
<td>32.2</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>304.5</td>
<td>381.7</td>
<td>79.8%</td>
<td>314.5</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>400.2</td>
<td>521.3</td>
<td>76.8%</td>
<td>394.0</td>
</tr>
</tbody>
</table>

In March 2018 there were 740.7 WTE nursing staff in post in surgery services compared to a planned WTE establishment of 944.9 WTE staff, giving a fill rate of 78.4%. This was similar to the previous year’s fill rate of 78.7%.

From March 2017 to March 2018, the fill rate for Leeds General Infirmary fell from 79.5% to 74.9%. The number of planned staff increased by 38.4 WTE staff, while staff in post fell by 10 WTE staff.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From June 2017 to May 2018 the trust reported a nursing staff vacancy rate of 21.8% in surgery. The trust does not have a target for vacancy rate.
At Leeds General Infirmary, the nursing staff vacancy rate in surgery was 26.0%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates
From June 2017 to May 2018 the trust reported a nursing staff turnover rate of 11.0% in surgery. The trust does not have a target for turnover rate.

At Leeds General Infirmary, the nursing staff turnover rate in surgery was 11.7%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From June 2017 to May 2018, the trust reported an annual nursing staff sickness rate of 4.2% in surgery which was higher than the trust’s target of 3.5%.

At Leeds General Infirmary, the annual nursing staff sickness rate in surgery was 4.2%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
From April 2017 to March 2018, the trust reported that 1.6% of qualified nursing shifts in surgery at Leeds General Infirmary were filled by bank staff and 4.1% of shifts were filled by agency staff. In addition, 7.0% of shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 10.1% of nursing assistant staff shifts in surgery at the hospital were filled by bank staff, 4.8% of shifts were filled by agency staff, and 4.4% of shifts were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>4,678</td>
<td>10.1%</td>
<td>1,112</td>
</tr>
<tr>
<td>Agency</td>
<td>2,236</td>
<td>4.8%</td>
<td>2,830</td>
</tr>
<tr>
<td>Not filled</td>
<td>2,050</td>
<td>4.4%</td>
<td>4,874</td>
</tr>
<tr>
<td>Total</td>
<td>46,116</td>
<td></td>
<td>69,516</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing
Medical cover was available on-site 24 hours a day. Consultants were available 24 hours a day, and were on site between 8am and 6pm; on-call cover was provided at evenings and weekends.

Resident consultant and speciality registrar anaesthetic cover was provided 24 hours a day, with on-call consultant cover provided out of hours.

On-call consultants were supported by on site registrars, and foundation level doctors supported wards.

We observed both formal medical ward rounds and safety brief meetings. Formal medical rounds took place in the morning to facilitate patients’ ongoing care or discharge plans. The ward rounds and safety huddles were thorough and efficient with all information clearly communicated. All staff
members had the opportunity to contribute to the meetings.

On the orthopaedic wards, patients over the age of 60 years were by the ortho-geriatric team on a regular basis; with the ortho-geriatric service available to provide input five days per week (Monday to Friday).

As shown in the staffing skill mix diagram below, 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 8% compared to 11%.

However, the proportion of registrar doctors at the service (38%) was higher than the national average (29%). In addition, the proportion of consultants (52%) was slightly higher than the national average (49%).

Gaps in middle grade rotas and insufficient levels of junior doctor cover on wards were highlighted on relevant CSU risk registers. This was discussed with the senior management team, who informed us that gaps were covered using locums; with some internal cover from consultants for middle-grade gaps. The team also cited other mitigating actions, such as increasing staffing on the senior fellows’ programme and the Medical Training Initiative (MTI) programme. The MTI is a national scheme designed to allow a small number of doctors to enter the UK from outside the EU for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries. In addition, we saw that the service had increased the Advanced Nurse Practitioner workforce; which also helped support the junior doctor workforce.

Junior medical staff we spoke with said they felt supported working in the trust and felt able to raise concerns as required.

The trust has reported their medical staffing numbers for March 2017 and March 2018 as shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>27.1</td>
<td>21.5</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>448.0</td>
<td>472.6</td>
</tr>
<tr>
<td>St James's University Hospital</td>
<td>135.5</td>
<td>148.4</td>
</tr>
</tbody>
</table>

In March 2018 there were 630.5 WTE medical staff in post in surgery services compared to a planned WTE establishment of 645.6 staff, giving a fill rate of 97.7%. This was similar to the previous year’s fill rate of 95.0%.

The fill rate at Leeds General Infirmary improved from 94.8% in March 2017 to 97.9% March 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From June 2017 to May 2018 the trust reported a medical staff vacancy rate of 2.2% in surgery. The trust does not have a target for vacancy rate.

At Leeds General Infirmary, the medical staff vacancy rate in surgery was 2.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
**Turnover rates**

From June 2017 to May 2018 the trust reported a medical staff turnover rate of 40.7% in surgery. However, the inclusion of trainee grades in the data is likely to have inflated the rates. The trust did not have a target for turnover rate.

At Leeds General Infirmary, the medical staff turnover rate in surgery was 39.7%. However, as stated, the inclusion of trainee grades in the data is likely to have inflated the rates.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From June 2017 to May 2018 the trust reported an annual medical staff sickness rate of 1.3% in surgery which was lower than the trust’s target of 3.5%.

At Leeds General Infirmary, the medical staff sickness rate in surgery was 1.6%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

From April 2017 to March 2018, Leeds General Infirmary reported that 3,118 shifts were filled by bank staff and 1,313 shifts were filled by locum staff in surgery. There were 253 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type at Leeds General Infirmary is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Shift type</th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>17</td>
<td>2,682</td>
<td>419</td>
<td>3,118</td>
</tr>
<tr>
<td>Locum shifts</td>
<td>496</td>
<td>817</td>
<td>0</td>
<td>1,313</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>0</td>
<td>250</td>
<td>3</td>
<td>253</td>
</tr>
</tbody>
</table>

The majority of shifts filled by bank and locum staff at Leeds General Infirmary were to cover doctor in training shifts, with 3,499 shifts covered compared to 513 consultant shifts covered.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As of December 2017, the proportions of consultant staff and junior (foundation year 1-2) reported to be working at the trust were similar to the England averages.
Staffing skill mix for the whole time equivalent (WTE) staff working at Leeds Teaching Hospitals NHS Trust

Total WTE (674.4)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>38%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Paper records were available for each patient that attended the wards and departments; the trust also used electronic patient management (PPM) to record key information about the patient’s hospital stay. Electronic whiteboards were used on all wards we visited; the boards recorded key information about patient risks and treatment including flags for living with dementia, NEWS scores, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Concerns around the secure storage of records had been raised at our previous inspection of the service in 2016. During our recent inspection, we saw some patient records were found to be stored in areas that were unsecure, and in unlocked trolleys. For example, whilst inspecting L34 (female orthopaedic ward) we found the doctor’s office unlocked with the door left ajar; patient notes and records were found to be unsecure in this area. On ward L22 we observed an unsecured medical records trolley on the corridor, out of the view of staff; we were told this had been temporarily removed from the doctor’s office to create more space.

We reviewed 12 sets of complete records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. In the nursing notes there were different assessments and care plans for a variety of conditions that had been actioned and evaluated. The vast majority of risk assessments were appropriately completed. We saw evidence of the enhanced care risk assessment completed for patients that required additional support.

We saw that electronic discharge summaries were completed for patients and a copy sent to their GP.
Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 89% compliance for documentation. Over the same period, Centre for Neurosciences CSU data showed 87% compliance for documentation.

The trust provided us with Health Record Keeping Standards (Medical) Analysis of specialty level audits for quarter 3 of 2017/18 (October to December 2017). The trust provided a sample of record keeping audit results. However, among the audit data submitted, only one related to surgical services at this location. We reviewed results for vascular surgery (undertaken March 2018, ward L15), and found good results overall.

**Medicines**

We saw the trust had an up to date medicine policy. Staff described how the pharmacy team carried out spot checks at ward level on the storage, management and administration of medicine. A clinical pharmacy service was available to inpatients; this was focused primarily on patient flow and medicines reconciliation. Dispensary services were provided for inpatients and discharge prescriptions. The ward clinical pharmacy service was available on the admissions units ten hours a day, seven days a week.

The electronic patient record (whiteboard, PPM+) allowed staff to record allergies and the trust also used a red wristband to alert staff that a patient had an allergy.

We checked the storage of medicines on the wards we visited. Medicines were stored in a locked room that required access from designated staff members. On the wards, we found nurses in charge carried the keys to gain access to locked controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) cabinets and locked drugs fridges.

Pharmacist colleagues who accompanied us on our inspection found controlled drugs were stored securely and access was restricted to authorised staff. Our checks of controlled drugs showed balance checks were carried out in accordance with trust policy and there were no discrepancies. We were told that ‘omnicell’ (electronic technology that communicates directly with pharmacy) roll out had improved efficiency of controlled drugs management and quality of recording on wards where this has been implemented.

The trust provided us with evidence of controlled drugs audits; which formed part of their rolling programme of controlled drugs reviews. Data was presented at individual ward level, and not by CSU. We reviewed checks of controlled drugs for quarter one of 2017/18 (date stamped to June, July and August 2018) and sampled results for eight surgical wards at the location. We noted five of the eights wards were found 100% compliant across all metrics (wards L15, L16, L22, L35 and L37). Some issues with the quality of controlled drugs record keeping were identified on ward L25 (neuro cranial and male orthopaedic spine) and ward L34 (orthopaedics). Issues with patients own controlled drugs were identified on ward L24 (neuro cranial and female orthopaedic spine) and L34 (orthopaedics). However, these wards scored positively for all other domains, including the storage and monitoring of controlled drugs. We also observed findings and actions resulting from controlled drugs audits were fed back to matrons and individual ward leads.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 91% compliance for medicine management. Over the same period, Centre for Neurosciences CSU data showed 90% compliance.

During our inspection, we found all emergency medicines reviewed were readily available and in date. We also observed oxygen cylinders stored correctly and in date.
We reviewed guidance from Leeds Medicines Information Services at the trust, entitled Management of Medicines stored in fridges in Clinical Areas (dated to February 2018). The guidance contained advice that “any fridge that continues to deviate from 2 to 8°C, or where the cause of the deviation is not known must be investigated further. Seek advice”. Contact details for sources of advice were detailed within the guidance. Within the guidance it was also noted, “Medicines Management or Medicines Information should always be involved if there are persistent temperatures outside 2 to 8 °C, or any temperatures outside 1 to 14 °C.”

We were advised by the pharmacy team that if wards reported an out of range fridge temperature then this was logged onto an enquiry form with action required and advice by the pharmacy team. We were informed that, once altered, the pharmacy team would check storage temperature ranges and the drugs effected, and drugs would be destroyed as necessary.

During our inspection we saw medications that required refrigeration were stored appropriately in secure fridges. We observed there was a process was in place to check and minimum and maximum fridge temperatures daily, and reset thermometers. We saw temperatures for all days were recorded. However, we found a number of fridges observed to be consistently out of temperature range with no record of action taken being recorded. For example, on ward L10, we observed fridge temperatures had been out of range for eight consecutive days at the time of inspection. On ward L24 we observed out of range fridge temperatures recorded over 24 days in August 2018, with temperatures reaching 17.8 °C. However, in both cases, we saw no evidence of actions being taken. Instances were reported to senior ward staff at the time of inspection.

Medicines were prescribed and dispensed using e-med medication charts. These contained the relevant information such as date, known allergies and electronic signature of the clinician. We reviewed 12 medicine records and noted medicines were prescribed and administered within national guidance. There were three main code reasons why medication was not given, these were: delay, withheld or missed. We saw that codes were recorded on the electronic system stating the reason why they were not administered.

During our inspection, some concerns were raised about the availability of intravenous medication on an evening on ward L28; which was set some distance away from other wards. Staff described that on an evening one registered nurse and one care support worker were on duty. Staff said that there was approximately a one-hour delay obtaining IV medications due to needing to request these, and the distance travelled.

In addition, a support worker on an orthopaedic ward commented that nurses left tablets on tables in front of patients and support workers had to administer these to patients, and explained they had not been trained to do this. A student nurse on a different orthopaedic ward also explained that they gave medicines to patients from tables due to lack of [nursing] staff.

During our inspection, a review of patient records showed that where patients had been assessed for risk of blood clots, appropriate treatment was given. The Corporate Audit Report for VTE Appropriate Thromboprophylaxis Audit, quarter four of 2017/2018 (produced May 2018) detailed that 92.5% of patients on prophylactic LMWH (199 out of 215 audited) had an appropriate dose based on weight and renal function. These results show a marked improvement on the 2017/18 results where 89.5% of patients were on appropriate thromboprophylaxis.

There was a Medicines Risk Management Group in place at the trust. We reviewed meeting minutes for June 2018, which stated medicine audit results and action plans were presented to the group.
Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported four incidents classified as a never event for surgery. The details of the never events are shown below:

- Retained foreign object – reported in June 2017. The incident occurred in April 2017 at Leeds General Infirmary and took 55 days to report.
- Unintentional connection of a patient requiring oxygen to an air flowmeter – reported in May 2018. The incident occurred in May 2018 at Leeds General Infirmary and took eight days to report.
- Wrong site surgery – reported in June 2017. The incident occurred in May 2017 at St James's University Hospital and took 30 days to report.
- Wrong site surgery – reported in July 2017. The incident occurred in July 2017 at St James’s University Hospital and took four days to report.

Staff we spoke with also described learning from never events that occurred in surgical services at the trust. Ward staff tended to discuss a recent never event that had occurred at the location, which involved unintentional connection of a patient requiring oxygen to an air flowmeter. Staff reiterated learning points and described removal (‘capping’) of medical air/medical air flow meters in appropriate areas and use of electronic nebulisers to mitigate risks. Theatre staff often discussed the two wrong site surgery never events that had occurred at St James’s Hospital; and stressed learning points from the events, which included use and documentation of the WHO safer surgery checklist. They also recounted learning events that had previously occurred at the trust in relation to wrong site anaesthetic block; and the ‘stop before you block’ programme of learning that had been implemented as a result.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018.

Trust level

A breakdown of all incidents reported in surgery is shown below:

- Pressure ulcer meeting SI criteria – 10 (35.7%)
- Slips/trips/falls meeting SI criteria – eight (28.6%)
- Surgical/invasive procedure incident meeting SI criteria – seven (25.0%)
- Treatment delay meeting SI criteria – two (7.1%)
- Sub-optimal care of the deteriorating patient meeting SI criteria – one (3.6%)
At Leeds General Infirmary there were 16 serious incidents reported from June 2017 to May 2018. A breakdown of incidents reported is shown below:

- Pressure ulcer meeting SI criteria – seven (43.8%)
- Slips/trips/falls meeting SI criteria – four (25.0%)
- Surgical/invasive procedure incident meeting SI criteria – three (18.8%). One of these incidents relates to the never event that was reported in June 2017 as described above
- Treatment delay meeting SI criteria – one (6.3%). This is the never event reported in May 2018 as described above
- Sub-optimal care of the deteriorating patient meeting SI criteria – one (6.3%)

(Source: Strategic Executive Information System (STEIS))

The Trust used Datix to report and capture incidents, complaints, PALS queries, claims and inquest information. Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. Staff informed us that they received feedback following incidents which assisted with lessons learnt and actions taken to prevent recurrence.

Lessons from incidents were triangulated at CSU level and by the corporate lessons learned group at trust level. Each CSU had a named patient safety and quality manager who worked between CSU and corporate levels to share learning. Groups identified key learning from these sources and produced various learning resources including newsletters, bulletins, videos and SBAR alerts. NHSi patient safety alerts were circulated to all areas of the trust, and displayed on the trust intranet.

The most commonly reported serious incidents in surgical services at the location related to pressure ulcers, and slips, trip and falls. We saw from data this was consistent with the types of incidents reported in the wider trust.

We reviewed a sample of completed serious incident root cause analysis (RCA) reports and associated actions plans, which identified areas of good practice and areas of concern, contributory factors and recommendations.

We reviewed NRLS (incident) data at the location for a four-month period (reported between May 2018 and August 2018). We analysed the data and found most of the 81 falls reported occurred in neurosurgery and trauma and orthopaedic service areas. Of the falls reported during this timeframe, 64 resulted in no harm and 17 resulted in low harm. Of the low harm falls, four occurred in neurosurgery, four in plastic surgery, and four in trauma and orthopaedics.

Staff we spoke with described a variety of mechanisms in place to share lessons learned. Senior staff discussed dissemination of fortnightly safety briefs (‘Quality and Safety Matters) and learning points bulletins; which had focused on a series of topics arising from serious incidents and complaints at trust level. Others mentioned the trust’s lessons learned intranet pages and social media videos produced by CSUs. Surgical staff who attended a focus group also discussed the development of a lessons learned application for smart phones, for staff to download and instantly receive lessons learned from incidents.

Matrons reported they met regularly with their ward leadership and the head of nursing for the surgery division to discuss learning from incidents. Matrons were responsible for sharing lessons learnt at ward level with the senior and junior sister within each ward and their staff. Staff we spoke with on the wards and in the theatres described lessons that had been learnt.

Staff in theatres described learning that was shared through “hot topics” team briefs. For example, around flushing and removal of lines and cannula after procedures, and who safer surgery
checklist refresher information; and we saw documented evidence of these. They also discussed learning shared through the monthly theatres newsletter called “risky business.”

On the wards, we were often told about changes that had been made to assess and observe patients who were at risk of falls, slips and trips, and pressure ulcers (see Assessing and responding to risk section for more detailed information).

We saw that the trust had developed a bespoke RCA document for investigation of falls resulting in fracture, serious head injury or death (dated February 2018); and an associate panel meeting template. The trust had developed a falls prevention action plan (most recent version seen dated to May 2018), which outlined ongoing objectives to reduce falls.

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 demonstrated an awareness of the duty and the importance of being open and honest when delivering care. RCA reports we reviewed demonstrated the duty of candour.

Mortality and morbidity was discussed at regular mortality sub-committee meetings, minutes for which we reviewed. We saw that deaths were screened via the trusts 'Mortality Screening Tool', accessed electronically via on the electronic patient record (PPM+). Screening tool criteria had been extracted from NHSi 'Learning from deaths'. A positive response to any of the criteria (one of which is an unexpected death) triggered a structured judgement review, and reviews presented at departmental mortality meetings. Post mortem results, coroner’s reports and incident investigation findings were used in conjunction with structured judgement review by clinical services to inform learning. Learning from meetings was fed into governance meetings and to the Mortality Improvement Group to extract any themes.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 84 new pressure ulcers, eight falls with harm and 13 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for surgery.
The prevalence rate of pressure ulcers in patients surveyed generally remained similar over time, except in June 2017 when a higher prevalence rate was recorded. Trends in total falls and CUTIs cannot be commented on due to the small numbers reported.

(Source: NHS Digital)

The trust submitted safety thermometer data; however, the results were not on display to the public. Instead, each ward displayed ward health check dashboards. Senior staff told us that safety thermometer results were usually displayed in the rooms used at ward level by staff. Staff informed us that safety thermometer results were discussed at clinical governance meetings and information fed back at ward level.

Is the service effective?

Evidence-based care and treatment

We saw trust policies and pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

The surgical division had care plans and pathways for a number of conditions including stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis; based on the acute Bufalo toolkit screening tool and care protocols.
Integrated pathways were in use for patients undergoing day surgery procedures including documentation to assess risk such as venous thromboembolism (VTE). Enhanced recovery pathways were in place, for example for patients undergoing elective joint replacement surgery.

The safety and outcomes sub-group received a six-monthly report giving an overview of the trust’s compliance with NICE guidance. Any non-compliance had to be presented to the safety and outcomes sub-group, prior to approval by the quality assurance committee.

New guidance was monitored through clinical governance meetings and we saw evidence of this through a review of clinical governance reports. For each piece of guidance, a nominated lead within the CSU completed an assessment of the trust’s compliance, and actions were put in place to achieve compliance with any recommendations not met.

Staff accessed policies, procedures and other guidance through the trust intranet. We reviewed policies and found them to be in date with version control and a named author.

Audits were undertaken for the completion and accuracy of care bundles, the use of NEWS, medication and documentation such as those which related to infection prevention and control. The results were collated monthly for all ward and reported via the ward metrics system. We observed results on display on all wards inspected. Individual wards would choose a hot topic monthly to review practice to ensure all training was embedded and the ward culture was consistent surrounding learning.

The surgical division participated in a number of national audits.

**Nutrition and hydration**

We reviewed care plan documentation and risk assessments of twelve patients and found the vast majority (eleven in each instance) of fluid balance charts and nutritional risk assessments completed appropriately.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 92% compliance for nutrition, and 97% compliance for hydration. Over the same period, Centre for Neurosciences CSU data showed 93% compliance for nutrition, and 93% compliance for hydration.

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Staff used the Malnutrition Universal Screening Tool (MUST) tool to identify adults who were malnourished or at risk of malnutrition. Patients were assessed regarding their nutritional needs and these were recorded in care plans; patients were referred to the dietician for additional advice if required. We observed protected meal times were in place and saw patients supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking.

Patients typically gave positive feedback about the variety and quality of food choices available. Individual multicultural patient needs were catered for including, vegetarian, vegan and halal choices. Drinks were readily available and in easy reach of patients. Patients assured us that food was warm, fresh and of good quality.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that Leeds General Infirmary scored 92.12% for ward food assessment.

Current guidance recommends fasting from food for six hours and fluid for two hours. Records we reviewed showed patients had adhered to fasting times prior to surgery going ahead. Staff on
some wards mentioned recently gaining access to fasting link nurses, who attended study days and offered teaching around fasting on the wards.

We saw records in notes for patients who received nutrition via nasogastric tubes, including the day and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained.

We saw that the theatres and anaesthetics CSU had led a ‘Think Drink’ campaign, aimed at reducing pre-operative fluid fasting times. This was being rolled out across the trust, who reported it had significantly reducing fasting times in the areas in which it had been launched. We saw patient information leaflets during our inspection advertising the campaign.

Data provided by the trust showed that of patients surveyed, most patients had been provided fasting information in written and verbal form, or in written form; a minority (two) reported only receiving verbal information. 98.8% of patients were aware they had to fast before surgery. Most patients (86%) found the information clear and helpful enough; 10% were unsure, and 4% disagreed. Following the ‘think drink’ campaign, most patients (69%) reported they did not feel thirsty (24%) or a little thirsty (45%); 17% reported they still felt thirsty, and 14% reported they felt very thirsty.

The trust provided us with fasting audit data, collected in July and August 2018. We saw that audits noted the last time the patient drank, and time to anaesthetics. We selected 20 cases at random from specialities at the location reported in August 2018 and found the majority appeared within reasonable range. Time since last food was not recorded, so this could not be assessed.

**Pain relief**

Staff used a pain-scoring tool to assess patient’s pain levels; staff recorded the assessment on paper and electronic records. We saw evidence of pain scores in patient documentation reviewed.

Some surgical patients received intravenous patient controlled pain relief post-operatively. This was in line with national best practice guidance from the British Pain Society.

We reviewed care plans related to pain management. Pain assessments were carried out and recorded in patient notes. Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief was accessed through medical staff, if required.

Most patients we spoke with had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. However, a (surgical outlier) patient on ward L22 did comment that on occasions he had to wait for more than 2 hours for pain relief at night.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 99% compliance for pain management. Over the same period, Centre for Neurosciences CSU data showed 98% compliance for pain management.
Patient outcomes

From February 2017 to January 2018, all patients at Leeds General Infirmary had a higher than expected risk of readmission for elective admissions when compared to the England average.

Patients in two of the top three specialties (based on count of activity) at this hospital (vascular surgery and the spinal surgery service) had a higher than expected risk of readmission for elective admissions when compared to the England average while patients in plastic surgery had a similar to expected risk of readmission.

Elective Admissions - Leeds General Infirmary

![Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

All patients at Leeds General Infirmary had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Two of the top three specialties (based on count of activity) at this hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average (trauma and orthopaedics and vascular surgery). Plastic surgery had a higher than expected risk of readmission.

Non-Elective Admissions - Leeds General Infirmary

![Non-Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics)

In addition to national audit action plans described below, we reviewed action plans resulting from ‘Getting It Right First Time’ (GIRFT) audit and review actives for a range of specialities. Many of these incorporated patient outcome findings from national audits. The trust provided us with a sample of GIRFT action plans for general surgery; urological; thoracic (including resection); vascular; ear, nose and throat; oral and maxillofacial, oncological; and ophthalmological surgery.
Actions plans detailed a summary of issues identified, actions to be taken, named individuals responsible, review dates, and updates as of July 2018. These are described where relevant.

**National Hip Fracture Audit**

In the 2017 National Hip Fracture Audit report (data gathered January 2016 to December 2016), the risk-adjusted 30-day mortality rate was 6.9% which was within the expected range. The 2016 report figure (data gathered January 2015 to December 2015) was 6.3%.

The proportion of patients having surgery on the day of or day after admission was 65.9%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts; however, the bottom inter-quartile range cut-off was 68.2%. The 2016 figure at LGI was 75.3%.

The perioperative medical assessment rate was 87.3% which failed to meet the national standard of 100%; however, the national aggregate was 88.7%.

The proportion of patients not developing pressure ulcers was 89.6%, which failed to meet the national standard of 100%. This was within the bottom 25% trusts; the bottom inter-quartile range cut-off was 94.8%. The 2016 report figure was 93.8%.

The length of stay was 23.7 days, which falls within the middle 50% of trusts. The 2016 report figure was 23 days.

*(Source: National Hip Fracture Database 2017)*

Following our inspection, the trust submitted details of interventions that had been undertaken in 2017 to improve hip fracture performance. These included implementing dedicated hip fracture theatre lists; weekend hip replacement cover (from July 2017); extending the role of the fragility fracture nurse; providing extra data clerks to enable real time data collection (to collect data before discharge); and rolling out INR ‘coaguchek’ devices for rapid pre-operative measurement. We also saw a new hip fracture care pathway was introduced in 2017.

The trust provided us with more recent data in relation to hip fracture service performance indicators, dated to October or December 2017 (depending on the measure). Timeframes shown below relate to years/months data were collected, as opposed to reported/published.

Overall, data showed an improved picture. For example:

Data showed the proportion of patients having surgery within 36 hours of admission had improved from 65% in 2016 to 75% in 2017 (January to October 2017).

From January to October 2017, showed falls assessments undertaken in 99% of cases, peri-operative medical assessment in 92% of cases, and no pressure ulcers had occurred in 97% of cases.

Mobilisation on day of surgery had improved from 61% in 2016, to 73% in 2017 (January to December). Average length of stay was shown to be 23 days from January to October 2017.

Emergency readmissions had fallen slightly from 18% in 2016, to 17% in 2017 (January to December).

There was a decline in reoperation rates from 2016 (range 3.7% to 2.5% from January to December 2016) to 2017 (range 1.4% to 1.9% from January to October 2017).

**National Vascular Registry**

In the 2017 National Vascular Registry (NVR) Audit report (based on data collected January 2014 to December 2016), the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.5% for abdominal aortic aneurysms. This was within the expected range; and better than the
national average of 1.4%. The 2016 figure at the trust was 0%.

For carotid endarterectomy, the median time from symptom to surgery was 12 days, which was better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 2.3%, which was within the expected range.

(Source: National Vascular Registry)

Following our inspection, the trust submitted a ‘Getting It Right First Time’ (GIRFT) action plan for vascular surgery, following on from GIRFT audit and review activities; and which incorporated National Vascular Register (NVR) data. The action plan was comprised of 14 recommendations, each with a number of actions.

We noted the service had nominated an abdominal aortic aneurysm (AAA) lead in radiology and vascular surgery, and the service had completed its first outpatient endovascular aneurysm repair (EVAR) in December 2017.

Risks around ensuring all AAA patients, both screened and non-screened, followed the same pathway and timelines stipulated by the National AAA Screening Programme had been added to the trust risk register. Review of aortic care pathways were ongoing.

We saw funding had been approved to install a hybrid theatre and use this to develop a seven-day service including weekend operating.

The service was working to introduce regular review of vascular patients by elderly medicine physicians. The plan noted that the introduction of such a service has been shown to reduce length of stay and reduce the rate of emergency re-admission for non-surgical problems in the first 30 days following surgery. The plan was completed and submitted to senior management in July 2018.

**Intercranial Injury**

We saw that mortality outlier alerts for intracranial injury had been highlighted at the trust in July 2016 (signal occurred in January 2016), and February 2018 (signal occurred November 2017). Historically, outlier alerts had also been highlighted in September 2011 and September 2012. Outlier alerts draw no conclusions as to what lies behind the figures; for example, there are a number of possible reasons for results, including random variation, poor data quality or coding problems, and case-mix issues.

CQC previously acknowledged (with respect to the 2016 alert) that the trust hosts the West Yorkshire Major Trauma Network and there are limitations in the ability to make accurate adjustments for case-mix with respect to intracranial injury using HES data; and that this will impact on trusts that are major trauma centres in particular.

We reviewed information with respect to the 2016 alert that showed the service had conducted case note reviews of 27 patients and that these reviews did not identify any avoidable deaths. We also identified that, after comparison activity with Major Trauma Centre peers, a significant difference in case mix was identified. Following this, the service undertook a detailed clinical coding audit of 45 cases, this identified clinical coding training needs and documentation issues; which the service told us was being actively addressed (and an action plan was provided). At that time, the trust provided an action plan to address this.

With respect to the November 2017 outlier alert, the Hospital Episode Statistics (HES) analysis identified 42 deaths from July 2017 to November 2017, compared to an expected 24.4 deaths. A
more longitudinal analysis showed for the period November 2016 to November 2017; 68 deaths, compared to an expected 45.6 deaths.

Following our recent inspection of the service, the trust informed us that the clinical team were completing a case note review to ascertain why the alert occurred, and this was to be discussed at the Mortality Improvement Group in September 2018.

**Patient Reported Outcome Measures**

In the patient reported outcomes measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance was similar to the England performance for all metrics relating to hip replacement, knee replacement and varicose vein.

Performance on groin hernias was about the same as the England average for improvement in patient outcomes. Performance was better for the proportion of patients who had reported worsened outcomes for groin hernia according to the EQ VAS indicator.

(Source: NHS Digital)
**Competent staff**

**Appraisal rates**

At Leeds General Infirmary, all staff in surgery had an appraisal completion rate of 90.9% as at June 2017 and 97.8% as at June 2018. A breakdown of appraisal completion rate for nursing and medical staff is shown below:

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<th>Staff group</th>
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<th></th>
<th></th>
<th>June 2018</th>
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<tr>
<td></td>
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<td>Required</td>
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<tr>
<td>Nursing and Midwifery Registered</td>
<td>236</td>
<td>273</td>
<td>86.4%</td>
<td>275</td>
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<td>Medical &amp; Dental staff - Hospital</td>
<td>261</td>
<td>269</td>
<td>97.0%</td>
<td>295</td>
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Both nursing staff and medical staff met the trust target for appraisal rate as at June 2018. Nursing staff had a higher appraisal completion rate as at June 2018 compared to the previous year, as at June 2017. The appraisal completion rate for medical staff remained similar between the two years.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff told us that they received appraisals and found them effective and reflected on their performance and career. They told us that colleagues encouraged them to undertake further courses to develop their skills and knowledge. Staff told us they had completed competency based training, mentorship training and academic degrees.

We spoke with several student / apprentice nurses who had developed through working in the trust. All those we spoke with said that they had been well supported by their mentor, that staff were friendly and approachable, and that they had enjoyed their placement at the hospital.

We also saw that clinical support workers were taking on more responsibilities for patients; which included completing patient records and evaluating their ongoing care. These staff told us that they felt competent in their roles and had received training and competency packages. They felt they were well supported by the registered nurses within the ward environment.

Apprentice nurses and support workers told us that managers were supportive if staff identified additional development training.

Preceptorship packages were in place for new staff and they were supernumerary for a period of time. Along with this staff were provided with competency packages to ensure the correct skills were observed.

The trust had a clinical education team that provided training and development to staff; and clinical educators were available in surgical specialities.

Staff on ward L24 described a bespoke ‘Care and Management of Neurosciences Patients’ training package; which covered the care of stroke and neurology. In addition, that during their preceptorship programme, staff within the CSU rotated around different neurology centre areas. Senior staff said this approach helped staff manage speciality outliers who may be housed on wards.
We discussed innovative practice on inspection. Ward L37 were proud that they had undertaken additional traction training which had enhanced a multidisciplinary team approach for patients requiring traction.

Theatre staff described a monthly theatre induction was in place. They also discussed the use of specialist induction packs for new starters. Staff told us that in-house link practitioners ensured members of the team completed the specialist induction pack within six months of starting; and this was checked and revisited by the education team. Established staff said they received priority training according to speciality, and described competencies were refreshed a minimum of every two years.

The trust provided us with falls theory and competency assessment training data at CSU level, for May 2018 to July 2018. The Falls Prevention Group Action Plan (dated May 2018) stated that 85% compliance was required by July 2018, 09% compliance by August 2018, and 95% compliance was required by September 2018. Data reviewed showed that relevant CSUs were close to meeting or had surpassed targets by July 2018.

Within the Centre for Neurosciences CSU, data showed compliance for completion of falls theory & competency assessment training was 98%, and compliance for falls theory training was 99% as of July 2018.

Within the Trauma and Related Services CSU, data showed compliance for completion of falls theory & competency assessment training was 80%, and compliance for falls theory training was 90% as of July 2018.

Within the Theatres & Anaesthesia CSU, data showed compliance for completion of falls theory & competency assessment training was 85%, and compliance for falls theory training was 96% as of July 2018.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision with regular meetings.

**Multidisciplinary working**

Nursing and medical staff reported good multidisciplinary (MDT) working and all surgical wards participated in multidisciplinary ward rounds. This, they said, resulted in a co-ordinated approach to treatment plans and decisions. We observed MDT working on inspection; teams worked collaboratively together using clear, concise communication.

There were established MDT meetings for discussion of patients on specific pathways or with complex needs; this included attendance from consultants, specialist nurses and radiologists.

Multidisciplinary safety huddles took place each morning to discuss patient care and identify risks as well as to share other information. Physiotherapy, occupational therapy staff and discharge planners supported wards throughout LGI and helped with continuity of care.

Specialist and link nurses were available to review patients in specialities, such as respiratory and diabetes, physiotherapy, tissue viability, speech and language, pharmacy, child and adolescent, critical care outreach nurse (CCOT) and adult mental health liaison.

Allied health professionals confirmed there was good multidisciplinary working and offered training to nursing staff where appropriate. Dieticians completed daily reviews of those patients referred for their input.
There was a multidisciplinary approach to assessment and discharge, which was facilitated by dedicated discharge co-ordinators. A discharge planning meeting was held each morning, Monday to Friday supported by the ward manager, physiotherapist, occupational therapist and a discharge coordinator. Individual patient needs were discussed and discharge planned accordingly with support of a social care charity (the Red Cross).

**Seven-day services**

Surgical services ensured there was a seven-day consultant rota providing dedicated and on-call cover.

Staff had 24/7 access to a full range of diagnostic services such as, x ray, computed tomography (CT) scans or magnetic resonance imaging (MRIs); and no services we visited reported issues with seven-day access to diagnostic services.

The critical care outreach team covered both hospital sites, providing 24 hours cover every day. The team supported patients stepped down from critical care and reviewed deteriorating patients that had been referred to them.

The speech and language therapy team worked Monday to Friday 08:30 to 16:30; however, there was no cover at weekends.

The physiotherapy and occupational therapy services offered a five-day service with some dedicated presence at weekends. Teams worked with care support workers on the wards to continue rehabilitation over the weekend. Staff told us that they had contact details of out of hours support.

A pharmacy service was available 24/7: the dispensary was open 8am - 8pm Monday to Friday, with an on-call pharmacist available outside these hours.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, seven days a week with all adult patients.

**Health promotion**

Health promotion information was available on all wards we visited. This included display boards and information leaflets. We saw information displayed on topics such as smoking cessation, healthy eating, drugs, and infection prevention and control.

A range of patient information leaflets were available for patients and families. These included those on preventing blood clots, preventing bed sores and pressure ulcers, and medicines management. However, we noted that a number of these had past their review date.

At the location, we also saw post-operative patient information available to patients within surgical specialities. For example, on topics such as dressing and wound care advice, and postoperative advice following carpal tunnel decompression.

Support was available for patients with smoking cessation which was discussed with patients as appropriate. There were also procedures in place to support patients withdrawing from drugs or alcohol, and the pharmacist gave advice and support when necessary.
Mental Capacity Act and Deprivation of Liberty training completion

Trust level

The trust reported that as of June 2018 Mental Capacity Act (MCA) training was completed by 87.2% of staff in surgical care at trust level compared to the trust target of 80%.

MCA training was completed by 96.8% of nursing and midwifery staff in surgery services. A breakdown of MCA training modules for nursing and midwifery staff at trust level is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
<td>Number</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
<td>eligible staff</td>
<td>rate (%)</td>
<td>target (%)</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act level 1</td>
<td>341</td>
<td>348</td>
<td>98.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>319</td>
<td>334</td>
<td>95.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

MCA training level 2 training was completed by 68.4% of medical staff in surgery services. Only level 2 MCA training was completed by medical staff as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
<td>Number</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
<td>eligible staff</td>
<td>rate (%)</td>
<td>target (%)</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>462</td>
<td>675</td>
<td>68.4%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust reported that as of June 2018 Mental Capacity Act (MCA) training was completed by 83.6% of staff in surgical care at Leeds General Infirmary compared to the trust target of 80%.

MCA training was completed by 98.3% of nursing and midwifery staff in surgery services. A breakdown of MCA training modules for nursing and midwifery staff at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
<td>Number</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
<td>eligible staff</td>
<td>rate (%)</td>
<td>target (%)</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act level 1</td>
<td>100</td>
<td>100</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>134</td>
<td>138</td>
<td>97.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

MCA training level 2 training was completed by 70.4% of medical staff in surgery services. Only level 2 MCA training was completed by medical staff as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
<td>Number</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
<td>eligible staff</td>
<td>rate (%)</td>
<td>target (%)</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>347</td>
<td>493</td>
<td>70.4%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)
Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We saw that the trust had an up to date policy dealing with consent and mental capacity.

Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. At our previous inspection in 2016, we found that consent to surgery was most often done on the day of surgery, and that patients didn’t always get a copy of their consent form.

At our recent inspection, records we reviewed showed that patients had given both verbal and written consent to surgery in line with trust policies and procedures and best practice and professional standards; however, we observed that patients were not always provided with a copy of their consent form when discharged (as these sometimes remained in patients’ notes).

We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients. First and second stage consent was adhered to for both elective and acute admissions.

The trust provided us with the corporate audit report, consent audit for quarter two 2017/18 (dated to November 2017). It was expected that each specialty identified 10 cases where consent had been obtained from patients in relation to the care and treatment provided to them using the trust consent form 1, 2 or 4 (patient agreement to investigation or treatment). As of November 2017, 31 (76%) specialties uploaded findings to the Clinical Audit Database. The trust provided a sample of consent audit results.

Plastic surgery specialty consent audit results showed good performance overall (for example, in relation to health professional completion, evidenced discussion of risk and benefits, and patient signature). However, in 30% of cases patients had not printed their name, and issues were identified with confirmation of signed consent. The data was not dated so we could not establish when this audit was undertaken; but it appeared to be part of the 2017/2018 audit.

Trauma and orthopedic specialty consent audit results were undertaken July to September 2018; using the Trust Mandatory Audit Toolkit for 2018/2019. The results showed good health professional completion, evidenced discussion of risk and benefits, and patients signing and printing their names. However, areas for improvement were identified around consent for the procedure to be done by the operating HCP, and HCP consenting for the procedure not being undertaken by them have relevant training to consent for the particular procedure (30%).

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff we spoke with were able to give a clear explanation about capacity assessment and the importance of recognising how ill health can impact on a patient’s capacity.

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff we spoke with were able to give a clear explanation about capacity assessment and the importance of recognising how ill health can impact on a patient’s capacity. Staff we spoke with were aware of the legislation around Deprivation of Liberty Safeguards (DoLs); and how to make a referral. Staff said that support was available from the safeguarding team if required.

From April 2017 to March 2018, 166 deprivation of liberty safeguard referrals were made from surgical core services areas across the trust. Of these, 81 were made from surgical core services areas at Leeds General Infirmary.

Staff told us that there was often a delay once the DoLS application was submitted, and local authorities struggled to meet the timeline of reviewing the patient between seven and 14 days.
The trust had implemented a flowchart for staff to follow if this occurred. Staff we spoke with said that they had access to mental health referral pathways and would use these if they had concerns about any patients.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of care records in line with national best practice.

The trust informed us that they have implemented a new digital way to ensure patients’ wishes about their care in an emergency are known, shared and respected. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is an emergency care plan to support conversations and record recommendations arising from discussion between clinician and patient or those close to the patient. The trust informed us that the data is easily accessible by all clinicians at Leeds Teaching Hospitals, and by other healthcare organisations in Yorkshire.

**Is the service caring?**

**Compassionate care**

We spoke with 21 patients in assessment units, and on surgical wards and in theatre areas at the location. On the vast majority of occasions, patients said they were happy with their care; and many expressed that staff were working exceptionally hard to deliver good quality care.

For example, patients commented that: “staff are wonderful”, “staff are brilliant, absolutely lovely”, “staff are pleasant”, “good service”, “staff are brilliant, food is brilliant, atmosphere is brilliant”, “the staff are brilliant, I couldn’t fault any of them”, “I’m more than happy to be here”, and “it’s been really nice and staff are helpful”.

A handful of patients (situated on orthopaedic wards) expressed that they had a mixed experienced. For example, these patients commented that “most staff have been lovely … one member of staff was a bit rude on the first day”, “not impressed by ward … staff are abrupt at night”, and “some staff are nice, some not so nice”.

During our inspection, we saw patient buzzers were typically answered quickly. Similarly, when asked, most patients we spoke with did not raise any complaints about the promptness of staff attending to their needs. However, a handful of patients did respond that “sometimes staff attend promptly, sometimes delayed”, and some noted they felt this occurred more frequently on a night time.

Patients who expressed negative responses typically caveated these with descriptions of what they perceived to be the reasons for their mixed experience. For example, “sometimes carers and nurses are rushed off their feet”, and “could do with a few more staff”.

We observed numerous thank you cards displayed on notice boards across wards visited. For example, on a major trauma ward we noted a particularly touching comment from a recent inpatient that read: “every member of staff has been so friendly and helpful. Nothing was too much trouble. I’ve never before come across a group of people who were so like-minded, in that every time I dealt with someone I felt I was the only person that mattered”.

We viewed some recent neuro-surgery inpatient ward FFT responses, which were generally very positive. For example, a patient thanked the “kind, caring staff who have been amazing throughout my treatment”.

During our visit, we observed staff use doors and curtains to enhance patient privacy and dignity. All patients questioned said they were treated with dignity and respect; and had their privacy maintained.

Monthly ward Health-check data for Trauma and Related Services CSU showed that from July 2017 to July 2018, wards achieved 98% compliance for patient dignity. Over the same period, Centre for Neurosciences CSU data showed they too achieved 98% compliance for patient dignity.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

We saw that the Theatres and Anaesthetics CSU had trialled a new patient feedback form that included written comments from patients, to gain more insight and detail into patients’ experiences and perspectives. This included deeper dive survey work that showed all patients (100%) felt comfortable during their time in theatre, and all (100%) indicated they were treated with dignity and respect. Written were overwhelmingly positive and included comments such as: “Staff very understanding efficient, polite & caring. Thank you all very much!”, “treated very well, very pleased.”, and “kind and helpful staff all round”.

**Friends and Family test performance**

The friends and family test (FFT) response rate for surgery at Leeds Teaching Hospitals NHS Trust was 40% which was better than the England average of 28%.

A breakdown of response rate by site can be viewed below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total responses</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapel Allerton</td>
<td>1,233</td>
<td>34%</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>7,867</td>
<td>38%</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>11,813</td>
<td>42%</td>
</tr>
</tbody>
</table>

A breakdown of the proportion of patients who would recommend Leeds General Infirmary for surgery by ward/unit is shown below:
## Percentage recommended

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>L46 Hand &amp; Plastic Day Unit</td>
<td>1,294</td>
<td>32%</td>
<td>95%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>85%</td>
<td>99%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>97%</td>
<td>50%</td>
<td>97%</td>
</tr>
<tr>
<td>L27 Plastic, Trauma and Vascular Day Case</td>
<td>1,194</td>
<td>42%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
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<td>94%</td>
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<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>L28 Surgical Day Unit</td>
<td>882</td>
<td>32%</td>
<td>100%</td>
<td>88%</td>
<td>87%</td>
<td>92%</td>
<td>93%</td>
<td>88%</td>
<td>84%</td>
<td>87%</td>
<td>84%</td>
<td>78%</td>
<td>78%</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>L23 ENT/Auristo-Facial</td>
<td>770</td>
<td>40%</td>
<td>97%</td>
<td>99%</td>
<td>100%</td>
<td>93%</td>
<td>93%</td>
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<td>99%</td>
</tr>
<tr>
<td>L22 Adult Plastic Surgery</td>
<td>801</td>
<td>40%</td>
<td>95%</td>
<td>96%</td>
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<td>96%</td>
<td>93%</td>
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<td>94%</td>
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</tr>
<tr>
<td>L15 Vascular Ward</td>
<td>530</td>
<td>59%</td>
<td>89%</td>
<td>95%</td>
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<td>99%</td>
<td>92%</td>
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<tr>
<td>L10 Major Trauma</td>
<td>432</td>
<td>54%</td>
<td>95%</td>
<td>56%</td>
<td>92%</td>
<td>97%</td>
<td>92%</td>
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<td>99%</td>
<td>97%</td>
<td></td>
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</tr>
<tr>
<td>L16 Cardiac Surgery/Vascular</td>
<td>440</td>
<td>43%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>96%</td>
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<td>103%</td>
<td>99%</td>
<td>96%</td>
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<td>99%</td>
</tr>
<tr>
<td>L24 Neuro Cranial&amp;Orho Spine</td>
<td>383</td>
<td>32%</td>
<td>97%</td>
<td>100%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
<td>92%</td>
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<td>92%</td>
<td>88%</td>
<td>89%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>L25 Neuro Cranial&amp;Orho Spine</td>
<td>209</td>
<td>29%</td>
<td>96%</td>
<td>95%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
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<td>97%</td>
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<td>94%</td>
<td>94%</td>
<td>97%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L35 Trauma &amp; Orthopaedics</td>
<td>204</td>
<td>30%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
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<td>80%</td>
<td>100%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>L28 Multi-Specialty Assessment</td>
<td>191</td>
<td>N/A*</td>
<td>97%</td>
<td>95%</td>
<td>83%</td>
<td>64%</td>
<td>82%</td>
<td>83%</td>
<td>87%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>L27 Multi-Specialty Assessment</td>
<td>169</td>
<td>55%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>L37 Trauma &amp; Orthopaedics</td>
<td>164</td>
<td>37%</td>
<td>92%</td>
<td>91%</td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
<td>75%</td>
<td>100%</td>
<td>75%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>LEVO Endovascular Laser Daycase LCI</td>
<td>157</td>
<td>45%</td>
<td>97%</td>
<td>97%</td>
<td>90%</td>
<td>91%</td>
<td>92%</td>
<td>100%</td>
<td>88%</td>
<td>100%</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>L34 Trauma &amp; Orthopaedics</td>
<td>138</td>
<td>38%</td>
<td>93%</td>
<td>86%</td>
<td>100%</td>
<td>93%</td>
<td>94%</td>
<td>100%</td>
<td>88%</td>
<td>100%</td>
<td>90%</td>
<td>85%</td>
<td>93%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Highest score to lowest score**

- 100%
- 50%
- 0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

*The response rate for L26 (multi-specialty assessment) was not available. The trust incorrectly entered a number of eligible patients smaller than the total number of responses.

From May 2017 to April 2018 the overall percentage of patients that would recommend the service was over 90% on every surgical ward at Leeds General Infirmary, except for the surgical day unit (L28) and the multi-specialty assessment unit (L26) which both had an overall recommend rate of 87%.

The multi-specialty assessment unit (L26) also reported the lowest monthly score of 64% in November 2017. This equated to 18 patients who said they would recommend the ward, seven who said they would not, and three who said they would neither recommend not recommend it (28 responses in total).

*(Source: NHS England Friends and Family Test)*

We reviewed Trauma and Related Services CSU Governance Meeting minutes from April to June 2018, and saw FFT responses were regularly discussed. For example, in the May 2018 minutes, it was documented that recommendation rates were low for L26 (at 82.8%), with the proportion of patients who did not recommend the service, high at 15.5%. Recommendation rates were also noted to be low on ward L34 at 85%. In the June 2018 minutes, it was noted that response rates were low on L26 and recommendations were low on L35. Comments for L22 were reviewed;
these were mainly good but a couple of negative comments about cleanliness (dirty bed, food on handrail, dried custard on tray) and staff attitude and lack of communication with staff were discussed. It also stated that “L34 comments were largely very good in view of the regular feedback”.

In the Centre for Neurosciences CSU we saw regular discussion of FFT response and recommendation rates had occurred, and the presentation of an embedded FFT dashboard; which detailed data at ward level.

**Emotional support**

We saw that ward managers and other more senior members of ward staff were visible on wards and relatives and patients were able to speak with them.

During our inspection we observed staff on wards and in theatres providing emotional support and reassurance to patients to minimise their distress. Overwhelmingly, patients, families and carers told us that they felt they received good emotional support from staff; for example, they felt “supported” and “reassured”.

A multi-faith chaplaincy service was available for patients. The chaplaincy team had members from the Christian, Jewish, Muslim, Hindu, Sikh, Buddhist and Humanist faith and belief traditions. We also saw there was a variety of chapels, prayer and quiet rooms available to meet the needs of different spiritual beliefs.

There was a bereavement service in place at the trust, who worked alongside the chaplaincy team and faith communities to help ensure the needs of patients and their families were met.

Staff explained that each ward has a mental health link nurse. Staff reported that although mental health link nurses might not be based on the same ward, that they were available for advice and support when needed.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, seven days a week with all adult patients.

A variety of clinical nurse specialists were available within the surgical service, and attended wards to provide additional support and advice to patients.

At handover meetings we observed, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

As part of an ‘always event’ campaign in 2017/18, the Theatres and Anaesthetics CSU had examined feedback from PALS, complaints data & Picker inpatient survey to develop a patient feedback questionnaire around ‘before and while you sleep’ themes. We saw that the Theatres and Anaesthetics CSU had trialled a new patient feedback form that included written comments from patients, to gain more insight and detail into patients’ experiences and perspectives. Written responses were overwhelmingly positive and included comments such as: “I was very nervous & the theatre staff were very sensitive to that & put me at ease & the whole operation experience was much easier. Thank you everyone!”, and “the staff in both anaesthetic & recovery rooms were very friendly & reassuring”.

We were informed of the Red Cross charity service (social charity) which staff said was an invaluable source for discharge facilitation. The service assisted with arranging meals, house key retrieval service, shopping assistance, and befriending; this supported and provided reassurance for patients nearing discharge. We were also given examples of how the service had gone above
and beyond for patients, for example, by arranging to feed the pets of patients in hospital, who had no one else to do this for them.

**Understanding and involvement of patients and those close to them**

We observed at staff handovers and from interactions staff had with patients that staff discussed patient needs and the needs of those close to them.

For instance, on one (orthopaedic) ward we observed how staff attended to a patient with dementia who was visibly upset, the staff gave reassurance and communicated this to the patient’s family and relatives at visiting time. Staff offered flexible visiting times for this patient’s family members.

We saw dementia awareness boards in a number of areas at the location (including surgical wards) that displayed information about the care needs of people living with dementia.

We saw evidence in patient records that patients and their relatives had been involved in making decisions about their care and treatment. Where applicable, we saw that relatives were involved in care planning and discharge arrangements for patients.

When we spoke with patients they told us that they knew what their planned care was for, had been informed in a way they could understand, and had felt involved in decision making. For example, a patient on a trauma ward awaiting elective surgery said they were “happy with care” and had been “kept informed” about the structure of the day and how long they might have to wait.

Patients we spoke with on orthopaedic wards often commented that they had received good explanations and had been given the opportunity to ask questions. For example, “doctors explained everything in simple a simple way, so it was easy to understand … could ask questions”, “doctors explain everything without the jargon”, and staff have “been good and don’t leave you in the dark”.

We saw that the Theatres and Anaesthetics CSU had trialled a new patient feedback form that included written comments from patients, to gain more insight and detail into patients’ experiences and perspectives. This included deeper dive survey work that showed 95% of patients surveyed said that medical procedures were explained in a way they understood; and 100% said they felt comfortable asking for explanations of anything they did not understand.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Surgical service CSUs provided elective (planned) and non-elective (acute) surgical treatments for patients.

The leadership team described a number of ways in which the service had been designed to meet the needs of local people following discussions with local commissioners; and the trust was home to a number of tertiary referral centres for the region. These included the major trauma centre for the region.

There was collaborative working between NHS trusts, universities and the local authority to improve patient outcomes.
We also saw the trust had been working with charities to supply the hospital with clothing for patients to wear during their stay. In Bexley wing at St James’s University Hospital, there was a boutique where patients could also use clothes that had been donated.

**Average length of stay**

**Leeds General Infirmary - elective patients**

From March 2017 to February 2018 the average length of stay for all elective patients at Leeds General Infirmary was 4.9 days, which was longer than the England average of 3.9 days.

Two of the top three elective specialties (based on count of activity) had a longer length of stay than the England average (spinal surgery and neurosurgery). The non-elective length of stay for plastic surgery was similar to the England average.

**Elective Average Length of Stay - Leeds General Infirmary**

![Graph showing average length of stay for elective patients at Leeds General Infirmary.](Note: Top three specialties for specific site based on count of activity.)

**Leeds General Infirmary - non-elective patients**

The average length of stay for all non-elective patients at Leeds General Infirmary was 9.2 days, which was longer than the England average of 4.9 days.

Two of the top three non-elective specialties (based on count of activity) had a longer length of stay than the England average (trauma and orthopaedics and plastic surgery). The non-elective length of stay for ENT was similar to the England average.

**Non-elective average length of stay - Leeds General Infirmary**

![Graph showing average length of stay for non-elective patients at Leeds General Infirmary.](Note: Top three specialties for specific site based on count of activity.)

(Source: Hospital Episode Statistics)

However, we acknowledge that these statistics are based on count of activity, and do not necessarily reflect the complexity of activities undertaken.
Meeting people’s individual needs

Assessments took place on admission and during pre-assessment to identify individual patient’s needs and this information was used to inform care planning. We were assured that staff were aware and responsive to the needs of different people.

We saw a wide range of literature and resources available for people living with and caring for people with a dementia. The trust had a lead nurse for dementia and patients were screened on admission for dementia, depression or delirium.

We saw on a neurosurgery ward that areas were painted with coloured stripes to help people with dementia identify different areas and bays.

We spoke with staff on orthopaedic wards who discussed the completion of dementia awareness training; and some staff described being a ‘dementia friend’ (Alzheimer’s Society initiative).

Wards and patient areas were accessible for people who used a wheelchair or walking aids. Disabled toilets and showering facilities were available in all the areas inspected.

The trust’s electronic systems permitted staff to flag patients with a learning disability. In addition, symbols were used on boards next to patients’ bedsides to identify patients’ needs, such as learning disabilities or living with dementia.

The trust told us they had a dedicated lead nurses for learning disabilities and autism and hidden disabilities. Staff we spoke with felt confident in caring for patients who may need additional support.

Side rooms were used for patients who were particularly anxious, living with severe autism or a learning disability, or those patients who needed isolation. Staff told us a MDT meeting was held to plan these admissions. This minimised distress to the patient as far as possible.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that Leeds General Infirmary scored 88.16% for disability domain and 76.25% for dementia domain. However, results were at hospital level, and not necessarily related to surgical services.

Staff on wards gave examples of reasonable adjustments made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients’ care and emotional needs. This was confirmed through feedback from patients and relatives during the inspection.

On the major trauma ward, we saw that staff had initiated a “Day One, Trauma care starts here” support package. This was a package of care aimed at supporting people with severe and life changing injuries, and their families; and weekly clinics were held on the ward to facilitate this. The package gave people free professional legal services and welfare benefits advice, and peer support. The peer support element was offered by ex-patients who had travelled the trauma journey and had volunteered to talk to patients and their families and share their experiences.

Each patient had a board at their bedside which indicated their preferences, for example what they liked to be called and dietary requirements. Different food choices and chaplaincy for different religions and faiths were available.

Staff were proactive in planning for the needs of bariatric patients. This was identified at pre-assessment and all necessary equipment was obtained in advance of surgical procedure.

Patients with diabetes were put on a specific insulin care plan and there was mandatory training on insulin administration.
A discharge team worked with other agencies and social services to develop packages of care, taking mental health needs into consideration.

Translation services were available and staff knew how to access these. Information leaflets were available for patients; however, we could not see these readily available in languages other than English. Nevertheless, we were informed that the trust had an online system where patients could request translation of information. We did not see any patients that required the use of a translating service at the location during our inspection, however, staff told us of specific examples when they had used the service.

**Access and flow**

We carried out a focused inspection in December 2017, due to concerns raised regarding the safe use of additional beds in non-designated areas during times of increased demand at the hospital. During our recent visit, we observed beds in non-designated areas; however, we did not see any of these in use. Staff told us that they had not recently had any extra patients in non-designated areas since the winter months.

Patient flow coordinators were in place to help manage the flow through the wards. Representatives from surgical services at the location attended a daily operational (DOP) meeting. This was a multidisciplinary forum, where access and flow throughout the location was discussed; for example, in relation to surgical ward capacity. Representatives from the theatres and anaesthetics CSU also attended to discuss emergency lists, and strategies to manage elective and non-elective surgical capacity.

We spoke with patient discharge clerks at the location, who helped facilitate the flow and discharge of patients. Several ward staff we spoke with commended their work, and commented that their appointment had been of tremendous benefit to help improve flow within the system.

We also observed other initiatives to improve patient flow and discharge planning and facilitation in the service. For example, staff we spoke with discussed the use of electronic discharge advice notes (EDAN), which included patient tablets to take out (TTO) on discharge and a GP discharge summary letter. We saw that an initiative called the ‘golden patient’ had been implemented, which worked toward patients being discharged before 12 midday. We were also informed of the Red Cross charity service (social charity) which staff said was an invaluable source for discharge facilitation. This service assisted with arranging meals, house key retrieval service, shopping assistance and befriending.

We saw that the service had developed a fractured neck of femur pathway to improve theatre efficiency. We reviewed a pilot summary report (dated to April 2018) and saw that the theatre service had mapped and audited observational data to identify bottle necks in the system; for example, number of patients operated on per day and time to theatre. After implementing measures to improve efficiency we saw that results from one week’s worth of auditing indicated several improvements. The service planned to monitor the initiative, assess turnaround times throughout the rest of the theatre list, and apply lessons learned to other theatres.

**Bed occupancy**

The trust provided data that showed the number and proportion of beds at the location occupied at midnight, as of 24 August 2018. Data showed a 93.7% midnight occupancy rate at the site.
Theatre Utilisation

The trust provided data that showed average theatre utilisation at the location from August 2017 to July 2018; average monthly session usage was 92%, and in-session utilisation 78% over the period.

Referral to treatment (percentage within 18 weeks) - admitted performance

From June 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average and from January 2018 to May 2018 was better than the England average.

The trust’s performance was generally consistent over time. In the most recently reported month (May 2018) 76% of patients were treated within 18 weeks compared to the England average of 67%.

(Source: NHS England)

We saw that non-compliance for 18-week RTT target was entered on the corporate risk register. The entry noted that failure to achieve targets was caused by demand exceeding planned levels of activity, insufficient capacity at specialty level in key areas, and the impact of acute flows on elective capacity.

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of RTT rates for surgery broken down by specialty is below. Of these, five specialties were above the England average:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>93.7%</td>
<td>80.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>88.3%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>87.9%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>76.8%</td>
<td>70.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>64.9%</td>
<td>63.4%</td>
</tr>
</tbody>
</table>

Four specialties had RRT rates that were below the England average. Two of these, plastic surgery (2.4% below England average) and trauma and orthopaedic surgery (2.4% below the England average), relate to services provided at the location. However, as indicated, these were only marginally below national averages:
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>79.3%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.8%</td>
<td>76.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.3%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>58.3%</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Leeds Teaching Hospitals NHS Trust

The percentage of patients whose operation was cancelled and were not treated within 28 days was consistently higher than the England average from April 2016 to March 2018. Performance deteriorated over time with particularly poor performance reported from October 2016 to March 2017 and from January to March 2018.

Cancelled Operations as a percentage of elective admissions - Leeds Teaching Hospitals NHS Trust

Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust was consistently above the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

We reviewed the corporate risk register (June 2018). An entry described that there was a risk that the trust does not achieve the 28-day cancelled operations target due to acute activity pressures, critical care capacity, availability of theatre time, patient flow and elective bed availability.

At our last inspection of surgical services at the trust, we were told by several staff that a lack of
critical care beds had had a significant impact on theatres. Following our recent inspection, we requested cancelled operations data from the trust. As shown below, data showed that from August 2017 to July 2018, 1.5% of all operations at the location were cancelled due to critical care capacity. We also saw that critical care bed capacity had been substantially increased at the location since our last inspection of the service. The most common reasons for cancelled operations were theatre scheduling (7.6%) and ward bed capacity (3.2%).

From August 2017 to July 2018, data showed that 15.2% of all operations at the location were cancelled. The location is a major trauma centre for the region, hence, might experience more cancelled elective operations due to the non-elective demand and acuity.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Number or proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cancelled operations</td>
<td>3450</td>
</tr>
<tr>
<td>Total operations completed</td>
<td>19269</td>
</tr>
<tr>
<td>Total percentage cancelled</td>
<td>15.2%</td>
</tr>
<tr>
<td>operations</td>
<td></td>
</tr>
<tr>
<td>Critical care capacity</td>
<td>1.5%</td>
</tr>
<tr>
<td>Failure of equipment</td>
<td>0.5%</td>
</tr>
<tr>
<td>No anaesthetist</td>
<td>0.3%</td>
</tr>
<tr>
<td>No operator</td>
<td>0.7%</td>
</tr>
<tr>
<td>Ran out of theatre time</td>
<td>1.0%</td>
</tr>
<tr>
<td>Scheduling</td>
<td>7.6%</td>
</tr>
<tr>
<td>Theatres</td>
<td>0.4%</td>
</tr>
<tr>
<td>Ward bed capacity</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

We reviewed minutes for the trust risk management committee meetings. In the April 2018 minutes we saw discussion of risks around delivery of the cardiac surgery service. This risk was described on the corporate risk register (ranked at 16). It was noted that 18-week RTT had been sustained, and the number of cancellations had reduced from 30% to 14%. It noted this would be the subject of a Leeds Improvement Method value stream commencing June 2018.

**Out of hours operations**

At our previous inspection of the service in 2016, we observed that routine operations out of hours were taking place at the trust (at St James University Hospital).

Following our recent inspection, we saw a standard operating procedure for acute surgery out of hours was in place at the trust (published March 2017, amended/reviewed August 2018). We also requested out of hours operation data for a 12-month period; this was provided for the period March 2017 to March 2018.

We reviewed data provided by the trust and found 150 out of hours operations had taken place at the location from March 2017 to March 2018. Data showed the categories of procedures undertaken. We saw categories of operations listed appeared to relate to immediate and urgent procedures only.

**Outliers**

Following our inspection, the trust provided us with data that showed the number of patients (spells) where the patient was an outlier at any point during their spell (when the 8am snapshot was taken) for a 12-month period (August 2017 to July 2018). When a patient had multiple outlier stays within the spell, only the first spell was counted. Data was based on the first outlier period (spell). Therefore, it does not show outlier data pertaining to second spells (for example, multiple moves), nor does it tell us how long the outlier stay was for.
The data below shows surgical outliers on non-surgical (medicine) wards for the period August 2017 to July 2018. Data shows on which CSU (medicine ward), and at which location, surgery patients were placed.

<table>
<thead>
<tr>
<th>CSU</th>
<th>LGI</th>
<th>SJUH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Medicine and Surgery</td>
<td>5</td>
<td>69</td>
<td>74</td>
</tr>
<tr>
<td>Cardio-Respiratory</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Centre for Neurosciences</td>
<td>15</td>
<td>28</td>
<td>43</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>36</td>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>Institute of Oncology</td>
<td>1</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Trauma and Related Services</td>
<td>64</td>
<td>23</td>
<td>87</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123</strong></td>
<td><strong>138</strong></td>
<td><strong>261</strong></td>
</tr>
</tbody>
</table>

The data below shows outliers on surgical wards for the period August 2017 to July 2018. These relate to patients under the care of other service areas who were based on a surgical ward. Data showed the CSU, and location, from which ‘non-surgical’ area (CSU) the patient came. As can be seen, this data shows 450 ‘non-surgical’ patients were placed on surgical wards at this location over a 12-month period; according to the criteria described earlier (8am ‘snap shot’, ‘first spell’).

At this location, most ‘non-surgical’ patients placed on surgical wards came from cardio-respiratory (n161, 36%) and centre for neuroscience (n144, 32%) CSUs.

<table>
<thead>
<tr>
<th>CSU</th>
<th>LGI</th>
<th>SJUH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Medicine and Surgery</td>
<td>29</td>
<td>46</td>
<td>75</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>20</td>
<td>530</td>
<td>550</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cardio-Respiratory</td>
<td>161</td>
<td>161</td>
<td>322</td>
</tr>
<tr>
<td>Centre for Neurosciences</td>
<td>144</td>
<td>2</td>
<td>146</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>3</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Emergency and Specialty Medicine</td>
<td>71</td>
<td>2534</td>
<td>2605</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Institute of Oncology</td>
<td>17</td>
<td>40</td>
<td>57</td>
</tr>
<tr>
<td>Women’s</td>
<td>4</td>
<td>202</td>
<td>206</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>450</strong></td>
<td><strong>3538</strong></td>
<td><strong>3988</strong></td>
</tr>
</tbody>
</table>

Further investigation of the data showed that, the greatest number of (‘first spell’) ‘non-surgical’ patients were placed on surgical wards L23 (ENT, oral max fax, and spinal) (35%), L15 (vascular) (22%), and L22 (plastics) (12%).

<table>
<thead>
<tr>
<th>LGI surgical ward/unit</th>
<th>Number of ‘first spell’ outliers ‘8am snap shot’</th>
<th>Proportion of ‘first spell’ outliers ‘8am snap shot’</th>
</tr>
</thead>
<tbody>
<tr>
<td>L23</td>
<td>157</td>
<td>34.9%</td>
</tr>
<tr>
<td>L15</td>
<td>101</td>
<td>22.4%</td>
</tr>
<tr>
<td>L22</td>
<td>55</td>
<td>12.2%</td>
</tr>
<tr>
<td>L24</td>
<td>49</td>
<td>10.9%</td>
</tr>
<tr>
<td>L35</td>
<td>31</td>
<td>6.9%</td>
</tr>
<tr>
<td>L25</td>
<td>28</td>
<td>6.2%</td>
</tr>
<tr>
<td>L37</td>
<td>19</td>
<td>4.2%</td>
</tr>
<tr>
<td>L16</td>
<td>9</td>
<td>2.0%</td>
</tr>
<tr>
<td>L26</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>450</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Bed moves at night

From April 2017 to March 2018, the trust reported 1172 ward moves at night (between 22:00 and 08:00) within surgical services at Leeds General Infirmary. As shown in the table below, the greatest proportions of these occurred on the vascular (13.3%), multi-speciality assessment (9.9%), and neuro cranial and orthopaedic spine wards (9.1% and 8.4%).

<table>
<thead>
<tr>
<th>LGI surgical ward/unit</th>
<th>Number of ward moves at night</th>
<th>Proportion of total ward moves at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>L15</td>
<td>156</td>
<td>13.3%</td>
</tr>
<tr>
<td>L27</td>
<td>116</td>
<td>9.9%</td>
</tr>
<tr>
<td>L24</td>
<td>107</td>
<td>9.1%</td>
</tr>
<tr>
<td>L25</td>
<td>99</td>
<td>8.4%</td>
</tr>
<tr>
<td>L22</td>
<td>97</td>
<td>8.3%</td>
</tr>
<tr>
<td>L28</td>
<td>90</td>
<td>7.7%</td>
</tr>
<tr>
<td>L10</td>
<td>89</td>
<td>7.6%</td>
</tr>
<tr>
<td>L35</td>
<td>86</td>
<td>7.3%</td>
</tr>
<tr>
<td>L23</td>
<td>84</td>
<td>7.2%</td>
</tr>
<tr>
<td>L16</td>
<td>75</td>
<td>6.4%</td>
</tr>
<tr>
<td>L34</td>
<td>66</td>
<td>5.6%</td>
</tr>
<tr>
<td>L37</td>
<td>40</td>
<td>3.4%</td>
</tr>
<tr>
<td>L16H</td>
<td>39</td>
<td>3.3%</td>
</tr>
<tr>
<td>L46</td>
<td>22</td>
<td>1.9%</td>
</tr>
<tr>
<td>L26</td>
<td>5</td>
<td>0.4%</td>
</tr>
<tr>
<td>LRAD</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1172</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Of these, most occurred on L15 Vascular Ward (13%, n156), L27 Multi Speciality assessment (10%, n116), and L24 and L25 Neuro Cranial and Ortho Spine wards (9% and 8% respectively).

Delayed discharges

From April 2017 to March 2018, the trust reported 2.3% of discharges across surgical services at Leeds General Infirmary were delayed. Trauma and related services CSU surgical wards experienced the greatest proportion of delayed discharges, which ranged from 1.6% to 16.6%.

<table>
<thead>
<tr>
<th>LGI surgical ward/unit</th>
<th>Number of discharges</th>
<th>Number of delayed discharges</th>
<th>Proportion of discharges delayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>L37</td>
<td>457</td>
<td>76</td>
<td>16.6%</td>
</tr>
<tr>
<td>L34</td>
<td>402</td>
<td>42</td>
<td>10.4%</td>
</tr>
<tr>
<td>L35</td>
<td>696</td>
<td>48</td>
<td>6.9%</td>
</tr>
<tr>
<td>L15</td>
<td>927</td>
<td>15</td>
<td>1.6%</td>
</tr>
<tr>
<td>L24</td>
<td>1136</td>
<td>10</td>
<td>0.9%</td>
</tr>
<tr>
<td>L22</td>
<td>1552</td>
<td>13</td>
<td>0.8%</td>
</tr>
<tr>
<td>L23</td>
<td>1714</td>
<td>11</td>
<td>0.6%</td>
</tr>
<tr>
<td>L25</td>
<td>967</td>
<td>6</td>
<td>0.6%</td>
</tr>
<tr>
<td>L28</td>
<td>769</td>
<td>4</td>
<td>0.5%</td>
</tr>
<tr>
<td>L16</td>
<td>1316</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9936</strong></td>
<td><strong>226</strong></td>
<td><strong>2.30%</strong></td>
</tr>
</tbody>
</table>
Learning from complaints and concerns

The trust had a complaints policy which was located on the intranet for staff to access if needed. We saw that wards and areas we visited had a complaints process that addressed both formal and informal complaints.

We saw posters and information leaflets displayed in ward areas about how to raise a concern; and information was also available on the trust website.

We spoke with staff who could tell us about the complaints process and how they would manage a complaint. Staff told us about some complaints and lessons learnt from these; although, they said many of the complaints tended to relate to waiting times and appointments for surgery, and cancellations.

We saw that the Theatres and Anaesthetic CSU had worked to thematically analyse and act on patients’ complaints and concerns. ‘Always events’ involve those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system. As part of an ‘always event’ launch (September 2018), the Theatres and Anaesthetics CSU had examined feedback from PALS, complaints data & Picker inpatient survey to develop a patient feedback questionnaire around ‘Before and while you sleep’ themes.

We saw evidence of discussion of patients’ complaints and concerns in the Centre for Neurosciences CSU Clinical Governance Meeting minutes. Minutes included embedded documents detailing specific concerns, and updates as to progress. For April and March 2018, the top three complaints and concerns included: Waiting times and appointments for surgery, clinical care and information given by medical and nursing staff, and staffing concerns expressed by families.

We also saw evidence of discussion of patients’ complaints and concerns in the Trauma and Related Services CSU Governance Meeting minutes. We saw in the June 2018 meeting minutes that 21 PALS were reported in May 2018. Themes included waiting times, cancelled surgery, difficulty in get appointments. We also saw that the service had previously analysed four complaints received about the attitude of staff on a specific ward (L22), and that a complainant had agreed to attend a study day on the ward to share their story.

Ward managers we spoke with were aware of themes and trends from complaints. Staff we spoke with said that learning from complaints was shared within teams through various methods, these included team meetings and safety huddles.

Summary of complaints

From May 2017 to April 2018 there were 58 complaints about surgical care at Leeds General Infirmary. Where the complaint had been closed the trust took an average of 70.6 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 40 days.

The trust has allocated multiple subjects to each complaint received. It is therefore not possible to provide number of complaints per subject.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust
From May 2017 to April 2018, there were 21 compliments within surgery at Leeds General Infirmary. The most common specialties receiving compliments were:

- Trauma and orthopaedics – seven (33.3%)
- Plastic surgery – five (23.8%)
- Neurosurgery - four (19.0%)
- Cardiac surgery – three (14.3%)

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Each CSU was led by a clinical director, general manager and head of nursing; the clinical director had overall responsibility for the CSU. We met with members and representatives of the senior leadership team from three CSUs at this location: Trauma and Related Services, Centre for Neurosciences, and Theatre and Anaesthetics.

Due to the sizes of CSUs, there were various matrons that covered different speciality areas. With the exception of those in the Theatre and Anaesthetics CSU, many covered both surgical and medical wards. The CSUs worked closely with other, we spoke with some matrons who told us they would cover and support other matrons within their CSU.

Matrons we spoke with during our visit told us they provided support to clinical areas and would visit wards daily to review the staffing and identify any issues that required to be escalated. Matrons attended the daily staffing meetings and provided feedback to the director of operations chairing the meetings.

Ward managers and charge nurses said they had constructive and positive relationships with matrons and that they visited wards daily. Staff felt managers communicated well and kept them informed about the management of the wards and service changes.

Staff were encouraged to undertake professional development and received annual appraisals. We saw there was a workforce strategy and people strategy in place at the trust. These outlined development opportunities and pathways for clinical staff; including leadership development.

At ward level, most staff said they were well supported by their managers, they were visible and provided clear leadership.

Most staff told us they would be confident to raise a concern with their managers, and were confident this would be investigated appropriately.

Vision and strategy

CSUs strategies adhered to the trust’s main vision, which was commitment to delivering the highest quality and safest treatment and care to every patient, every time.

The trust vision was supplemented by the five trust goals: to be the best for patient safety, quality and experience; to be the best place to work; to be a centre of excellence for specialist services, research, education and innovation; to offer seamless, integrated care; and to be financially sustainable.
Vision and strategies were supported by the ‘Leeds Way’ values; offering patient centred care, and being fair, collaborative, and accountable. We saw posters throughout the wards and areas outlining the ‘Leeds Way’ were on display giving information to patients and staff about the trust’s values and expected behaviours.

We saw each CSU had its own 2017/18 clinical business strategy, each outlined key quality measures and current performance. We saw each contained a vision for service delivery, subdivided by speciality. For example, in the Trauma and Related Services CSU Clinical Business Strategy, the overall aim was to “develop the service to provide quality treatment for an increasingly aging population, in a sustainable manner, whilst offering an excellent training environment”, identifying “key opportunities to develop the way in which we prevent and manage hip fractures as well as other trauma and orthopaedic injuries”, and “further enhance the reputation and extend the level of care offered within the Major trauma centre”. The service planned to achieve its aims by focusing on the following key areas: Increased fractured neck of femur pathway efficiency, improved efficiency in the management of trauma, improve junior doctor feedback reducing the risk of the removal of training grade posts, and Respond to increase in semi elective trauma demand.

The Theatres & Anaesthesia CSU’s 2017/18 clinical business strategy detailed its strategic aim was to “develop a responsive service which delivers a safe, high quality patient experience that is respectful of patients, staff and colleagues”. The service planned to achieve its aims by focusing on the following key areas: Ensuring every patient experiences a safe and quality service, providing a responsive service; which allows flexibility and supports developments in surgery, growing an innovate workforce, and developing the CSU’s research portfolio.

The trust had implemented the Leeds Improvement Method (LIM), working in conjunction with the Virginia Mason Institute and partner organisations, and had supported senior clinicians and managers to undertake the ‘lean for leaders’ programme.

Members and representatives of the senior management team we spoke with were proud of the LIM and how they had used implemented this. For example, they shared their involvement in the nutrition project undertaken on orthopaedics wards, and the increased hydration of neck of femur patients; which had resulted in better outcomes.

Members said they shared the improvement work with other CSUs at Friday meetings. They spoke about other rapid improvement projects that had been implemented across services; for example, electronic discharge advice notes (EDANs), information sharing between flow teams, and board rounds. They commented that any staff member can attend the Friday meetings, and they also shared information through a twitter page and on the trust intranet. They also said that this information was shared trust wide through team briefs and audit meetings.

**Culture**

We saw that staff had a positive culture with staff being open, honest, and willing to share information with us on inspection. Most staff told us the division had strong leadership, and senior managers were visible and engaged with staff.

When we spoke with the senior management team, they said the culture was one of working together. They also spoke about improvements in the operating theatres, which had improved standard behaviour and collaboration of teams. This they said, had a positive impact on prioritisation of patients.
Charge nurses and ward managers told us that they had appropriate access to senior staff members. The senior management team were proud of staff working within the directorate and their resilience during ‘winter pressures’.

However, different levels of staff on orthopaedic wards shared that they and colleagues felt stressed because of staff shortages and workload, and morale was low. For example, they told us: “not enough staff which makes it uncomfortable for safety”, “staff feel stressed due to workload and lack of staff”, “…two less staff all the time. Staff morale is low due to staff shortages … high sickness rate on ward and high staff turnover”, “not enough staff”.

These staff typically expressed that more senior ward staff and managers were approachable and supportive; however, their comments sometimes indicated that senior management did not recognise the impact of staff shortages on the ‘shop floor’: for example, “hope something gets done … nothing really changes”.

Staff reported there was a strong culture of learning and improvement and training and development was actively encouraged. Senior ward staff were able to access support and leadership courses to help them in leading their services. Student nurses said that they felt supported by their colleagues, mentors and peers.

However, at pre-inspection focus groups some clinical support workers said there was lots of documentation to complete within 18 months for the front-loaded course. They told us there was inconsistent assessment with the provider, and staff often felt unsupported to complete the work necessary. They also told us that when overstaffed, clinical support workers relocations were sometimes not communicated well by managers, which impacted on staff culture.

Junior doctors said they felt supported by more senior staff and peers; however, some felt that the induction process could be improved upon, and several expressed frustrations with rostering.

Despite the challenges, staff spoke positively about the service they provided for patients and delivering high-quality care was a priority. All staff were clear about their roles and responsibilities, described delivering patient-focused care, and working well together.

**Governance**

Each CSU had monthly governance meetings, which fed into the executive management group meeting. Senior management teams we spoke with felt that senior leaders were aware of their CSUs risk, concerns and improvements; and we saw evidence of CSU risk discussions and action planning in Risk Management Committee Meeting minutes.

We saw evidence of governance oversight at CSU level (governance performance meeting minutes) and speciality level (governance and clinical audit meeting minutes).

Staff in leadership roles had access to dashboards looking at performance, finance, governance and staff engagement.

CSU governance performance meeting minutes showed monitoring of mortality and morbidity, performance dashboards, ward metrics, audit progress, and patient outcomes. We reviewed a selection of recent Centre for Neurosciences CSU, Trauma and Related Services CSU and Theatres and Anaesthetics CSU governance meeting minutes and saw there was a record of attendance, minutes were sufficiently detailed, with ownership of subjects discussed, and who was taking forward any actions. However, we noted in the Trauma and Related Services governance meeting minutes that under ‘actions agreed’ there was only the initials of the person responsible listed. However, we did see associated actions listed under the key points of discussion section.
This meant it was sometimes not clear from the documentation what actions (if any) were being taken forward.

Speciality level governance and clinical audit meeting minutes we reviewed showed discussion of ward dashboards, clinical outcomes, best practice guidance and national audit reports, policy and procedure updates at speciality level.

We saw mortality and morbidity was discussed at regular speciality-led meetings (for example, the Vascular Surgery Morbidity & Mortality Meeting, and Orthopaedic Trauma Mortality Meeting). We saw discussion of new and pending generic and individual cases for review and learning points. Minutes detailed that actions arising from reviews were monitored through the use of mortality and morbidity action tracking tools.

We saw that ward managers and matrons attended monthly meetings, these were Connecting Leaders In Care meetings (CLIC). The meetings were approximately for three hours where staff received feedback from the chief nurse. Professional briefings and education sessions on patient care topics were discussed. We saw from the chief nurse briefings that positive feedback was received and information shared regarding incidents. In June 2018, we saw that information was circulated about the use of medical air instead of oxygen.

Ward sisters, senior managers and clinical leads displayed knowledge, skills and experience. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.

**Management of risk, issues and performance**

We reviewed risk registers for all CSUs where there was a surgical base at the location. Each risk had an initial, current and a target risk rating. The date that risks were added were included, and review dates were seen. Each risk had existing controls, gaps and mitigating actions. We saw that key risks identified by ward managers we spoke were included on the risk registers; for example, in relation to staffing, medical outliers, cancellations, and increased length of stays.

We saw that senior managers in the Centre for Neurosciences, and Trauma and Related Services CSUs completed monthly patient safety walk-rounds, which were reported back to the CSU governance meetings.

The senior leadership teams were cited on what the risks were and steps taken to mitigate the risk. For example, they discussed various workforce strategies (such as band four practitioners) to mitigate registered nurse staff shortages, and the appointment of advanced nurse practitioners.

The management teams spoke with us about the effects of cancellations on patients and the service over the winter period.

A clinical director highlighted the demand for trauma services was the CSUs biggest risk, and they spoke about how the flow by road or air to LGI had changed the service, and a major concern was the acceptance of patient back to their local hospital (repatriation).

Medical leads discussed risks around gaps in established training rotas and deanery pressures; and cited mitigating actions such as increasing staffing on the senior fellows’ programme and the Medical Training Initiative (MTI) programme. Senior management teams spoke with us about other local developments to improve performance that the trust had been involved in, such as local deanery training, trust based surgical rotations, physician’s assistants, and medical input into ortho-geriatric medicine.
The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

Following our inspection, we asked the trust to provide us with risk management strategy documents for surgical clinical service units or specialities in the service. However, these were not provided. Therefore, we could not be assured that these were in place.

**Information management**

Information management systems were used effectively for patient care and for audit purposes; to monitor and improve quality.

Computerised whiteboards were in use in clinical areas, these contained patient information that staff could be reviewed instantly. They showed when observations were required to be completed, and provided indicators and flags when these were not managed appropriately.

Computers were available on surgical wards. During the inspection, all computers were locked securely when not in use.

Staff accessed information relating to polices and guidance electronically. The system was easy to navigate.

Concerns around the secure storage of records had been raised at our previous inspection of the service in 2016. At our recent inspection, we saw most patient records were all stored in areas that were secure or observed. However, we did see some patient records stored in areas that were unsecure, and others unattended in unlocked trolleys (see Records section for more information).

Staff received training on information governance and were aware of the importance of managing confidential patient information. Information provided by the trust showed that 70.3% of medical staff and 96.1% of nursing staff at the location had completed information governance training. Medical staff training compliance rates were worse than the trust’s target level of training of 80%.

We saw that increasing the use of information technology was part of the trust’s vision. The Leeds digital way provided a summary what this would include. Further risk assessments had been launched onto the patient’s electronic record, these included nutritional screening tool for malnutrition. We saw at our inspection that staff completed this online and communications to support staff to complete it electronically.

The trust informed us that they were one of six demonstrator sites for ‘Sacn4Safety’; an electronic programme that utilises standards to associate and track patients, products, places and processes. December 2017 saw the completion of the two-year programme phase; and the trust informed us implementation was ongoing to ensure maximum benefits are realised.

**Engagement**

The trust conducted an annual staff survey, which had informed a staff survey action plan for 2018/19. Leadership teams and managers told us they provided regular updates to staff regarding staffing levels, and how these were progressing.

We saw that staff were involved in changes at the trust and within the CSUs; and were engaged with different Leeds Improvement Method workstreams.

The trust had an annual awards event where staff were nominated and received awards. Each of the CSUs also held events to celebrate the successes within the units. Staff were clear about their
roles and responsibilities, patient focused and worked well together to engage patients and families.

People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and the Patient Advice and Liaison Service were available in all ward and reception areas. Internet feedback via NHS choices was gathered along with complaint trends and outcomes.

The trust participated in the friends and family test, and we saw results displayed on surgery wards. The friends and family test (FFT) response rate for surgery at Leeds Teaching Hospitals NHS Trust was 40%, which was better than the England average of 28%. Ward managers on surgical wards assured us that they continually reassess FFT response rates, and encouraged ward staff to drive this initiative.

We saw the Theatres and Anaesthetics CSU had implemented a “think drink” campaign, and had engaged with patients to assess the usefulness of the information, and impact of the campaign.

The Theatres and Anaesthetics CSU had also held an always event. ‘Always events’ involve those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system. As part of an ‘always event’ campaign during 2017/18, the Theatres and Anaesthetics CSU had examined feedback from PALS, complaints data & Picker inpatient survey to develop a patient feedback questionnaire around ‘Before and while you sleep’ themes. The survey ran for three weeks and gained 144 responses. The CSU also invited 12 patients who responded to the survey to attend a focus group with staff (December 2017). As described elsewhere in the report, four core themes were developed (see, Caring section).

**Learning, continuous improvement and innovation**

Senior management teams, and staff on the ground, were proud of the breadth and quality of learning, continuous improvement and innovation that took place within surgical services at the trust – and St James University Hospital.

The trust had an improvement work stream to reduce pressure ulcers. Staff had implemented a stop the line: bedside pressure ulcer incident review. This involved reviewing the care that had been given to ensure all appropriate actions had been taken.

Staff on ward L37 were proud that they had undertaken additional traction training, which had enhanced a multidisciplinary team approach for patients requiring traction.

The senior management team spoke about the increase in robotic surgery, the increase in tertiary referrals and specialisms (such as transplants), and collaborative initiatives to improve patient care and outcomes (such as integrated spinal surgery; with neurology and orthopaedics specialists working together).

The trust was involved in completing a number of clinical trials and local academic studies related to surgical services. We spoke with staff involved in research studies who were well supported in completing the trials.

We saw a New Interventional Procedures Group had been created to provide the trust with assurance that new procedures involving either an implantable medical device or a new interventional procedure are safe, effective and affordable. We were informed that 46 applications had been approved in past two years. These included: new orthopaedic joints to give patients greater stability and range of movement, robot assisted gynaecological, urological and thoracic
surgery, insertion of biodegradable stents for frail patients with bile duct blockage, a bench top incubator for preserving livers before transplantation, and various cardiac implants and invasive techniques for patients with conditions that would otherwise have been rapidly fatal.

We saw that the first nurse-led sedation for Transcatheter Aortic Valve Implantation (TAVI) took place at the trust. This is a specialist cardiovascular procedure that enables an aortic valve to be replaced without the need for open-heart surgery and provides better outcomes for patients as well as significantly reducing their recovery time. The procedure was performed without an anaesthetist or operating department practitioner in the room. The trust told us that the milestone 1000th TAVI procedure also took place in 2017; and the trust are now one of the largest centres for the procedure. In addition, we were informed that the trust had the highest survival rate amongst patients undergoing TAVI; both in the immediate period post-surgery and longer-term.

The trust also celebrated completing their first day-case aortic aneurysm repair. Aortic aneurysm repair is undertaken to prevent aortic rupture, an event that is nearly always fatal. The trust described that traditionally this required a major open operation with a 5-10 day post-op hospital recovery; and that endovascular aneurysm repair (EVAR) has revolutionised this, by using image guidance to re-line the aorta from the inside. Having previously performed EVAR as a one-night stay, the Leeds vascular radiology and vascular surgery teams completed the operation as a day-case for the first time.

The trust is the largest solid organ transplant centre in the UK, and had a record year of liver transplants in 2017/18. In the last year, the surgical team completed 175 liver transplants and started the 176th just before midnight on 31 March 2018.
Facts and data about this service

The trust has 164 critical care beds. A breakdown of these beds by type is below.


This trust

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Services provided</th>
<th>Bed numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult critical care - L02</td>
<td>Adult High Dependency Unit</td>
<td>6</td>
</tr>
<tr>
<td>Adult critical care - L03</td>
<td>General Intensive Care Unit</td>
<td>8</td>
</tr>
<tr>
<td>Adult critical care - L04</td>
<td>Cardiac Intensive Care Unit</td>
<td>8</td>
</tr>
<tr>
<td>Adult critical care - L05</td>
<td>Cardiac Intensive Care Unit</td>
<td>7</td>
</tr>
<tr>
<td>Adult critical care - L06</td>
<td>Neuro Intensive Care Unit</td>
<td>8</td>
</tr>
<tr>
<td>Adult critical care - L07</td>
<td>Neuro High Dependency Unit</td>
<td>7</td>
</tr>
<tr>
<td>Cardio-respiratory - L20</td>
<td>Coronary care unit</td>
<td>10</td>
</tr>
<tr>
<td>Trauma and related services - L08</td>
<td>Plastic surgery and trauma High Dependency Unit</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

Leeds Teaching Hospitals NHS Foundation Trust has 60 critical care beds across eight wards based at Leeds General Infirmary in Leeds. This facility admits critically ill patients from Leeds and the surrounding area and regional referrals via the West Yorkshire Operational Delivery Critical Care Network.

The critical care service has speciality specific and general intensive care units (ICU) and high dependency units (HDU). Providing level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care to adult patients.

National Audit and Research Centre (ICNARC) data was collected from the general intensive care unit (ICU) and the neuro ICU.
The data showed that between 1 April 2017 and 31 March 2018 on the general ICU (ward L03) there were 765 admissions with an average age of 58 years. Of these:

- 32.5% were unplanned admissions from the emergency department or outside of the hospital
- 23.5% were admitted following emergency surgery
- 16% were planned admissions from theatre following elective surgery
- 13% were transfers from another critical care unit
- 12% were from ward areas
- 2% were unplanned admissions from theatre following elective surgery
- 1% were transfers from another hospital

The average (mean) length of stay on the unit was two days.

Data from 1 April 2017 and 31 December 2017 on the neuro ICU (ward L06) showed that there were 534 admissions with an average age of 54 years. Of these:

- 39% were unplanned admissions from the emergency department or outside of the hospital
- 22% were admitted following emergency surgery
- 15% were planned admissions from theatre following elective surgery
- 9% were transfers from another critical care unit
- 9% were from ward areas
- 4% were unplanned admissions from theatre following elective surgery
- 2% were transfers from another hospital

The average (mean) length of stay on the unit was 2.5 days.

The critical care outreach team (CCOT) provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The outreach team offer a twenty-four-hour service, seven days a week. The critical care service is part of the West Yorkshire Critical Care Network.

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Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training. We reviewed mandatory training information on site with senior nurses which showed high levels of compliance consistent with the tables below.

Staff told us the unit manager planned staffing rotas to enable staff to complete training modules, supported by the education team.
There were systems in place which enabled individual staff and their managers to be alerted when training was due for renewal. Mandatory training comprised of face to face and online learning.

Role specific training was also completed, including annual training in life support, blood transfusion safety, arterial blood gases training, health and safety and diversity training. During inspection, we saw that 93% of staff on critical care had completed basic life support training at 30 June 2018. Managers told us the outreach team completed intermediate life support training and the advanced critical care practitioners completed advanced life support training.

Training on sepsis was mandatory and was part of the trust induction programme. It was also formed part of other training courses such as the ALERT course training for nursing staff.

**Leeds General Infirmary**

A breakdown of compliance for mandatory training courses as of June 2018 for qualified nursing staff in the critical care department at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity at work</td>
<td>246</td>
<td>246</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>246</td>
<td>246</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>246</td>
<td>246</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>246</td>
<td>246</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>246</td>
<td>246</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>243</td>
<td>244</td>
<td>99.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>242</td>
<td>246</td>
<td>98.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>242</td>
<td>246</td>
<td>98.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>241</td>
<td>246</td>
<td>98.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>236</td>
<td>244</td>
<td>96.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>224</td>
<td>246</td>
<td>91.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>216</td>
<td>246</td>
<td>87.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary critical care department, the 80% target was met for all 12 mandatory training modules for which qualified nursing staff were eligible. Nursing staff had an overall training completion rate of 97.5% and 11 of the 12 modules had completion rates above 90%.
<table>
<thead>
<tr>
<th></th>
<th>In date</th>
<th>Expired/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity at Work</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>Equality &amp; Diversity General</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>Fire Safety - All Staff</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control Specialist Clinical</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Information Governance</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Medicines Safety - Once only</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Moving &amp; Handling Lower Risk</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>Prescribing Standards - Once Only</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>Resuscitation Training Advanced</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Resuscitation Training Advanced Update</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Resuscitation Training Level 2 PMST</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Risk &amp; Safety Matters</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults - Level 1</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults - Level 3</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Safer Blood Transfusion</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>425</td>
<td>41</td>
</tr>
<tr>
<td><strong>Proportion as a %</strong></td>
<td>91%</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Safeguarding**

Trust protocols and guidance on safeguarding were easily accessible and there was a safeguarding team who could be contacted if further advice was needed.

Staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. Senior nurses were confident about staffs understanding of safeguarding.

We saw staff managing a potential safeguarding concern during inspection and saw that safeguarding concerns were escalated, documented and communicated as per policy and process.

Staff had an awareness of female genital mutilation (FGM). The mandatory process of reporting and recording newly identified cases of FGM was part of the trusts safeguarding policy.

There was a trust policy for when where sedation was used in treatment. This was based on regional critical care network guidance.

The trust set a target of 80.0% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of June 2018 for qualified nursing staff in the critical care department at Leeds General Infirmary is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>243</td>
<td>246</td>
<td>98.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>243</td>
<td>246</td>
<td>98.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>184</td>
<td>227</td>
<td>81.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>183</td>
<td>227</td>
<td>80.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary critical care department, the 80.0% target was met for all seven safeguarding training modules for which qualified nursing staff were eligible. Nursing staff had an overall completion rate of 90.4%, meeting and exceeding the trust target. Five modules had completion rates above 90.0%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

A breakdown of current compliance for safeguarding training courses for medical staff in the critical care department at Leeds General Infirmary is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>24</td>
<td>24</td>
<td>100%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>24</td>
<td>24</td>
<td>100%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>19</td>
<td>23</td>
<td>82.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>19</td>
<td>23</td>
<td>82.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>17</td>
<td>23</td>
<td>73.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Cleanliness, infection control and hygiene**

Ninety eight percent of nursing staff and 88% of medical staff had completed mandatory training in infection control and prevention. The exceeded the trust target of 80%. There were identified link workers within the nursing team for infection prevention and control who received additional training.

ICNARC data for the general ICU showed there had been 0.4 unit acquired infections in blood per 1000 patient bed days between 1 April 2017 and 31 March 2018. This was better than similar units who had a rate of 1.1. The ICNARC report for 1 April 2018 to 30 June 2018 showed this had further improved and there had been no cases of unit acquired infections in blood.

Between 1 April 2017 and 31 December 2017, the neuro ICU had no cases of unit acquired infections in blood, this was significantly better when compared with similar units who had a rate of 2.3. The ICNARC report for 1 April 2018 to 30 June 2018 showed this had been maintained.
Between 1 April 2017 and 31 March 2018 there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA) on either ICU, and one case of unit acquired clostridium difficile on the general ICU.

We were told by the infection prevention team that RCA investigations were undertaken for all hospital acquired infections including ventilator associated pneumonia. There were quality improvement protocols in place to reduce the incidence of bloodstream infections. Key to this was the introduction of the blood stream infection bundle in December 2017. This included the introduction of ‘Buggles’ to both units. These were an adaptation of safety huddles and focused on infection prevention and control concerns.

The units were visibly clean, tidy and dust free. Hand hygiene points were visible at the entrances of each unit. Alcohol hand gel and hand wash facilities were available at each bed space. We spoke with domestic and housekeeping staff who were aware of policy and processes for cleaning the ICU environment and we saw daily cleaning schedules for specific areas had been completed. Empty bed spaces also had terminal clean checklists completed to indicate they were clean and ready for the next patient.

However, we did observe in two areas sharps disposal bins that had been overfilled and one which had a blood-filled syringe resting on the lid of the bin. This was communicated to staff and immediately resolved.

We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene, personal protective equipment (PPE) and isolation. We saw information on display about preventing legionella and how to manage blood spills.

The unit had facilities for respiratory isolation and we found appropriate waste segregation and disposal systems in place.

Monthly cleaning and hand hygiene audits were in place. Ward health checks results were displayed in each of the areas we visited. For example, ward L03, general ICU, had an overall cleaning score of 98% for August 2018. This data was captured in a critical care service infection prevention dashboard. Included was information on hospital acquired infection rates, cleaning scores and training figures.

**Environment and equipment**

All the units were compliant with health building notice (HBN) 04-02 and had windows allowing natural light into the bed space. Access was via intercom with a security camera. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance and managed in line with agreement with commissioners. In the main bay, bed spaces were separated by curtains to maintain patients’ privacy and dignity.

On ward L08 it was acknowledged that whilst the patients on the unit required higher levels of observation the majority did not meet the critical care criteria for level two care. This was true of the patients on the ward during our inspection. It was noted there were no toilet or showering facilities for patients. This was also mentioned by a patient we spoke with who was having to use a commode in their room because of this.

We discussed this on site with the matron who stated a decision had been made that the unit would become a high observation unit providing level one care for major and orthopaedic trauma, plastic reconstructive surgery and vascular surgery patients. We requested more information about this following the inspection. It was acknowledged that estates work was required to provide
washing and toilet facilities and consideration was required for compliance with single sex accommodation guidance. No timeframes were provided in relation to this.

Theatres were on the same corridor as the units providing easy access. Storage areas were well maintained and stock levels were managed by a dedicated central store team and pharmacist technician. Stock was replenished by the stores department daily, during inspection we observed a number of dedicated stock crates outside the critical care units. The crates held several items including sharps, ‘chlor clean’ tablets, oxygen masks, scalpels and dressings. The crates were unlocked and easily accessible to members of the public. The management team were informed of this potential risk at the time of inspection. We were advised that stock was delivered and items re stocked within a short time frame, minimising the risk.

The replacement of equipment was part of the trust wide capital replacement programme. There was adequate equipment in the unit to meet the needs of patients. We saw that specialist equipment was available for patients with a high body mass index (BMI) when required. A standard hoist and bariatric hoist were available on the units.

There was a process in place for quality control and calibration check of blood gas analyser machines. We also observed a flow chart advising staff what to do if there were problems with the machines.

We checked 21 pieces of equipment across the units and found evidence of up to date electrical safety testing. There was a clear process of assurance for the maintenance of medical equipment and estates management, which staff could describe to us.

The maintenance performance report from the medical equipment inventory which included in-house and external maintenance was updated daily. This was the responsibility of the medical physics department. Assurance work in medical physics was undertaken using a registered quality management system (ISO9001), and was audited regularly.

Training for new equipment introduced to the unit was provided by the manufacturer and refresher training and competency checks were carried out by clinical educators annually. There were key trainers across the critical care clinical service unit (CSU). At the previous inspection, training compliance rates for high risk equipment were a concern. Equipment training compliance was recorded on a system called MELVIS. We requested training compliance figures and current compliance for the critical care CSU was 78%. This was an improvement from the last inspection.

Appropriate emergency equipment was available at each bed space and there were resuscitation trolleys centrally located on each unit. On L04 and L05 (cardiac intensive care unit) there were additional internal resuscitation trolleys for emergency use. The trolleys had defibrillators, endotracheal tubes, and several emergency drugs. Both units also had additional cardiac chest opening trolleys, difficult intubation and chest drainage trolleys. We saw both resuscitation trolleys were clearly labelled and checked daily in line with trust policy. The resuscitation and difficult intubation trolleys on each unit had an information folder with a contents list. We saw evidence of daily checks being completed. Contents were checked and found to be sealed and in date.

Assessing and responding to patient risk

The critical care outreach team (CCOT) provided cover twenty-four hours a day, seven days a week. This level of provision had been in place since May 2017. At the inspection in 2016 CCOT out of hours cover had been provided by staff on the ICU.
The trust used the national early warning score system (NEWS) as a tool for identifying deteriorating patients. The wards had an electronic system for recording patient observations which formed part of the electronic records system. This allowed the CCOT to remotely view any patients with elevated NEWS scores. There was a clear escalation policy in place for when patients had an elevated NEWS score, this included when patient’s needed transfer to the critical care unit.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They had a number of other roles including, attending cardiac arrest calls and providing support for patients with tracheostomies or requiring non-invasive ventilation. They also reviewed patients who were discharged from ICU to ward areas.

Sepsis screening tools and pathways were in use, with a clear process of reporting and escalation. We observed grab bags for sepsis screening. These had been developed by the service and included equipment for taking blood cultures as part of the BUFALO screening tool.

We observed completed daily bedside safety checks. Grab bags and emergency kits such as for tracheostomies, were in place. These reduced the amount of time required to respond to an emergency as all the necessary equipment was ready in one place.

Within patient records risk assessments and care bundles were completed, for example, for falls and pressure areas. The electronic whiteboards in the units would ‘flag’ when any assessments were due for renewal as a reminder for staff.

We also saw a flow chart in use for invasive lines to ensure they did not remain in place for longer than required.

Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

**Nurse staffing**

Nurse staffing was based on guidance and standards from D16 NHS standard contract for adult critical care and Guidelines for the Provision of Intensive Care Services 2015 (GPICS). We observed staffing levels during our inspection, reviewed staffing rotas and spoke with several members of nursing staff. We were assured that nurse staffing levels met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients’ ratio for level two patients.

Vacancy rates and sickness did make staffing a challenge. This was particularly noted on the neuro ICU which had 14 whole time equivalent nurse vacancies, support with staffing was also being provided by critical care to the neurosciences ward. This situation had been ongoing for approximately 18 months.

Senior nurses and managers were aware of the pressures. Staffing was managed across both sites and all the critical care areas to ensure nurse staffing levels met the needs of the patients. Gaps in staffing were covered by agency staff or bank staff. Many of these shifts were filled by the unit’s own staff working additional bank shifts. From reviewing rotas, we were assured that staffing was in line with GPICS.
In January 2019 critical care was one of two areas in the trust who were running an apprentice nurse training scheme lasting four years. The trust employed staff as a band three and provided a base placement to gain clinical skills with educational input provided by a local university. After four years these staff will be able to register with the Nursing and Midwifery Council.

Support with staffing was also provided by senior nurses who may have been planned to work non-clinically. We saw this during our inspection, the co-ordinator was caring for a patient so the matron for the unit was working clinically. However, some staff told us they were concerned about the sustainability of achieving safe staffing levels.

Planned and actual staffing numbers were displayed on each unit. Staffing levels during our inspection met GPICS guidance ratios for the level of care the patient’s required. Electronic rostering was in place and this enabled ‘rules’ to set up to further support safe staffing levels. For example, ensuring appropriate skills mix and a coordinator on was on each shift. Any staff movement to other areas was recorded on the electronic rostering system.

Since the last inspection the service had implemented a critical care patient flow team. Part of their role was looking at nurse staffing across all critical care areas. The team consisted of six band six critical care nurses who worked 12-hour shifts from Monday to Saturday. There was a patient flow coordinator based at each site.

The flow coordinator looked at staffing and patient acuity and any agency requirements. This mean that the coordinators on ICU and HDU could then focus on the clinical aspects of their role and were not spending significant time overseeing staffing issues.

On one of the days during the inspection critical care was in (red) escalation due to staffing and patient acuity. The inspection team sat in on the morning patient flow call. This was attended by the flow coordinators from each site, the site coordinator, matron and general manager. We were shown a flow chart which was red, amber and green (RAG) rated to clearly identify the level of escalation for the service. This determined who attended the patient flow call.

The service had adapted clinical emergency medicine books (CEM books) typically used in accident and emergency departments. This live system enabled the service to look at the demands within their department, share this information and make better informed decisions.

We viewed the system whilst on site. There were eight parameters which each had a weighted scoring system to give an overall RAG rating for the service. The system was updated at regular times during the day and included information on staffing levels for nurses, the CCOT, advanced critical care practitioners (ACCP) and medical staff. This ensured a consistent and risk based approach was used when making decisions about staffing.

We observed nurse handovers in three of the units. A team handover was given and then one to one handover took place at the bedside. A more detailed handover also took place between the shift co-ordinators.

There was a specialist critical care pharmacist who visited each of the units Monday to Friday to check prescriptions and reconcile patient medicines.

From speaking with physiotherapy staff and reviewing patient records, we were assured that physiotherapy provision was sufficient to deliver the respiratory and rehabilitation elements of patient care.
Leeds General Infirmary had a staffing fill rate of 92.2% in March 2018, higher than the fill rate of 85.3% in March 2017, although the trust has decreased planned WTE staff by 5.4 between March 2017 and March 2018. The service had to operate with 40.6 less WTE staff in post than planned in March 2017 and with 20.9 less in March 2018. This site however had 14.2 more WTE staff in post in March 2018 than in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

### Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 9.9% in critical care. The trust did not set a trust target for vacancy rates.

A breakdown by site is shown below:

- Leeds General Infirmary: 10.6%
- St James’s University Hospital: 8.9%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

More recent data seen on site from September 2018 indicating a worsening position with a registered nurse’s vacancy of 27%. However, 12 new staff had been employed, this gave a predicted vacancy rate of 9%.

### Turnover rates

As from June 2017 to May 2018 the trust reported a turnover rate of 7.4% in critical care. The trust did not set a target for turnover rates.

A breakdown by site is shown below:

- Leeds General Infirmary: 8.7%
- St James’s University Hospital: 5.6%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

### Sickness rates

From June 2017 to May 2018 the trust reported a sickness rate of 2.9% in critical care, lower than the trust target of 3.5%.

A breakdown by site is shown below:

- Leeds General Infirmary: 2.7%
- St James’s University Hospital: 3.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and agency staff usage

From April 2017 to March 2018, Leeds General Infirmary reported 0.6% of qualified nursing shifts filled by bank staff and 2.1% shifts filled by agency staff in critical care. There were 1.4% of shifts not filled by either bank or locum staff.

Over the same period, 7.1% of nursing assistant staff in critical care at Leeds General Infirmary was filled by bank staff, 4.6% of shifts were filled by agency staff and 4.8% of shifts were not filled by either bank or agency staff to cover staff absence.

A breakdown of agency and bank usage by staff type at Leeds General Infirmary is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>470</td>
<td>7.1%</td>
<td>218</td>
</tr>
<tr>
<td>Agency</td>
<td>304</td>
<td>4.6%</td>
<td>776</td>
</tr>
<tr>
<td>Not filled</td>
<td>319</td>
<td>4.8%</td>
<td>523</td>
</tr>
<tr>
<td>Total</td>
<td>6,648</td>
<td>36,588</td>
<td>43,236</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The critical care service had a clinical director and three clinical leads, one of whom had a quality improvement focus. Medical staffing was in line with GPICS recommendations. Two consultants were available during week days from 8am to 8pm, and at weekends from 8am to 6pm. Overnight cover was provided by an on-call consultant who could attend within 30 minutes. Consultants were supported by a registrar who was available twenty-four hours a day. However, from Monday to Thursday out of hours the registrar also covered the trauma bleep.

There were cross cover arrangements in place between the neuro and general ICU and HDU’s. The majority of gaps in the rotas could be covered by existing staff working extra shifts. The service had a locum consultant who worked across the units who had been employed at the trust for 12 months. We were assured that at all times a consultant was able to attend within 30 minutes.

Medical staffing on the cardiac ICU did not fully meet GPICS recommendations (Guidelines for the Provision of Intensive Care Services) as the medical cover was provided by cardiac anaesthetists and not always consultant intensivists. Out of hours they were also required to cover cardiac surgery. However, improvements in cover had been made since the last inspection.

Patients on the HDU’s were under the specialty consultant care, however critical care consultants would also review them daily. We observed this during our inspection and saw evidence of this taking place from reviewing patient records.

Support was also provided to medical staff by the appointment of 12 advanced critical care practitioners (ACCP’s).
It was identified from reviewing medical rotas and speaking with consultants that consultant work patterns provided continuity of patient care as block working was in place. This was in line with GPICS recommendations. The consultant to patient ratio was also in line with the recommended range of 1:8 to 1:15.

We observed consultant wards rounds, and in the ten patient records we reviewed we saw that twice daily consultant led ward rounds took place from Monday to Friday in each unit. Daily ward rounds took place at weekends.

**Vacancy rates**

From June 2017 to May 2018 the trust reported a vacancy rate of -9.5%, in critical care, indicating that the service was overstaffed.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From June 2017 to May 2018 the trust reported a turnover rate of 37.3% in critical care. However, the inclusion of trainee grades in the data is likely to have inflated the rates.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From June 2017 to May 2018 the trust reported a sickness rate of 0.3%, critical care, well below the trust target of 3.5%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Records**

The service had moved to an electronic records system, however some elements such as the ICU charts were still paper based. There was a project team in place who were working towards a complete paperless system.

Nursing and medical records were stored securely in each of the areas we visited. Information provided by the trust showed 98% of nursing staff and 92% of medical staff had completed information governance training, which was above the trust target of 80%.

With the assistance of staff to help navigate the electronic record system, we reviewed ten sets of nursing and medical records in detail looking at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Care bundles and pathways were in use for pressure area care and indwelling lines. There was evidence in the notes we reviewed of holistic assessment which focused on details other than physical health needs, for example, mental health conditions.

Medical records were completed in line with trust and professional standards. We saw that patients were reviewed by a consultant within 12 hours of admission to critical care and there was daily multidisciplinary team (MDT) input.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital.
A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. This was done electronically and viewed on the trusts electronic patient management system.

We saw the physiotherapy team completed records that met with NICE Guideline CG83 (rehabilitation after critical illness) requirements during a patient’s stay in critical care.

In the records we reviewed, we saw admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) Guideline CG50 (acutely ill patients in hospital). CCOT staff told us discharge information was thorough with clear escalation plans for individual patients.

**Medicines**

During our inspection we found medicines were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records and saw that accurate records and checks were completed in line with trust policy. Controlled drugs stock was checked at each handover shift by the nurse in charge and a quarterly audit was completed by the pharmacy team.

We observed in each area fridge temperatures were monitored and recorded in line with trust policy. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

A specialist critical care pharmacist visited all units Monday to Friday to check prescriptions and reconcile patient medicines. There was access to on call pharmacy provision at other times. There were ACCP’s on the units who were non-medical prescribers.

We reviewed ten medicines charts on the electronic system. We found them to be fully completed in line with trust and national guidance, for example with any allergies noted. Oxygen and preventative treatment for venous thromboembolism (VTE) was also prescribed. Clinical indication, and start and stop dates for antimicrobials were also evident. The medicines chart we reviewed had antibiotics prescribed in line with national guidance. Patients weight and height were also recorded.

Each electronic prescription chart had been reviewed by the pharmacist. There was consultant pharmacist leader for antimicrobial stewardship, parenteral nutrition, thrombosis and anticoagulation.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

We saw information displayed for staff on ‘med of the month’. At the time of inspection this was about a drug called Dopamine. Information was displayed on how the drug worked, any adverse effects and special notes.

A medicines update was provided at the monthly governance meetings. Regular audits such as safe and secure handling of medicines and medicines reconciliation took place.

‘Druggles’ had been introduced on some of the units as a trial to explore further ways of sharing information specifically around medicines.
Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for critical care.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. Incidents relating to pressure ulcers, falls and medication errors were monitored through the ward health check metrics.

The service had pioneered ‘code red’ a process of reviewing incidents within 24 hours of them occurring. During inspection we were informed of an incident which occurred relating to the safe delivery of blood products in a timely manner to a blood fridge store on the cardiac intensive care unit. This incident was immediately reported, investigated and actions were taken to prevent recurrence. All staff including unit, theatre and blood store were advised of the incident via team brief and safety huddles. No patient harm was caused and clear lines of communication were evident.

There was a Quality Improvement (QI) programme in place in relation to the timely identification of the deteriorating patient. A number of different measures were in place to monitor the effectiveness of the QI programmes, such as the monitoring of the occurrence and harm levels of associated incidents and numbers of cardiac arrest calls. At CSU and unit level this was monitored through ward metrics. These included information on the number of days since the last patient falls/pressure ulcer's etc. We saw this information displayed on each of the units we visited.

The service had several ways of sharing information from incidents. Integral to this was the development of safety huddles. This Improvement Academy work began in 2013, since then the structure and purpose of safety huddles had been expanded and embedded and rolled out across the trust well as other trusts in the area. The trust had won a Health Service Journal award for this work and were put forwards for an NHS parliamentary award.

We observed safety huddles in different areas. They were attended by various members of the multidisciplinary team, including the consultant on call, the nurse in charge, patient flow coordinator and therapy staff. The safety huddles were supported by a standard operating procedure (SOP).
Areas covered included staffing and capacity, any infection control issues and any communications to be shared.

At the start of the nursing handovers we observed there were team briefings. These had a checklist and included any information about patient safety incidents. For example, information was shared about an incident involving problems with suction equipment.

There were various other systems in place to feedback learning from incidents. This included team meetings and a closed social media group for staff which included ‘messages of the week’. We also observed lessons learned in safety briefing documents which staff referred to.

We reviewed monthly departmental governance meeting minutes and found incidents were a standing agenda item. A ‘tracker’ was used to monitor progress and themes of incidents and there was evidence of discussions around this in the minutes we reviewed.

Information provided by the trust stated the number of device related pressure ulcers had reduced by 50% in 2017/2018.

The electronic incident reporting system included a prompt on the duty of candour. This 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 demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Monthly critical care specific mortality and morbidity meetings took place, which was in line with GPICS recommendations. Feedback from consultants we spoke with was this process was embedded within the service. Structured judgement reviews took place, from reviewing meeting minutes it was evident that discussions took place and any actions required were taken forward. For example, a delay in antibiotic administration potentially due to a transition from paper to electronic medication charts as the patient moved from the emergency department to ICU was flagged to risk management.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Safety thermometer data was collected and displayed on patient safety boards as part of the ward metrics. This included information on pressure ulcers and falls. For example, on L03, there had been five category two pressure ulcers since April 2018, and one patient fall.

Information was also collated weekly for each unit, and shared with staff. This included data on seven parameters; infection rates such as MRSA, category three pressure ulcers and falls. The recent data from the trust showed it had been 125 days since the last category three pressure ulcer and 195 days since the last fall on cardiac ICU.
Staff told us themes and trends were discussed at staff meetings to raise awareness and share learning. Learning from pressure ulcers was shared at handover and in staff group huddles to communicate lessons learnt and actions taken. We observed information on staff notice boards on tissue viability, the focus of the month was repositioning.

**Is the service effective?**

**Evidence-based care and treatment**

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Policies and guidance were accessed on the trust intranet which was easy to navigate. We reviewed ten policies and found them to be in date with an author and version control. Many of the policies had flow charts and links to other guidance to inform and advise staff. For example, the sedation policy had links to screening flow charts.

The recent introduction of CEM books was still under development. As part of this the aim was to have quick access to policies ‘on a page’. This would enable staff to quickly view SOP’s and guidance documents for critical care. Governance meeting minutes from September 2018 showed this process was underway with single page guidance on tracheostomy speaking valves having been uploaded to CEM books.

We saw from critical care meeting minutes that there was an agenda item for sharing knowledge from conferences and reviewing articles from the critical care journal.

The trust was part of the West Yorkshire Critical Care Operational Delivery Network (WYCCODN). This group met six times a year to representatives from each trust in the network. They shared and reviewed critical care specific guidance from their units, such as nutrition and pain management. Each area was marked against a standard framework and given a score. The unit with the highest score shared their guidance with the rest of the group. If it was identified that there was an area or topic for which there was not guidance available, the group would develop this.

The service had a SOP for delirium screening and diagnosis. The trust policy identified non-pharmacological treatments and approaches to use prior to looking at pharmacological interventions. We saw evidence of screening for delirium in each of patient records we reviewed in line with NICE guidance.

We saw evidence of screening for sepsis in the patient records we reviewed in line with NICE guidance. Staff we spoke with were aware of sepsis and the referral process to follow. The trust used BUFALO sepsis screening protocol. Sepsis blood culture grab bags were available on all units.

We saw admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. We saw evidence of outreach team activity data collection. This included heat maps to monitor activity and the number of referrals to the team per patient speciality.

Since the last inspection significant work had been undertaken regarding NICE CG83 rehabilitation after critical illness. The team visited other hospitals to see what work they had done and utilised the WYCCN quarterly rehabilitation forum to look at what the service was doing in comparison to the rest of the region. A critical care rehabilitation team had been established based
at the St James’s University Hospital site. The service had also developed information leaflets for patients and relatives which were shared with the WYCCN.

There was a system in place to identify patients requiring rehabilitation. This was supported by a critical care rehabilitation pathway which was used by members of the multidisciplinary team. We saw from our observations and reviewing patient records that 45 minutes of therapy was delivered to patients each weekday. This involved both the physical elements of rehabilitation but also psychological rehabilitation, for example, taking time to talk to patients about their time on the unit and what has happened to them.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in each of the patient records we reviewed.

The completion of nutritional assessments was monitored through the ward health check metrics. Completion rates from April 2018 to June 2018 were 98-100%.

The unit had a protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

There was access to a dietitian and they would attend the units each day with on call support at weekends. There was access to speech and language therapists as required. The provision was in line with GPICS recommendations.

During our inspection we saw that water was available for those patients able to drink and assistance was provided as required for those patients. We found fluid balance charts were fully completed in each of the records we reviewed.

**Pain relief**

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was discussed on ward rounds and reviewed by the pharmacy team.

From the notes we reviewed we found evidence of pain scores being completed and appropriate action taken in response to any indicating a patient was experiencing pain. The trust used a pain scale which was recorded on the patient observation tool at the patient bedside. We observed pain management being discussed at individual one to one handovers at the patient’s bedside.

The patients and relatives we could speak with reported pain control being effective and that it was provided in a timely way.

**Patient outcomes**

**ICNARC Participation**

Since May 2018 ICNARC data had been collected centrally by small team of data clerks working together rather than separate ones for different sites. They worked closely with clinical staff to collate information and ensure accuracy.
At this site neuro and general ICU contributed data to the Intensive Care National Audit Research Centre (ICNARC). Data collection on the cardiac ICU had recently commenced as such there was no reported data.

The plastic surgery and trauma HDU did not contribute to ICNARC data collection as most of the patients did not meet level two criteria and as previously explained the unit was to become a high observation area.

We reviewed the annual report data from April 2017 to March 2018 and the quarterly report from April 2018 to June 2018.

**Hospital mortality (all patients)**

**Leeds General Infirmary**

At Leeds General Infirmary, the risk adjusted hospital mortality ratio for ward 6 (the neuro intensive care unit) was 1.03 in 2017, increasing slightly to 1.29 in the most recent data from April 2018 to June 2018. Both figures were within the expected range.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>733 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

At Leeds General Infirmary, the risk adjusted hospital mortality ratio for the general intensive care unit was 1.2 in 2017/2018. This was within the expected range. The figure in the 2016/17 annual report was the same.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>2017/18</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>756 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.2</td>
<td>1.2</td>
<td>1</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Hospital mortality (for low risk patients)**

**Leeds General Infirmary**

At Leeds General Infirmary, the risk adjusted hospital mortality ratio for patients in ward 6 (the neuro intensive care unit) with a predicted risk of death of less than 20% was 1.19 in 2017. This was within the expected range. The figure in the 2015/16 annual report was 0.7.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>607 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>0.7</td>
<td>0.8</td>
<td>1</td>
<td>none</td>
<td>Within expected range</td>
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</tbody>
</table>
At Leeds General Infirmary, the risk adjusted hospital mortality ratio for patients in the general intensive care unit with a predicted risk of death of less than 20% was 1.3. This was within the expected range. This was the same as the figure in 2016/2017.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>2017/18</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>502 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>1.3</td>
<td>1.3</td>
<td>1</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The neuro ICU had an unplanned readmission rate within 48 hours of 1.2% for the period of 1 April 2017 to 31 December 2017. This was just below (better) than the rate for similar units which was 1.5%, and was within the expected range when compared to the England average.

The general ICU had an unplanned readmission rate within 48 hours of 0.5% this was also lower (better) when compared with similar units who had a rate of 1.1%. This was for the time period of 1 April 2017 to 31 March 2018.

Between January 2018 and March 2018, the trust achieved 92% compliance for sepsis screening. There had been a focus on improving the timeliness of antibiotic treatment for suspected or confirmed sepsis. Between January 2018 and March 2018, data showed that 77% of patients had received antibiotics within an hour.

We were provided with a copy of the services clinical audits for best practise and quality improvement projects plan. This included four workstreams, including best practice audits on policies and guidelines, trust mandatory audits and national audits.

These workstreams were reflected in the annual audit plan for the service. There was a designated consultant audit lead for each site and a nursing audit lead. A wide range of areas were covered, including tracheostomy insertion checklist and endotracheal tube cuff pressure management.

**Competent staff**

**Appraisal rates**

**Leeds General Infirmary**

As at June 2017 and June 2018, 93.2% and 99.6% respectively of nursing staff within critical care at Leeds General Infirmary received an appraisal. The June 2018 appraisal rate exceeded trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th></th>
<th>Rate</th>
<th>June 2018</th>
<th></th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
<td>Rate</td>
<td>Completed</td>
<td>Individuals required</td>
<td>Rate</td>
</tr>
<tr>
<td>Nursing and midwifery staff</td>
<td>221</td>
<td>237</td>
<td>93.2%</td>
<td>244</td>
<td>245</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Information provided by the trust following the inspection showed that of 27 medical staff based at this site 93% had had a recent appraisal. This was just below the trust target of 95%.

All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. There was a preceptorship programme in place and new staff would initially be supernumerary for eight weeks, however this could be extended on an individual basis if required.

New consultants had a robust programme of induction and were excluded from any on call responsibilities.

We spoke with the clinical educator, they were in a dedicated role in line with GPICS standards. They provided a variety of education and maintained central records for equipment training, mandatory training and post-registration training on the units.

Nursing staff, including students, told us they felt well-supported. The student programme whilst strongly educationally focused to ensure placement requirements were met, also aimed to get students keen and excited to work in ICU.

All registered nurses in critical care are required to complete Step one of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the units (excluding ward L08). While completing Step one competencies; there was a mentor and buddy system in place, time to complete training and support from the education team. The education team logged the type of experience nurses were gaining to track progress and facilitate skills development.

Step one competencies aim to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor and /or practice educator.

Educational support was available for all staff. If any learning needs were identified, the clinical educator would roster themselves to with individual staff. Documentation would be in place to monitor progress and weekly catch up meetings were held.

For non-registered staff there were opportunities to progress to apprentice support workers then on to advanced support workers.

Staff were also encouraged to share their skills and learning. Teaching took place on Wednesday afternoons on neuro ICU with staff encouraged to pick a topic and educate their peers.

Clinical supervision had been introduced for nursing staff in 2016. Clinical supervision provides staff with an opportunity to reflect and review their practice. This may involve looking at individual cases, changing individual practice or looking at learning needs.

Staff had an hour of clinical supervision every three months. Senior staff were provided with training on how to facilitate supervision.

The ACCP’s we spoke with reported good support from medical colleagues and that support and advice was always available when needed.

The work on staff development and training was clearly outlined and supported by the adult critical care education and training strategy. We were consistently told by all staff that training was encouraged and professional development was a key priority for the trust. Staff reported being supported to attend training.
Additional training known as priority training was provided for all staff. Staff reported this was beneficial as it was very interactive and used scenarios staff had encountered. An example of this was nasogastric tube management, where actual patient x-rays were used.

This site also provided cardiac surgery advanced life support (CALS) training for staff. Staff fed back this made them feel valued and empowered. The day before our visit there had been an emergency on the cardiac ICU. Staff who had been involved told us due to having CALS training there was a level of confidence within the team.

The CCOT were also involved in delivering training. They delivered an introduction to the deteriorating patient as part of the introduction to professional practice programme.

The unit had link nurses, for example, in nasogastric feeding, end of life care, tissue viability and infection prevention and control.

Information provided by the trust showed that as of May 2018 27% of staff on the general ICU, 9% on cardiac ICU and 16% on neuro ICU had a post registration award in critical care nursing. This was significantly below the GPICS minimum recommendation of 50%.

Due to national problems with accessing post registration award in critical care nursing and staff turnover, the trust had developed an inhouse critical care course in partnership with a university. The current academic level was six and there were plans to increase this to level seven which is equivalent to master’s level. The first cohort of staff had just commenced the course, and the West Yorkshire critical care network peer review report from December 2017 noted that significant progress had been made towards achieving the GPICS standard of 50%.

**Multidisciplinary working**

During our inspection we observed good multidisciplinary team working. This was supported by the various staff we spoke with and in the patient records we reviewed. There was a lead pharmacist, physiotherapist and dietitian for critical care. Access to speech and language therapy and nurse specialists was available when required, such as tissue viability and infection prevention and control.

MDT staff did not always accompany medical staff on the ward round, however there was regular, structured MDT input which inputted into care planning and decision making. We saw evidence of this from speaking with staff and reviewing patient records.

Multidisciplinary staffing was generally in line with GPICS recommendations; however, it did not meet the full recommendations. We spoke with physiotherapy staff who confirmed that in line with GPICS recommendations they could provide the respiratory management and rehabilitation components of care. Daily microbiology ward rounds took place Monday to Friday with an on-call service at weekends. However, there was a shortage of critical care pharmacy provision at this site.

We observed four handovers taking place and the completion of transfer documents for patients going to ward areas. This was in line with NICE CG50 acutely ill adults in hospital. The critical care outreach team followed up all patients discharged to the wards from intensive care.

There were policies and procedures in place to support patients who would benefit from admission to critical care. As previously mentioned the HDU was predominantly nurse led and had criteria led discharge pathways.

There were clear internal referral pathways to therapy and psychiatric services. Staff were clear on when and how to refer patients.
Seven-day services

We saw from patient records daily consultant led ward rounds took place twice daily. Consultant cover was available twenty-four hours a day, seven days per week, in line with GPICS standards. Specialist critical care pharmacy staff were available Monday to Friday. There was access to pharmacy on-call service at other times. Physiotherapists provided treatment seven days a week with an on-call service available overnight. Speech and language therapy was offered Monday to Friday. X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

Health promotion

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate. There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations. Staff told us the pharmacist and consultant lead intensivists would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required. The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions. A range of patient information leaflets were available for patients and families. This included information such as preventing blood clots and pressure ulcers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Leeds General Infirmary

The trust reported that, as of June 2018, Mental Capacity Act (MCA) level 1 and 2 training was completed by 98.0% of nursing staff in critical care at Leeds General Infirmary, compared to the trust target of 80.0%.

Information provided by the trust showed that 92% of medical staff at this site had completed Mental Capacity Act training. This exceeded the trust target of 80%.

Staff were aware of the process if a patient required any form of restraint. Staff told us where possible this would be avoided; however, a policy was available in the intranet and staff told us they could access specialist safeguarding nurses for advice.

During inspection, staff we spoke with demonstrated an understanding of capacity and when best interest decision-making was appropriate. There was an up to date adult critical care policy for deprivation of liberty safeguards. This included a flow chart which gave clear guidance on when an application should be considered.
Staff told us the trust used the regional critical care network guidance for sedation and we saw there was a flow chart to help staff decide if sedation holding was appropriate. The trust policy outlined the phases of sedation and target Richmond Agitation-Sedation Scale (RASS) scores, linked to the status of the patient and ventilator settings.

In the records we reviewed there were prompts to undertake RASS scores twice a day and screening using the Confusion Assessment Method (CAM) for ICU. These tools are used to measure the agitation, sedation or delirium levels of a patient.

It was recognised that gaining consent from patients in critical care could be difficult. However, staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients. Where patients could verbalise, we observed staff seeking consent before undertaking any interventions.

### Is the service caring?

**Compassionate care**

The patients and relatives we could speak with were consistently positive about the care given. Feedback was that staff were caring and compassionate to both patients and their relatives.

We observed all members of staff providing care for patients’ in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.

During the inspection all the units were very busy, despite this staff calmly provided care and attended to the needs of their patients. The privacy and dignity of patients was maintained when care and treatment was being delivered by pulling curtains round.

Patients and relatives we were able to speak described how they were very happy with the care being given. One relative explained how they were pleased that the care for their son was supportive in terms of them transitioning between child and adult services.

Relatives reported flexible visiting and high standards of care delivery.

Patient boards at each bedside told staff about to any individual information relevant to that patient using magnetic symbols. This included any needs related to their care but also information about the person. For example, ‘I have a child attending school’ or ‘I have procedure anxiety’. These were particularly helpful for visiting staff who may only interact with patients for a short time, such as pharmacists or visiting consultants.

The use of these symbols was monitored through the ward metrics. Data showed an increase in compliance from 80% in April 2018 to 100% in May and June 2018.

Across the service there had been 100% of respondents recommending the service, with a response rate of 21%, this was only slightly below the England average response rate of 28%.

Staff told us the trust were focused on improving FFT response rates, as an incentive prizes were being offered to areas with the highest response rate.

Staff spoke about the important of patient feedback and how in addition to FFT data collection, iPads had been utilised to ask two questions and take any comments about patient care. This was done at the point of discharge; an online survey could also be completed by patients once they were at home. Data supplied by the trust showed there had been 60 responses, 97% of these were positive.

Patient dignity was monitored through the ward health check metrics, the most recent data from
June 2018 showed compliance was 100%. Compassion audit data for neuro ICU for the same time period was also 100%.

The service had a pet as therapy (PAT) dog, Maggie, who visited the units to interact with both patients, visitors and staff each Wednesday.

The service had critical care specific patient experience meetings. These were attended by unit managers, matrons, consultants and the patient experience team. We reviewed minutes of the June 2018 meeting. Items discussed included, FFT feedback, a patient story and patient update information, including patient diaries and unit information leaflets.

**Emotional support**

The use of patient diaries was well established and included as part of admission packs for patients. Relatives were encouraged to contribute to these. Patient diaries can help patients to understand what has been happening whilst they have been critically ill. Patients who have been in a critical care environment often report memory loss and some may suffer from psychological problems. Research has found patient diaries help to fill in some missing gaps and have also given the patient understanding as to how poorly they have been. Information booklets explaining their purpose were provided to relatives.

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients.

We observed staff providing emotional support for relatives in very sad and difficult circumstances on the neuro ICU. Bereavement follow up support was offered to all relatives on this unit.

The prayer room included a remembrance book and following a bereavement, a hand-written letter of sympathy was sent to families as well as offering an opportunity to respond to any questions families may have. In this letter families were also offered a free of charge calligraphy service to have their relative included in the remembrance book.

The intensive care psychological assessment tool (IPAT) was also used as part of the rehabilitation pathway. A score of seven or more would indicate a level of risk and a referral would be made for ongoing support.

Nonphysical risks were included in the critical care rehabilitation pathway document. This included prompts for patients in areas such as reoccurring nightmares and expressing a wish not to talk about their illness.

During MDT critical care meetings, reviews of journal articles took place to update staff. From reviewing meeting minutes, we found the types of articles reviewed were not just focused on clinical interventions. The minutes from April 2018 review an article about 'intensive care survivor reported symptoms'. This was about the prevalence of anxiety, depressions, fatigue and post-traumatic stress symptoms for ICU patients at three months and one year after discharge, and the importance of early recognition and appropriate support.

The trust was committed to drive awareness and culture surrounding organ donation. Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. The units had a lead organ donation specialist nurse, who was available at all times. Staff made referrals via the team manager.
Understanding and involvement of patients and those close to them

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.

We observed medical and nursing staff taking time to explain what was happening to relatives so they understood the care and treatment.

The relatives we spoke with said they felt informed and involved with the care of their relative. An example of this was the mother of a patient being involved in mirror therapy to better understand the condition of her son. Mirror therapy is a way of stimulating different regions in the brain that control stimulation, pain and movement.

The handovers we observed included a discussion about each patient’s preferred name. The service has also launched an incentive called ‘Respect’. This summary document included sections about the person and their health and any care preferences they may have.

Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation and were aware of the referral process surrounding organ donation.

There were information leaflets and information boards for relatives in the main reception in visitor waiting areas such as; pressure ulcer prevention, blood transfusion, hand decontamination, infection prevention, Methicillin Resistant Staphylococcus Aureus (MRSA), C Difficile, and deep vein thrombosis (DVT).

A visitor information folder gave information about the unit, including facilities on the unit, patient property, parking permits, patient diaries, hand hygiene, restaurant facilities, multi faith centre and shuttle bus information.

In June 2018 the service developed and launched a website called ICU unwrapped. This was an information source for families to provide support and explain what things happen on ICU. It included pictures and explanations of the different staff and teams involved in delivering care as well as easy to understand clinical information. People who visited the website could also leave any feedback.

Is the service responsive?

Service delivery to meet the needs of local people

Critical care provision on the ICU flexed to meet the differing needs of level two and level three patients. The HDU provided level two care, there were clear pathways between the units if patient care needed to be stepped up or down.

The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

Overnight rooms for relatives were available, however we noted there was limited access to shower and changing facilities. On the general ICU the unit was working with a local charity to redecorate the room to make the area less clinical. They also had comfort bags containing wash products donated by a retail company.

The general and cardiac ICU’s had follow up clinics in place in line with GPICS guidance. Appointments were offered to any patients who were on the units for three days or more. Patients
were offered an appointment three months after discharge from the unit. Patient diaries were discussed at the follow up clinic to identify individual patient needs post discharge. The clinic was run by the critical care outreach team with a medical focus; if patient needs were identified referrals were made via their general practitioner.

Follow up clinics on the general and cardiac ICU were in line with GPICs recommendations. This was an improvement from the last inspection. Whilst neuro ICU was not in line with GPICS, there was follow up support for this patient group. Due to the types of patients who would be cared for on this unit, they often remained in the healthcare system for a long time following discharge from critical care. Some patients continued to receive long term rehabilitation at Chapel Allerton Hospital. There were good working relationships between the two units and if any individual issues were identified related to the patients stay on ICU these were shared. There were appropriate referral systems in place to manage these.

The service was actively involved in the regional critical care operational delivery network.

There was an Advanced Respiratory Unit based at the St James’s University Hospital site. The unit supported patients requiring home ventilation. Any patients with complex weaning problems were referred to the respiratory team.

Service users were a key element of the adult critical care vision. Key to this was a focus on FFT, complaints management, carer input and literature and online support. Our inspection findings provided assurance that these plans had been implemented.

**Meeting people’s individual needs**

Staff we spoke with knew how to access interpreting services for patients whose first language was not English. We observed interpreters being arranged for meetings with families to ensure information about care and treatment plans were clearly communicated. Patient information leaflets were available in different languages.

There was a loop system available for people who used a hearing aid. Staff told us they would contact the vulnerable adults team or senior staff for advice and support if they were working with someone with a learning disability.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. Staff told us that when caring for someone with a learning disability, they could also seek support from the trust safeguarding team, which included a specialist learning disability nurse. The care we observed and the patient records that we reviewed reflected that individual needs were assessed and care planning was informed by this.

Patients and relatives were encouraged to contribute to patient diaries to record the pathway and care within critical care. Staff explained that they discussed this alongside individual patient likes and dislikes as an engagement tool.

Staff we spoke with told us they could access equipment to care for bariatric patients as required.

A visitor’s information booklet was available on each unit which included information about the on-site multi-faith chapel and trust chaplaincy service and menu options, for example, vegan, vegetarian and halal.

A feedback form had been devised to ask patients about their views on the critical care rehabilitation team. This specifically asked about the transition from critical care to ward based care which can be a difficult period of adjustment for patients.
The Trust had recently introduced an initiative where all CSU's attended the Patient Experience Sub Group, to present the improvements they have made in response to patient feedback. Critical Care presented information on patients who experienced having a tracheostomy and how frightening this could be. Patients also fed back one of the hardest things for them was not being able to get any fresh air. In response, the service was developing patient information to help patients understand more about having a tracheostomy. They also found a way for patients with tracheostomies to leave the department and go outside.

The trust recognised a key opportunity to obtain patient and relative feedback was through the FFT programme. Steps had been taken to make this more accessible to patients and their relatives using text messaging and providing access to a FFT app. The app enabled the FFT survey to be translated into over 90 languages. For patients not able to read, it is also enabled people to speak to them in their own language.

Access and flow

At the last inspection in 2016 issues had been identified in terms of access and flow, in particular around delays in getting patients admitted to critical care and out of hours discharges.

Access and flow remained a challenge for the service as it provided specialist critical care provision for a large geographical area. However, several actions had been taken to try and make improvements. We were provided with a high-level patient pathway for those needed adult critical care. This was used as a starting point to help the service in their aim of admitting 20 more patients to critical care each month following surgical treatment. Analysis and root cause investigations took place. An action plan was developed supported by metrics to measure progress. This included things such as, the number of cancelled operations and the length of delays for elective patients.

Another key aspect to improve access and flow was the development of the cross-site patient flow team. This team of critical care nurses provided 12-hour cover six days a week. They met with bed managers and matrons at regular times throughout the day managing access and flow across all the units at the trust. The team used information on CEM books to strengthen escalation processes. This included data on bed occupancy, demand and acuity on the units linked to staffing.

A 24-hour flow chart had been developed for the patient flow bleep holder, included in this were the key times that data needed to be inputted into CEM books. This ensured consistency with the type and time of information added to the system to support informed decision making.

Two metrics within CEM book that significantly impacted the level of escalation for the units were, ‘available beds now’ and ‘predicated beds’. At 7am the electronic patient record system was used to identify any expected ‘step downs’. This was identified by the nurse then agreed by the consultant. This process was being trialled on the neuro ICU with a view to rolling it out across all sites. This process had previously taken some time to complete but using technology had allowed it to be done much quicker. The early identification of potential critical care beds helped to better plan for admissions each day.

Within CEM books there was also the ability to add free text to share information but also evidence why decisions were made. For example, we saw that on one day there were four level
three patients with no beds plan being cared for outside of ICU. This impacted decisions made about staffing and elective patients as the priority was to move those patients into an ICU bed.

A matron of the day was also available to support the escalation process in terms of access and flow. They attended the patient flow meetings. An escalation process had also been implemented for cancelled operations, these were also discussed as part of the patient flow meetings. We were told by matrons that work was ongoing to try and standardise the flow of elective admissions. This would help reduce any ‘peaks and troughs’ during the week in terms of patient numbers.

**Bed occupancy**

From May 2017 to April 2018, Leeds Teaching Hospitals NHS Trust's adult bed occupancy rates were lower than the England average from May to October 2017 before increasing in November 2017 to above the average for England. The rates were similar to the England average from December 2017 to April 2018.

![Adult critical care Bed occupancy rates, Leeds Teaching Hospitals NHS Trust.](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

**Delayed discharges**

We were provided with the most recent ICNARC annual quality report. This showed that between 1 April 2017 and 31 December 2017 there were 3,850 available bed days on neuro ICU. The percentage of bed days occupied by patients delayed more than eight hours was 6.9% this was worse than similar units which had an average of 2.3%.

The quarterly report from 1 April 2018 to the 30 June 2018 showed this had improved slightly to 5.4% compared to 3.2% in similar units.

We were provided with the most recent ICNARC annual quality report. This showed that between 1 April 2017 and 31 March 2018 on the general ICU there were 5,110 available bed days. The percentage of bed days occupied by patients delayed more than eight hours was 3.5% this was much better than similar units which had an average of 6.1%.

The quarterly report from 1 April 2018 to the 30 June 2018 showed this had further improved to 1.6% compared to 5.3% in similar units.

The last inspection highlighted that a total of 3,122 patients across the units at this site had waited over four hours to be discharge from ICU. Whilst there were still some delays, particularly
on the neuro ICU, it should be noted the total number was 441 which is a significant reduction.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers

ICNARC data from 1 April 2017 to 31 December 2017 showed that of 579 admissions to the neuro ICU there was one non-clinical transfer (0.2%); this was in line with that of similar units.

ICNARC data from 1 April 2017 to 31 March 2018 showed that of 796 admissions to the general ICU unit there were nine non-clinical transfers (1.1%); this was slightly higher than similar units who reported a rate of 0.3%. However, it was in line with national averages.

Non-delayed out of hours discharges to the ward

At Leeds General Infirmary, in the general intensive care unit, 5.1% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range. The figure in the 2015/16 annual report was 6.4%.

At the previous inspection it was highlighted that there was a high number of transfers occurring out of hours (between 22.00pm and 07.00am). In total between April 2015 and March 2016 this totalled 473 patients.

ICNARC data from 1 April 2017 to 31 December 2017 on neuro ICU showed that the proportion of admissions that were non-delayed, out-of-hour’s discharges to the ward was within expected limits, however was still higher when compared to similar units. Based on 431 admissions, 4.2% were discharged out of hours, compared to similar units who had a percentage of 2.3.

ICNARC data from 1 April 2017 to 31 March 2018 on the general ICU showed that the proportion of admissions that were non-delayed, out-of-hour’s discharges to the ward was within expected limits, however was still higher when compared to similar units. Based on 428 admissions, 4.7% were discharged out of hours, compared to similar units who had a percentage of 1.8.

It is worth noting the total number of out of hours transfers for both units was 38. This is a significant reduction compared to the last inspection where it was 473.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICU dashboard monitored the number of cancelled elective operations due to no critical care bed being available post operatively. Data from January 2018 to March 2018 showed the percentage was 7.69, this was better than the National average of 9.07%.

Cancellations within cardiac surgery were highlighted and discussed with the senior management team. The team were fully sighted on this. A cardiac improvement workstream was ongoing with a review planned in November 2018. Whilst there had been a number of cancellations, this was closely monitored and each case reviewed. Consultants reported a much safer and robust system in place to manage elective cases using a risk based approach.
Learning from complaints and concerns

Summary of complaints

From May 2017 to April 2018 there were eight complaints about critical care. The trust took an average of 61.4 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 40 days.

Two complaints were partially upheld, five were fully upheld and one was still under investigation.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>St James's University Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
</tr>
</tbody>
</table>

The trust has allocated multiple subjects for each complaint received. It is therefore not possible to provide a breakdown of complaints by subject.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We saw information displayed for patients and families about how to contact the Patient Advice and Liaison Service (PALS) and on how to make a complaint. There was also information encouraging relatives to speak to the nurse in charge if they had any concerns to try and resolve any issues before they escalated.

All staff we spoke with said they would try and resolve any concerns at the time they arose. Often this may be dealt with by the nurse in charge. However, staff were aware of the policy for managing concerns.

We saw from reviewing a number of different meeting minutes, complaints were a standing agenda item. These included governance meetings, patient experience and team meetings. As with incidents, a tracker was used to monitor complaints in terms of responding to them and identifying any themes.

We spoke with the senior management team about the data we had with regards to complaint response times. We were told the complaints received were complex and involved a number of the trusts CSU’s and ICU generally formed a small part of the complaint. They reported they provided a response to the critical care aspects in a timely way, however as other services were involved, providing a full response was a challenge and as such trust timeframes may not always be met. This was reflected in their overall response times and something they had little control over.

Is the service well-led?

Leadership

Critical care, unlike many other trusts had its own CSU. This meant all aspects of management and the care and treatment of patients could be specifically focused on critical care.

Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. There were two lead consultants and a quality lead. Each speciality unit had a
designated matron and had supernumerary coordinators in place for each shift in lines with GPICS.

The service had utilised the Leeds Improvement Method (LIM), in conjunction with the Virginia Mason Institute and partner organisations in various workstreams to make improvements, for example, with access and flow. Senior clinicians and managers had undertaken the Lean for Leaders programme, this was part of the trust’s Quality Improvement Strategy.

The critical care outreach team (CCOT) had a clinical lead and each unit had its own clinical educator.

The leaders we spoke with were experienced and knowledgeable. The matrons were very clinically engaged and could support with staffing if there were pressures within the units.

There was strong nursing and medical leadership on the unit. From our observation and from speaking with staff, it was clear that staff had confidence in the leadership at all levels. The service ensured that there were experienced staff on every shift including night and weekends. Staff consistently reported feeling very supported by their teams and managers.

We met the leadership team and it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. There was clear evidence of actions taken and processes put in place to mitigate these.

Areas for improvement identified at the previous inspection has been addressed and built up on. Staff of all levels could tell us about the improvements made and we saw clear evidence to support this.

The West Yorkshire critical care network peer review report from December 2017 found a clear MDT commitment to providing safe and effective care to patients. The service demonstrated improvements in a number of areas, with the senior management team being fully sighted on areas where further work was needed.

The focus on training and development meant there were succession plans in place within the service. This was supported by the talent and leadership chapter in the trust’s people strategy. Overall training was supported by a trust workforce and people strategy.

There was a significant focus on developing and training for staff at all levels to ensure effective leadership and drive continuous improvement. This was evident from training and appraisal records and from discussions with staff during the inspection.

The leadership team and senior staff were highly visible and approachable. Matrons visited their units daily and were involved in daily safety huddles and patient flow meetings. Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

Vision and strategy

The critical care CSU was aligned to the trust’s vision of commitment to delivering the highest quality and safest treatment and care to every patient, every time. Along with this the trust had five goals. These were; to be the best for patient safety, quality and experience; to be the best place to work; to be a centre of excellence for specialist services, research, education and innovation; to offer seamless, integrated care; and to be financially sustainable.

Since the last inspection the vision for critical care had been refreshed. An engagement exercise had been undertaken to develop a vision and statement to support the directorate to operate as
one unit. The key focus had been on quality and safety with an overall vision of delivering outstanding care. We saw the strap line, 'outstanding critical care' throughout the units and headlining meeting minutes and documentation.

There were posters throughout the units illustrating the eight elements integral to the unit’s vision. These were; quality, research and innovation, environment, education and training, service users, governance/risk, finance/business and people. Each of these areas was linked to specific outcomes and strategies. For example, linked to quality was; pressure ulcers, handovers and transfers out of the unit.

The vision also involved external partners, staff and service users.

In the areas we visited there were posters outlining issues from the previous inspection and what actions had been put in place. From our discussions with staff from all disciplines it was evident there had been a team approach to the changes implemented as all staff could articulate them.

The values of the ‘Leeds Way’ were; offering patient centred care, and being fair, collaborative, and accountable. These were seen displayed in the areas we visited. Staff felt they were reflected in the values and behaviours of staff within the service.

The overall approach to strategy was taken through services working closely with NHS and social care partners in the Sustainability and Transformation Partnership and the West Yorkshire Association of Acute Trusts to identify the best pathways for sub-acute care, acute care, integrated and specialist care within the area.

The strategy had extensive consultation with staff and partners in other NHS organisations and social care. As part of these discussions were held in public places and crowd-sourcing techniques via the internet were used. At CSU level a key theme was the “bottom up” involvement of clinical teams.

We reviewed the Quality Improvement Strategy for critical care for 2018-2020. This was stretching and challenging looking at innovative ways of working to achieve the highest standards of care for patients. The strategy was based on the five domains in the National Outcomes Framework (2012) and the CQC framework. Each domain within the strategy had clearly identified areas of focus within it. For example, within safe there was, preventing and reducing skin damage, managing pain and developing the nursing and medical handovers using patient passports.

The service also had a Clinical Business Strategy (2017) which we reviewed. This outlined progress since the last inspection and had timelines for improvement up to 2022.

The service had also used the Leeds Improvement Method. Most recently this had been done in a lean for leadership project. This had five stages; sort, simplify, sweep, standardise and self-discipline. Currently the service was at stage two with an aim to be at stage three within a month.

The service recognised the importance of knowing how they were doing in relation to the goals and aims within their strategy and vision. The Quality Improvement Strategy outlined metrics to evidence this. They included, the number of patients with a hospital acquired infection and the number of incident compared to the number of patients being cared for.

During our inspection we found evidence that a number of areas identified in the strategy had already made significant progress. For example, in relation to CG83, rehabilitation after critical illness and in terms of access and flow.
**Culture**

Staff we spoke with told us they felt proud of their work and the care they provided to patients and their relatives. They said they felt able to raise concerns and were aware of the importance of being honest and open. They were able to explain the duty of candour and the need to apologise to patients and relatives in line with trust policy if there had been a mistake.

Senior staff told us following a meeting with a family about an incident which was not clinically led, they still felt there were areas where they could have been more open and honest about care decisions. They discussed this and arranged another meeting with the family to specifically discuss the clinical aspects of care.

Despite the units being busy and challenging places to work we found generally high levels of staff morale within all the teams we spoke with. Staff reported feeling well supported particularly after significant events. Debriefs were well established and staff fed back these were very helpful. Education was also being provided to senior nurses on how to undertake debriefs.

Staff were highly engaged and we found effective systems in place for sharing information across teams. Safety huddles were embedded and were attended by members of the MDT. Safety briefings were another method of sharing information.

The service used closed social medic groups as another way of sharing information with staff. Staff told us often messages were posted thanking the team on particularly busy or challenging shifts. These made staff feel valued and appreciated. ‘Shout outs’ and ‘well dones’ were given as part of the team briefs at the start of the shift.

There was a genuine view of critical care being one unit across the two sites. The language used by staff supported this as well as the systems and processes in place to manage staffing and access and flow. We observed staff thanking each other at the end of a shift in particular those who had come from St James’s Hospital to help.

Staff well-being was a key focus for the service. Staff played a key part in the strategy and vision for the service and there was a strong focus on valuing staff and their well-being when we spoke with senior staff and the leadership team.

The trust had employed a psychologist based at the St James’s University Hospital site. Staff told us they could approach the psychologist for advice. The trust acknowledged staff emotional well-being and offered one to one support via regular mentor meetings and offered senior management support if a need was evident.

There was targeted work being done in relation to well-being for new starters. A recruitment and retention strategy had been devised. We reviewed this document which covered a wide range of areas from retiring and returning staff, education and adult critical care branding.

**Governance**

Critical care had its own CSU. We were provided with the adult critical care ward to board flow chart. This clearly showed how information was shared and escalated. All elements of governance within the service reported into monthly critical care, governance, triumvirate and senior managers meetings. Sub groups fed into these meetings each producing a summary of any risks for discussion, for example, medicines management, falls, and patient experience.
We reviewed governance meeting minutes, which were well attended. Meetings had a standard agenda and covering staffing and updates for each of the units. Performance dashboards and metrics were reviewed, as well as trackers for monitoring incidents and complaints.

Staff were able to describe escalation pathways and the systems for disseminating information. Key to this was safety huddles and team briefs which took place each shift.

Individual staff at all levels were clear about their role and responsibilities and the systems for escalating any concerns. Matrons and senior managers were very visible on both units and had an ‘open door policy’ for staff.

The West Yorkshire critical care network peer review report from December 2017 showed improved compliance, particularly in cardiac ICU, with GPICS standards overall regarding governance and data. This section of the report related to areas such as incident reporting, clear operation policies and evidence of implementation of evidence based care.

**Management of risk, issues and performance**

The trust provided support to develop individual CSU’s to enable them to manage their own risks. There was a board escalation process in place for those risks that scored at 15 or above. These were included in the corporate risk register.

There was a critical care risk register which contained 14 risks. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating. Each of the risks had an initial RAG rating, a current score based on mitigation already in place, and a target score when further mitigation had been put in place.

There were clear descriptions of each risk and dates for review with associated controls and action plans in place.

The risks related to medical and nurse staffing, defibrillation equipment needing replacement, finance, hospital acquired infections, compliance with CG83 rehabilitation after critical illness and access and flow.

From our discussions with the leadership team they were clear about key risks to the service and mitigating actions and the risk register reflected this.

The service had a dashboard to monitor performance month on month compared to national averages. This included graphs to enable trends to be looked at. The service had a robust audit plan which was aligned to best practice guidelines to monitor quality.

The service contributed to ICNARC and since the last inspection the service had begun to collect data for the cardiac ICU.

Areas identified as requiring improvement at the last inspection had received significant focus and work. An access and flow team had been put in place and work in this area was reflected in improved outcomes in the services ICNARC data.

Significant work had been done in relation to CG83 rehabilitation after critical illness, above what was recommended by NICE.

The Quality Improvement Strategy for the service pulled all these elements together with a focused plan for oversight, monitoring and delivery of the objectives.
**Information management**

Electronic patient records and medication charts were in use. The computers we saw had their screens locked when they were not in use.

Computerised whiteboards were used on the units. They contained patient information that could be viewed instantly. They also alerted staff when any assessments needed updating.

Information technology was used in a number of ways to both monitor and audit the quality of care, and as tools for data collection from patients and their relatives.

Staff accessed information relating to policies and guidance electronically. The system was easy to navigate.

Staff received training on information governance and were aware of the importance of managing confidential patient information. We found that paper records were stored securely within the unit.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients’ bedside.

**Engagement**

Within the critical care service there had been a focus and recognition of the importance of engagement of both staff and patients and their relatives. There were a number of improvement projects using the LIM which staff were actively encouraged to engage with. Examples of these included, hospital acquired infection collaboratives and work to reduce patient falls.

The trust conducted an annual staff survey, this showed an overall improvement in staff engagement scores from 2016 to 2017. The information was reviewed and the critical care team made commitments to staff based on the outcomes of this survey. This included; proactively sharing patient feedback with staff and investing in high quality staff training.

An important element of staff engagement was by recognition and reward of their work. This included things such as, an annual awards event where staff were nominated and received awards, quality improvement forums and the use of social media to thank staff.

At this site, teams from L03, L06 and L07 were all presented with certificates for achieving 150,100 and 200 days respectively, since a pressure ulcer happened on their wards. The cardiac ICU also won team of the year at the annual awards ceremony in March 2018.

The service had a staff engagement group and a band five staff council. At this a variety of issues could be discussed with proposed solutions encouraged by the staff who attended.

There was good support for staff in terms of health and well-being. The leadership team recognised the pressures of the roles. There was information on the trust intranet about how to deal with stress and what support was available for staff, debriefs played a key part in this.

There was evidence of staff engagement throughout the units. This had contributed to the progress made since the last inspection. Staff across the service felt part of team with a shared purpose.

Examples of this included, the development of the Quality Improvement Strategy. The infection control team spoke with us about working closely with quality improvement team. They described an approach of collegiate engagement involving staff at all levels supported by link and key workers. This resulted in staff being interested an engaged.
There were information boards on the unit to share information about the service with staff and visitors. They were titled, ‘how are we doing?’ This included performance data as well as training opportunities and successes within the units.

The service proactively engaged with patients and families through a number of different ways to plan and improve services.

There was some access to clinical psychology for patients on ICU through the patient follow up clinic. There was access to mental health liaison services for all inpatients.

The service had a critical care patient experience group, as part of this complaints were reviewed to look at ways of improving services. Within the MDT meeting minutes were reviewed we saw that one of the purposes outlined by the group was patient experience.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network.

The service had 12 advanced critical care practitioners (ACCP’s) and others in training. By November 2018 they aimed to have twenty-four-hour cover by ACCP’s on HDU. Senior management told us they were a proud workforce who were writing protocols and investigating devices to change practice.

The service was holding the National Adult Critical Care conference in 2020 to describe their journey and the progress they had made.

Supporting and seeking innovation was part of the services Quality Improvement Strategy. Research and innovation were one of the eight elements linked to the critical care vision. This was aiming for twenty-four hours a day seven day a week research capability. This was supported by work with the Institute for Critical Care and plans to build the North East Critical Care research network. There was an adult critical care research strategy and the service had a goal of being recognised nationally as a lead in research.

We spoke with the research team who were all intensive care nurses. They had strong links with education and told us about current projects such as lung protective ventilation strategies and a trial of new inotropes

A significant amount of work had been by the service since the last CQC inspection. In particular regarding patient access and flow, and work related to rehabilitation after critical illness. Progress continued to be made with further improvement planned.
Leeds Teaching Hospitals NHS Trust has two Emergency Departments (EDs) located at Leeds General Infirmary (LGI) and St James’s University Hospital (SJUH). Each department has admission criteria determining which patients can be seen there and these are well publicised within the hospital and around the city. There is an agreement in place with the ambulance service regarding which patients can be transported to each department.

St James’s ED is the Leeds centre for acute general medical patients and older people. It does not accept paediatric patients or patients with trauma related injuries arriving by ambulance, although these patients may self-present to the department. In cases of acute illness in children, or severe injury in adults and children, patients will be assessed and stabilised before being transferred to LGI, in line with trust protocol.

The ED is open 24 hours a day, seven days a week and has a minor injuries unit, general practitioner (GP) service and clinical decisions unit (CDU). Urgent and emergency care is part of the trust’s emergency and speciality medicine (ESM) clinical services unit (CSU).

Activity and patient throughput

**Total number of urgent and emergency care attendances at Leeds Teaching Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018**

From July 2017 to June 2018 there were 221,559 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)
Urgent and emergency care attendances resulting in an admission

![Graph showing percentage of A&E attendances resulting in an admission at this trust and England average over 2016/17 and 2015/16.]

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2016/17 compared to 2015/16. In both years, the proportions were higher than the England averages.

Updated analysis for March 2017 to February 2018 showed that 34.1% of attendances at the trust resulted in admission which placed the trust in the highest quantile in comparison to national rates.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2017 to February 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>75,158</td>
</tr>
<tr>
<td>Discharged*</td>
<td>97,767</td>
</tr>
<tr>
<td>Referred^</td>
<td>17,663</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>392</td>
</tr>
<tr>
<td>Died in department</td>
<td>256</td>
</tr>
<tr>
<td>Left department#</td>
<td>11,903</td>
</tr>
<tr>
<td>Other</td>
<td>292</td>
</tr>
<tr>
<td>Not known</td>
<td>17,136</td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The department was meeting the trust target of 80% compliance with mandatory training in 14 of the 17 required modules. However, compliance was low for resuscitation training.
During inspection we asked senior staff to explain this; they were unable to offer a definitive reason but told us there may have been issues with access to training courses due to high demand. Following inspection, we were informed that the retirement of one of the trust’s paediatric resuscitation officers meant that capacity to deliver training had been limited. There had been a resuscitation officer seconded to the vacant position since our inspection and a training programme was in place.

Staff we spoke with told us they were up to date with most mandatory training, but confirmed there had been problems accessing paediatric resuscitation training. We were told that mandatory training included staff being taught how to recognise and respond to patients presenting with mental health needs, learning disabilities and dementia.

### Mandatory training completion rates

The trust set a target of 80.0% for completion of mandatory training.

#### Trust level

A breakdown of compliance for mandatory training courses as at June 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and safety matters</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity general</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling lower risk</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>236</td>
<td>236</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>235</td>
<td>236</td>
<td>99.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control specialist clinical</td>
<td>234</td>
<td>235</td>
<td>99.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>234</td>
<td>236</td>
<td>99.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>230</td>
<td>233</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>231</td>
<td>236</td>
<td>97.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>223</td>
<td>236</td>
<td>94.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2</td>
<td>131</td>
<td>154</td>
<td>85.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 1</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>160</td>
<td>209</td>
<td>76.6%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2 update</td>
<td>103</td>
<td>154</td>
<td>66.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 80.0% target was met for 14 of the 17 mandatory training modules for which qualified nursing staff were eligible. The service had 100% completion rate for seven training modules and a further six modules had completion rates above 90%. Nursing staff had an overall mandatory training completion rate of 95.2%, exceeding the trust target of 80.0%.
PRTD paediatric life support level 2 update had the lowest completion rate at 66.9%, while resuscitation training level 2 and PRTD paediatric life support level 1 had completion rates of 76.6% and 76.9%, respectively.

A breakdown of compliance for mandatory training courses as at June 2018 at trust level for medical staff (working across both sites) in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling lower risk</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk and safety matters</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity general</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>86</td>
<td>96</td>
<td>89.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>55</td>
<td>62</td>
<td>88.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>109</td>
<td>124</td>
<td>87.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>115</td>
<td>135</td>
<td>85.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>specialist clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>103</td>
<td>123</td>
<td>83.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>111</td>
<td>136</td>
<td>81.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>110</td>
<td>136</td>
<td>80.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>109</td>
<td>136</td>
<td>80.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 3 ALS</td>
<td>12</td>
<td>19</td>
<td>63.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2 ILS</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>33</td>
<td>114</td>
<td>28.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>(update)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>33</td>
<td>114</td>
<td>28.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2 PMST</td>
<td>13</td>
<td>100</td>
<td>13.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 80.0% target was met for 12 of the 17 mandatory training modules for which medical staff were eligible. Eight training modules had completion rates above 85.0%. Medical staff had an overall mandatory training completion rate of 75.0%, lower than the trust target of 80.0%.

The trust target was not met for five training modules, with the lowest completion rate of 13.0% for resuscitation training level 2 PMST. Resuscitation training advanced and resuscitation training advanced (update) both had a completion rate of only 28.9%. Resuscitation training level 2 ILS had a completion rate of 50%, although this equates to only one eligible staff member not completing the training.

St James’s University Hospital urgent and emergency care department

A breakdown of compliance for mandatory training courses as at June 2018 for qualified nursing staff in the urgent and emergency care department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and safety matters</td>
<td>89</td>
<td>89</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity general</td>
<td>89</td>
<td>89</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
At St James’s University Hospital urgent and emergency care department the 80.0% target was met for 12 of the 15 mandatory training modules for which qualified nursing staff were eligible. Nursing staff had an overall mandatory training completion rate of 92.8%, exceeding the trust target of 80.0%.

Six training modules had a 100% completion rate and a further six modules had completion rates above 90%.

The 80.0% trust target was not met for three modules. PRTD paediatric life support level 2 (update) had the lowest completion rate of 45.3%, while resuscitation training level 2 and PRTD paediatric life support level 2 had completion rates of 71.9% and 75.0% respectively.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

During our inspection we found that there were systems in place to identify and manage those at risk of abuse, including domestic violence. Medical and nursing staff we spoke with told us they had completed safeguarding training as part of their mandatory training, which included specific teaching about child sex exploitation (CSE), female genital mutilation (FGM) and domestic violence. They could tell us how to access policies and knew how to recognise and raise potential safeguarding concerns. They could give us examples from their own experiences and told us of instances where they had worked in collaboration with ambulance staff to raise concerns and ensure patients were safe.

Staff told us the department had good links with safeguarding teams, who provided advice, support and regular training. There were weekly meetings between ED and safeguarding teams to discuss referrals. There was a safeguarding link nurse in the department and staff told us that information and support was readily available. Safeguarding training at level three was mandatory for band seven nurses at the time of our inspection, but we were told it was planned to also include band six nurses, to increase knowledge and awareness.
Safeguarding training completion rates

The trust set a target of 80.0% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as at June 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>233</td>
<td>236</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>233</td>
<td>236</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>186</td>
<td>226</td>
<td>82.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>186</td>
<td>226</td>
<td>82.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>7</td>
<td>9</td>
<td>77.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 80.0% target was met for six of the seven safeguarding training modules for which qualified nursing staff was eligible. Nursing staff had an overall mandatory safeguarding training completion rate of 90.8%, exceeding the trust target of 80.0%. Two training modules had a 100% completion rate and a further two modules had completion rates above 90%.

One training module, Prevent (WRAP), had a completion rate of 77.8%, although this equates to only two eligible staff members not completing the training.

A breakdown of compliance for safeguarding training courses as at June 2018 at trust level for medical staff in urgent and emergency care (working across both sites) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
<td>28</td>
<td>31</td>
<td>90.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>121</td>
<td>136</td>
<td>89.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>53</td>
<td>68</td>
<td>77.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>23</td>
<td>31</td>
<td>74.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>22</td>
<td>31</td>
<td>71.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>89</td>
<td>136</td>
<td>65.4%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>24</td>
<td>67</td>
<td>35.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 80.0% target was met for two of the seven safeguarding training modules for which medical staff was eligible. Medical staff had an overall safeguarding training completion rate of 72.0%, not meeting the 80.0% trust target.
Five modules had completion rates lower than the trust target. Safeguarding children level 2 had the lowest completion rate of 35.8%, followed by safeguarding children level 1 with a completion rate of 65.4%.

St James’s University Hospital urgent and emergency care department

A breakdown of compliance for safeguarding training courses as at June 2018 for qualified nursing staff in the urgent and emergency care department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>61</td>
<td>85</td>
<td>71.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>61</td>
<td>85</td>
<td>71.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At St James’s University Hospital urgent and emergency care department the 80.0% target was met for five of the seven safeguarding training modules for which qualified nursing staff was eligible. Nursing staff had an overall safeguarding training completion rate of 85.0%, meeting and exceeding the trust target.

Three modules had a 100% completion rate and two modules had completion rates above 95%. Two modules had completion rates below the trust target. Safeguarding vulnerable adults - level 2 and safeguarding children level 2, both had a completion rate of 71.8% below the trust target of 80.0%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

During inspection we found all areas of the department to be clean and tidy, including patients’ cubicles, waiting areas, toilets, corridors and dirty utility. However, we did see posters attached to the wall in the resuscitation area using sticky tape, which appeared dirty. We saw regular cleaning in progress and witnessed daily cleaning checklists being completed by domestic staff. The department employed band one non-clinical support workers and they were responsible for some of the cleaning duties, including patient trolleys and some items of equipment. Checklists were completed by the nurse in charge of each shift to ensure standards of cleanliness were monitored and maintained. We reviewed completed checklists for the month prior to our inspection and all entries had been fully completed.

The trust had an infection, prevention and control policy, which provided guidance for staff regarding cleaning, decontamination and personal protective clothing. Infection control training was part of the trust’s mandatory training programme. The trust had set a compliance target of 80%; in urgent and emergency care at SJUH, the compliance rate was 98.9% for nurses and 85.2% for medical staff.
We found that all clinical and non-clinical waste and laundry items were separated appropriately. We saw notice boards throughout the department which displayed information about handwashing and infection prevention. There were four cubicles within the department which could be used for isolation purposes, to enable the prevention and management of actual or potential infection.

Disposable curtains were being used in the department. All had labels to say when they were next due to be changed and all those we checked were in date. We saw consistent use of ‘I am clean’ labels on equipment, mattresses and commodes; all had been signed and dated appropriately. We checked ten mattresses in the majors’ area and resuscitation room; all were clean and intact. Sharps bins were stored at an appropriate height and were not overfilled. They had been signed and dated appropriately and apertures were temporarily closed when not in use, in line with national guidance. All cleaning materials and hazardous substances were stored appropriately.

We observed staff using correct hand decontamination techniques, and all staff we saw were compliant with ‘bare below the elbows’ and uniform policies. We observed staff cleaning equipment between patients. Handwashing facilities, hand sanitising gel and personal protective equipment (PPE), including aprons and gloves, were readily available in the majors’ area.

Environment and equipment

The main ED area was an adequate size with well-maintained equipment available, but we had concerns about the layout and location of the MIU, and about the mental health assessment room.

The patient waiting areas had sufficient seating: the seats were secured to the floor and those in the main area faced the reception desk, so patients could be easily observed. There were separate entrances for patients walking in and those arriving by ambulance, and entry into the main department from the ambulance doors was secure. In the main waiting area there was evidence of a water leak; we were informed that this had been reported and was due to be repaired imminently.

The main department had two waiting rooms: waiting room one was situated in the main reception area and waiting room two was closer to the majors’ department and triage area. Staff told us they often had difficulties locating patients because it was unclear which waiting room they had been directed to. We were informed that the department’s electronic system was being updated to show a patient’s exact location when waiting.

We found that all consulting and treatment cubicles were an appropriate size and contained the necessary equipment. Major incident equipment was stored in a cupboard adjacent to the designated decontamination area; all equipment was in date and appropriately stored. There was an isolated water supply for decontamination purposes. The major incident equipment store and decontamination facilities were overseen by one of the department’s consultants.

The resuscitation room had five bays: the layout allowed patients to be observed easily in this area. One of the bays could be used for children if required, with paediatric equipment readily available. Resuscitation equipment was found to be compliant with safety checks and we saw that checklists were completed daily. Resuscitation trolleys were appropriately stocked and electrical equipment testing was up to date. We saw that some of the monitors used for recording patient observations were not compliant with safety checks and were told these were due to be replaced. We checked the risk register and found that this issue had been identified and escalated: some of the monitoring equipment had already been replaced and further monitors were due to be replaced imminently.
The minor injuries unit (MIU) was located downstairs from the main ED. Following registration at reception, patients were required to walk along a corridor, go to the floor below using a staircase or lift, and then walk along a second corridor before arriving in the unit. There were no clear directions visible. The X-ray department was located within the main ED, so those patients seen in MIU who required an X-ray were required to return upstairs.

We were told that the MIU had originally been situated next to the main reception, but this space was now occupied by St James’s acute medical assessment area (referred to as JAMAA). The staff we spoke with in the MIU felt the change had been negative in terms of both location and available space; the MIU was now shared with the physiotherapy department and staff felt they did not have adequate cubicle space in which to see patients. Staff were also concerned that privacy and patient confidentiality were compromised because of the department layout.

We spoke with two patients in the MIU who both told us they had found getting to the department difficult: the first had needed to ask for directions twice and the second had a leg injury and had not realised the distance from the main department. Staff told us that patients often commented about the location and they had recently been unable to find a patient who was directed to the MIU after registering at reception; this patient was later found by a porter in another area of the hospital, in a distressed state. Staff informed us they had made managers aware of the difficulties, but felt they had not been listened to. We spoke with senior staff about this and they told us they were aware of the issues; the possibility of relocating the MIU was under discussion. We were told that a porter had been assigned to assist patients in accessing the MIU, but we did not see evidence of this happening during our inspection.

The mental health assessment room was in the majors’ area, in the ‘green’ bay, and could be easily accessed in an emergency. Viewing windows in the doors were made of toughened glass and covered with frosted privacy film; there was a small unobscured circle at the top of the window to allow observations to be carried out. The room had two doors, one opened inwards and one outwards. One door led directly into the waiting area, meaning conversations within the assessment room could potentially be overheard. The Psychiatric Liaison Accreditation Network (PLAN) 2017 standards outline recommendations for mental health assessment rooms: there should be a strip alarm around the wall if staff do not carry personal alarms, and the room should not have any ligature points. The assessment room in the department had a single alarm on the wall, which was also identified as a ligature point. This was fed back to the trust and, following our inspection, we were assured a review was taking place.

Assessing and responding to patient risk

An initial patient streaming assessment for walk-in patients was done at the reception desk, following registration, by a band six nurse. The service was planned for the streaming nurse to work between the hours of 10am and 10pm, seven days a week; outside of these hours streaming was done by a receptionist, following a set of assessment criteria. We witnessed during inspection that the streaming nurse was redeployed to work in the main department for part of the shift due to staff shortages; we were told this did not happen on a regular basis. We were told by staff in the MIU that receptionists, when streaming, would telephone them for advice if they were unsure. Staff said patients were occasionally inappropriately referred by both reception staff and streaming nurses, but felt this was unavoidable due to the streaming assessment being intentionally brief.
The streaming process was a ‘hands-off’ approach; the streaming nurse gained an overview of the patient’s presenting problem, through discussion and visual observation, then directed them to the area most appropriate for their needs. No clinical observations or investigations were completed at the point of streaming. Patients could be sent directly to the following areas: the MIU; the GP service located within the department between 10am and 11pm; the medical and surgical assessment units; gynaecology; maternity; the frailty unit; or triage for further assessment and direction to the ED main area.

Triage training was provided as part of the department’s staff nurse induction process; we were told that generally staff with 12 months experience in the department could triage patients, but this depended on individual knowledge, confidence and experience. There was a recognised triage tool used in the department. Patients with mental health needs were identified at triage and an initial mini-mental state examination would be done; the outcome of this would trigger a more in-depth assessment later in the patient’s journey. A similar assessment was undertaken to assess mental capacity.

For patients streamed to the GP service, strict exclusion criteria were followed. These included patients who had already been assessed by their own GP or another health care professional; these patients were streamed directly to the ED. During inspection we found two different versions of the standard operating procedure for GP referrals, with no apparent version control. We highlighted this to the nurse in charge and we were assured it was immediately acted upon.

Safety huddles took place in the department every three hours at specified times; these were listed on a whiteboard and were ticked when completed. The huddles were attended by the senior nurse, senior doctor, and patient flow co-ordinator on duty, and lasted a maximum of ten minutes. The purpose of the huddles was to address current issues in all areas of the department. Operational teleconference meetings took place across site with LGI ED to discuss any issues with capacity and staffing. The use of clinical emergency medicine (CEM) books allowed further oversight of the two departments and we were told that staff often swapped between sites if needed; information was regularly updated on CEM books by senior staff. Regular huddles also took place between staff from ED, CDU, the frailty unit and JAMAA.

The department used a national early warning score (NEWS) which was recorded electronically on patients’ records. The NEWS was calculated using a patient’s clinical observations and indicated whether their condition was stable, improving or deteriorating and requiring escalation to a higher level of care. We saw that electronic recording of observations gave staff a clear oversight of a patient’s condition and they were automatically alerted if a patient’s NEWS had changed. We looked at the electronic records of ten patients during our inspection, and all had up to date clinical observations and NEWS recorded. We were told that electronic handheld devices were due to be implemented in the department, in November 2018, which would make recording easier.

Staff told us they felt patients with sepsis were well managed in the department. Pre-prepared equipment packs were used to help speed up delivery of the ‘sepsis six’; a series of six tests and treatments given to a patient within one hour of suspected sepsis diagnosis. Audit results from April to June 2018 showed that sepsis screening and oxygen administration were effective, but improvement was needed in the provision of early antibiotic therapy; in the adult ED, 99% of patients who met the sepsis screening criteria received appropriate screening, but only 55% of those screened received antibiotics within one hour. At the time of our inspection the department had an improvement program in place to reflect the national sepsis commissioning for quality and
innovation (CQUIN); results showed that more than 70% of eligible patients were receiving antibiotics within one hour. The program was scheduled to continue until April 2019.

We saw evidence of shared learning between the EDs at both hospital sites, particularly relating to trauma. There was recognition that patients with traumatic injuries may either self-present to SJUH or be under-triaged in the pre-hospital setting, for example elderly patients who had fallen and whose needs may have initially been deemed medical rather than trauma related. We saw there was specific guidance in place regarding stabilisation, treatment and transfer of trauma patients.

The staff we spoke with informed us there were three trust-employed security officers and a security supervisor available across site at all times; they were very responsive when called to the department, for example to help manage patients with challenging behaviours. ED staff attended a personal safety training course which had both face to face and practical aspects, including safety awareness and conflict resolution. Level one training was mandatory for all staff and had a 97% compliance rate. The requirement for level two and level three training was determined on an individual basis.

The department worked alongside the local police to provide a consistent approach to safety. We saw evidence of safety planning for upcoming local events to ensure adequate resources and equipment were available. A study day was due to take place in September 2018, with the police, focusing on aspects of ballistics training, trauma and security. Safety in the department had been reassessed, on the advice of West Yorkshire police, and a ‘lock-down’ plan developed; this included a detailed procedure to be followed when patients presented with gunshot or stab wounds, and a competency document that senior nurses were required to sign. We saw plans detailing the security controls within the department, and we were told by staff that the resuscitation room was to become accessible only by staff using an authorised swipe card. We spoke with staff who had experienced the ‘lock-down’ process, and they told us it had been well managed and efficient.

Patients told us they felt safe in the department, and this was corroborated by the results of the emergency department survey shown below. We saw that patients at risk of falls had been assessed and risk assessments completed. All cubicles were equipped with patient call bells, and each patient we spoke with had access to a call bell.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q33. In your opinion, how clean was the emergency department? 8.6 About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors? 9.3 About the same as other trusts

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median from June 2017 to February 2018.

The trust did not submit data from March to May 2018.

Arrival to initial assessment times were on average 2.4 minutes better than the England average from June 2017 to February 2018. Over this period the overall trend remained static with a slight increase during the winter months of January and February 2018.

Ambulance – Time to initial assessment from June 2017 to February 2018 at Leeds Teaching Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

St James’s University Hospital

From July 2017 to June 2018 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at St James’s University Hospital.

Percentages increased month on month from July 2017 to January 2018 reaching its highest point of 61% in January 2018. Percentages remained higher over the winter months, January to March 2018, after which percentages decreased to 55% in June 2018.

Following the inspection, the trust provided ambulance handover data for both main hospital sites which showed:

<table>
<thead>
<tr>
<th>Month</th>
<th>LGI % &gt; 30 minutes</th>
<th>SJUH % &gt; 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2017</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>August 2017</td>
<td>0.7%</td>
<td>0.2%</td>
</tr>
<tr>
<td>September 2017</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Month</td>
<td>Over 30 mins (%)</td>
<td>60 mins (%)</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>October 2017</td>
<td>2.4%</td>
<td>0.7%</td>
</tr>
<tr>
<td>November 2017</td>
<td>0.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>December 2017</td>
<td>2.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>January 2018</td>
<td>1.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td>February 2018</td>
<td>1.1%</td>
<td>2.7%</td>
</tr>
<tr>
<td>March 2018</td>
<td>1.5%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

**Ambulance: Number of journeys with turnaround times over 30 minutes - St James’s University Hospital**

![Bar chart showing ambulance turnaround times](chart1)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - St James’s University Hospital**

![Line chart showing percentage turnaround times](chart2)

(Source: National Ambulance Information Group)

We reviewed 20 sets of patients’ notes, including patients who had self-presented and arrived by ambulance; 17 of these patients were triaged within 15 minutes. One patient was triaged at 16 minutes, one at 33 minutes and one at 46 minutes. The median time to triage was 4.5 minutes.

We tracked the arrival of ten ambulance patients; all were seen by the ambulance assessment nurse within five minutes of arrival. Six were taken immediately into available cubicles in the initial assessment area. Of the remaining four, one was fit to sit in the waiting room and three were moved when cubicles became available, all within 10 minutes of arrival. However, staff told us that when the department was busy, and there was reduced capacity in the assessment cubicles, patients would often be triaged and then were required to wait on trolleys in the corridor. When this happened, they felt there was no robust system in place to care for them. We reviewed the department’s escalation policy and there was a clearly stated plan to be initiated should patient assessment waits exceed 15 minutes. Staff also told us they were worried about what would happen during winter months when pressure on the department was likely to increase; we were told by senior staff that winter planning had involved all hospital departments, and included avoidance of non-designated bed space usage, re-allocation of staff, increased comfort rounds for patients and a focus on improving flow through the ED.
We spoke with ambulance staff who told us that having a dedicated ambulance handover nurse in the department had improved the handover and turnaround process; they said patient handover was usually completed within ten minutes.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From May 2017 to April 2018 the trust reported 29 “black breaches”, with a decreasing trend over the period.

Six “black breaches” were reported in May 2017, after which numbers decreased to zero in August 2017. Although numbers increased again to four in October 2017 no “black breaches” were reported in November 2017. Six “black breaches” were reported during January 2018 before decreasing once again to two in April 2018.

![Total Black Breaches Chart]

(Source: *Routine Provider Information Request (RPIR) - Black Breaches tab*)

**Nurse staffing**

The trust reported the following qualified nursing staff numbers as at March 2017 and March 2018 for urgent and emergency:

**St James’s University Hospital**

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>90.4</td>
<td>104.0</td>
</tr>
</tbody>
</table>

St James’s University Hospital had a staffing fill rate of 81.8% as at March 2018. The trust had increased planned staff figures by 4.4 WTE staff between March 2017 and March 2018. In March 2017 the site had 13.6 less WTE staff and in March 2018, 19.8 less WTE staff in post than what was planned for.

(Source: *Routine Provider Information Request (RPIR) – Total staffing tab*)
The trust told us they used a range of tools to assess nurse staffing levels in the department, including professional judgement and the safer nursing care tool, to enable safe staffing based on patient acuity. There were three different levels of staffing provided by the trust: the minimum, current and establishment staffing levels. During our inspection these were defined for us. The minimum staffing level was the lowest number of staff that could be permitted, per shift, to maintain patient safety; senior nursing staff confirmed that the minimum level was based on professional judgement. The current staffing level was the number of staff that were planned for each shift. The establishment level was the level the trust was working towards when full investment and recruitment had been achieved; this was based on a three-year plan commencing in 2018.

Staff we spoke with during our inspection said there was confusion around staffing levels, but confirmed to us that levels were considered acceptable once the minimum number of staff had been achieved.

The levels of staff for the current 24-hour period were displayed on a board in the department for the public to see, along with guidance on actions to be taken when numbers fell below safe levels. Actions included the requesting of agency or bank staff and contracted staff working additional hours; it was also possible to move staff between the trust’s two EDs if capacity allowed. Staff were encouraged to complete incident forms when staffing fell below minimum levels if the CSU was unable to provide mitigation, or if any incidents occurred as a result of reduced staffing levels.

Staff were allocated to work in designated areas during each shift, and this information was also clearly displayed.

In the majors’ area the staffing levels were as follows:

<table>
<thead>
<tr>
<th>Registered nurses</th>
<th>Early shift</th>
<th>Late shift</th>
<th>Night shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current level</td>
<td>15</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Minimum level</td>
<td>10</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthcare assistants</th>
<th>Early shift</th>
<th>Late shift</th>
<th>Night shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current level</td>
<td>8</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Minimum level</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

In the MIU the staffing levels were as follows:

<table>
<thead>
<tr>
<th>Registered nurses (ENPs)</th>
<th>Early shift</th>
<th>Late shift</th>
<th>Night shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current level</td>
<td>2</td>
<td>2</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Minimum level</td>
<td>2</td>
<td>2</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
In the CDU the staffing levels were as follows:

<table>
<thead>
<tr>
<th>Healthcare assistants</th>
<th>Early shift</th>
<th>Late shift</th>
<th>Night shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current level</td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Minimum level</td>
<td>1</td>
<td>1</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

The trust provided information to show the number of shifts that were staffed below the minimum level, at the minimum level and at (or above) the current level. We looked at three non-consecutive weeks of registered nurse rotas across all areas of the department:

<table>
<thead>
<tr>
<th>Departments</th>
<th>Shifts below minimum level</th>
<th>Shifts at minimum level</th>
<th>Shifts at current level</th>
<th>Shifts above current level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majors’ area</td>
<td>7</td>
<td>17</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>MIU</td>
<td>1</td>
<td>0</td>
<td>37</td>
<td>5</td>
</tr>
<tr>
<td>CDU</td>
<td>8</td>
<td>1</td>
<td>42</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>18</td>
<td>118</td>
<td>17</td>
</tr>
</tbody>
</table>

We looked at three non-consecutive weeks of healthcare assistant (HCA) rotas across all areas of the department:

<table>
<thead>
<tr>
<th>Departments</th>
<th>Shifts below minimum level</th>
<th>Shifts at minimum level</th>
<th>Shifts at current level</th>
<th>Shifts above current level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majors’ area</td>
<td>11</td>
<td>9</td>
<td>39</td>
<td>4</td>
</tr>
<tr>
<td>MIU</td>
<td>2</td>
<td>0</td>
<td>39</td>
<td>1</td>
</tr>
<tr>
<td>CDU</td>
<td>4</td>
<td>0</td>
<td>21</td>
<td>38</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>9</td>
<td>99</td>
<td>43</td>
</tr>
</tbody>
</table>

The trust said that staffing shortfalls were sometimes mitigated using additional non-rostered staff (for example clinical educators, matrons or staff from other areas) and decreasing operational activity, although we did not witness this in the ED at the time of inspection. Staff movements were made on a shift by shift basis, by site co-ordinators and senior nurses. The electronic system did not record real-time information about staff movements; at the time of our inspection, there was no way of monitoring that the actions were happening in practice. We were told that monitoring using a paper based system was to be implemented.
Emergency nurse practitioners (ENPs) and HCAs in the MIU worked 12-hour shifts seven days a week; the unit was not open overnight. One ENP was a band seven, the rest were band six. We were told the ENPs had previously rotated with those at LGI, but there was no rotation in place at the time of our inspection due to staffing vacancies at both sites.

Nurses in the main department rotated between both hospital sites to gain experience and maintain skills.

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 6.5% for qualified nursing staff in urgent and emergency care. The trust did not set a target for vacancy rates.

The breakdown by site was as follows:
- Leeds General Infirmary: -3.2% (indicating that this site was overstaffed)
- St James’s University Hospital: 20.2%

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 19.3% for qualified nursing staff in urgent and emergency care. The trust did not set a target for turnover rates.

The breakdown by site was as follows:
- Leeds General Infirmary: 17.9%
- St James’s University Hospital: 21.6%

At Leeds General Infirmary 28.0 WTE staff members have left the trust over the period and at St James’s University Hospital 18.6.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

We were told on inspection that staff felt the turnover of qualified nursing staff was high; this was apparently due to work pressures and some nurses wanting to travel or gain experience in other areas. Because of this, some staff told us that they felt they were being expected to take on more senior roles sooner than they felt was appropriate, but all said they felt well supported by senior staff in the department.

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 3.1% for qualified nursing staff in urgent and emergency care. This was slightly lower than the trust target of 3.5%

The breakdown by site was as follows:
- Leeds General Infirmary: 2.7%
- St James’s University Hospital: 3.8%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*
Bank and agency staff usage

Trust Level

From April 2017 to March 2018, the trust reported that 5.0% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 0.3% of shifts were filled by agency staff. In addition 4.7% of shifts were not filled by bank and agency staff to cover staff absence.

Over the same period, 11.2% of nursing assistant shifts in urgent and emergency care were filled by bank staff 2.4% of shifts were filled by agency staff and 5.6% of shifts were not filled by bank and agency staff to cover staff absence.

The trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James’s Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>1,393</td>
<td>11.2%</td>
<td>1,858</td>
</tr>
<tr>
<td>Agency</td>
<td>300</td>
<td>2.4%</td>
<td>109</td>
</tr>
<tr>
<td>Not filled</td>
<td>700</td>
<td>5.6%</td>
<td>1,662</td>
</tr>
<tr>
<td>Total shifts</td>
<td>12,456</td>
<td></td>
<td>37,360</td>
</tr>
</tbody>
</table>

Leeds General Infirmary

From April 2017 to March 2018, Leeds General Infirmary reported that 3.2% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 0.1% of shifts were filled by agency staff. In addition 2.6% of shifts were not filled by bank and agency staff to cover staff absence.

Over the same period, 5.3% of nursing assistant shifts in urgent and emergency care were filled by bank staff, 0.6% of shifts were filled by agency staff and 3.4% of shifts were not filled by bank and agency staff to cover staff absence.

The trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James’s Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>324</td>
<td>5.3%</td>
<td>624</td>
</tr>
<tr>
<td>Agency</td>
<td>36</td>
<td>0.6%</td>
<td>11</td>
</tr>
<tr>
<td>Not filled</td>
<td>206</td>
<td>3.4%</td>
<td>496</td>
</tr>
<tr>
<td>Total shifts</td>
<td>6,120</td>
<td></td>
<td>19,220</td>
</tr>
</tbody>
</table>

St James’s University Hospital

From April 2017 to March 2018, St James’s University Hospital reported that 6.8% of qualified nursing shifts in urgent and emergency care were filled by bank staff and 0.5% of shifts were filled by agency staff.

Over the same period, 11.2% of nursing assistant shifts in urgent and emergency care were filled by bank staff, 0.4% of shifts were filled by agency staff and 5.6% of shifts were not filled by bank and agency staff to cover staff absence.

The trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James’s Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>1,184</td>
<td>6.8%</td>
<td>624</td>
</tr>
<tr>
<td>Agency</td>
<td>12</td>
<td>0.7%</td>
<td>13</td>
</tr>
<tr>
<td>Not filled</td>
<td>36</td>
<td>2.1%</td>
<td>496</td>
</tr>
<tr>
<td>Total shifts</td>
<td>6,120</td>
<td></td>
<td>19,220</td>
</tr>
</tbody>
</table>
filled by agency staff. In addition 6.4% of shifts were not filled by bank and agency staff to cover staff absence.

Over the same period 16.9% of nursing assistant shifts in urgent and emergency care were filled by bank staff, 4.2% of shifts were filled by agency staff and 7.8% of shifts were not filled by bank and agency staff to cover staff absence.

The trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James's Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

### Bank/agency Nursing Assistant Qualified nurse Total

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>1,069</td>
<td>16.9%</td>
<td>1,234</td>
<td>6.8%</td>
<td>2,303</td>
<td>9.4%</td>
</tr>
<tr>
<td>Agency</td>
<td>264</td>
<td>4.2%</td>
<td>98</td>
<td>0.5%</td>
<td>362</td>
<td>1.5%</td>
</tr>
<tr>
<td>Not filled</td>
<td>494</td>
<td>7.8%</td>
<td>1,166</td>
<td>6.4%</td>
<td>1,660</td>
<td>6.8%</td>
</tr>
<tr>
<td>Total shifts</td>
<td>6,336</td>
<td></td>
<td>18,140</td>
<td></td>
<td>24,476</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

**Medical staffing**

Medical staff worked across sites at both LGI and SJUH EDs, however junior doctors had extended periods at each site to gain more experience. Consultant cover at SJUH met national guidance, and there was consultant cover until midnight each night. A consultant was available 24 hours a day at LGI for advice if needed.

There were 11 advanced clinical practitioners (ACPs), both qualified and trainee, who were included in the medical rota and worked across both hospital sites.

The medical rota was overseen by a designated rota coordinator.

The trust reported the below medical staffing numbers as at March 2017 and March 2018 for urgent and emergency care; this is recorded as LGI but covers both sites.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>115.9</td>
<td>115.3</td>
</tr>
</tbody>
</table>

Leeds General infirmary had a staffing fill rate of 112.8% as at March 2018, indicating that the site had 15.6 more WTE staff in post than planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of -8.8% for medical staff in urgent and emergency care, indicating that this service was over staffed. The trust did not set a target for vacancy rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 52.3% for medical staff in urgent and emergency care. The trust did not set a target for turnover rates. Over the period 69.6 WTE staff members left the trust. However, the inclusion of trainee grades in the data is likely to have inflated the rates.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 1.8% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

From April 2017 to March 2018, there were 4,065 reported shifts filled by bank staff and 621 shifts filled by locum staff in urgent and emergency care. There were 200 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th></th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bank shifts</strong></td>
<td>444</td>
<td>3,063</td>
<td>558</td>
<td>4,065</td>
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<tr>
<td><strong>Locum staff</strong></td>
<td>328</td>
<td>293</td>
<td>0</td>
<td>621</td>
</tr>
<tr>
<td><strong>Unfilled shifts</strong></td>
<td>20</td>
<td>179</td>
<td>1</td>
<td>200</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)*

Medical staff we spoke with told us that locum doctors were used regularly but were often well known to them and familiar with the department.

**Staffing skill mix**

As of December 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower. The trust had 11% less middle career doctors and 17% more registrars working at the trust when compared to the England averages.
Staffing skill mix for the 117 whole time equivalent staff working in urgent and emergency care at Leeds Teaching Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (Str) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

The department used a combination of paper-based and electronic patient records. Initial attendance information was recorded on the electronic system and printed out, then the triage, medical assessments and treatments were recorded on this. The electronic system allowed access to a patient’s hospital notes and clinic letters, and discharge information summaries could be generated and sent to a patient’s GP.

Nursing assessments were completed on the electronic system and there was a section for recording comfort rounds. These were usually completed by non-clinical support workers who had restricted access to the electronic system; this was password protected, and allowed them to record the appropriate comfort round information.

The patient record included what was referred to as ‘two-step plus time’ information. This was a process used to ensure patients knew what to expect during their ED journey; each member of staff attending to a patient would explain what the next two steps of their treatment process would be and gave the approximate timings of these. If unsure of this information they would discuss with another staff member. Completion of this information was a mandatory action on the electronic system and staff would be alerted if it had not been done.

At the time of our visit we were told the department was soon to introduce handheld electronic devices on which to record patient observations and monitor NEWS. This would mean staff no longer had to access a desktop computer to enter and monitor information, making the process easier and more efficient.

Paper records were scanned onto the electronic system once completed; if patients were admitted to hospital the original copies of their paper notes were transported with them to the ward. The quality of all scanned data was checked on two separate occasions by reception staff and any errors were recorded, enabling the capture of themes and trends. Original paper copies were kept...
for two weeks. For deceased patients, notes were stored separately until all additional paperwork was completed, and then retained for one year. There was an ongoing process in place for all hospital notes to be transferred onto the electronic system. Reception staff told us they did not often need to request hospital notes for patients from the medical records department, as most were stored electronically, but on the occasions they did there were no issues or delays reported.

At the time of our inspection, Yorkshire Ambulance Service was in the process of introducing an electronic patient report form, and training was taking place within the department. The staff we spoke with reported a few problems initially, but all felt it would ultimately be more efficient. Reception and ambulance staff were observed to be working well together during the training process.

**Medicines**

The department used an automated medicine dispensing system, which staff with authorisation gained access to using fingerprint recognition. Two authorised fingerprints were required for access to controlled drugs. The pharmacy department had oversight of the system; stock levels and discrepancies could be monitored.

Fridge temperatures were monitored twice daily and recorded on a checklist; we found fridge temperatures to be within the required range and checklists had been completed appropriately.

We found that patient group directions (PGDs) were within their review date and that master copies were held by the hospital pharmacy department. PGDs enabled nurses to administer certain ‘prescription only’ medicines without a prescription from a doctor. We reviewed the annual PGD audit and were satisfied that only named individuals had administered medicines using a PGD.

We found a box of intravenous saline on floor in the resuscitation room. We highlighted this to staff and it was moved immediately. All other intravenous fluid and portable gas cylinders were stored appropriately.

The department aimed to introduce electronic prescribing by November 2018, with a workstation in each treatment cubicle to enable this. The department’s electronic record system allowed access to patient’s prescribed medicine details, and information regarding new medicines started in the department could be sent electronically to the patient’s GP.

We reviewed 20 sets of patients’ notes and all had medicines prescribed appropriately. An antimicrobial audit completed in July 2018 showed that patients’ allergies had not been recorded in 30% of cases; this led to information and lessons learned being shared with all staff. The 20 sets of notes we looked at during our inspection all had allergy information recorded.

**Incidents**

Staff told us they knew how to report incidents and were encouraged to do so; there was a strong culture of incident reporting and dissemination of lessons learned between the EDs at both hospital sites. Incidents and safety alerts were discussed at governance meetings and fed back to staff using a structured format; we viewed some of this feedback and saw it was well written and designed to engage the interest of staff. Feedback and sharing of information was also done by email, at staff handover and through private social media groups. We saw evidence of learning, for example the incorrect application of a plaster cast had led to further staff training being implemented.
The duty of candour is a regulatory duty that relates to openness and transparency; it 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 the duty of candour and could explain it adequately to us, although none were able to give examples of when it had been applied in their own practice.

Data we reviewed showed that there had been 270 incidents reported within the ESM CSU that had not received a response. Further information provided to us showed this number had dropped to 110 as of 24 September 2018. We reviewed governance meeting minutes for the three months prior to our inspection; the outstanding incidents had been identified and were being reviewed by senior staff, but we found no clear action plan in place to address the issue and it had not been added to the risk register at the time of our inspection.

We saw several incident reports relating to patients who had absconded from the department. Staff told us there were issues with adherence to the missing persons policy due to staffing availability at times of high demand; all staff we spoke with were aware of the policy and told us how they would escalate issues.

Following a change in senior staffing structure the department matron had begun attending morning handover whenever possible, to speak with night staff and obtain feedback from any incidents that had occurred overnight, therefore maintaining oversight of issues in the department.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported two incidents classified as never events for urgent and emergency care. Both incidents occurred at St James’s University Hospital.

The first incident took place in March 2018, when a patient required oxygen to be administered and the tubing was connected to the wall air outlet instead of the wall oxygen outlet. No harm came to the patient as a result of this error.

The second incident took place in May 2018. The patient was put on air instead of oxygen by the paramedic crew. This was noticed by staff and was corrected. No harm came to the patient as a result of this error.

(Source: NHS Improvement - STEIS)

Following the never events, we were told a thorough investigation was conducted and we saw evidence from governance meeting minutes that this had been reviewed and monitored. A process was in place to prevent recurrence: air flow outlets within the department had been capped off so they could not be used by mistake instead of oxygen. The department had a supply of nebuliser machines available should patients require air-driven nebuliser treatment. We saw that the air flow outlets were checked, and the checks were recorded daily, by the senior nurse in the department.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs), including the two never events, in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018.

A breakdown of all incidents reported in urgent and emergency care is shown below.

- Slips, trips and falls meeting SI criteria: Five incidents (41.7%)
- Treatment delay meeting SI criteria: Two incidents (16.7%)
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident (8.3%)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident (8.3%)
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident (8.3%)
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant): one incident (8.3%)
- Medical equipment/ devices/disposables incident meeting SI criteria: One incident (8.3%)

Site specific information can be found below:

St James’s University Hospital

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs), including the two never events, in urgent and emergency care at St James’s University Hospital which met the reporting criteria set by NHS England from June 2017 to May 2018.

A breakdown of all incidents reported in urgent and emergency care at St James’s University Hospitals shown below.

- Slips, trips and falls meeting SI criteria: two incidents
- Treatment delay meeting SI criteria: two incidents
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident
- Medical equipment/ devices/disposables incident meeting SI criteria: one incident
Safety thermometer

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within ten days of the suggested data collection date.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff were aware of policies and procedures and knew where to find them. The department used CEM Books, a secure computer application to aid department management and provide guidance for staff. Staff could access CEM Books from computers or from their own smartphones, and were able to view department policies, procedures and pathways, and see the status of the department and any concerns. It was possible for staff to also view the status of the ED at LGI, enabling cross-site communication and oversight.

The department participated in national Royal College of Emergency Medicine (RCEM) audits to monitor standards of care and improve practice. Action plans were put in place based on audit result recommendations. The department’s policies were based on national guidance and we saw from meeting minutes that National Institute for Health and Care Excellence (NICE) guidelines were discussed and updated at governance meetings. The department also submitted data to the
trauma audit and research network (TARN), which enabled analysis of the effectiveness of trauma care and highlighted areas for improvement.

**Nutrition and hydration**

Staff we spoke with said patients were routinely offered food and drinks as part of comfort rounds. We spoke with 16 patients and 12 had been offered food or drinks since their arrival; two had not been offered anything yet and two had only just arrived. Staff told us that plans were being put into place to provide hot food choices for patients in the department; this was due to commence in October 2018. There was a band one non-clinical support worker in the department who was responsible for attending to the nutrition and hydration needs of patients, and could access the electronic system to record each patients’ dietary and fluid intake when necessary. There were vending machines in the waiting room with healthy drink and snack options available.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Pain relief**

We spoke with 16 patients and 9 told us that they had been asked to score their pain. Three told us they had not been asked but did not present with any pain, and four could not remember if they had been asked. All told us that staff had ensured they were comfortable. We reviewed 20 patients’ records and all had pain assessments recorded. Ten of these patients required pain relief and this was given in a timely manner.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “how many minutes after you requested pain relief medication did it take before you got it?” This was the about same as other trusts.

The trust scored 7.4 for the question “do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Patient outcomes**

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**St James’s University Hospital**

In the 2016/17 Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma audit, St James’s University Hospital emergency department failed to meet any of the standards. The department submitted 106 records to this audit.
The department was in the upper UK quartile for one standard:
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 51.9%; UK: 26.0%.

The department was in the lower UK quartile for two standards:
- Standard 1a (fundamental): \( \text{O}_2 \) should be given on arrival to maintain sat's 94-98%. This department: 7.6%; UK: 19.0%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised \( \beta_2 \) agonist bronchodilator therapy. This department: 67.5%; UK: 77.0%.

The department’s results for the remaining four standards were all between the upper and lower UK quartiles:
- Standard 3 (fundamental): High dose nebulised \( \beta_2 \) agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 25.5%; UK: 25.0%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 20.4%; UK: 19.0%.
    - Standard 5b (fundamental): within 4 hours (moderate). This department: 19.6%; UK: 28.0%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
    - This department: 50.9%; UK: 52.0%.

(Source: Royal College of Emergency Medicine)

Following the moderate and acute severe asthma RCEM audit, from 2016/17, staff told us that problems had been identified with data collection; the electronic records system had been updated to help rectify this.

RCEM Audit: Consultant sign-off 2016/17

St James's University Hospital

In the 2016/17 Consultant sign-off audit, St James’s University Hospital emergency department failed to meet any of the standards. The department submitted 75 records to this audit.

The department was in the upper UK quartile for three standards:
- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 53.9%; UK: 11%.
- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to
the emergency department with the same condition within 72 hours of discharge. This department: 50.0%; UK: 12%.

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 28.0%; UK: 10.0%.

The department was in the lower UK quartile for one standard:

- Standard 2 (developmental): Consultant reviewed: fever in children under one year of age. This department: 0.0%; UK: 8.0%.

(Source: Royal College of Emergency Medicine)

The consultant sign-off audit from 2016/17 showed that the department was in the upper quartile for three of the four standards; ongoing education was being provided regarding this.

RCEM Audit: Severe sepsis and septic shock 2016/17

St James’s University Hospital

The hospital did not participate in 2016/17 Severe sepsis and septic shock audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

St James’s University Hospital

The hospital did not participate in the 2015/16 Vital signs in children audit

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

St James’s University Hospital

In the 2015/16 Procedural sedation in adults audit, St James’s University Hospital failed to meet any of the audit standards (which were all 100%).

The department was not in the upper England quartile for any fundamental standards or developmental standards:

The department was in the lower England quartile for three fundamental standards and one developmental standard:

- Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. This department: 66.0%; England: 90.0%.

- Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  - Standard 4a. A doctor as sedationist
  - Standard 4b. A second doctor, ENP or ANP as procedurist
  - Standard 4c. A nurse
  This department: 2.0%; England: 40.8%.
- **Standard 6 (developmental):** Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. This department: 2.0%; England: 41.0%.

- **Standard 7 (fundamental):** Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - Standard 7a. (Fundamental): Return to baseline level of consciousness.
  - Standard 7b. (Fundamental): Vital signs within normal limits for the patient.
  - Standard 7c. (Fundamental): Absence of respiratory compromise.
  - Standard 7d. (Fundamental): Absence of significant pain and discomfort.
  - Standard 7e. (Developmental): Written advice on discharge for all patients.
This Department: 0.0%; England 2.6%

The department’s results for the remaining three standards were all between the upper and lower England quartiles.

- **Standard 1 (fundamental):** Patients undergoing procedural sedation in the emergency department should have documented evidence of pre-procedural assessment, including:
  - Standard 1a. ASA grading
  - Standard 1b. Prediction of difficulty in airway management
  - Standard 1c. Pre-procedural fasting status
This department: 26.0%; England: 7.6%.

- **Standard 2 (developmental):** There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. This department: 64.0%; England: 51.8%.

- **Standard 5 (fundamental):** Monitoring during procedural sedation must be documented to have included all of the below:
  - Standard 5a. Non-invasive blood pressure
  - Standard 5b. Pulse oximetry
  - Standard 5c. Capnography
  - Standard 5d. ECG
This department: 32.0%; England: 23.9%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16**

**St James’s University Hospital**

In the 2015/16 Venous thrombo-embolism risk in lower limb immobilisation in plaster cast audit St James’s University Hospital failed to meet any of the audit standards (which were all 100%). The department was not in the upper England quartile for any of the two standards.

The department was in the lower England quartile for one of the two standards.

- **Standard 1 (fundamental):** If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. This department: 66.7%; England median: 100.0%. 
The department was between the upper and lower England quartile for one of the two standards.

- **Standard 2 (developmental):** Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. This department: 9.8%; England median: 2.0%.

  *(Source: Royal College of Emergency Medicine)*

We did not see any action plans relating to the procedural sedation in adults 2015/16 audit, or the venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16 audit.

The department did not participate in the severe sepsis and septic shock 2016/17 audit, or the vital signs in children 2015/16 audit, due to insufficient data collection.

Local audits were also carried out in the department. Junior doctors were involved in audit activity with oversight from senior doctors; there were two consultant audit leads who worked between the EDs at both hospitals.

### Unplanned re-attendance rate within seven days

From June 2017 and May 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and slightly worse than the England average.

With the exception of October 2017, when percentages were 0.5% better, figures were marginally worse than the England figures by an average of 0.6% per month. Although there were some variances month on month, a slight decrease in trend can be seen, from 9.3% in June 2017 to 8.8% in May 2018.

### Unplanned re-attendance rate within seven days - Leeds Teaching Hospitals NHS Trust

*(Source: NHS Digital - A&E quality)*

### Competent staff

New staff starting work in the department had a comprehensive induction plan, which had been devised by the department’s clinical educator. This included objectives, training plans and competencies to be signed off. New starters also had a supernumerary period which could be tailored to their needs, but staff told us this was sometimes cut short due to departmental pressures. All staff we spoke with said the induction process had been effective and they had felt well supported.
Mental health, learning disabilities and dementia training was provided at induction, and updates were made available to staff. The local mental health trust provided staff with Mental Health Act training.

Medical and nursing staff worked across sites between the EDs at LGI and SJUH; this meant they had the opportunity to maintain competencies in different areas of care, for example working at LGI provided more experience of trauma and caring for unwell children.

We were told that, despite trauma and paediatric care both being centred at LGI, the ED at SJUH regularly saw trauma patients and children who self-presented to the department. We saw comprehensive standard operating procedures in place for the management of trauma patients and children; we were assured that staff were aware of them and received training in these areas.

There was no trauma team on site at SJUH, but we spoke with several staff members of different grades who told us that trauma management within the department worked well and staff were aware of the guidance in relation to stabilisation and transfer of patients to LGI. At the time of our inspection there was work ongoing around dealing with gunshot wounds and stabbings. All staff told us that trauma training was regularly updated; staff participated in the advanced trauma life support and advanced trauma nursing courses.

Medical staff had assigned mentors and set objectives. They attended regular teaching sessions, along with the ACPs, and participated in fortnightly real-time simulation training based on real-life scenarios. These sessions involved staff from both sites. Some staff felt that junior doctors working at SJUH were not exposed to caring for patients with minor injuries, so potentially became de-skilled in this area.

We saw that development and leadership was available for staff at all levels, and there was a clinical educator within the department who staff spoke highly of. Shift handovers often included ‘ten-minute learning bites’: short teaching sessions based on relevant issues or subjects.

We spoke with reception staff who told us they worked across both hospital sites, so had good knowledge and experience of each ED. They said they found this very useful when advising and assisting patients.

Nursing staff told us they were well supported through revalidation completion. Revalidation is the process that all nurses and midwives in the United Kingdom need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing.

### Appraisal rates

#### St James's University Hospital

As at June 2017 and June 2018, 98.8% and 100.0% of nursing staff within urgent and emergency care at the St James's University Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th></th>
<th>Rate</th>
<th>June 2018</th>
<th></th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
<td></td>
</tr>
<tr>
<td>Nursing and</td>
<td>83</td>
<td>84</td>
<td>98.8%</td>
<td>89</td>
<td>89</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Multidisciplinary working

We saw many examples of good teamwork within the department; doctors, nurses and other healthcare professionals working well together to support each other and to provide effective patient care. There was good communication and staff we spoke with told us they felt supported and part of the team.

We observed a discharge assessment team working as an integral part of the department and covering CDU, the frailty unit and JAMAA. The team operated from 8am to 8pm seven days a week and included physiotherapists and occupational therapists, with additional support from social services. Their purpose was to avoid unnecessary patient admissions and assist with patients who were being discharged: they could actively identify eligible patients so did not have to wait for patients to be referred. We spoke with one of the physiotherapists in the team who told us that they often helped patients with mobility issues, and had input into adapting patients’ packages of care and other services provided in the community.

Some staff told us that speciality reviews were not always timely, but that this had improved with the introduction of the flow co-ordinator. Most staff we spoke with felt relationships with other teams were very good and they worked well to support each other; they spoke highly of relationships with the end of life care team. We were told that delays with referrals usually occurred when the hospital was busy and there were bed shortages.

We saw the department had good links with the radiology department and had timely access to reports. Discrepancies were reported daily by the radiology team and passed to the ED medical team for review. Staff told us that they worked effectively alongside mental health teams, and found it beneficial that the acute liaison psychiatry service (ALPS) was based within the department.

The staff in the department had good working relationships with the local police, and there was a community support office within the department. Staff training alongside the police was ongoing at the time of inspection and included teaching around violent crimes, security and forensics management.

There were two porters working in the department at all times; one porter covered ED based tasks and the other was responsible for patient transfers. We spoke to two of the porters and they told us they felt well supported and part of the ED team.

The ENPs working in the MIU told us that they did not feel well supported by ED doctors; they had often asked for help when the MIU was busy but said they very rarely received it, possibly due to the majors’ area also being busy.

Seven-day services

The ED was operational 24 hours a day, seven days a week, and access to services such as radiology, pharmacy and pathology was available at all times, either through direct referral or on-
The department also had access to mental health liaison and specialised mental health support 24 hours a day, seven days a week.

**Health promotion**

We saw several notice boards in the department displaying health promotion advice, including information relating to measles and smoking cessation. In the entrance to the department there was information about a wellbeing café intended to help people with mental health problems or those who felt isolated. The waiting room had posters which clearly displayed advice for patients to check if they were in the right place for treatment and signposted them to other areas which may be more appropriate. We witnessed written and verbal advice being given to patients when they were discharged from the department.

Healthy food and drink options were available to patients in the waiting room vending machines.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff told us that they routinely obtained verbal consent from patients but would not usually document this. We witnessed staff of all grades explaining procedures to patients and gaining their consent verbally. Staff told us that they would document if a patient refused to provide consent or if they did not have capacity to make a decision, and this would be escalated. Staff we spoke with demonstrated good knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in relation to their role. Staff told us they were prompted to record a patient’s mental capacity during the initial assessment; further, more detailed, assessment would be undertaken later if required.

**Mental Capacity Act and Deprivation of Liberty training completion**

**Trust wide**

The trust reported that, as of June 2018, Mental Capacity Act (MCA) training level 1 and 2 was completed by 99.1% of nursing staff in urgent and emergency care compared to the trust target of 80.0%.

The trust reported that as of June 2018 MCA training level 2 was completed by 79.1% of medical staff in urgent and emergency care (both sites) compared to the trust target of 80.0%.

**St James’s University Hospital**

The trust reported that, as of June 2018, Mental Capacity Act (MCA) training level 1 and 2 was completed by 97.6% of nursing staff in urgent and emergency care at St James’s University Hospital compared to the trust target of 80.0%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)
Is the service caring?

**Compassionate care**

We observed many interactions between staff, patients and others (for example carers and relatives) during our inspection. We found all staff to be polite, respectful, professional and non-judgmental in their approach. Staff of all grades introduced themselves to patients, and asked what patients preferred to be called. We observed staff responding to patients’ needs in a compassionate and timely manner; the patients we spoke with all had call bells available and those that had asked for assistance said they had not waited long before a member of staff attended. Staff conducted regular comfort rounds to assess patients’ needs, such as if they required assistance to the toilet, if they were comfortable and if they would like anything to eat or drink. The rounds also ensured patients’ privacy and dignity was maintained and that all had a call bell in reach.

We had some concerns about privacy and dignity in some areas of the department. The reception desk where patients registered was directly adjacent to the waiting room seating area. Patients were assessed by the streaming nurse here and the reception area was very open, with little privacy for patients. We observed two patients booking in with personal problems, and they could be easily overheard by staff in reception and other patients in the waiting room. The mental health assessment room was adjacent to waiting room two, and patient consultations taking place there could potentially be overheard.

According to staff we spoke with in the MIU, privacy was also an issue there. The waiting room was open and adjacent to the nurses’ station and cubicles, so patients and staff could easily be overheard. Two staff told us that when they made telephone calls during which they discussed patient information, they went into the dirty utility as it was the only place they could speak in private.

We saw that friends and family test (FFT) information was available in several areas of the department. In July 2018, SJUH ED was commended for its FFT completion rate. The department had a display of thank you cards and letters received from patients. We observed positive comments about the care and treatment they had received, however some of the cards were dated 2011.

**Friends and Family test performance**

The trust’s urgent and emergency care friends and family test performance (% recommended) was slightly worse than the England average from June 2017 to March 2018 before improving in the most recent two months, April and May 2018.

Recommendation rates were consistently slightly lower than England rates, by an average of 2.3% per month from June 2017 to March 2018. The lowest recommendation rates of 82.4% and 78.8% were reported in January and March 2018, 4% and 5.5% lower than the England average respectively. Percentages improved to one percent better in April 2018 and 2.4% better than the England average in May 2018.
Emotional support

We saw staff providing emotional support to anxious patients and to a patient’s relatives who were upset. We observed staff move a distressed patient from their cubicle to sit near the nurses’ station; talking to staff and interacting with others visibly calmed the patient.

There was religious and spiritual support available to patients within the hospital, and to families and carers following bereavement. The department had two private rooms that could be used by those such as family and friends of patients in the resuscitation room. The rooms did not have telephones or facilities to make hot drinks; staff told us this was because items had previously been stolen on multiple occasions.

We saw that written bereavement support and advice was available.

Understanding and involvement of patients and those close to them

The patients we spoke with were all happy with the care that they had received whilst in the department. We spoke with 16 patients and six relatives; 12 patients said they felt involved in their care, had been given enough information, and understood their treatment plans. Two patients said they were yet to find out any information and two had only recently arrived in the department.

During our inspection we met an elderly patient with mental health needs, who required admission, and had been in the department since the previous afternoon as there was no in-patient bed available. We spoke with the patient's family and were told that the care in the department had been excellent: staff had provided food and drinks; communication had been good even though the department was busy; a hospital bed had been provided; and one-to-one care had been in place overnight to ensure the patient’s safety. The relatives told us that staff had kept them well informed and had gone to great measures to ensure the patient would remain near their family and support network. A bed became available for the patient, as a short-term measure, on the CDU and transfer to the nearby mental health facility was being planned for later that day.
We saw that staff explained procedures to patients clearly and used appropriate language, whilst remaining respectful. Advice was given to patients when they were discharged and we observed staff ensuring this was understood by patients and relatives.

Patients were regularly given ‘two-step plus time’ information. This was a process used to ensure they knew what to expect during their ED attendance; each member of staff involved with a patient would explain what the next two steps of their treatment process would be and gave the approximate timings of these. It was mandatory for this information to be completed on the electronic patient record. Patients were also kept updated with waiting times; these were clearly displayed in the waiting room.

### Emergency Department Survey 2016

The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain. **Question**  | **Trust 2016** | **2016 RAG**
---|---|---
Q10. Were you told how long you would have to wait to be examined? | 3.6 | About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse? | 8.4 | About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand? | 7.9 | About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say? | 8.9 | About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examine and treating you? | 8.8 | About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there? | 9.0 | About the same as other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so? | 7.5 | About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you? | 8.6 | About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you? | 7.5 | About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department? | 8.8 | About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment? | 7.9 | About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department? | 8.8 | About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you? | 7.2 | About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you? | 6.8 | About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand? | 8.3 | About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests? | 7.6 | About the same as other trusts

---
<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Staff told us that the local community was very aware of the differences between the two EDs and this was well signposted both inside and outside the hospital. Although there was no trauma or paediatric speciality provision at SJUH, staff were trained in all areas and most worked across both hospital sites. Trauma patients or children presenting at SJUH would be assessed and, if necessary, urgent intervention would be provided and transfer to LGI arranged. If no urgent treatment was needed patients would be treated at SJUH if appropriate, or otherwise redirected to LGI.

We saw information regarding the Homeless Admissions Leeds Pathway (HALP) which provided support for patients who were homeless, vulnerably housed or at risk of homelessness, from hospital admission to discharge, and supported the staff who were caring for them.

The department was participating in a commissioning for quality and innovation (CQUIN) scheme focusing on patients who regularly attended the ED. This aimed to provide support and lead to a reduction in inappropriate admissions.

There were service level agreements in place with mental health facilities in the local area managed by the local mental health and community trusts. These included: a centre close to the hospital providing in-patient care, a crisis assessment service and a section 136 suite, where those detained by the police for their own safety could be assessed by a mental health professional; a centre providing services for older people, perinatal care and specialist services for attention deficit hyperactivity disorder (ADHD); and a centre offering support for patients with specialised mental health disorders which had a psychiatric intensive care unit (PICU).
Meeting people’s individual needs

Patients attending the department who were known to be living with dementia or learning disabilities were flagged on the computer system to aid identification and enable effective provision of support.

Staff had access to dementia training and told us they felt their awareness of dementia had increased after participating in this. We were told that patients with dementia were moved through the department as quickly as possible, for example to the frailty unit, as staff recognised that ED was not an ideal environment for them. Staff said they considered the location of dementia patients within the department, and would try to place them in a cubicle which could be easily observed. There were distraction aids available for use by patients to help minimise agitation, and there was a dementia ‘bus stop’ where patients could sit and talk to others; we were told this often lessened anxiety and restlessness.

The department liaised with the hospital’s learning disability specialist nurse, who provided advice and support. We were told of an example of a patient with a learning disability who had complained about their care whilst in the department: the senior staff had met with the patient to discuss the issues, and they had actively involved the patient in plans to improve care and treatment. We were told that work was ongoing to improve the experience of patients with learning disabilities, and staff were looking at ways in which they could provide sensory equipment and specialised cubicles in the future.

The department had access to mental health care provision and specialised mental health support for children, adults and older adults. Mental health services could be accessed 24 hours a day, seven days a week. The ALPS team was based in the department and aimed to respond to referrals within one hour, to assess patients at risk of self-harm and suicide. There was a liaison psychiatry service for patients over 18 with co-existing mental and physical health problems, and staff could access specialist practitioners such child and adolescent mental health services (CAMHS) if needed.

Alcohol and drug services could be accessed between 9am and 5pm. The department used a clinical awareness withdrawal assessment tool to assess patients who were withdrawing from the effects of alcohol; staff told us they were aware of this and knew how to use it.

If patients in the department required one to one support for any reason, we were told this would be provided by care support workers where possible. Security staff were available but were only called when necessary, for example if patients presented a risk to themselves or others.

Staff in the ED could refer patients to a teen midwife service and to school nurses.

The department was accessible for people with mobility problems or those using wheelchairs, and there were accessible toilets in the waiting area.

We saw multiple ‘what to expect’ flow charts displayed on walls, which gave patients information about their journey through the department.

Telephone interpretation services could be accessed in the department, but we did not find written information available in different languages or formats.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.
<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

## Access and flow

The department had a full-time flow co-ordinator: a band four member of staff who was responsible for overseeing operational issues such as speciality response times, bed booking, potential four-hour breaches and patient comfort. We were told that the flow co-ordinators at SJUH had worked previously as health care assistants, and some occasionally worked extra clinical shifts to maintain their skills. Staff in the department told us they felt this was a challenging role to perform, but that it was becoming more established and better respected amongst teams within the hospital. The duty flow co-ordinator attended the three-hour safety huddles in the department to feed back issues and discuss actions.

Staff told us that the main issue with flow through the department was a lack of medical beds within the hospital. Patients requiring admission for mental health problems also faced potentially long waits for admission. Staff told us they were worried about winter pressures and the impact of increased demand on an already busy department.

The department had introduced a dedicated ambulance handover nurse to co-ordinate and manage patients arriving by ambulance. Both ED and ambulance staff told us they had seen a reduction in ambulance waits because of this. We spoke with patients in the department who had arrived by ambulance and they all told us they had been assessed very quickly.

A new streaming process was introduced in July 2018 with an aim of optimising flow through the department. Patients could be directly referred to other areas within the hospital, according to specific criteria, without being seen first in the ED. Referrals could be made to JAMAA, surgical assessment, maternity or gynaecology assessment, the frailty unit, the integrated GP service and the early pregnancy unit. We were informed that there had been a lot of focus on use of referral pathways to ensure patients went to the right place on arrival. An audit carried out from 1 to 14 August 2018 showed that 46 patients had been streamed to other areas during this time; further patients had been referred following assessment. Staff told us that a review was ongoing to improve this, and further training was being provided.

The CDU was located adjacent to the ED and was open 24 hours a day, seven days a week. It had 11 beds over two observation bays, two side rooms used for patient assessment, and a waiting area. The CDU accepted patient referrals from ED, for observation or awaiting transport, and from GPs, the frailty unit and JAMAA. Staff told us that patients would usually stay in the CDU for 24-48 hours, but some were occasionally there for up to seven days. They told us that the patients would often be admitted to the CDU if there were no available beds on the medical wards.

JAMAA was open from 8am until 10pm during the week and from 10am to 6pm at weekends. Patients could be referred here from their GP, from clinics within the hospital and directly via the streaming process in ED. Patients from ED remained registered on the ED system until initial
JAMAA assessment had been completed as, following completion of initial observations, some patients were found to have conditions more appropriate for ED treatment.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for any of the months over the 12-month period from June 2017 to May 2018.

From June 2017 to May 2018 performance was consistently much higher than the 60 minutes standard by. Patients at the trust had to wait a median time average of 57 minutes longer from arrival to treatment than the England median. Median waiting times increased month on month during the winter months from December 2017 to February 2018, reaching the longest median waiting time of 171 minutes in February 2018. Median waiting times decreased from March to May 2018 although remained well above the standard and England median waiting times by a median time average of 58 minutes.

**Median time from arrival to treatment from June 2017 to May 2018 at Leeds Teaching Hospitals NHS Trust**

(Source: Source: NHS Digital - A&E quality indicators)

We reviewed 20 sets of patients’ notes and 15 patients were seen within one hour. All were seen within 1.5 hours.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From July 2017 to June 2018 the trust failed to meet the standard and performed generally worse than the England average.

From July 2017 to October 2017 performance against this metric was slightly lower than the England average. The percentage of patients admitted, transferred or discharge within four hours decreased to well below the England average during the winter months from November 2017 to March 2018. The lowest percentage of 69% of patients, admitted, transferred or discharged within four hours, was reported in January 2018. Percentages however improved to similar to the England average in May and to slightly below in June 2018.
We reviewed 20 sets of patients’ notes and 18 were admitted, transferred or discharged within four hours. One patient was in the department for more than five hours awaiting mental health admission, and one patient for more than seven hours awaiting medical admission.

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From July 2017 to April 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average; this improved to better than the England average in the most recent two months, May and June 2018.

From July 2017 to January 2018 performance against this metric deteriorated sharply to well above the England average. And remained poor in February and March 2018. Percentages improved to lower than the England average in May 2018 and similar to the England average in June 2018.

The table below shows the numbers of patients waiting more than four hours to admission by month:
<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2017</td>
<td>589</td>
</tr>
<tr>
<td>August 2017</td>
<td>602</td>
</tr>
<tr>
<td>September 2017</td>
<td>740</td>
</tr>
<tr>
<td>October 2017</td>
<td>937</td>
</tr>
<tr>
<td>November 2017</td>
<td>1,136</td>
</tr>
<tr>
<td>December 2017</td>
<td>1,512</td>
</tr>
<tr>
<td>January 2018</td>
<td>1,773</td>
</tr>
<tr>
<td>February 2018</td>
<td>1,499</td>
</tr>
<tr>
<td>March 2018</td>
<td>1,713</td>
</tr>
<tr>
<td>April 2018</td>
<td>1,038</td>
</tr>
<tr>
<td>May 2018</td>
<td>305</td>
</tr>
<tr>
<td>June 2018</td>
<td>383</td>
</tr>
</tbody>
</table>


We reviewed 20 sets of patients’ notes and 10 of these patients had been admitted to hospital. Looking at the time of the decision to admit to the time of admission, three patients were admitted within one hour, five patients were admitted between one and two hours, one patient was admitted between two and three hours and one patient waited more than four hours to be admitted.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from July 2017 to June 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

(Source: NHS England - A&E Waiting times)

We reviewed 20 sets of patients’ notes and none of these patients waited more than 12 hours for admission.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From June 2017 to January 2018 the monthly median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently worse than the England average.

From June to September 2017 patients that left the trust before being seen were on average 2% higher than the England average. In October and the winter months of November and December 2017 trust performance deteriorated and percentages were on average 3% higher than the England rates.
Percentage of patient that left the trust’s urgent and emergency care services without being seen - Leeds Teaching Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From June 2017 to May 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Over this time period, patients at the trust spent on average 41 minutes longer in A&E than the England average.

During the winter months of December 2017 to March 2018, patients spent an average of 52 minutes longer in A&E than the England average. Trust performance however improved in April and May 2018, although total time spends in A&E remained longer than the England average.

Median total time in A&E per patient - Leeds Teaching Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)
Learning from complaints and concerns

Summary of complaints

St James’s University Hospital

From May 2017 to April 2018 there were 110 complaints about urgent and emergency care services at St James’s University Hospital. The service took an average of 46 working days to investigate and close complaints. This is not in line with the trust’s complaints policy, which states complaints should be closed within 40 days.

Ten complaints (9.1%) were not upheld, 40 (36.4%) were partially upheld, 35 (31.8%) were fully upheld and 25 (22.7%) were still under investigation.

The trust has allocated multiple subjects for each complaint received. It is therefore not possible to provide a breakdown of the number of complaints by subject.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Senior staff told us they felt complaints were responded to in a timely manner, usually on the day received or on the following day. Weekly meetings took place to discuss complaints and they were also discussed at fortnightly consultant meetings. Learning was disseminated to staff at handover, by email and in a safety newsletter using a structured format.

We did not see any clear information displayed informing patients how to formally raise concerns or complaints. There were, however, posters displayed advising patients to speak to senior staff should they have any issues.

Number of compliments made to the trust

From May 2017 to April 2018 there were 39 compliments in urgent and emergency care. Compliments received for urgent and emergency care accounted for 16.0% of all compliments received by the trust.

St James’s University Hospital

St James’s University Hospital received 22 compliments; 56.4% of all compliments received for urgent and emergency care.

A breakdown by team, unit and ward is shown in the table below:

<table>
<thead>
<tr>
<th>Team/Unit/Ward</th>
<th>Compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency (A&amp;E)</td>
<td>21</td>
</tr>
<tr>
<td>Minor injuries</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The senior leadership team consisted of a clinical director, general manager, head and deputy head of nursing, lead clinician, service manager, business manager, and matron. All staff we spoke with told us that leaders were approachable, supportive and well respected, and that there was regularly a visible management presence in the department. We were told that senior managers often conducted ‘walk arounds’ of the department and had provided assistance at times of high demand.

The nursing team in the department was led by experienced staff who provided clinical and professional supervision. We observed that staff were encouraged to develop their skills and knowledge, and all staff spoke highly of the department’s senior nurses. At the time of our inspection, a change in nursing leadership was taking place in the department.

We saw clear examples of leadership within the department’s medical team; on several occasions we witnessed junior doctors and ACPs being supported by more senior colleagues and consultants, with feedback and advice being given. We spoke with junior doctors and ACPs who told us they felt there was strong leadership within the department and they were well supported.

Vision and strategy

The trust’s vision was ‘to be the best for specialist and integrated care’ and this was supported by a five-year strategy based on a set of values and behaviours referred to as ‘The Leeds Way’. These values were described as patient-centred, fair, collaborative, accountable and empowered; we were told that staff were involved in developing the values and those we spoke with in the ED said their impact on the culture had been very positive.

Senior staff told us the department aimed to build on work already in place to achieve the trust’s vision, with a focus on reducing hospital admissions. This involved collaboration with the frailty unit, CDU and other specialities, to manage patients’ needs both in and out of hospital.

Many staff told us that space was an obstacle in the department and the possibility of a co-located walk-in centre/urgent treatment centre was under discussion.

Culture

Senior staff we spoke with said they were proud of their team and we witnessed positive examples of teamwork and support during our inspection. Staff in the ED told us the department culture was very open and transparent, they felt valued, and the whole team supported each other very well.

Staff in the MIU, however, told us morale there could be quite low and that they often felt isolated due to the department’s location.

The department had a psychologist for staff to access; confidential sessions were available weekly on a ‘drop-in’ basis. We spoke with a member of staff who had accessed this service after a traumatic incident at work and were told a session was arranged for the following day and was very helpful.

An anonymous telephone helpline operated across both EDs to provide support for staff. ‘Listening Ears’ was developed following an incident that occurred in 2017, which had an impact on all staff. It was set up and run by staff from both sites who had received training from a clinical psychologist; a staff member was always available to answer the telephone should a colleague need someone to talk to, and this could be done in complete confidence. The service was originally specific to ED but was being implemented in other areas of the hospital.
Governance

The ED was part of the ESM directorate which had a clear governance structure. ED specific cross-site governance meetings took place monthly and involved medical and nursing leads, the business manager, the quality governance manager and a pharmacy representative. ESM governance meetings also took place, in conjunction with LGI.

We were told that clinical governance meetings did not involve junior doctors or nurses due to time constraints and work commitments; following our discussions with staff, we were not assured that information from governance meetings was always fed back effectively.

We did not receive assurance that senior staff had a robust oversight of the implementation of actions within the department, such as short notice staff movements and the role of the porter assigned to the MIU.

There were joint monthly governance meetings between the ED and GP service to discuss specific cases, risk reports and incidents. At the time of our inspection there was an audit taking place looking at the effectiveness of the GP service.

There was an established partnership between the ED and local mental health provider; there were several sub-groups who met monthly to discuss issues, risks and plans. The groups fed back to the trust board, to provide assurance and ensure oversight could be maintained.

Management of risk, issues and performance

We spoke with senior staff about the location of the MIU and lack of signage. They accompanied us to walk the patient’s route to the MIU and agreed that there were issues. We were told that the possibility of relocating the MIU, and the introduction of a co-located urgent treatment centre, were being discussed.

Managers told us that the risk register was regularly reviewed and discussed at monthly clinical governance meetings. Risks were also discussed twice yearly at executive level. There was a nominated clinical lead for risk and learning in the ED. Safety incidents and learning were shared and discussed with the clinical team.

We reviewed the risk register and saw that nurse staffing shortages, failure to meet the emergency care standard and delays in mental health admissions were highlighted, which were all issues we had discussed with senior staff. However, risks relating to the MIU and outstanding incident reports were not recorded.

Information management

The department collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. Information was used to monitor the performance of the department, and performance data was shared with staff through the CEM Books computer application. Information governance training was part of the trust’s mandatory training programme, with a compliance target of 80%. Data provided by the trust showed that compliance in urgent and emergency care at SJUH was 98.9% for nursing staff and 80.1% for medical staff.

At our last inspection we found patient identifiable information on display on computer screens in patients’ bays. At this inspection all computer screens we checked in the department had been locked when not in use, and required entry of an authorised user’s password for activation.
The department used a combination of paper and electronic records; we observed that all information was managed and stored safely. There was work ongoing at the time of our inspection to introduce further electronic documentation such as ambulance patient report forms.

Engagement

Staff in the main ED told us they felt involved in developments and all appeared engaged in ‘The Leeds Way’ values and behaviours. However, we found that staff we spoke with were not aware of escalation plans and winter planning for the department.

Staff in the MIU told us they did not feel as though they were listened to, and they had not been involved in changes to their department. They were not aware that discussions had taken place involving the potential relocation of the MIU.

Staff told us about the ‘commending excellence in the emergency department’ (CEED) awards: they could nominate their colleagues to receive an award in recognition of their achievements and contribution to the department. Information and examples were clearly displayed on a notice board in the main corridor.

The department participated in the friends and family test; we saw posters regarding this and detailing how patients could become involved.

We were told of examples of patient engagement in the department. Patients could join support groups within the hospital, and had been involved in implementing changes and improvements in the department’s practices.

Learning, continuous improvement and innovation

The ‘Listening Ears’ initiative had been nominated for a Nursing Times award, and was being implemented in other CSUs within the trust.

Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment for most medical specialities. There are 1,119 medical inpatient beds located across 59 wards;

- St James’s University Hospital: 840 beds across 42 wards

St James’s University Hospital

St James’s University Hospital has 840 beds across 42 wards. Of these 111 beds across 12 wards are day case beds, and 729 beds across 30 wards are open Monday to Sunday.

(Source: Routine Provider Information Request – Sites tab)

The trust had 72,660 medical admissions from March 2017 to February 2018. Emergency admissions accounted for 33,728 (46.4%), 4,577 (6.3%) were elective, and the remaining 34,355 (47.3%) were day case.

Admissions for the top three medical specialties were:
- Gastroenterology: 17,438 (24.0%).
- General medicine: 10,302 (14.2%).
- Cardiology: 9,527 (13.1%).

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

Mandatory training was provided monthly. There were systems in place to ensure that staff could access mandatory training and staff we spoke with told us they were up to date with their training. Staff were expected to be compliant with the training and their compliance rate was discussed at their annual appraisal. Senior staff told us that staff could not progress through the next gateway for their appraisal if they were not up to date with their training.

New staff completed mandatory training as part of their corporate induction training which incorporated both e-learning and face to face training.

The trust set a target of 80.0% for completion of mandatory training.

**St James’s University Hospital**

A breakdown of compliance for mandatory training courses as of June 2018 for qualified nursing staff in the medicine department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; diversity general</td>
<td>614</td>
<td>614</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training basic awareness</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>614</td>
<td>614</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 1</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>614</td>
<td>614</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>614</td>
<td>614</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>611</td>
<td>614</td>
<td>99.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>583</td>
<td>597</td>
<td>97.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>581</td>
<td>596</td>
<td>97.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>580</td>
<td>595</td>
<td>97.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>497</td>
<td>512</td>
<td>97.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>592</td>
<td>614</td>
<td>96.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>558</td>
<td>614</td>
<td>90.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>463</td>
<td>606</td>
<td>76.4%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At St James’s University Hospital medicine department, the 80% target was met for 14 of the 16 mandatory training modules for which qualified nursing staff were eligible. Seven training modules had completion rates of 100.0%, although for two of these modules there was only one
staff member eligible to complete the training modules. A further seven modules had completion rates above 90.0%. The trust target was not met for two training modules, infection prevention and control and resuscitation training level 2, although both modules had completion rates above 75.0%.

A breakdown of compliance for mandatory training courses as of June 2018 for medical staff in the medicine department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation training level 2 PMST</td>
<td>34</td>
<td>37</td>
<td>91.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training basic awareness</td>
<td>33</td>
<td>36</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>215</td>
<td>247</td>
<td>87.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>383</td>
<td>447</td>
<td>85.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>383</td>
<td>447</td>
<td>85.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>381</td>
<td>447</td>
<td>85.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>375</td>
<td>447</td>
<td>83.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>312</td>
<td>376</td>
<td>83.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2 intensive life support</td>
<td>28</td>
<td>34</td>
<td>82.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>319</td>
<td>393</td>
<td>81.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>348</td>
<td>437</td>
<td>79.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>336</td>
<td>446</td>
<td>75.3%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>320</td>
<td>447</td>
<td>71.6%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>311</td>
<td>447</td>
<td>69.6%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>299</td>
<td>447</td>
<td>66.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training level 3 advanced life support</td>
<td>15</td>
<td>23</td>
<td>65.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training advanced update</td>
<td>164</td>
<td>354</td>
<td>46.3%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>164</td>
<td>354</td>
<td>46.3%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At St James’s University Hospital medicine department, the 80.0% target was met for ten of the 19 mandatory training modules for which medical staff were eligible. Two modules had completion rates above 90.0%, and a further eight modules had completion rates above 80.0%.

Medical staff did not meet the 80.0% trust target for nine modules. Of these, one module had a completion rate of 79.6%, just below the trust target. Three training modules had completion rates between 60% and 70.0%. A further three modules had completion rates below 50.0%. The training module PRTD obstetric basic life support level 1 had a 0.0% completion rate, although this equates to only one eligible staff member not completing the training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

Safeguarding policies for children and adults were in place and staff knew how to access them. The policy detailed the different types of abuse and which issues staff should report. We spoke with staff who told us how to make referrals and discussed circumstances where safeguarding issues were raised.
Annual reports were completed by the trust for safeguarding children and adults. We reviewed the report for 2016/17 which identified the number of referrals and type of abuse documented. The report identified key achievements and challenges for the report period and priorities for the next period.

The trust recorded how many safeguarding referrals were completed monthly. Between April 2017 to March 2018, trust wide, the trust recorded that medicine wards had made 156 adult safeguarding referrals and no child safeguarding referrals.

Staff had access to the safeguarding team and information was available on the intranet for support. Staff told us that they could access the safeguarding team and felt they were supportive. The trust held meetings where safeguarding issues were raised and discussed. The steering group monitored any risks, service improvement requirements and learning points along with areas of good practice.

We saw wards had information displayed regarding safeguarding and who to contact.

The trust set a target of 80.0% for completion of safeguarding training.

**St James’s University Hospital**

A breakdown of compliance for safeguarding training courses as of June 2018 for qualified nursing staff in the medicine department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>589</td>
<td>614</td>
<td>95.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>589</td>
<td>614</td>
<td>95.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>50</td>
<td>60</td>
<td>83.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>41</td>
<td>55</td>
<td>74.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>392</td>
<td>544</td>
<td>72.1%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>387</td>
<td>544</td>
<td>71.1%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>39</td>
<td>55</td>
<td>70.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At St James’s University Hospital medicine department, the 80.0% target was met for three of the seven safeguarding training modules for which qualified nursing staff were eligible. Two training modules had completion rates above 95.0%. Four modules had completion rates below the trust target, although these had completion rates above 70.0%.

A breakdown of compliance for safeguarding training courses as of June 2018 for medical staff in the medicine department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>359</td>
<td>447</td>
<td>80.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>312</td>
<td>447</td>
<td>69.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>114</td>
<td>167</td>
<td>68.3%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>112</td>
<td>167</td>
<td>67.1%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
At St James’s University Hospital medicine department, the 80.0% target was met for one of the seven safeguarding training modules for which medical staff were eligible. Six training modules had completion rates below the trust target, of which five modules had completion rates between 50.0% and 70.0%. Safeguarding children level 2 had the lowest completion rate of 29.1%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

Areas we visited had suitable hand washing facilities on entering the wards. We saw that wall mounted hand gels did not always contain hand gel and the trust were advocating hand washing on entering the wards. Most staff were observed to be arms bare below the elbows and using personal protective equipment (PPE), such as gloves and aprons, when required. However, on ward J15 we saw that dirty linen was placed on the floor rather than using the appropriate linen skip.

Patients with infections were treated in side rooms to prevent cross infection. There was clear signage on display identifying rooms where patients were being barrier nursed and on most occasions, we observed staff wearing appropriate personal protective equipment (PPE) before entering. However, on ward J12 and J14 we observed three occasions where the doors to barrier nursing rooms were propped open with a bin or chair. On ward J14, PPE was not always used by staff when entering rooms where barrier nursing was in place where we also observed staff not washing hands after exiting. This meant that they were not adhering to infection control policies.

We saw that patients who were isolated had the relevant care plans such as an infection control isolation care plan which was completed.

Each ward displayed monthly information relating to their ward. This included infection control data such as hand hygiene results and how many days since specific infections such as clostridium difficile or MRSA. Hand hygiene results varied, for example ward J28 in May 2018 compliance was 60% increasing to 100% in June 2018. On ward J15 hand hygiene results varied with 100% compliance in May and June 2018 and 80% in July 2018.

The trust completed monthly ward healthcheck metrics based on two questions, these looked at whether an invasive devices care plan was in place and were required precautions in place for patients requiring isolation. Information provided by the trust for emergency and specialty medicine (ESM) clinical service unit showed percentages varied between June and August 2018. For example, ward J8 was consistently below 90% for the three months at 78% raising to 89% in August 2018. The lowest compliance was 56% on ward J15 in July 2018, however this increased to 100% in August 2018. Six areas out of 14 received 100% for all three months, these included J16, J17, J20, J21, J26 and J29.

A ‘stop the line’ approach was in the process of being adopted, this involved a review of the infection control incident around the patient’s bedside. It looked at areas of good practice or recommendations that were required. We saw documented patient evidence of the report which reviewed the care and ongoing plan.
To support staff in maintaining levels of infection control, wards had dedicated housekeepers and a central trust domestic team. Staff cleaned equipment after use and a sticker was used to indicate equipment that had been cleaned. Housekeepers kept the sluice area clean and tidy and ensured commodes were cleaned and ready for use. We saw that sluices were clean and tidy and checked commodes on various wards. These had been cleaned and labels applied to identify that they had been cleaned.

Healthcare associated infections (HCAI) were recorded by each CSU and reported within the assurance report to the Infection prevention and control committee. Information provided by the trust showed that there were 12 cases of clostridium difficile in emergency and specialty medicine CSU. There were two cases of MRSA in April and May 2018.

The trust displayed information indicating that it was two years since the last case of MRSA bloodstream infection in cardiorespiratory CSU. The abdominal medicine and surgery CSU completed a healthcare associated infections (HCAI) awareness week in April 2018. Themes were taken from lessons learnt and route cause analysis reports as well as common infection control issues. Staff completed interactive sessions and were asked to make pledges in how they could support infection control within their own practice.

Environment and equipment

Some of the wards we visited remained to look cluttered and had limited spaces to store equipment. On ward J28, for example, we observed an empty bed, hoist and weighing chair stored in the corridor, posing a potential falls risk to patients and visitors. The entrance to ward J27 was also cluttered, there were two beds in the entrance corridor on arrival. On ward J27 the ward was very long with an unusual layout. At the far end of the ward there was a small bay which accommodated two patients. The vision of this area was to become a high observation bay. Past this bay was another bay for four patients. We saw that all patients in both areas were of the same sex enabling privacy and dignity and toilets were accessible in each bay. An area was accessible for a staff member to stay to monitor the patients as it was far away from the nurses’ station. On ward J8 there was damage to the call bell in the toilet and wet clothes and towel on the floor of the shower room.

In contrast wards in Bexley wing based with the Leeds Cancer Centre building were very spacious with plenty of room. This was a modern purpose-built oncology centre opened in 2008 focusing on patients’ needs with a focus on teaching and research alongside treatment.

At our inspection in May 2016 we noted that stock such as medicated body wash was stored in an unlocked cupboard. At this inspection we found store cupboards remained unlocked and contained equipment that could be hazardous or dangerous to patients. For example, on ward J26 within cupboards we found photocopier toner cartridges, disposable razors and disinfectant gel. We raised this with the ward manager who told us that this would be removed if patients posed a risk and would check to see if the items required locking away. On ward J27 and EAU we found chlorine based tablets for cleaning and disinfecting in a jar in an unlockable room. We told staff who removed them immediately. On ward J19 further chlorine based tablets had been dissolved into a bottle and left, there was no date to identify when this had been completed. These were stored in an unlocked cupboard. On ward J14 we found medicated body wash in the sluice, this was in a cupboard that could be locked, however it was not.

We carried out an inspection in December 2017 at the hospital due to concerns raised regarding the safe use of additional beds in non-designated areas during times of increased demand. Areas such as corridors, treatment rooms, day rooms and additional beds in patient bays were utilised. The trust reported that they had not used any non-designated areas for a period of months. Staff told us that they had not recently had any extra patients in non-designated areas since the winter months.
Areas such as JAMAA (St James acute medical assessment area) and frailty unit were small and plans were in place to review capacity within these areas. There were six cubicles in JAMAA and staff told us that capacity was an issue at times. Within the frailty unit there was only three cubicles spaces and staff told us it impacted on the ability to use the unit to its full potential.

We checked different types of equipment such as infusion pumps and blood pressure monitoring equipment. Most of these were in good working order and had been safety tested and checked according to manufacturer’s recommendations. We saw on ward J29 one blood pressure monitoring machine should have been checked in February 2018.

Resuscitation equipment was available in every area; the trolleys were sealed with a tag. However, we visited the respiratory day unit which did not have a resuscitation trolley. We were told that they would use the one on ward J12 which was next to the unit. We checked the equipment on various wards since April 2018 and they had been checked daily. The oxygen cylinders were full and the defibrillation equipment was charged and tested.

The trust completed monthly ward healthcheck metrics specifically looking at emergency equipment. Four questions were asked which included the checking of resuscitation and hypoglycaemic equipment daily, removal of air flow meters when not in use and suction equipment. Information provided by the trust for emergency and specialty medicine (ESM) clinical service unit showed percentages varied between June and August 2018. Six ward areas out of 14 had 100% compliance for all three months. Four wards had 100% compliance for two months and three wards for one month. The lowest compliance was on ward J28 with 50% in July 2018 and 33.3% in August 2018. Information was provided with overall totals therefore it did not identify which specific questions the ward may not have been compliant with.

Staff told us they had access to equipment when they needed it. They expressed they had no problems obtaining pressure-relieving equipment, such as mattresses.

Assessing and responding to patient risk

Patients identified as being at high risk of falls were cohorted into falls bays, this involved a group of patients in a bay being closely supervised by a staff member. We observed the use of falls bays on several wards. We also saw patients having one to one supervision who were at high risk of falls.

The trust had an enhanced care risk assessment tool and enhanced care activity log for patients. This included a review of the risks and categorised them into low, medium or high risk with an evaluation of the risk. We saw two patients on ward J7 where there were no enhanced risk assessments in place, one of these was receiving one to one supervision due to a high risk of absconding. We reviewed 14 enhanced risk assessments forms and saw that these were completed identifying the level of risk and evaluation. In one of the risk assessments it identified that the patient required to be in a falls cohort bay, however the assessment had not been updated to reflect they were no longer in a falls bay.

The trust reviewed monthly within the wards healthcheck metrics information regarding falls. It looked at whether patients who were at high risk of falls had enhanced care risk assessments in place. We saw that the results varied between March and August 2018 for different wards, with no data submitted for elderly ward J9. Compliance had significantly improved for most wards in August 2018, except for ward J15 where compliance had reduced.
On some occasions due to staffing levels the required level of care was not provided to at risk falls patients. We observed a patient fall during our inspection on ward J12, we reviewed the documentation where it identified that the patient also had a previous fall the previous day. Risk assessments had been completed and one to one care was agreed to be provided. We asked why the patient did not have the one to one supervision when the patient fell and were told that the staff member had left to support other patients on the ward. On ward J14, a staff member left the falls cohort bay unattended to take one of the patients to the toilet as there were no other staff available to take over monitoring the falls bay. Another patient on J14 required one to one supervision however there was no-one to accommodate this, a staff member supported the one to one supervision alongside supervising a patient that was walking up and down the ward. On ward J19 we saw a staff member leave the falls cohort bay to obtain specific medicines. The staff member returned and attended to a patient behind a curtain in their bed space. This meant that they did not have visual contact with the other patient in the fall cohort bay.

We revisited the trust on 25 September 2018 and found on ward J7 a falls cohort bay had been without the required supervision in the morning and previous day due to staff shortages. One patient had fallen within the falls bay in the morning. We also saw that one patient who was being supervised due to being at high risk of absconding was left alone for two minutes while the staff member went off to make them a drink.

On J14 a staff member from a commissioned firm was due to provide one to one supervision however they had not turned up on duty. This patient had been assessed as a high risk on their enhanced care risk assessment. The nurse in charge told us that it had been escalated to the matron and there was no available staff on the ward to provide the supervision. We asked how they would mitigate managing the patient, a plan was in place to review the patient every 30 minutes. However, when we reviewed the patient’s notes we saw that the intentional rounding form did not show this level of checks. On the ward there was another patient that required one to one supervision and two falls cohort bays also had a staff member supervising them.
We spoke with staff who provided care in the falls cohort bays or one to one supervision who told us they felt unsupported at times. Some staff felt that when they were in the falls cohort bays they felt obliged to attend to other patient’s needs as there was no staff available to respond. This meant they went behind patient’s curtains to attend to their needs, which then put patient at risk of falls.

We reviewed incident data submitted through National Reporting and Learning System (NRLS) and found that several incidents had been submitted when patients had fallen and not had the required supervision. For example, patients had fallen when the staff member supervising the falls cohort bay were managing other patient’s needs. We saw that one fall occurred as the staff member providing one to one care left the cohort bay to take a patient to the toilet. On the incident form it was noted that the ward was short staffed and no-one was able to cover.

Falls sensors were available on wards however we saw on NRLS where a patient required the use of a falls sensor one could not be accessed for them. It identified that staff had tried to contact other wards however there were none available to use.

The trust was developing a pilot of ‘stop the line’ for falls with moderate harm or above in both emergency and specialty medicine and neurosciences CSU’s. This looked at bringing key members of the multidisciplinary team together at the bedside within six hours to review the circumstances of the incident. This will aid learning from incidents in a timely manner. A month-long trial in July 2018 was commenced at both St. James University Hospital and Leeds General Infirmary sites on specific wards.

The ward healthcheck metric reviewed other falls information such as falls risk assessments on admissions, care plans in place, appropriate footwear in place and whether the patient had their mobility aid within reach. The majority of wards within emergency and speciality medicine (ESM) CSU had a high compliance between March and August 2018 for risk assessments in place, the exception was ward J14 where there had been a reduction in August 2018 to 60% from 100% the previous month. Ward J14 had also seen a reduction in compliance for care plans within August 2018 to 75% from 100% in July 2018. All other areas except for wards J16 and J22 received 100% compliance for a number of months.

Information provided by the trust showed that staff in each CSU completed falls training. We saw that compliance rates for medicine CSUs such as emergency and specialty medicine, cardio-respiratory, abdominal medicine and surgery were mostly above 90%. Compliance rates for training were discussed in the falls meetings and we saw documents that reflected this.

Patients who required non-invasive ventilation were cared for on the acute respiratory unit on ward J10. The unit had 12 patient bed spaces, two were single rooms just outside of the unit. Patients in the side rooms were normally patients that required to be isolated or more stable patients because they were not in visible site of the staff. A staff member would normally manage these patients outside along with some patients within the unit. The trust had a critical care outreach team who were available seven days a week, outside of hours staff on the wards could contact the critical care on call doctors for advice and support. Patients on the unit required either level two or level three care, the unit only allowed a specific number of patients on the unit with certain conditions. For example, the unit could not accommodate more than three patients with a tracheostomy.

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating indicating when a patient may have required a higher level of care. The scores were uploaded onto an electronic device and were visual on the ward electronic ward board. The current NEWS score was recorded with a coloured indication if the score was high. It identified the time since the last recording and would go red if the score was overdue to be recorded. We reviewed 20 patient records and saw that NEWS charts were calculated and recorded appropriately.
Information supplied by the trust showed that NEWS compliance audits were completed monthly. We reviewed compliance for the abdominal medicine and surgery, cardio-respiratory and emergency and specialty CSUs. Audits from April 2018 consistently showed that observations were recorded and the correct NEWS was calculated. Results for documentation of interventions of raised NEWS (three or more in one parameter or total five or above) varied throughout the CSUs from 53% to 84%.

The audits also reviewed whether a sepsis screen was completed when the NEWS was above five. Audits from April 2018 showed variances and increases in compliance. For example, in cardio-respiratory CSU, compliance had increase from 33% to 71% and abdominal medicine and surgery it had increase from 60% to 100%.

At our inspection in May 2016 we saw that patients waited for beds in the corridor of the ward they were due to be admitted onto. At this inspection we did not see any patients waiting in the corridor to be admitted.

**Nurse staffing**

All wards we visited had registered nurse vacancies, for example ward J93 had three whole time equivalent (WTE) vacancies and J26 had 11.5 WTE vacancies. As a result of the staffing on J26, six beds had remained closed following the refurbishment. Staff from other areas had committed to send staff for an ongoing period and support J26. With the reduced beds on J26 this meant that there were 20 beds available for patients with a ratio of three registered nurses and three health care assistants. However, we were told that on some occasions there were only two registered nurses.

We saw that many wards did not meet the levels of their planned registered nursing requirements as documented on their staffing requirements boards. We saw on ward J14 that two registered nurses were required to support 22 patients on the ward, however on two days of the inspection only one registered nurse was on the ward. We revisited the ward on 25 September 2018 where two registered nurses were in place. However only one registered nurse was on the ward the previous day and one planned for the next day. On ward J19 there were two registered nurses for 29 patients instead of the planned three nurses. Five patients on the ward required one to one supervision due to high risk of falls and behaviour. Two of these were based in a falls cohort bay and three were in individual side rooms. These had the appropriate supervision, however it meant that there was only one healthcare assistant along with student nurses available to support all other patients on the ward.

Ward J10 was the acute respiratory care ward and there were 12 patient beds. The respiratory care unit (RCU) was based at the end of J10 which also had 12 beds with a mix of both level two and three patients. Staffing levels were collated for the ward including RCU. Planned levels of registered nurses were five per shift with three allocated to RCU, this allowed one registered nurse to have four patients within RCU. However, staff told us that the trust had identified that safe staffing levels were four registered nurses rather than the agreed establishment of five. On the day of our inspection, the planned levels of registered nurses were met. Staff told us that the unit sometimes would have two registered nurses and two healthcare assistants. At times agency staff would work in the unit, however they did not always have the competencies to support patients on ventilators.

Staff told us on ward J8 they always had two registered nurses for 31 patients when the current level was three registered nurses. We reviewed 252 registered nurse shifts and saw that 45% there were two registered nurses and 52% had three registered nurses. The ward was an elderly medicine ward with patients who were at high risk of falls and confusion. They told us that they felt it delayed patient care and impacted on time to spend with patient and relatives on their care and updates.
We saw that ward J7 did not have the required level of healthcare assistants during our visit. This impacted on the ability to have the required level of supervision within the falls cohort bays.

We visited ward J17 which consisted of 22 patient beds. At the end of the ward was J17a which consisted of five individual isolation rooms for patients with confirmed clostridium difficile. At the time of our inspection four patients were in these rooms. For both J17 and J17a there were three registered nurses between the two areas, instead of the planned four registered nurse’s requirements. One clinical support worker remained in J17a however registered nurses moved between J17 and J17a. Staff told us there were often only two registered nurses for the whole of both areas.

On many wards we were told that vacancies had been recruited to and were awaiting to commence. These included nine new starters on ward J27 and two on ward J28.

Other initiatives to support the reduced number of registered nurses had been implemented. These included occupational therapists having more of a supporting and co-ordinating role on wards such as J8 and J14 since June 2018. Clinical support workers who had completed further training had responsibilities for a bay of patients and co-ordinated the care. The ward manager on ward J28 had implemented twilight shifts for different levels of staff to manage patient care at peak times.

Senior managers met several times a day with matrons to review each area’s staffing and bed capacity. We observed one of the meetings and each area provided their overview which indicated a specific rag rating. Staffing issues and shortages were discussed and mitigation to manage the situation.

During winter months the trust recruited extra staff to work on the ward from non-clinical areas. We spoke with some of these staff who told us they worked one to two shifts and supported.

The trust was in partnership with the local university and community NHS trust and had employed several apprentice nurses and nursing associates to work across the CSUs. Further cohorts of nursing associates were due to commence in 2018. The trust participated in various recruitment days to promote the services and trust.

We were told about the J10 cell project. This was where student nurses under minimal supervision would manage and provide care for patients on the ward for a three-month period. They would then progress to manage patients within RCU. Staff would coach and support them through the transition. The students were third year students that would qualify within the next year. Staff told us that students felt this was beneficial and the ward had retained one qualifying nurse on the ward and other areas of the trust were following the project. The project was due to be completed again in the near future.

### St James’s University Hospital

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual WTE staff</td>
<td>645.4</td>
<td>624.6</td>
</tr>
<tr>
<td>Planned WTE staff</td>
<td>806.5</td>
<td>796</td>
</tr>
<tr>
<td>Fill rate</td>
<td>80.0%</td>
<td>78.5%</td>
</tr>
</tbody>
</table>

St James’s University Hospital had a staffing fill rate of 78.5% in March 2018, lower than the fill rate of 80.0% in March 2017, even though the trust has decreased planned WTE staff by 10.5 between March 2017 and March 2018. The service had to operate with 161.1 less WTE staff in...
post than planned in March 2017 and with 171.4 less in March 2018. This site had 20.8 less WTE staff in post in March 2018 than in March 2017. Following the inspection the trust advised that this figure did not include the flexible labour and increase in bank staff to offset the vacancies.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 17.8% in medicine. The trust did not set a trust target for vacancy rates.

The breakdown by site was as follows:

- St James’s University Hospital: 19.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 13.7% in medicine. The trust did not set a trust target for vacancy rates.

The breakdown by site was as follows:

- St James’s University Hospital: 13.6%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 3.9% in medicine; this was slightly higher than the trust target of 3.5%.

- St James’s University Hospital: 3.9%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Trust level

From April 2017 to March 2018, the trust reported that 2.7% of qualified nursing shifts in medicine at the trust were filled by bank staff and 2.2% of shifts were filled by agency staff. In addition, 9.1% of shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 6.3% of nursing assistant staff shifts in medicine at the trust were filled by bank staff, 6.6% of shifts were filled by agency staff and 3.5% of shifts were not filled by either bank or agency staff to cover staff absence.

Please note that the trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James’s Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.
St James’s University Hospital

From April 2017 to March 2018, the trust reported that 2.3% of qualified nursing shifts in medicine at St James’s University Hospital were filled by bank staff and 2.5% of shifts were filled by agency staff. In addition, 9.9% of shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 4.4% of nursing assistant staff shifts in medicine at St James’s Hospital were filled by bank staff, 6.7% of shifts were filled by agency staff and 3.1% of shifts were not filled by either bank or agency staff to cover staff absence.

Please note that the trust was not always able to differentiate between the total shifts for qualified nurses available at Leeds General Infirmary and St James’s Hospital. Therefore, this analysis includes some shifts that were available at both hospitals.

Medical staffing

There was consultant cover available on-site Monday to Friday for all specialities. Different wards had a variety of medical cover, for example ward J19 had four consultants which provided cover over a two-week period. Ward J15 had three consultants who completed ward rounds several times a week. Weekend and on call cover was completed rotationally on some wards, ward J21 completed this over a two-week period. Four consultants covered ward J10 and respiratory care unit (RCU) and were on call for the week. Consultant cover was in place on Saturday and Sunday who reviewed patients and new admissions. Both middle and junior grades were available when consultants had left.

Weekend cover and out of hours covers was in place. Most wards had a junior doctor in place and registrars would cover several wards and review patients that were escalated to them. One registrar covered wards J10 including RCU, J9 and J12. Staff on the respiratory care unit told us that medical staff responded appropriately to acutely ill patients. One junior doctor was in place on each of the elderly and acute admission wards along with a registrar who covered all four areas.

We observed both medical ward rounds and safety brief meetings. Medical rounds would take place in the morning to facilitate patients’ ongoing care or discharge plans. Staff on ward J27 told us the medical staff would review acutely ill patients with the night medical team. The ward rounds and safety huddles were thorough and efficient with all information clearly communicated. All staff members had the opportunity to contribute to the meetings. Medical cover was agreed at the
morning meetings and we saw that medical staff were allocated to review medical outliers and any patients that had been referred from other specialities that required to be reviewed by a consultant.

Ward J14 was designated for patients who were medically fit for discharge who were waiting for a package of home care or a care home. Patients remained under the same consultant's care they had during their admission. A member of the medical team would attend the ward twice weekly to identify if the patient required a review. Staff could access the team in-between as required and they would be reviewed.

Medical cover was provided in JAMAA until the unit closed at 10pm. A consultant on call was available and staff told us that this could be easily accessed.

Junior medical staff told us that the support they received from senior colleagues when they were on call was good. The majority of staff told us they had time to be able to attend specific medical training.

An acute medicine consultant would lead the virtual acute medical unit (vAMU) between Monday and Friday. A daily ward round was completed and test results were checked by the consultant and referred to the appropriate clinics.

The trust reported their staffing numbers below as at March 2017 and from March 2018 for medicine.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>399.3</td>
<td>403.5</td>
</tr>
</tbody>
</table>

The trust had a staffing fill rate of 94.8% in March 2018, lower than the fill rate of 97.3% in March 2017, although the trust increased planned WTE staff by 18.9 from March 2017 to March 2018. The service had to operate with 17.3 less WTE staff in post than what was planned for in March 2017 and with 34.4 less in March 2018.

St James’s University hospital

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>399.3</td>
<td>403.5</td>
</tr>
</tbody>
</table>

St James’s University Hospital had a staffing fill rate of 95.9% in March 2018, lower than the fill rate of 99.0% in March 2017, although the trust has increased planned WTE staff by 9.6 between March 2017 and March 2018. The service had to operate with 4.2 less WTE staff in post than what was planned for in March 2017 and with 16.8 less in March 2018. This site had 3.0 less WTE staff in post in March 2018 than in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 4.2% in medicine. The trust did not set a trust target for vacancy rates.

The breakdown by site was as follows:

- St James’s University Hospital: 3.3%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 37.8% in medicine. However, the inclusion of trainee grades in the data is likely to have inflated the rates. The trust did not set a trust target for turnover rates.

- St James’s University Hospital: 42.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 0.9% in medicine; this was much lower than the trust target of 3.5%

- St James’s University Hospital: 0.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

St James’s University Hospital

From April 2017 to March 2018, St James’s University Hospital reported that 1,425 shifts were filled by bank staff and 56 shifts were filled by locum staff in medicine. There were 150 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type at St James’s University Hospital and shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information was not stored on their electronic rostering system and held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Shift type</th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>179</td>
<td>1,172</td>
<td>74</td>
<td>1,425</td>
</tr>
<tr>
<td>Locum shifts</td>
<td>55</td>
<td>1</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>29</td>
<td>121</td>
<td>0</td>
<td>150</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In December 2017, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 550 whole time equivalent staff working in medicine at Leeds Teaching Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital - Workforce statistics (01/12/2017 - 31/12/2017)

Records

Nursing and medical notes were a mixture of both paper and electronic observations. These were stored in various places, some in traditional records trolleys and others at the patient’s bedside. We saw that notes trolleys had covers and lockable lids however we found on several wards they were not stored securely and not locked when not in use. On ward J29 we saw the medical notes trolleys were at the main desk however these were not locked. In JAMAA the notes were stored in the corridor and these were also not locked. On ward J21 nursing notes had been left open in the main corridor of the ward. Information governance training for medical staff was 70% which was below the trust’s set target of 80%.

On ward J14, notes were stored on open shelves in the doctors’ room at the end of the ward. This room was empty and unattended on several occasions but the door left open. We observed one wandering patient enter the room on more than one occasion and pick up and move other patient notes. We raised this with the ward manager who informed us that the lock on the door had been broken and not repaired. This meant that we were not assured that information was stored securely. We revisited the ward on 25 September 2018 to find that the door remained unable to be locked. Staff on duty told us that the door would not be locked as staff required to access it, they also told us that patients did wander in.

On JAMAA we saw that patients were leaving samples in a basket just inside the entrance to the ward. Patients’ personal details, including their date of birth and address were clearly visible.

We reviewed 20 sets of patient records and saw they were clearly recorded and the majority were legible, signed and dated. In the nursing notes there were different assessments and care plans for a variety of conditions that had been actioned and evaluated. The majority of risk assessments were completed. We saw evidence of the enhanced care risk assessment completed for patients that required additional support.

We reviewed the medical records of 15 medical outliers in none medical areas. These included CDU and surgical wards J42, J46 and J50. These also contained relevant information and appropriate assessments and documentation.
Medicines

We checked the storage of medicines on the wards we visited. Medicines were stored in a locked room that required access from designated staff members. We found the majority of treatment rooms were locked however the treatment room door had not shut properly from the last person leaving when we entered ward J6. The key code for the treatment room on ward J93 was not working and was open at the time of our inspection, however work to rectify this was completed during our time on the ward. We found the keys were in one of the cupboards on J93 which meant that medicines were not stored securely and safely. We raised this at the time of our inspection with the ward manager.

Some of the wards we visited used an automated drug dispensing cabinet to store and manage medicines, others used a traditional locked cabinet or specific locked cupboards at the patient’s bedside. Staff would need to use a keypad for the automated drug dispenser which would record the staff member accessing the medicines.

We reviewed 10 electronic patient prescription charts. These contained the relevant information such as date, known allergies and electronic signature of the clinician. There were three main code reasons why medication was not given, these were: delay, withheld or missed. We saw that codes were recorded on the electronic system stating the reason why they were not administered.

We observed staff on ward J27 administering medication, this was completed with the appropriate checks in place.

Controlled drug checks were required to be completed weekly as documented in the medicine management policy. We saw that weekly checks were completed on the wards we reviewed. The trust completed quarterly medicine audits to check whether controlled drug checks were acceptable. We saw that in the audit for February 2018, most of the medicine wards were recorded as acceptable with eight identified as not acceptable. This improved in the next audit (May 2018) where all medicine wards were documented appropriately. The latest audit in July 2018 showed that most wards were recorded as acceptable with eight recorded as not acceptable. These included respiratory care unit, wards J7, J26 J87 and J88.

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. We found that most of days were recorded. Weekly recordings were collected and reviewed and staff told us they received feedback if days were not recorded. Room temperatures were also monitored and recorded. A flow chart was in place to inform staff how to escalate if the room temperature was above a specific level. However, we found on ward J6 that the temperature had been above 25 degrees for eight days and there was no record of escalation.

Information provided by the trust showed that they audited the quality of antimicrobial prescribing. It reviewed how many patients were audited and the number on antibiotics. We reviewed June 2018 data which showed that most medicine wards followed the appropriate guidelines except for wards J88 at 89% and J14 at 67%. The percentage of patients that were on antibiotics with a duration or review was high with most at 100%, the exceptions were J20 and J21 within the 90% range and J92 at 64%.

Incidents

Staff knew how to report incidents using the electronic reporting system and told us they were encouraged to do so. We reviewed incident data and saw that in-depth information was supplied. Additional information was often added with actions of how to prevent reoccurrences. Some ward managers reported that they learned from incidents and how they had improved documentation.

Staff told us they received feedback about incidents by ward managers who would discuss route
cause analysis reports and action plans with them. Staff said there were a variety of ways incidents were discussed, these included emails, safety huddles, secure social media sites and files kept on the wards. Incidents were also discussed in care quality groups which ward managers attended.

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. The majority of staff we spoke with were aware and could explain appropriately for their grade the principles of duty of candour.

Information provided by the trust showed that falls incidents were discussed at meetings that were required to be investigated further as a root cause analysis. At the falls meetings there was a discussion to how and why the fall occurred and whether the fall was unavoidable. Areas of good practice and recommendations were discussed.

We saw documents that identified patient deaths were discussed in speciality morbidity and mortality meetings. These were then discussed at CSU governance meetings. In the governance meetings for emergency and specialty medicine CSU in April 2018 we saw they discussed the quarterly reports on learning from deaths.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

In accordance with the Serious Incident Framework 2015, St James’s University Hospital reported 37 serious incidents (SIs), in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

Of these the most common types of incidents reported were:

- Slips/trips/falls meeting SI criteria with 19 (51.4% of total incidents)
- Pressure ulcer meeting SI criteria with 13 (35.1% of total incidents)
- Treatment delay meeting SI criteria with two (5.4% of total incidents)
We looked at examples of serious incident investigations and found they had been investigated thoroughly. Staff, patients and relatives had been involved with the process. The reports were open and honest. Any learning from the incident was documented and the incident shared at meetings to review the content of the report.

Serious investigation reports were discussed at the clinical governance meetings, with lessons of learning noted.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection took place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 124 new pressure ulcers, 20 falls with harm and 25 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for medical services.

From May to November 2017 pressure ulcers reported decreased from 17 in May to three in November 2017. From five to seven pressure ulcers were reported for the three month period from December 2017 to February 2018. After this period pressure ulcers reported increased, reaching its highest point of 18 in April 2018, after which they decreased to 12 in May 2018. The overall trend remained stable although as described above there were variances in numbers reported over the period.

Falls reported remained fairly stable with between one and two falls reported for most months over the period May 2017 to May 2018. The highest numbers of falls (four) were reported in July 2017 and no falls were reported in May 2017 and April 2018.

Reported new urinary tract infections in patients with a catheter increased from two in June 2017 to five in September 2017. No new UTIs were reported in October 2017, after which two CUTIs per month were reported from November 2017 to January 2018. Following three months with no new UTIs, the number increased sharply to six in May 2018.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections in patients with a catheter and at Leeds Teaching Hospitals NHS Trust

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only

Source: Safety thermometer - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies and procedures relevant to their role.

The trust had a procedure for implementing best practice guidance, including all types of NICE guidance. For each piece of guidance, a nominated lead within the CSU completed an assessment of the trust's compliance and actions were put in place to achieve compliance with any recommendations not met.

The safety and outcomes sub-group received a six monthly report giving an overview of the trust's compliance with NICE guidance. The trust told us that the report was shared with the trust's commissioners.

The trust’s procedure also set out the process to be followed if a decision was taken not to implement specific recommendations from NICE guidance. Any non-compliance had to be presented to the safety and outcomes sub-group, prior to approval by the quality assurance committee.
The leadership team we spoke with explained that they had a quality manager part of whose role it was to support them in ensuring that the trust process for implementing, say, NICE guidance, was adhered to. This was an item reviewed at the clinical governance meetings.

**Nutrition and hydration**

Most patients told us they enjoyed the food they were given. They said that the food provided was adequate and there was plenty of choice. Patients also said they had plenty of drinks and snacks offered between meals. We saw on ward J6 patients had access to additional dietary requirements to help support their condition. A permanent dietitian was on the ward to support patients with their needs.

We saw water jugs were in reach of patients and saw refreshments were available for both patients and families on JAMAA (St James acute medical assessment area) and ward J6.

We looked at 20 patient records and found that they contained risk assessments for malnutrition. We saw that fluid balance charts were not always in patients notes however these were only completed for patients with a clinical need where monitoring was required.

The trust completed monthly ward healthcheck metrics specifically looking at nutrition and hydration. Up to five patient’s records were reviewed, seven questions in relation to nutrition and five for hydration were completed. These included the completion of risk assessments, care plans and food charts for nutrition. Within the hydration questions it reviewed whether an initial assessment was completed, fluid balance charts for patients at risk and if the chart had been calculated correctly. We saw that each area displayed the latest results and compliance rates.

Information provided by the trust for emergency and specialty medicine (ESM) clinical service unit showed percentages varied between June and August 2018 for nutrition scores. Wards J16, J17, J21, J22, J26 had a consistent compliance between 88% and 100%. Nine wards had a compliance below 80% for one month or more. For example, ward J28 had 61% compliance in July 2018 and 50% in August 2018. Ward J07 compliance reduced from 64% to 59% in July 2018 and then increased to 93% in August 2018.

Information provided by the trust for emergency and specialty medicine (ESM) clinical service unit showed percentages varied between June and August 2018 for hydration scores. Two wards received 100% compliance for the three months, which were J16 and J17. Nine wards had a compliance below 80% for one month or more. For example, ward J14 had 100% compliance for June and July 2018 which reduced to 60% in August. Three wards had a compliance of below 80% for all three months, ward J15 compliance was 76% which reduced to 39% in August 2018. In June 2018 compliance on ward J07 was 39%, this increased each month to 73% in August 2018.

A red tray and jug system was in place to support patients who required assistance with feeding. Mealtimes were protected; however, we did see relatives were encouraged to stay and help with meal times if they wished. We saw patients being supported to eat and drink and that drinks were readily available and were in easy reach of patients. On some wards there were wipe board in the kitchen which noted patient’s nutritional needs.

The trust completed a trust-wide mealtime audit. The results showed that one in five red trays were not used for patients who needed them. The requirements were if a patient nutritional score of one or above housekeeping staff needed to be alerted by 7.30am to ensure that their meals were served on a red tray.

On ward J28 staff told us they participated in additional initiatives to support patients with their needs. For example, as part of hydration week additional nutritional supplements were provided
and a further emphasis provided to patients and families regarding hydration needs.

Patients in the discharge lounge had access to meals and drinks.

**Pain relief**

Patients we spoke with had no concerns about how their pain was managed and staff checked with patients that pain relief administered had been effective. A pain scoring tool was used to assess the patient’s pain level. Pain relief was prescribed, administered and there were systems in place to review whether additional medication was required.

At a safety huddle on ward J27 we observed staff discussing patients whose pain control was not effective. Medical staff explored alternatives and a plan was made to review these patients as a priority.

We saw that each month the ward healthcheck metric audit reported in terms of pain management. This looked at five patient records to identify whether pain scores were recorded and reassessed when required. It also identified whether the documented pain score matched the patient’s reported description. Information provided by the trust for emergency and specialty medicine (ESM) clinical service unit showed that all 14 wards received a high compliance with most months between June and August 2018 receiving 100% compliance. The lowest compliance was 89% in August 2018 on ward J14.

Staff in the discharge lounge could access the patient’s electronic prescription and administer certain pain analgesia prior to travelling home.

**Patient outcomes**

Every month each ward completed a ward healthcheck metrics report. This involved a staff member from another area reviewing five patient records and other certain information. These included whether observations and risk assessments such as falls, pressure area care and continence were completed. The metrics reviewed whether discharge plans were in place and if referrals were completed for supported discharge. The review also looked at whether resuscitation equipment had been checked and well as the safe storage of medicines. Five observations were completed watching staff with their hand hygiene to identify if the correct principles were adhered to.

The most up to date ward healthcheck metric reports were on display in all areas we visited. This showed all the indicators and percentage of compliance.

**Relative risk of readmission**

**St James’s University Hospital**

From February 2017 to January 2018, patients at St James's University Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions.
- Patients in medical oncology had a higher than expected risk of readmission for elective admissions.
- Patients in clinical haematology had a much higher than expected risk of readmission for elective admissions.
Non-Elective admissions

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions.
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions.
- Patients in medical oncology had a similar to expected risk of readmission for non-elective admissions.

Elective Admissions - St James's University Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Non-Elective Admissions - St James's University Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Heart Failure Audit

St James's University hospital

St James’s University Hospital did not take part in the 2015/16 Heart Failure Audit.

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 241 in patients with diabetes at the trust, 78.2% of whom reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this trust in quartile 2. Trust performance deteriorated between 2016 and 2017.
In 2016, 90.8% of patients reported they were satisfied or very satisfied with their overall care of diabetes while in hospital and the trust was placed in quartile 4.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

St James’s University Hospital

St James’s University Hospital did not submit data to the Myocardial Ischaemia National Audit Project (MINAP).

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 83.0%, which did not meet the audit minimum standard of 90%. The 2016 figure was 54.1%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 14.6%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 64.9%. This is within the expected range. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The case mix adjusted one year relative survival rate for the trust in 2016 is 42.0%. This shows good practice. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

The trust provided us with their summary of learning from the national audit. It showed areas where the trust had performed well and a summary of actions to be taken as a result of the findings. This included key areas of focus for the trust to concentrate on, these included reducing waiting times and having regular pathway meetings.

National Audit of Inpatient Falls 2017

At Leeds Teaching Hospitals NHS Trust the crude proportion of patients who had a vision assessment (if applicable) was 56%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 39%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 10%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 80%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)
The trust provided us with action plans in how to increase the standards to meet national requirements. It showed the groups responsibility for taking forward the changes and identified dates for completion which were in 2019. We spoke with staff who attended the falls steering group; they were completing collaborative work with wards J15 and J28 and focusing on lying and standing blood pressures, vision and delirium standards.

**Competent staff**

**Appraisal rates**

**St James’s University Hospital**

As at June 2017 and June 2018, 93.6% and 97.8% respectively of registered nursing and medical and dental staff within medicine at St James’s University Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017 Completed</th>
<th>Individuals required</th>
<th>Rate</th>
<th>June 2018 Completed</th>
<th>Individuals required</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery</td>
<td>586</td>
<td>635</td>
<td>92.3%</td>
<td>601</td>
<td>614</td>
<td>97.9%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>186</td>
<td>190</td>
<td>97.9%</td>
<td>192</td>
<td>197</td>
<td>97.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>772</strong></td>
<td><strong>825</strong></td>
<td><strong>93.6%</strong></td>
<td><strong>793</strong></td>
<td><strong>811</strong></td>
<td><strong>97.8%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

Staff told us that they received appraisals and found them effective and reflected on their performance and career. They told us that colleagues encouraged them to undertake further courses to develop their skills and knowledge. Staff told us they had completed competency based training, mentorship training and academic degrees.

We spoke with several nurse associates and apprentice nurses who had developed through working in the trust. Clinical support workers were also taking on more responsibilities for patients, these included completing patient records and evaluating their ongoing care. All staff told us that they were competent in their roles and had received training and competency packages. They felt they were well supported by the registered nurses within the ward environment.

Preceptorship packages were in place for new staff and they were supernumerary for a period. Along with this staff were provided with competency packages to ensure the correct skills were observed. We spoke with student nurses and new staff who had completed some of their final training at the trust who felt they had been provided with the correct training. They told us that they had been supported and had completed various training packages.

Staff on ward J10 on the respiratory care unit (RCU) were required to complete further competency packages and study days due to the level of patient need and complexities. We saw competency packs that were robust and skills were required to be assessed to ensure staff were competent in their role. However, we were told that some agency staff did not know or have the competencies to use ventilators or specialist machines. We spoke with two agency clinical support workers. Both said that they had received an induction on their first shift to the ward. They attended patient handovers and were involved in changes to ensure continuity of care.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision with regular meetings.
The trust had a clinical education team that provided training and development to staff.

During winter months the trust recruited extra staff to work on the wards from non-clinical areas. We spoke with some of these staff who told us they felt competent to complete duties on the ward.

**Multidisciplinary working**

We saw examples of good multidisciplinary team (MDT) working. Staff described effective working relationships between consultants, nurses and allied health professional staff. We observed various safety huddles, board rounds and medical handovers which incorporated staff from a variety of disciplines. As part of the meetings, they discussed plans of care and treatment for each patient and made sure that there was a joined up approach in providing treatment.

MDTs took place daily regarding all patients, they discussed details of their medical condition, ongoing and discharge plans. We saw on ward J28 that the nurse gave a nursing review of each patient which enabled the medical team to prioritise which patients needed to be seen.

Safety huddles took place on wards every day which discussed staffing and safe patient care including falls. We observed a safety huddle led by one of the consultants on ward J27, nurses, doctors and therapists were present. Individual patients and their needs were discussed and where there were concerns, for example patient’s pain control was an issue, a plan was made to review these patients as a priority.

We observed a handover on ward J10 and doctors were allocated to review patients on outlying wards. Patients admissions and potential discharges were discussed.

Ward J6 had a dedicated multi-disciplinary team consisting of medical staff, nurses, physiotherapists, dieticians, psychologists and social workers. We spoke with staff who told us that multidisciplinary team meetings took place twice a week.

The trust had adopted new ways of working and we saw on two wards occupational therapists (OTs) working in a different way. OTs worked alongside nursing staff providing a leadership and managerial role within the team as well as utilising their multiagency skills.

The early discharge team provided a multi-disciplinary approach with various disciplines to support patients to be discharged home early with the appropriate intervention. Also within the frailty unit a MDT approach allowed patients to be discharged home with the correct care needs to prevent a hospital admission.

**Seven-day services**

The critical care outreach team covered both hospital sites, providing 24 hours cover every day. The team supported patients stepped down from critical care and reviewed deteriorating patients who had been referred to them. The team supported patients who were on respiratory care unit that required non-invasive ventilation (NIV).

Staff had 24/7 access to a full range of diagnostic services such as, x ray, computed tomography (CT) scans or magnetic resonance imaging (MRIs).

The pharmacy department was open seven days a week, 365 days a year. An on-call pharmacist was also available when the department was closed.

At the JAMAA unit services were provided daily; between 8am to 10pm Monday to Fridays and 10am until 6pm on weekends and bank holidays.
Allied health professionals such as occupational therapists, dietitians and physiotherapists were based over the wards at a weekend. Staff told us that they had contact details of who to contact out of hours.

The discharge lounge was open daily from 9am to 7pm, however staff told us that sometimes the area was underutilised. On average around 15 patients a day used the lounge. Staff told us that they were working towards increasing the usage of the discharge lounge and relaunching the service.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, seven days a week with all adult patients. Staff had access to other specialist staff, such as psychologists.

**Health promotion**

There were several displays outside each ward, these included information regarding how to prevent falls, nutrition and how to increase your appetite. The displays were detailed and provided a lot of information for both patients, carers and families.

Advice leaflets were also available for patients to take with them that assisted in maintaining their own health. We observed that leaflets were available for patients covering certain conditions and lifestyle choices such as: alcohol consumption and smoking cessation. On ward J7 we saw a display focused on how to stay active. This provided ideas and examples of how to stay active and ways to overcome certain barriers.

A preventing ill health CQUIN was to be introduced in September 2018 to screen patients for alcohol use. Refresher sessions for staff were held to inform their knowledge of alcohol units and latest government guidance.

We saw that services were available to support people prior to discharge. On the elderly assessment unit, patients could undertake assessments to ensure that they would be safe at home.

We saw medical staff supporting patients to understand their condition; on wards J10 and J12 we saw staff supporting patients in ensuring they could use their inhalers correctly.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)**

Staff told us that they worked well with the local mental health trust to improve the care of patients with mental health conditions. Support was available from the acute liaison psychiatric (ALP) team every day. Ward staff met with the local mental health trust and ALPs team to discuss referrals and any issues raised. Staff on ward J27 told us that a staff member from ALPS joined the safety huddle to discuss a patient’s ongoing care.

Staff told us that an adult nursing care assessment was completed for every patient on admission. If this indicated further assessment was needed, this could be done by the ward staff, who could also refer to the ALPs team who could see the patient the same day if a referral was received by 11am.

Staff understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 was mixed. On wards J28 and J15 staff told us assessment of capacity and DoLS were medically led decisions and staff did not demonstrate a real understanding of capacity assessment. We reviewed four records and found that three
demonstrated that capacity assessments had been completed, these were decision specific and clearly documented.

On reviewing one of the incident forms on ward J14 we identified that one elderly patient had been restrained on a bed and administered medication due to behaviours they were demonstrating. We reviewed the medical and nursing notes and found there was no documentation that incident had been recorded. The record also showed no evidence to support that patient did not have capacity in relation to refusing medication. It did not identify that the patient was living with dementia, had mental health needs or a DoLS in place. Due to the absence of information within the records it meant that staff did not demonstrate an understanding of how and when to apply relevant legislation governing consent and decision making, and recognise the difference between lawful and unlawful restraint practices. We also saw that two patient records on ward J27 also did not contain detailed information about the patient’s mental health condition.

We found that throughout the service, DoLS was, overall, being recorded correctly. We reviewed six patients with DoLS applications, however, there was no consistency around where and how this information should be stored. On some wards, a DoLS application could be found in the nursing records stored behind the nurses’ station. On other wards the application was in the medical notes. On a third ward, this information was also recorded on the electronic whiteboard. Here we saw a person on an expired DoLS still showing as having a DoLS in place, and on the same ward, someone on a current DoLS that had been in place several months with no indication on the whiteboard.

We saw that DoLS applications had been completed correctly, on ward J29 we saw that a patient required an urgent extension. The form included plenty of detail about why the extension was necessary. On ward J14 we found one expired DoLS form in the nursing notes dated 27 April 2018. A second DoLS form was present but not dated or signed. Nursing notes showed that this patient was reviewed again on 20 August 2018 but this review was not documented in either these or the medical notes.

Staff told us that there was a delay once the DoLS application was submitted as local authorities were struggling to meet the timeline of reviewing the patient between seven and 14 days. The trust had implemented a flowchart for staff to follow for if this occurred. We saw in one patient’s records on ward J14 that it was documented that the emergency DoLS had now expired, but that restrictions could continue in line with trust policy.

We observed a patient on ward J26 who was subject to a DoLS. We saw that the patient was with their family, and a staff member was positioned just outside the bay, who resumed their supervision and care of the patient when their family left.

Patients told us that staff would ask for consent before completing any care or procedures. We observed staff ask patients and explain why they were completing observations.

We saw that one patient in the discharge lounge was in a chair that was reclined back leaving the patient unable to get out of the chair. The patient was quiet upset, crying and wanted to get out of the chair. The nurse reassured them that their transport would be arriving soon. The patient was waiting to be discharged back to their nursing home and had been admitted with falls. The nursing documentation identified that the patient was at high risk of falls, however the nurse did not seem to realise that this was a form of restraint for the patient.

Mental Capacity Act and Deprivation of Liberty training completion

St James’s University Hospital
The trust reported that as of June 2018 Mental Capacity Act (MCA) training level 1 and 2 was completed by 95.4% of nursing staff in medicine at St James’s University Hospital compared to the trust target of 80.0%.
The trust reported that as of June 2018 Mental Capacity Act (MCA) training level 2 was completed by 72.8% of medical staff in medicine at St James’s University Hospital compared to the trust target of 80.0%.

Deprivation of Liberty Safeguards training data was part of the Mental Capacity Act training.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

The trust supplied us with further data to show the compliance within each clinical service unit. This showed that overall compliance was met with the highest at 98%.

Current compliance in September 2018 by clinical service units.

<table>
<thead>
<tr>
<th>Clinical Service Unit</th>
<th>Mental Capacity Act Level 1</th>
<th>Mental Capacity Act Level 2</th>
<th>Actual number out of date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Medicine and Surgery CSU</td>
<td>97%</td>
<td>88%</td>
<td>43</td>
</tr>
<tr>
<td>Emergency and Specialty Medicine CSU</td>
<td>98%</td>
<td>86%</td>
<td>38</td>
</tr>
<tr>
<td>Cardio-Respiratory CSU</td>
<td>98%</td>
<td>84%</td>
<td>28</td>
</tr>
</tbody>
</table>

(Source: Data Request ALL14)

Is the service caring?

Compassionate care

We spoke with 39 patients, relatives and carers. The majority of people had positive experiences and felt that staff were doing everything they could. On ward J8 relatives of two patients said that staff were attentive to their needs and staff were ‘fabulous’ and ‘very patient’ when assisting patients with mobility, eating and drinking. However, staff appeared very busy and there was limited opportunity for them to provide activities or stimulation to patients.

During our inspection we heard discussions between staff and patients and these were carried out in a compassionate and supportive way. Staff were always polite, kind, respectful and professional in their approach. We saw on ward J27 a staff member who showed empathy and compassion for a patient and their situation.

Staff respected patient’s privacy and dignity. We saw that curtains were drawn most of times when patients required care. Most patients we spoke with were happy with the standard of care and felt safe. Patients on ward J10 told us that staff responded promptly to call bells. One patient on ward J26 told us that staff had moved them due to the noise in one of the patient bays.

We saw thank you cards from patients and families. One expressed their thanks to the ward staff for making their relative pain free and comfortable. It also stated that they felt nothing was too much trouble for staff. Staff told us how they supported a family member to stay with their partner who was terminally ill. We were told of instances where staff celebrated occasions and provided patients and families with cards and presents.

The Friends and Family Test response rate for medicine at the trust was 36% which was better than the England average of 25% from June 2017 to May 2018.
A breakdown of response rate by site can be viewed below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Total responses</th>
<th>Response rate (Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>St James’s University Hospital</td>
<td>13,136</td>
<td>35%</td>
</tr>
</tbody>
</table>

A breakdown of the percentage of patients who would recommend the trust for surgery by site is shown below:

**St James’s University Hospital**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDWE Endoscopy Unit SJUH</td>
<td>1434</td>
<td>37%</td>
<td>99% 94% 96% 93% 97% 94% 96% 97% 96% 95% 95% 91% 95%</td>
</tr>
<tr>
<td>J06 Cystic Fibrosis</td>
<td>202</td>
<td>18%</td>
<td>92% 94% 94% 94% 91% 100% 100% 96% 93% 95% 93% 93% 95%</td>
</tr>
<tr>
<td>J06 Elderly Medicine</td>
<td>120</td>
<td>35%</td>
<td>71% 92% 90% 100% 94% 78% 100% 90%</td>
</tr>
<tr>
<td>J09 Respiratory Medicine</td>
<td>333</td>
<td>44%</td>
<td>94% 100% 96% 100% 95% 88% 89% 94% 89% 95%</td>
</tr>
<tr>
<td>J10 Respiratory Medicine</td>
<td>181</td>
<td>39%</td>
<td>96% 100% 100% 100% 83% 93% 100% 100% 100% 100% 100% 98%</td>
</tr>
<tr>
<td>J12 Respiratory Medicine</td>
<td>447</td>
<td>45%</td>
<td>97% 95% 100% 100% 97% 91% 89% 80% 89% 96% 96% 94%</td>
</tr>
<tr>
<td>J12D Respiratory Day Unit</td>
<td>118</td>
<td>20%</td>
<td>100% 100% 70% 94% 100% 100% 100% 100% 100% 97% 96%</td>
</tr>
<tr>
<td>J14 Elderly Medicine</td>
<td>275</td>
<td>58%</td>
<td>75% 85% 91% 86% 86% 70% 78% 93% 92% 96% 84% 87%</td>
</tr>
<tr>
<td>J15 Elderly Medicine</td>
<td>318</td>
<td>47%</td>
<td>82% 88% 92% 90% 81% 84% 78% 92% 92% 79% 93% 86%</td>
</tr>
<tr>
<td>J16 General Medicine</td>
<td>159</td>
<td>80%</td>
<td>100% 84% 89% 89% 76% 86% 86% 85% 86%</td>
</tr>
<tr>
<td>J17 Elderly Medicine</td>
<td>181</td>
<td>48%</td>
<td>100% 92% 100% 86% 100% 100% 93% 94% 74% 100% 100% 94%</td>
</tr>
<tr>
<td>J19 General Medicine</td>
<td>367</td>
<td>57%</td>
<td>100% 98% 97% 89% 96% 92% 91% 83% 88% 100% 94% 94%</td>
</tr>
<tr>
<td>J20 Infection &amp; Travel Med</td>
<td>425</td>
<td>75%</td>
<td>97% 91% 93% 100% 88% 97% 96% 94% 95% 89% 94% 85% 93%</td>
</tr>
<tr>
<td>J21 General Medicine</td>
<td>517</td>
<td>64%</td>
<td>98% 91% 96% 96% 92% 93% 94% 90% 69% 94% 92%</td>
</tr>
<tr>
<td>J26 Acute Medicine Admissions</td>
<td>850</td>
<td>42%</td>
<td>98% 94% 95% 89% 95% 94% 90% 95% 84% 88% 95% 97% 93%</td>
</tr>
<tr>
<td>J27 Acute Medicine Admissions</td>
<td>562</td>
<td>23%</td>
<td>94% 97% 88% 85% 96% 96% 85% 100% 86% 95% 93% 91% 92%</td>
</tr>
<tr>
<td>J28 Elderly Medicine Admissions</td>
<td>592</td>
<td>47%</td>
<td>95% 89% 86% 93% 82% 89% 92% 97% 100% 89% 86% 91%</td>
</tr>
<tr>
<td>J29 Elderly Medicine Admissions</td>
<td>1048</td>
<td>81%</td>
<td>99% 96% 86% 97% 96% 100% 99% 92% 93% 97% 100% 99% 96%</td>
</tr>
<tr>
<td>J30 Supported Discharge</td>
<td>165</td>
<td>59%</td>
<td>89% 87% 92% 86% 93% 81% 89%</td>
</tr>
<tr>
<td>J49 Renal In-patient/Transpl</td>
<td>335</td>
<td>48%</td>
<td>96% 96% 96% 87% 96% 100% 100% 94% 88% 95% 92% 94%</td>
</tr>
<tr>
<td>J50 Renal In-patient/Transpl</td>
<td>261</td>
<td>36%</td>
<td>100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%</td>
</tr>
<tr>
<td>J60 Oncology</td>
<td>345</td>
<td>13%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Rate 89% 85% 81% 100% 94%
Day Case Area

<table>
<thead>
<tr>
<th>Area</th>
<th>J82 HBP &amp; Upper Gastro Intest</th>
<th>J87 Haematology Day Case Unit</th>
<th>J91 Gastroenterology Ward</th>
<th>J92 Gastroenterology Ward</th>
<th>J93 NSO In-Patients</th>
<th>J96 NSO In-patients</th>
<th>J97 NSO In-patients</th>
<th>JBRT Brachytherapy</th>
<th>JENO Endocrine Day Unit</th>
<th>JONA Oncology Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>351</td>
<td>129</td>
<td>592</td>
<td>282</td>
<td>264</td>
<td>263</td>
<td>325</td>
<td>378</td>
<td>838</td>
<td>273</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>13%</td>
<td>56%</td>
<td>34%</td>
<td>27%</td>
<td>31%</td>
<td>34%</td>
<td>52%</td>
<td>N/A*</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>96%</td>
<td>88%</td>
<td>96%</td>
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*The response rate for JENO endocrine unit is not available because the trust incorrectly reported a number of eligible patients less than the total number of responses for this unit*

From May 2017 to April 2018 the overall percentage of patients that would recommend the service was 90% or over for most medicine wards at St James’s University Hospital, except for four wards which had overall recommend rates below 90% but above 80%.

**Highest score to lowest score**

- 100%
- 50%
- 0%

**Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.**

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Patients, families and carers told us that they felt they received good emotional support from staff. Relatives of a patient on ward J28 felt that staff had supported them with coming to terms with a medical diagnosis.

On ward J21 we saw that a patient sat with a staff member at their desk for a period of time, they interacted and occupied the patient. We also observed in other areas that staff members supported relatives, for example they would take relatives to the patient rather than giving them directions.

A patient’s relative on ward J26 told us that they could visit outside of visiting hours to support their relative who was finding certain aspects of their stay difficult. The relative could calm and reassure the patient who listened and responded to them which meant that they could continue with their treatment.
A chaplaincy service was available to provide pastoral, religious and spiritual support for patients and relatives. We were told that chaplains and volunteers would visit the wards on request or as part of their routine visits.

We saw on ward J14 that one particular staff member sang to patients, people commented that they felt that it made patients calmer and more relaxed. There was 24 hour access to a psychiatric liaison team. Quiet rooms were available in some areas if staff needed to speak confidentially or if they were feeling distressed and needed somewhere quiet to sit.

**Understanding and involvement of patients and those close to them**

Patients told us that staff explained their care and treatment to them in a way they could understand. They felt they were involved with their decision making and could make informed decisions. Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions. We saw evidence in patient’s records that patients or their family plus multidisciplinary teams had been involved in the decision-making process.

We saw evidence in patient records that patients and their relatives had been involved in making decisions about their care and treatment. Relatives were involved in care planning and discharge arrangements for patients.

On ward J26 one relative told us that the patient’s consultant telephoned them during the ward round to discuss the ongoing care.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Planning for service delivery was made in conjunction with a number of other external providers and commissioners to meet the needs of local people. For example, the trust worked with external partners to support and facilitate patients’ discharge home. Voluntary services, social services and community services supported a virtual ward which allowed patients to be monitored at home.

The Leeds Cancer Centre was designed to hold various services to be close together, including support groups and patient information centre.

The leadership team described a number of ways in which the service had been designed to meet the needs of local people following discussions with local commissioners.

The trust had been working with charities to supply the hospital with clothing for patients to wear during their stay. This promoted the PJ paralysis initiative. In Bexley wing there was a boutique where patients could also use clothes that had been donated. Staff also contributed to donating clothes plus unused presents they had to donate to patients celebrating their birthdays whilst in hospital. Comfort packs had been created for families on ward J92 staying at the hospital for long periods of time with ill patients. These contained items for people to refresh themselves in order to be able to stay at the hospital with their relatives.
Average length of stay
St James's University Hospital

From March 2017 to February 2018 the average length of stay for medical elective patients at St James's University Hospital was 6.8 days, which was slightly longer than England average of 5.9 days. For medical non-elective patients, the average length of stay was 9.8 days, which was longer than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gynaecological oncology was longer than the England average.
- Average length of stay for elective patients in the adult cystic fibrosis service was shorter than the England average.
- Average length of stay for elective patients in clinical haematology was longer than the England average.

Elective Average Length of Stay - St James's University Hospital

![Graph showing average length of stay for elective specialties]

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was longer than the England average.
- Average length of stay for non-elective patients in geriatric medicine was longer than the England average.
- Average length of stay for non-elective patients in respiratory medicine was longer than the England average.

Non-Elective Average Length of Stay - St James's University Hospital

![Graph showing average length of stay for non-elective specialties]

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)
Care streams had been implemented to review patients who had been in hospital for a specific time. For admissions more than seven days they were classed as ‘stranded’ and more than 21 days as ‘super stranded’. The senior management team told us that work had begun at reviewing patient’s records to understand the reason and identify any reason why discharges were delayed. Information provided by the trust showed that there were 173 super-stranded patients in the hospital in July 2018 with the majority within elderly and speciality medicine CSU.

The trust provided us with information regarding the CSU’s average length of stay. We saw there had been improvements within emergency and speciality medicine CSU with reductions on average from seven to five days between January and August 2018. However, for two other CSUs there had been more fluctuation which had seen the average length of stay increase. For example, oncology CSU had seen a reduction to an average of five days in June 2018 which then had increased to seven days in September 2018.

The trust had set an improvement goal of a 50% reduction for super stranded patients within medicine and elderly care by November 2018. An associated plan was in place to support changes with the care streams.

(Source: Data request UEC2)

Meeting people’s individual needs

The service took account of people’s individual needs. We saw that staff cared for patients as individuals and various events took place to support people. These included the use of volunteers to sit and chat to patients, visiting dogs and children attending to visit patients. A dog and its owner attended the ward as part of pets as therapy, where we saw interaction from patients with patients and families. The owner told us that they visited the hospital every two weeks where they would visit multiple wards. On ward J15 local charities attended to support and talk with patients. We saw that staff managed patients’ needs and placed them near to the nurses’ station if they required monitoring.

Patients on ward J6 had access to fridges and showers in their individual rooms and a gym on the ward to help support and manage their condition.

On ward J92 there was a Bexley Boutique, this was an area where staff and family donated clothing and other articles such as make up that patients could access and keep. The boutique had been put forward for a nomination within the Nursing Times journal and staff had recently presented about it in London. Staff were looking at the possibility of increasing the use of the boutique and adding further items that patients could access. The trust was in the process of replicating the boutique at Leeds General Infirmary.

On the elderly wards there was lots of old memorabilia such as pictures and activities to entertain and distract patients. Ward J17 were trying to recruit a play specialist to work with patients. On ward J14 there were two communal rooms targeted at meeting the needs of patients living with
dementia. One of these was decorated in the style of a 1950s lounge and kitchen and included a vintage television and plastic kitchen appliances. The other room was in the style of a pub with a mock bar, tables and chairs. Although we did not observe either of these rooms in use during our visit, staff told us that certain patients responded well to the familiar environments and would be more likely to eat their meals in the pub area. On ward J92 staff told us of a patient who was living with dementia who liked to fold clothes. Staff supported the patient with this and provided them with clothing to occupy and distract them.

Dementia friendly signage was used on the elderly medicine wards, including pictorial signs for toilet and shower rooms. Other wards were due to be decorated such as ward J28 where further changes to the environment would be made to support patients living with dementia. Wards trialled various plates and cutlery to support patients however changes had been made as a response from feedback from patients and families.

Each patient had a magnetic board at their bedside which indicated their preferences, for example what they liked to be called and dietary requirements. In addition, magnetic symbols were used to identify patients’ needs such as learning disabilities or living with dementia. A number of wards had dementia champions and as part of their role they promoted the use of ‘know who I am’ booklets and a ‘forget me not flower’ symbols at the bedside. We saw several documents completed that showed the patients like and dislikes. Staff who had received extra training in supporting people with memory difficulties wore the ‘Forget-Me-Not’ badge.

The trust’s electronic systems permitted staff to flag patients with a learning disability. The trust told us they had a lead professional for learning disabilities and autism.

The trust had a lead for learning disabilities, in post since May 2018, supported by a registered nurse for two days each week. We saw evidence that this was promoted around the trust, photos of both practitioners were on display on the wards. The trust had adopted a charter for patients with learning disabilities from the Get Me campaign. Some staff were champions in these areas and supported other staff and patients with any additional needs. We saw that this information was on display on ward 6, however when asked they no longer had a champion as they had left the trust. The trust also supported patients to complete the hospital passport which included information such as patient’s anxieties, likes and dislikes for staff to understand their individual needs.

The trust was completing a learning disability and autism audit in September 2018, that explored the patient’s experience and any reasonable adjustments made. This also included a questionnaire for staff member to complete.

Patients had access to interpreting and translation services. These could be either face to face or by telephone and could book in using the electronic system. We did not see any patients that required the use of a translating service however staff told us of specific examples when they had used the service.

We saw that the trust was working towards reducing the amount of cancelled bookings for the interpreting service so that a better streamline service could be provided.

There was clear signage throughout the wards providing patients with information about why they were there and what the ward was for. However, the majority of this was only provided in English.

The trust had specialist nurse teams to support patients with specific conditions, these included respiratory, diabetes and cystic fibrosis.

We saw that patients could access Wi-Fi on certain wards to communicate and keep updated during their inpatient stay.
A range of information leaflets were available however we found that several had not been reviewed for a period. This meant that individuals were not supported to access up to date information relevant to their individual needs. For example, what to do if you have a complaint leaflet had a review date of August 2017, planning your future care was October 2016 and hand hygiene leaflets had no review date.

There had been no mixed sex accommodation breaches between June 2017 and June 2018. RCU was a mixed sex area due to the level of patient need and males and females were positioned next to each other.

**Access and flow**

We carried out an inspection in December 2017 at the hospital due to concerns raised regarding the safe use of additional beds in non-designated areas during times of increased demand. Areas such as corridors, treatment rooms, day rooms and additional beds in patient bays were utilised. The trust reported that they had not used any non-designated areas for a period of months. Staff told us that they had not recently had any extra patients in non-designated areas since the winter months.

We visited surgical wards where there were patients who were classed as medical outliers. We reviewed 12 patient’s medical notes which identified that they had received daily reviews from the medical team and consultant reviews between one to two times a week. Referral criteria were in place to ensure that correct patients were moved, patients with cognitive impairment or risk of falling were not expected to be moved. However, we saw patients had been transferred to non-medical wards who were at risk of falls and suffered with confusion.

We spoke with staff on speciality medical wards that would have patients from other specialities such as oncology wards. A system was in place for patients to be reviewed by the medical team. Each ward had a specific consultant team that would review the patients. Staff told us that they could contact the medical team. We saw medical outlier information of who to contact displayed.

We visited the clinical decision unit (CDU) based in accident and emergency department and found that there were six patients identified as medical and not adhering to the criteria of CDU, the longest patient had been there for three days. Three patients were waiting for beds to acute medical wards and three were due to be discharged. We reviewed three sets of notes and found they had been reviewed by the medical team. Staff told us that it was common to have patients in CDU waiting for beds on a medical ward for a period of days.

The trust had developed CDU guidelines which indicated that the unit was designed to be used by patients who required further assessment for up to 24 hours after attending the emergency department. The expectation was that above 80% of patients were expected to be discharged from CDU back to their normal home environment and care pathways were completed for these patients. As a result of having medical patients on CDU waiting for beds on medical wards, the correct patients could not be admitted to the unit. This also meant that medical patients were being cared for in areas that were not designed for patients with longer stays and staff were required to complete different paperwork and records as the care pathways were not appropriate to meet their needs. Staff in the department told us they had direct access and had no issues with medical teams responding. Consultants would visit the unit when the patients had been there on day one, four, seven and ten.

We revisited the CDU during our well led inspection in September 2018 and found that 12 patients were waiting to be admitted to medical wards. One patient had been on the unit for seven days, three patients for five days and three patients for three days.
Figures showed that on average 44% of patients between March 2018 and August 2018 on CDU were admitted to medical wards with the remaining 56% meeting the protocol for CDU.

Patient flow coordinators were in place to help manage the flow through the wards. We saw that they attended daily meetings to provide a review of bed availability and capacity to senior managers. A clinical site report was completed which documented outstanding actions. The report identified if any surge escalation beds or non-designated areas were in use. We saw that patients were in surge beds; however, no patients were in non-designated areas.

Patients whose condition was improving or who were near ready to be discharged home were required to move wards at times to accommodate more acutely ill patients to be in the appropriate ward. Patients were given a score by medical staff to identify who the most appropriate patients were to move to other wards. Patient scores were visible on the electronic whiteboards which identified their score.

There was a frailty unit based in the urgent and emergency department which was supported by consultants from elderly medicine. The unit was open Monday to Friday between 9am and 5pm and allowed patients to be admitted from the unit straight to the elderly medical wards or discharged home. The area had three designated trolley spaces and own designated seating area. A high majority of patients were seen and discharged home with support from social services, therapy and discharge teams. The trust told us that the unit had reduced elderly and frailty admission by 12%.

We spoke with staff who provided us with an oversight of the virtual acute medical unit (vAMU). Eligibility criteria were in place, these included patients who needed further investigations but who did not require a hospital stay. This was a hospital avoidance scheme targeted at patients under 80, or over the age of 80 who was ambulatory. Daily ward rounds were held to discuss the results and hot clinics were held three times a week. Venous thromboembolism (VTE) clinics were held once a month and run by advanced clinical practitioners.

Patients in some ward areas such as wards J6 and J10 could access the departments directly which meant they did not need to wait in the emergency department to be admitted. Patients had telephone access to discuss with medical and nursing staff their condition where a decision could be made about if they needed to attend the hospital. Patients could attend the respiratory day unit who required an urgent review by a respiratory consultant.

A virtual ward was in place for patients with respiratory conditions, 10 virtual bays were in place and patients would receive up to four nursing visits at home every day. The virtual ward was overseen by the consultant who would complete a virtual ward round. This meant that patients were not admitted to hospital, also patients may be discharged home from hospital and be admitted to the virtual ward.

Staff from the early discharge assessment team (EDAT) were based on wards. This allowed patients to be supported with the possibility of being discharged home early. The team attended the relevant meetings such as safety huddles, MDT and care planning. They also liaised with social services and care agencies.

An initiative called the ‘golden patient’ was implemented which worked toward patients being discharged before 12 midday.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From June 2017 to May 2018 the trust’s referral to treatment performance for admitted patients (percentage admitted within 18 weeks of referral) was consistently better in comparison to the England average, by an average of 5.3%.
There was a slight deterioration in performance in January 2018, followed by a trend of improvement from February to May 2018.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Six specialties were above the England average for admitted RTT (percentage within 18 weeks).

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<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>91.3%</td>
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<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.3%</td>
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<tr>
<td>Thoracic medicine</td>
<td>99.8%</td>
<td>92.8%</td>
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<tr>
<td>Rheumatology</td>
<td>99.0%</td>
<td>94.4%</td>
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<tr>
<td>Cardiology</td>
<td>97.7%</td>
<td>82.4%</td>
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<tr>
<td>Gastroenterology</td>
<td>95.7%</td>
<td>93.8%</td>
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</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

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<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>70.4%</td>
<td>82.4%</td>
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</table>

(Source: NHS England)

**Patient moving wards per admission**

The trust did not provide data for ward moves per admission. They provided the following information:

“Currently we do not measure the number of moves for individual patients; we do know that for some patients with complex discharge needs and protracted lengths of stay this can be up to four moves within their admission period. In times of extremis when there is a requirement for speciality acute beds for the most acute and dependent patients a “fit to lodge” risk assessment is actioned and patients may be selected to board on other wards to create capacity and maintain safety for acute demand.”

(Source: Routine Provider Information Request – Ward moves tab)

**Patient moving wards at night**

Please note that the following analysis excludes ward moves at night from assessment centres and day wards.
St James’s University Hospital

From April 2017 to March 2018 there were 2,123 patients at St James’s University Hospital moving wards. Ward J96 (Institute for oncology - inpatients) had the highest number of bed moves, 470 followed by Ward J15 (Elderly medicine) with 193 and ward J19 (General medicine) with 188 bed moves at night. On average there were 177 bed moves at night per month. Much higher numbers were reported during the winter months of November (256) and December 2017 (285).

(Source: Routine Provider Information Request – Ward moves at night tab)

We asked to the trust to submit further data to review ongoing bed moves at night for medical wards.

![Bar chart showing bed moves per month](chart.png)

(Source: SUR46 data request)

We were told that patients were transferred late at night. Information provided by the trust showed on 22 August 2018 there was 53 patients identified as medical outliers, outside of their CSU bed base. The majority of patients transferred were from the acute medical and elderly admission wards to other areas. It showed that patients were moved at various times, 33 patients moved wards between 10pm and 6am. Six of these moved between 10pm and midnight and 10 between midnight and 1am. Eight moved between 2am and 3am and two patients moved between 4am and 5am.

Staff on the surgical wards also told us that they normally would not receive patients until after 7pm at night. We spoke with the senior management teams for the CSUs who were aware of this and were working towards changing the culture of staff to move patients earlier. Patients were scored in a morning to identify, if required, which were the most appropriate patients to move to other wards.

Learning from complaints and concerns
The trust had a complaints policy which was located on the intranet for staff to access if needed. The department had a complaints process that addressed both formal and informal complaints. We saw posters displayed in ward areas about how to raise a concern.
We spoke with staff who could tell us about the complaints process and how they would manage a complaint. Staff told us about some complaints and lessons learnt from these. The learning from the complaint was shared within teams through various methods, these included team meetings and safety huddles.

Complaints were discussed in relevant meetings, these included governance and team meetings. Points of learning and changes were discussed.

Ward managers we spoke with were aware of themes and trends from complaints. Complaints were discussed at team meetings or shared with staff in a newsletter.

Some staff told us that some complaints were due to patients feeling they were kept waiting. The department manager also told us that many of the complaints were due to patients not being seen in a timely manner.

**Summary of complaints**

**St James’s University Hospital**

From May 2017 to April 2018 there were 58 complaints about medical services at St James’s University Hospital. The service took an average of 54.4 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 40 days.

Seven complaints (12.1%) were not upheld, 20 (34.5%) were partially upheld, 18 (31.0%) were fully upheld and 13 (22.4%) were still under investigation.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From May 2017 to April 2018 there were 73 compliments within medicine. Compliments received for medicine accounted for 29.9% of all compliments received by the trust.

**St James’s University Hospital**

St James’s University Hospital received 49 compliments; 67.1% of all compliments received for medicine.

A breakdown by team, unit and ward is shown in the table below:

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<thead>
<tr>
<th>Team/Unit/Ward</th>
<th>Compliments</th>
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<tbody>
<tr>
<td>Clinical Oncology/Radiotherapy</td>
<td>11</td>
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<tr>
<td>Gastroenterology</td>
<td>7</td>
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<tr>
<td>Endoscopy</td>
<td>7</td>
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<tr>
<td>Acute Medicine</td>
<td>5</td>
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<tr>
<td>Speech and Language Therapy (SALT)</td>
<td>3</td>
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<tr>
<td>Nephrology</td>
<td>3</td>
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<tr>
<td>Elderly Medicine</td>
<td>3</td>
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<tr>
<td>Clinical Haematology</td>
<td>3</td>
</tr>
<tr>
<td>Anticoagulant Service (ACS)</td>
<td>2</td>
</tr>
<tr>
<td>Medical Oncology/Chemotherapy</td>
<td>2</td>
</tr>
</tbody>
</table>
Is the service well-led?

Leadership

Each CSU was led by a clinical director, general manager and head of nursing, the clinical director had overall responsibility for the CSU. We met with the senior leadership team from two of the CSUs, cardiorespiratory and emergency and specialty medicine.

Due to the sizes of the CSU there were various matrons that covered different areas. For example, in cardiorespiratory there were matrons for cardiology and respiratory; emergency and specialty medicine there were matrons for acute medicine and elderly. The abdominal medicine and surgery CSU matrons covered both medical and surgical wards. Matrons told us they provided support to clinical areas and would visit wards daily to review the staffing and identify any issues that required escalation.

The CSUs worked closely with each other. We spoke with some matrons who told us they would cover and support other matrons within their CSU. Staff told us that matrons attended the wards daily and were supportive to staff. Matrons attended the daily staffing meetings and provided feedback to the director of operations chairing the meetings.

Ward managers were in place, they felt supported by the matrons and felt they could talk openly and candidly to them. We spoke with the ward managers who told us of some areas they wanted to improve. These included improving the ward healthcare metrics and supporting and engaging with new staff commencing their role. Staff felt supported by their ward managers and felt that they provided leadership.

Ward managers felt restricted with their control of nurse staff levels on their wards. When staff were required to move sometimes leaving their own ward with low levels they were overruled by senior managers and not consulted in the decision. This sometimes would leave a ward with low staffing numbers with patients with high complex needs. Different wards and CSUs had different rag rating tools that they used which meant that the results may not correlate.

Staff on wards told us they would have team meetings, this varied on wards to how often they were completed. However, staff told us they would receive information at safety huddles, handovers and through emails when needed. Staff felt they worked together across services or departments. For example, staff on ward J26 felt the acute medical wards and acute elderly wards supported each other.

Vision and strategy

The vision used by the CSUs we visited was the trust’s vision, which was committed to delivering the highest quality and safest treatment and care to every patient, every time. It was supported by the ‘Leeds Way’ values, (patient centred, fair, collaborative, and accountable).

We saw posters throughout the wards and areas outlining ‘The Leeds Way’ were on display giving information to patients and staff about the trust’s values and expected behaviours.
We saw that the CSUs had detailed clinical business strategies which included the developments of the CSUs. The oncology CSU identified in 2017 a five-year plan and goals they were striving to achieve; objectives were set in how to achieve them. The elderly and specialist medicine had merged together to form one CSU from the former urgent care and acute medicine CSUs. The combination of the two allowed further cohesion and were working towards virtual hubs where patients could receive a rapid assessment without admission to an acute bed.

Staff told us of some of the plans to develop and change the CSUs. We were told of the changes to increase capacity in JAMAA (St James acute medical assessment area) and frailty unit. The purpose of these were to see more patients who had attended the accident and emergency department and provide them with the appropriate care and discharge needs to avoid a hospital admission.

**Culture**

We saw that staff had a positive culture with staff being open, honest, and willing to share information with us on inspection. Staff were loyal to the organisation but were prepared to challenge leaders if they thought patient safety was compromised. Most staff felt they worked above and beyond to support patients with many areas having staff shortages. They felt they worked well as a team and supported each other. Staff on one ward told us that they felt it was one of the best teams they had worked in.

Staff felt there were opportunities to develop their skills and competencies, which was encouraged by senior staff. We spoke with nurse apprentices and associate nurses who had been given the opportunity to progress and develop within the trust.

Junior doctors told us they felt well supported by senior colleagues and were provided with learning to increase their knowledge and competence.

Ward managers told us how proud they were of their teams and how they felt everyone including medical staff worked well together.

We saw that the ‘bee positive’ scheme was in place in many areas we visited. This provided staff with the opportunity to praise and thank other staff. We saw examples such as thanking staff for their hard work, contributing to a charity bake sale and dedicating specific staff members.

‘You’re amazing’, was another initiative in place for staff to celebrate success and praise. This involved passing on a thank you note to a staff member who they felt had been amazing that day. The trust communication teams had been involved to upload photos of who had received the praise to be able to share on social networks.

Staff on ward J92 had taken part in a sponsored walk from Whitby to Scarborough. They raised a substantial amount of money and used this to refurbish one of the day rooms where patient’s families could stay during their admission.

Staff had been provided with psychological support to improve health and wellbeing and in turn to reduce sickness and improve staff retention. This had started with new starters at their induction and was due to be rolled out across the CSUs.

**Governance**

Each CSU had monthly governance meetings which then would feed into the executive management group meeting. The senior management teams felt that the trust board were aware of their CSUs risk, concerns and improvements. We reviewed governance minutes for both abdominal medicine and surgery CSU and emergency and specialty medicine CSUs. These were set out slightly different and there was no attendance list for abdominal medicine and surgery CSU. This meant that we were unsure of who was attending the meetings.
Relevant information was discussed at the governance meetings, this included feedback from specialty governance forums and clinical indicators and performance such as falls and pressure ulcers. Within the emergency and specialty medicine minutes we saw there was ownership of each subject discussed and who was taking forward any actions. These were also linked to supporting information and papers. The abdominal medicine and surgery CSU minutes were not as robust and did not contain any individuals that would take forward any actions.

We saw that each CSU completed monthly performance measures, these included five sections:
- section A – national operational standards
- section B – national quality contract requirements
- section C – NHSE quality and contract requirements
- section D – local quality and contract requirements
- section E – internal monitoring

Information was recorded and colour coded to identify where targets were met.

We saw that ward managers and matrons attended monthly meetings, these were connecting leaders in care meetings (CLIC). The meetings were approximately for three hours where staff received feedback from the chief nurse. Professional briefings and educations sessions on patient care topics were discussed. We saw from the chief nurse briefings that positive feedback was received and information shared regarding incidents. In June 2018 we saw that information was circulated about the use of medical air instead of oxygen.

The ward healthcheck metrics were completed monthly, this allowed senior managers to review the performance on each ward. We saw that the results were discussed in the governance meetings. However, we saw some wards had consecutive low months, this meant we were not always assured that there were ongoing improvements on some of the wards.

Staff in a leadership role had access to dashboards looking at performance, finance, governance and staff engagement.

Management of risk, issues and performance

One of the risks was staffing and this was evident on the risk registers. Staff also told us that they felt low staffing levels had an impact on their ability to complete their work and we saw that, as a result, some patients did not always receive supervised care. This meant that patients were at risk of falls as staff were multi-tasking and managing other patients as well as the supervised patients. This was evidenced on the risk register that the trust may fail to prevent harm to patients in relation to falls due to insufficient staffing. We saw staff completed incident reports when staffing was not at the required level, leaving patients vulnerable. Senior management were cited on the risks associated with low staffing and were trying to implement other measures to support both patients and staff.

Within the risk register it had been identified that there were risks due to the volume of patients requiring medical beds. As a result, patients were placed in areas such as clinical decision unit (CDU), non-medical wards and general medicine wards instead of speciality areas. The number of patients moved during the night also remained the same as our inspection in May 2016. This included some patients who were moved to wards with a risk or falls or living with dementia. These had been identified as a high risk, with current score of 20. The trust had recently implemented initiatives to reduce the length of stay or admission, however it was too early to identify if these had made any impact to this.

We looked at the risk registers for all the CSU where there was a medicine base at St. James University Hospital. Each risk had an initial, current and a target risk rating. The date that risks were added was included and review dates were seen. Each risk had existing controls, gaps and mitigating actions.
Bed flow meetings were in place several times a day. At these meetings staffing and escalation was discussed and reviewed. We attended a briefing and found that each area was discussed to identify what steps were being taken to mitigate certain risks. A plan of support was discussed to assist areas that may be at more risk. Each area rated their own service, we asked how the rag rating was populated and this varied between area. A clinical site report was completed at each meeting and distributed to staff.

**Information management**

Information management systems were used effectively in patient care and for audit purposes to monitor and improve quality. Computerised electronic whiteboards were in place which contained patient information that staff could review instantly. It showed when observations were required to be completed and provided indicators and flags when these were not managed appropriately. It also provided information regarding the patient’s length of stay, estimated date of discharge and risk assessments.

Patients on the virtual ward were managed on authorised computer software, this provided daily updates to staff who could review and action information.

We saw that increasing the use of information technology was part of the trust’s vision. The Leeds digital way provided a summary what this would include. Further risk assessments had been launched onto the patient’s electronic record, these included nutritional screening tool for malnutrition. We saw at our inspection that staff completed this online and communications to support staff to complete it electronically.

Mostly we observed good practice in relation to information security. Although in some areas patient’s medical notes were not always secured safely which meant that they could be accessed by unauthorised people. Staff locked their computers and did not leave records open and unattended on screen. However, on ward J27 we noted that a computer next to one of the bays was left unlocked and a patient’s full records were left visible.

Ward managers had access to information on individual ward dashboards called ward healthcare metrics. These contained information covering a range of indicators from documentation audits to hand hygiene which they could use to monitor performance. They were displayed on the ward in graphs and percentages for patients and visitors to understand.

**Engagement**

The trust conducted an annual staff survey, when we met with the senior leadership teams they told us how they had worked on actions within the staff survey action plan for 2018/19. This included activities that involved staff within the CSUs. The leadership told us they provided regular updates to staff regarding staffing and how this was progressing. We saw within the action plan festivities to celebrate the 70th anniversary of the NHS. Staff told us they held tea parties and included both patients and families throughout.

We saw that staff were involved in changes at the trust and within the CSUs. We saw that when the emergency and specialty medicine CSU was being merged staff were involved and asked their thoughts on the name of the CSU.

The trust had an annual awards event where staff were nominated and received awards. Each of the CSUs also held events to celebrate the successes within the units. We saw nominations and awards were proudly displayed on wards.

At the entrance of wards, we saw notices for patients and families to ‘speak to sister’ or ‘get a message to matron’. This provided information of the relevant matron to contact.
We saw on notice boards thank you cards and letters from patients and relatives displayed.

On ward J92 we saw that one of the rooms had been completely refurbished to represent a more homely living area. A note pad was left in the room asking people using the facilities to comment, we saw several positive comments.

The trust participated in the friends and family test, this was completed on each medical ward and area.

Staff were kept up to date with what was happening in the trust with emails and a monthly newsletter. Staff told us that they could access all the information they needed via the trust intranet.

The trust had launched a patient experience competition to ask wards how they share feedback from patient, carers and families. The trust was looking at ways wards displayed the feedback. The deadline for the submissions on middle of September.

**Learning, continuous improvement and innovation**

The trust was involved in completing clinical trials and completed local academic studies. We spoke with staff involved in research studies who were well supported in completing the trials

The trust had an improvement work stream to reduce pressure ulcers. Staff had implemented a stop the line: bedside pressure ulcer incident review. This involved reviewing the care that had been given to ensure all appropriate actions had been taken. For example, were risk assessments completed and the appropriate equipment in place. Staff told us the initiative had made an improvement in reducing pressure ulcers.

Staff on ward J27 were due to complete rotations for a period of three months into the intensive care unit (ICU). This was in preparation of part of the ward becoming a high observation area.

We observed promotion of the “end pyjama paralysis” initiative on both elderly wards J7 and J8. Staff we spoke with informed us that they try to assist patients in getting dressed into day clothes and encourage patients to spend time out of bed and in communal areas where possible. Days had been launched where staff had come to work in their pyjamas to promote the initiative. However, we noticed limited evidence of this in practice on either ward, staff told us it was sometimes difficult to prioritise due to staffing pressures.

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**Surgery**

**Facts and data about this service**

The Leeds Teaching Hospitals NHS Trust (LTHT) provides surgical care across 34 surgical wards at four sites:

- Chapel Allerton Hospital: one ward, 32 inpatient beds
- Leeds General Infirmary: 16 wards, 59 day case beds, 263 inpatient beds
- St. James’s University Hospital: 16 wards, 56 day case beds, 226 inpatient beds
- Wharfedale Hospital: day surgery unit and accompanying ward with 23 day case beds.

Surgical care at St. James’s University Hospital (SJUH) comprises 226 inpatient beds and 56 day-case beds spread over 16 surgical wards and a surgical assessment unit (SAU). Excluding those used for women’s and paediatric services, there are 23 operating theatres within four
ELECTIVE AND NON-ELECTIVE SURGICAL SERVICES AT SJUH ARE MANAGED BY CLINICAL SERVICE UNITS (CSUS) AND SURGICAL SPECIALITIES. THEY PROVIDE A RANGE OF SERVICES INCLUDING DAY, GENERAL, LOWER AND UPPER GASTROINTESTINAL, BREAST, COLORECTAL, UROLOGICAL, OPHTHALMOLOGICAL, AND TRANSPLANT SURGERY.

THE TRUST HAS ONE OF THE HIGHEST NUMBERS OF ADMISSIONS IN THE COUNTRY. THE TRUST HAD 54,616 SURGICAL ADMISSIONS FROM MARCH 2017 TO FEBRUARY 2018. EMERGENCY ADMISSIONS ACCOUNTED FOR 16,056 ADMISSIONS (29.4%), 27,080 (49.6%) WERE DAY CASE, AND THE REMAINING 11,480 (21.0%) WERE ELECTIVE. FROM AUGUST 2017 TO JULY 2018, A TOTAL OF 20,365 OPERATIONS WERE CARRIED OUT AT SJUH.

IN MAY 2016 THE CQC CARRIED OUT AN ANNOUNCED COMPREHENSIVE INSPECTION OF SURGICAL SERVICES AT THE LOCATION; FOCUSING ON SAFE, RESPONSIVE AND WELL-LED DOMAINS. WE RATED SAFE AND RESPONSIVE AS REQUIRES IMPROVEMENT, AND WELL-LED AS GOOD. IN DECEMBER 2013 THE CQC CARRIED OUT AN ANNOUNCED COMPREHENSIVE INSPECTION, IN WHICH WE RATED EFFECTIVE AND CARING AS GOOD. SCORES WERE AMALGAMATED, AND AS OF MAY 2016, SURGICAL SERVICES AT THE LOCATION WERE RATES AS REQUIRES IMPROVEMENT OVERALL.

FOLLOWING OUR 2016 INSPECTION, WE TOLD THE TRUST THAT THEY MUST TAKE THE FOLLOWING ACTIONS TO IMPROVE SURGICAL SERVICES AT THE HOSPITAL: ENSURE HOSPITAL POLICY IS FOLLOWED WITH REGARDS TO CONTROLLED DRUG ADMINISTRATION; ENSURE ALL ASPECTS OF THE WHO CHECKLIST ARE FOLLOWED (IN PARTICULAR THE POST BRIEF); ENSURE BEST PRACTICE AND GUIDELINES ARE FOLLOWED WITH REGARDS TO CONSENTING PATIENTS FOR SURGERY; AND ENSURE LEVEL THREE PATIENTS IN RECOVERY ARE CARED FOR BY APPROPRIATELY TRAINED STAFF. WE ALSO SUGGESTED THAT THE TRUST SHOULD CONSIDER ENSURING CLINICAL AREAS IN GEOFFREY GILES THEATRES ADHERE TO SAFETY AND INFECTION CONTROL GUIDANCE; AND THE TRUST SHOULD CONSIDER THE USE OF TAMPER PROOF SEALS ON RESUSCITATION TROLLEYS.

AT OUR MOST RECENT UNANNOUNCED INSPECTION, WE FOLLOWED KEY LINES OF ENQUIRY AND RATED ALL DOMAINS.

DURING OUR INSPECTION, WE VISITED THE SURGICAL SERVICE AREAS AND SPOKE WITH 21 PATIENTS, AND 52 MEMBERS OF STAFF. THESE INCLUDED DOCTORS, NURSES, SUPPORT WORKERS, THERAPY STAFF, OPERATING DEPARTMENT PRACTITIONERS (OPD’S), ADMINISTRATION AND DOMESTIC STAFF AND MANAGEMENT. WE OBSERVED CARE AND TREATMENT, LOOKED AT NINE COMPLETE PATIENT RECORDS (AND SPECIFIC DOCUMENTATION IN SEVERAL OTHERS) AND SEVEN MEDICINES CHARTS. WE ALSO INTERVIEWED KEY MEMBERS OF STAFF, MEDICAL STAFF AND THE SENIOR MANAGEMENT TEAM WHO WERE RESPONSIBLE FOR LEADERSHIP AND OVERSIGHT OF THE SERVICE.

WE OBSERVED PATIENT CARE, THE ENVIRONMENT WITHIN WARDS AND THEATRES, HANDOVERS AND SAFETY BRIEFINGS. WE ALSO REVIEWED THE HOSPITAL’S PERFORMANCE DATA IN RESPECT OF SURGICAL SERVICES.

**IS THE SERVICE SAFE?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**MANDATORY TRAINING**

Mandatory training completion was monitored centrally, and non-compliance was tracked and flagged to line managers for individual follow-up. Staff we spoke with reported the trust provided a robust e-learning plan and supported staff in completing training.
A breakdown of compliance for mandatory training courses as of June 2018 at St James’s University Hospital for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>of staff</td>
<td>of eligible</td>
<td>rate</td>
<td>target</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td></td>
<td>trained</td>
<td>staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 3 advanced life support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training basic awareness</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>407</td>
<td>408</td>
<td>99.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>407</td>
<td>408</td>
<td>99.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>407</td>
<td>408</td>
<td>99.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>407</td>
<td>408</td>
<td>99.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>406</td>
<td>408</td>
<td>99.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>384</td>
<td>390</td>
<td>98.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>399</td>
<td>406</td>
<td>98.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>309</td>
<td>315</td>
<td>98.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>394</td>
<td>405</td>
<td>97.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>392</td>
<td>408</td>
<td>96.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>61</td>
<td>64</td>
<td>95.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>363</td>
<td>408</td>
<td>89.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>264</td>
<td>340</td>
<td>77.6%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At St James’s University Hospital, the surgery service had an overall training compliance rate of 96% for qualified nursing staff. The 80% target was met in 16 out of 17 mandatory training modules for which qualified nursing staff were eligible.

Resuscitation training level 2 showed 78% compliance, slightly below the trust target of 80%.

A breakdown of compliance for mandatory training courses as of June 2018 at St James’s University Hospital for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Completion</td>
<td>Trust</td>
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</tr>
<tr>
<td></td>
<td>of staff</td>
<td>of eligible</td>
<td>rate</td>
<td>target</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td></td>
<td>trained</td>
<td>staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation training level 3 advanced life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2 intensive life support</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards</td>
<td>83</td>
<td>97</td>
<td>85.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>134</td>
<td>165</td>
<td>81.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>134</td>
<td>165</td>
<td>81.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>134</td>
<td>165</td>
<td>81.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>132</td>
<td>165</td>
<td>80.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety</td>
<td>117</td>
<td>149</td>
<td>78.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
At St James’s University Hospital, the surgery service had an overall training compliance rate of 72% for medical staff. The 80% target was met for seven out of 18 mandatory training modules for which medical staff were eligible.

In three modules, less than 50% of staff had completed the training; with only 41% of staff having completed training in the two advanced resuscitation training modules. Only 25% of staff had completed the PRTD paediatric life support level 1 module; however, this only equated to three staff not completing the training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

The service had systems in place for the identification and management of adults and children at risk of abuse.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse and which issues staff should report.

There was an established safeguarding team in the trust, led by a head of safeguarding. The safeguarding team reviewed and investigated individual notifications and provided advice, support and training to staff. Staff we spoke with had knowledge of the services available, found the team accessible, and were confident about the referral process.

From April 2017 to March 2018, 36 adult safeguarding referrals were made from surgical services across the trust. No child safeguarding referrals were made in this time frame.

From January 2018, the trust started to record falls and pressure ulcers under specific safeguarding referral domains (neglect/self-neglect), where relevant. Since our last inspection of the service, the safeguarding team had worked closely with the Pressure Ulcer Collaborative, and had introduced a flowchart for staff to define when and how to highlight the development of pressure ulcers as a safeguarding issue. The safeguarding team had also worked alongside the clinical nurse specialist for tissue viability to engage and ensure learning is taken from relevant Local Safeguarding Adult Board (LSAB) reviews.

**Safeguarding training completion rates**

Following our previous inspection of the service in 2016, the trust was required to ensure that staff had completed safeguard training at the appropriate levels for their role; in line with national recommendations. At the service, we saw that the quality and content of mandatory safeguarding training had been refreshed in July 2017.
A breakdown of compliance for safeguarding training courses as of June 2018 at St James’s University Hospital for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>394</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>394</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>295</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>295</td>
</tr>
</tbody>
</table>

At St James’s University Hospital, the surgery service had an overall training compliance rate of 87% for qualified nursing staff. The 80% target was met for five of seven safeguarding training modules for which qualified nursing staff were eligible.

The two remaining modules almost met the trust target (safeguarding children level 2 and safeguarding vulnerable adults level 2, both with 77%).

A breakdown of compliance for safeguarding training courses as of June 2018 at St James’s University Hospital for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>121</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>116</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>41</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>38</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>38</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>27</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>26</td>
</tr>
</tbody>
</table>

At St James’s University Hospital, the surgery service had an overall training compliance rate of 57.7% for medical staff. The 80% target was not met for any of the seven safeguarding training modules for which medical staff were eligible.

Training compliance was lower than 50% for four out of seven modules. The lowest training compliance rates reported were for safeguarding vulnerable adults level 2 (38%) and safeguarding children level 2 (36%).

(Source: Routine Provider Information Request (RPIR) – Training tab)
Clinical staff in the service also received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. The service had around the clock access to mental health liaison, and other specialist mental health support if staff were concerned about safeguarding risks associated with a patient’s mental health.

During our inspection, nursing staff we spoke with could describe what signs to look for and how they would escalate any safeguarding concerns. Some staff described using safeguarding control notes/plans, a feature added to the electronic patient record system since our last inspection.

Nursing staff we spoke with were able to detail the actions they had taken in relation to safeguarding concerns. For example, a sister discussed a referral made shortly before our visit. This was in relation to a patient who had made concerning comments that posed a potential risk to public safety. The sister described documentation, escalation, and appropriate referral of the case to the safeguarding team.

Cleanliness, infection control and hygiene

The trust had an infection prevention and control (IPC) policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination, and IPC practices.

Equipment cleaning labels were used, and this provided assurance that re-usable patient equipment has been cleaned and was ready for use.

During our inspection, we observed staff interactions with patients were compliant with key trust infection control trust guidelines; for example, with respect to hand hygiene and the use of personal protective equipment (PPE).

During our inspection, we observed surgical patients under isolation due to infection and the risks of cross contamination. Signage was adequate and staff were able to explain the reasoning behind the need to isolate. We saw stricter isolation procedures were in place for relevant areas; such as the transplant ward. There was an isolation bay in Geoffrey Giles PACU at SJUH.

Staff across different wards and theatres told us they had link nurses for infection prevention and control. We also saw there were hepatitis clinical nurse specialists for relevant areas.

We saw information displayed on cleanliness and infection control on safety information notice boards across surgical wards and units.

We found most ward environments we visited were visibly clean, tidy and dust free. Hand hygiene points were visible at all ward entrances, main entrance and exit points and staff/patient corridors. Signage was visible regarding infection control across the hospital, alcohol hand gel was available at every bed space. We observed separation of clinical and non-clinical waste in line with trust policy in ward areas at the location.

However, we did see a clinical waste bin overflowing and debris on floor in a dirty utility room (J46), and we also saw used towels and gowns left on the floor in a shower room in a side bay in this area.

We also observed a needle in the middle of the main corridor on a ward (J83), this had been swept into a pile of debris by domestic service staff. We escalated this to a senior member of staff, who removed the needle.

During our inspection, we visited the David Beavers day unit. At the time of the inspection, this area was being used as for day case and inpatient accommodation. We saw the area did not
comply with Health building note 04-01 adult in-patient facilities guidance; as the bed spaces were too small to accommodate inpatient beds safely. During the inspection we saw less than a meter between bed space; this raised the potential risk of IPC concerns. During the inspection we raised this with senior managers and they told us they were review IPC on the unit.

Following our onsite inspection, we received a “Report on Infection Prevention and Control visit to David Beevers Day Unit (DBDU) SJUH”, this was dated 14 September 2018. The report found that bed/trolley spacing was not compliant with IPC guidelines. In addition, that there were currently two clinical hand wash basins on the unit; and at a minimum, there should be one hand wash basin per four beds (HBN 00-09). The report also identified that antimicrobial hand rub dispensers were not available at each bed/trolley space, and due to the lack of space beside both trolleys and beds, the drip stands were sometimes placed at the foot of the bed.

During our inspection, we saw daily cleaning schedules for specific areas had been completed and updated. We observed housekeeping staff changing material privacy curtains around patient bed spaces.

At our previous inspection of the service in 2016, it was identified that the trust had to ensure that infection prevention and control protocols were consistently followed in theatres.

At our recent inspection, we saw systems and processes were in place to prevent and protect people from health care associated infection, and NICE guidance CG74 was adhered to (the guideline governs protocols in relation to the pre-operative, intraoperative, and post-operative phases).

In many areas visited, we found theatre environments to be clean and generally tidy. However, several specific issues were identified. For example, we observed three clinical waste bins in storage areas/corridors outside of Geoffrey Giles theatre areas, where the bin lids had been left open; increasing the risk of cross contamination and non-adherence to hospital policy. This was reported to senior members of staff and the inspection manager.

Sharps bins in most of the areas visited were secure, dated and signed, and stored off the floor. However, we noted a sharps bin kept on the floor in an anaesthetic room in Geoffrey Giles theatres. We also saw sharps bins on the floor in a theatre and in the anaesthetic room in the David Beevers suite.

Theatre areas had facilities for safe storage of linen and cleaning equipment. We found appropriate waste segregation and disposal systems in place. However, in the Geoffrey Giles theatres we did see a clinical waste bag in a liner, but not housed in a foot operated pedal bin, as recommended. In the David Beevers unit we found the waste bin in the anaesthetic room was too small, and an additional waste bag was hanging from it.

In the Geoffrey Giles and David Beevers theatres, we saw some hand wash basins were not compliant with HTM-64, as they were housed in vanity cases and not elbow sensor operated.

The general environments of PACU in the different theatres we visited were clean and tidy. However, in the David Beevers suite we saw disposable curtains were in use in the PACU, but these were not dated; so, it could not be identified when they should be replaced.

Senior staff told us that theatre units had up to do date air unit handling verification. We sampled a section of air handling units and found all air flow within theatres observed were working and within limits (for example, in Geoffroy Giles theatres, three, five and seven).

Following our inspection, we reviewed ward health check audit information provided by the trust for the abdominal medicine and surgery CSU, for the period August 2017 to July 2018. Data
showed 94.6% compliance for decontamination of hands by staff at the point of care using five moments for hand hygiene, 92% compliance for completion of invasive devices care plans, and 93.8% compliance for patients requiring source isolation. The exceptions for high hand hygiene compliance included surgical wards J45 (male colorectal and urology) at 78.3% and J44 (female colorectal and urology) at 81.7%. The exceptions for high completion of invasive devices care plans included J47 at 72% (acute surgery ward) and the surgical assessment unit (JSUA) at 70.6%.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that SJUH scored 98.43% for cleanliness.

The trust provided us with theatre and PACU safety audit data, presented at trust level. We analysed a 12-month period of data from August 2017 to July 2018. Data showed 99% compliance for finding theatre and PACU environments clean, tidy and clutter free.

The trust provided healthcare acquired infection data for the period August 2017 to July 2018. As shown in the table below, data showed within the abdominal medicine and surgery CSU there had been one case of MRSA, 19 cases of MSSA, 24 cases of Clostridium difficile, 44 cases of E.coli, 16 cases of Klebsiella, and eight cases of Pseudomonas.

<table>
<thead>
<tr>
<th>Ward</th>
<th>MSSA</th>
<th>MSRA</th>
<th>CDI</th>
<th>E.coli</th>
<th>Klebsiella</th>
<th>Pseudomonas</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>J82</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>J83</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>J42</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>J91</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>J50</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>J92</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>J44</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>J45</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>J46</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>J49</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>J47</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>J48</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>J43</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>1</td>
<td>24</td>
<td>44</td>
<td>16</td>
<td>8</td>
<td>112</td>
</tr>
</tbody>
</table>

The highest numbers of infections were predominantly associated with wards: J82 (Upper Gastrointestinal (UGI) & Hepato-Pancreato-Biliary (HPB) surgery), J83 (general surgery and transplant), and J42 (urology/short stay elective surgery).

We saw an entry in the Abdominal Medicine and Surgery CSU risk register (dated to June 2018) that noted these concerns, but which also described releasing staff time for effective IPC precautions was a challenge due to minimal staffing numbers on many shifts.

During our inspection, we spoke with senior staff on J83 who commented that they often housed surgical and medical outlier patients on the ward, and this sometimes presented an IPC concern.

The trust had a policy for MRSA screening for emergency patients. Elective patients were screened at pre-assessment. The trust provided MRSA audit data for 2017-29018 that showed across the abdominal medicine and surgery CSU, 100% of the eligible patients sampled were screened for MRSA within 48 hours. However, only 50% of relevant patients had wounds and
lacerations screened. In addition, of patients requiring isolation, only 50% of patients sampled who required isolation had been isolated in a side room as per the trust’s MRSA pathway and guideline.

We saw that each CSU had separate action plans for reductions in hospital acquired Clostridium difficile infections and MRSA and MSSA infections for 2018/19 (dated to May 2018).

There was a surgical site infection (SSI) surveillance programme in place at the trust. The trust participated in the PHE SSI surveillance scheme. Each quarter, a different surgical speciality was chosen to participate, determined by a rolling programme, or as a result of identifying higher than average SSI rates in a previous surveillance period. However, recent surveillance activity (over the last 12 to 18 months) predominantly related to services provided at Leeds General Infirmary.

Data from the Getting It Right First Time (GIRFT) SSI surveillance audit conducted between May and October 2017 showed 120 instances of SSI at the trust between May 2017 and October 2017. Of these: 27 cases related to urological surgery (23%), 20 cases related to spinal surgery (17%), 21 cases related to cranial neurosurgery (17%), 19 cases related to vascular surgery (16%), and 13 cases related to cardiothoracic surgery (11%). Remaining SSI cases related to other specialities, and amounted to 5% or less each. We did not know the number of corresponding surgeries undertaken during this period, so we were unable to calculate respective SSI rates.

Environment and equipment

Access to ward areas was via intercom with security cameras, staff gave access for admission from the main ward reception desk.

Most surgical wards and patient areas visited were spacious and side rooms were available for those who needed them. In the main bays, bed spaces were separated by curtains to maintain patients’ privacy and dignity. Toilets for use by staff and visitors were clean and wheelchair accessible. We found the wards was accessible to wheelchair users, with clear signage, and call buzzers were available by beds. There were designated areas for those waiting for surgery and post-operative patients.

During our inspection, we visited the David Beavers day unit. At the time of the inspection, this area was being used as for day case and inpatient accommodation. On the unit, we observed less than a meter between bed spaces. In addition, patients had no access to lockers to store their personal property. We spoke with a post-operative patient who was concerned there were no secure areas or lockers in which to store her possessions. Separate male and female showers and toilet facilities were available. During our inspection, senior management took action to improve the patient experience in this area. This included limiting the number of beds on the unit, considering the suitability of patients for the unit, and they discussed the capital longer term plan for the unit. They agreed that the unit would be fully reviewed.

Following our inspection, the trust provided an interim SBAR to describe the use of David Beavers Day Unit for inpatients requiring an overnight stay (dated 10 September 2018). The trust also submitted a “Report on Infection Prevention and Control visit to David Beavers Day Unit (DBDU) SJUH”, this was dated to 14 September 2018. The SBAR document (dated 10 September 2018) described a 16 trolley/bed base and stated the service was to restrict the number of inpatient overnight beds to nine until further information was obtained, reviewed and a way forward agreed. The IPC report (dated to 14 September 2018) described 23 spaces within the bed/trolley base and proposed the number of beds/trolleys will be reduced to an identified maximum number (nine). Therefore, we could not be assured of what service plans for trolley/bed
limitation entailed, and what had been implemented post-inspection.

We visited the surgical assessment unit during our inspection; which was very busy at the time of our arrival. We noted that there were not enough chairs to accommodate patients and their companions, and observed a relative sitting on the floor. We brought this to the attention of staff.

Following our inspection, the trust provided us with a revised standard operating procedure for the surgical assessment unit and a surgical assessment unit action plan (both dated September 2018). Documents included review of pathways for admission, and escalation procedures to be followed should patient waiting / triage times exceed defined limits, and should more than 27 patients be waiting in the department.

Ward areas we visited at the location were tidy and generally free from clutter.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that St James Hospital scored 98.43% for condition appearance and maintenance.

Staff we spoke with said that they had adequate stocks of equipment to meet the needs of their patients, for example, moving and handling equipment. Bariatric equipment was also available from the equipment pool if required; this included theatre trollies, beds, wheelchairs and commodes.

There was a rolling programme of equipment replacement; and we saw evidence of equipment risks escalated to CSU risk registers where appropriate.

We inspected equipment for evidence of portable appliance testing (PAT). This is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. With few exceptions, we found equipment was electrically safety tested within the review date and serviced in line with manufacturers’ guidelines.

Sterilisation of reusable surgical equipment was performed off-site by an independent company, and returned the next day.

At our previous inspection in 2016, we told the trust they 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. At our recent inspection, we saw that substances hazardous to health were securely stored in the areas inspected at the location.

In ward areas, resuscitation trollies were easily located on main corridors. At the 2016 inspection, we said the trust should consider the use of tamper proof seals on resuscitation trollies. During our recent inspection, we reviewed ten resuscitation trollies, all of which had a tamper proof, numbered seal. We saw the trollies were regularly checked, in line with trust policy. Equipment we reviewed was clean, tidy, ready for use and staff had checked the equipment as per trust policy.

The only exception to this finding was at the David Beevers day unit, where we found monthly checks had been completed, but there were significant gaps in daily check activity. For example, we could see no evidence of daily checks having taken place on seven days in July 2018 (13/7, 16/7 and 18/7 to 22/7); and observed checks had only taken place on 13 occasions in May 2018 and on 13 occasions in April 2018.

Monthly ward Health-check data for the Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 96% compliance for emergency equipment checks.

We reviewed trollies used for difficult airway access within theatres and noted these were easy to access, orderly, and equipment was in date and ready to use. We did, however, find that some trolley tops were a little dusty.
Theatres environments were generally found to be adequate; however, we noted storage facilities to be an issue. At our last inspection in 2016, we observed several pieces of equipment stored in corridors in Geoffrey Giles theatres which could cause an obstruction. At our recent inspection, we saw lack of adequate storage facilities throughout the depart, with equipment and machines stored in corridors. We also observed some store rooms and preparation rooms with boxes on floor containing sterile equipment. We spoke with several members of staff who commented that there was a lack of storage facilities across theatre areas.

We observed that some areas within theatres would benefit from an uplift; for example, in Geoffrey Giles theatre areas we saw several work units and floors that were in need of minor repairs.

We also found the female changing area in the David Beevers theatre area was dated, and the ceiling superficially damaged.

**Assessing and responding to patient risk**

We saw that the trust had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. A series of prompts were built into the trust's electronic patient record (electronic observations (e-obs) recording system on PPM whiteboards) to support staff in managing risks posed to individual patients. For example, in relation to allergy alerts, deteriorating patients, national early warning scores (NEWS), and those at risk of falls.

We observed staff handover from a night shift to a day shift. The hand over was robust, incorporating risks, care given overnight, clinical summary, nutrition and hydration (diet), social, pain assessment, observations, consultant plan and next steps with respect to multidisciplinary care planning.

We observed risk factors and mitigating actions, such as falls and pressure ulcer prevention, being discussed at safety huddles and during handovers. We also observed boards above patient’s beds which identified any individual risk factors.

To address patient falls, elective patients were assessed pre-admission and all patients were assessed on admission to assess (or reassess) potential risks surrounding mobility and history of falls. The trust had instigated close observation bays where a clinical support worker was allocated to closely observe patients who were at risk of falls. On inspection we observed close monitoring of patients at risk of falls. For example, on ward J47 (acute male surgical ward) we observed a clinical support worker monitoring patient in a designated four-bedded high risk falls bay.

We saw that wards visited had access to either ward-based physiotherapists and occupational therapists, or the ability to make a referral.

Staff discussed learning from pressure ulcer incidents, and changes to practice. Nurses informed us that all patients are screened for pressure ulcers using the Waterlow screening chart which is a risk assessment tool checking age, skin type, appetite, mobility, continence and weight. Patients who scored 10 or above were given an individualised care plan which detailed how pressure ulcer prevention or pressure ulcer care would be managed. Immediate care was instigated to address pressure care by ongoing assessment, mobility assessment, turns to alleviate pressure, pressure relieving devices (e.g. air flow tron mattresses) and nutrition and hydration assessment.

We saw that collaborative work around pressure ulcers had been carried out in the abdominal medicine and surgery CSU. For example, wards J45 and J47 had piloted new tools such as ‘purple clock’, which used a turn clock to cue patient repositioning for pressure ulcer prevention. Ward J45 had also instigated ‘react to red’ campaigns to raise awareness of pressure ulcers. On
ward J83 we saw a ‘SKIN’ (surface, keep moving, incontinence, nutrition) pressure ulcer information board; which was very detailed and informative.

Monthly ward Health-check data for Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 96% compliance for falls assessments, and also 96% compliance for pressure area care.

We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling and venous thromboembolism (VTE) compliance in nine patient records, and found these fully completed with few (minor) omissions. For example, we could not identify that fluid balance charts were completed on two occasions. In addition, we could not identify evidence of VTE risk assessment in three cases; however, in two cases we were unable to access the electronic record to identify if assessments had been completed there.

Following our inspection, the trust provided VTE risk assessment audit data for CSUs, and at individual ward level. Data referred to the number of patients who had received a VTE risk assessment within 24 hours of admission. We reviewed data for May 2018 to July 2018, which showed 92.6% 24-hour VTE risk assessment compliance within the adult theatres and anaesthesia CSU (David Beevers Day Unit) and 85.1% compliance within the abdominal medicine and surgery CSU.

However, when we analysed data at ward level, we saw variable performance across surgical service areas reviewed within the abdominal medicine and surgery CSU over the 3-month period. As shown in the table below, six surgical wards recorded average 24-hour VTE risk assessment compliance of 60% or less over this period, with two of wards (J44, 43%; JSUA, 49%) reporting less than 50% compliance.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Ward Name</th>
<th>May-18</th>
<th>Jun-18</th>
<th>Jul-18</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>J44</td>
<td>Colo-rectal/Urology (female)</td>
<td>47%</td>
<td>35%</td>
<td>47%</td>
<td>43%</td>
</tr>
<tr>
<td>JSUA</td>
<td>Surgical Assessment Area</td>
<td>49%</td>
<td>49%</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>J42</td>
<td>Urology</td>
<td>52%</td>
<td>57%</td>
<td>52%</td>
<td>54%</td>
</tr>
<tr>
<td>J46</td>
<td>Acute General Surgery</td>
<td>57%</td>
<td>50%</td>
<td>57%</td>
<td>55%</td>
</tr>
<tr>
<td>J43</td>
<td>Short Stay Electives</td>
<td>58%</td>
<td>56%</td>
<td>58%</td>
<td>57%</td>
</tr>
<tr>
<td>J47</td>
<td>Acute General Surgery</td>
<td>57%</td>
<td>66%</td>
<td>57%</td>
<td>60%</td>
</tr>
<tr>
<td>J45</td>
<td>Colo-rectal/Urology (male)</td>
<td>58%</td>
<td>76%</td>
<td>58%</td>
<td>64%</td>
</tr>
<tr>
<td>J82</td>
<td>HBP &amp; Upper Gastro Intestinal</td>
<td>64%</td>
<td>71%</td>
<td>64%</td>
<td>66%</td>
</tr>
<tr>
<td>JAL</td>
<td>Admissions Lounge</td>
<td>95%</td>
<td>98%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>BDWE</td>
<td>Day Ward Endoscopies Bexley Wing</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

We saw the Abdominal and Medicine CSU held a VTE risk assessment meeting in May 2018. We were provided with a summary of this meeting, which highlighted actions to improve compliance by August 2018. In the August 2018 data, we saw that compliance had improved overall (88.3%). However, low compliance rates were still observed in several areas; such as J44 (37.5%), J45 (47.1%), JSUA (61.2%), J42 (64.0%) and J43 (68%).

At trust-level, we saw the Quality Management Group (July 2018) had met to discuss an SBAR Proposal for VTE risk assessment, presented by the VTE Steering Group.

At our inspection of the service in 2016, we told the trust to ensure that all NEWS and observations were calculated and escalated in line with trust guidance. At our recent inspection,
nursing staff we spoke with were able to articulate the deteriorating patient and were able to describe when they would escalate to senior staff for further review. Staff also told us that they had access to an outreach team if NEWS scores were abnormal and they required additional help and support. Senior staff told us patients with elevated NEWS were discussed at ward safety huddles and during handover. This was observed by the inspection team.

We reviewed nine sets of patient notes and saw evidence of correct calculation of NEWS observations, and appropriate escalation of deteriorating patients in these.

We reviewed NEWS compliance audits conducted from July 2017 to June 2018. Across NEWS audit metrics, we saw an average of 96% compliance within the abdominal medicine and surgery CSU. Prescribing of observations, minimum twice daily recording, correct NEWS Score, and 24h cumulative fluid chart scores were consistently high. However, we noted that documentation of interventions of raised NEWS (three or more in one parameter or five) showed 68% compliance on average over the timeframe.

Monthly ward Health-check data for Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 96% compliance for patient observations.

Senior staff informed us that effectively managing patients with suspected and confirmed sepsis was a key focus of the trust. There was a sepsis steering group in place at the trust, and we saw evidence of meeting minutes (July 2018), which included review and monitoring of associated action plans (dated to June 2018). We also saw that the trust had organised a sepsis conference (May 2018), led by local and national sepsis leads. We also evidence of in-depth sepsis learning needs analysis, undertaken by the trust's improvement academy.

During our inspection, we saw wards displayed posters about the risk of sepsis; which all displayed the ‘BUFALO’ acronym (designed to help clinicians to remember the elements of the sepsis six care bundle) and prompts for putting patients on a sepsis pathway. BUFALO bags were available in the service; which were equipped with all necessary items to take a sample of blood for culture testing. Staff we spoke with were aware of sepsis escalation policy and processes. Staff could demonstrate use of the both electronic and paper-based (when in use) adult sepsis screening tools (dated to January 2018).

We saw that the trust had made good progress screening patients with suspected sepsis. For the quarter January to March 2018, the trust achieved 92% compliance for screening patients who met the required criteria. For 2017/18, estimated mortality rates for septic patients at national level was 30% on average. The figure at the trust for 2017/18 was around 13%. Audit results for the quarter January to March 2018 showed that 77% of patients received antibiotics within the hour, and antibiotics were reviewed appropriately for 98% of patients.

In theatres, staff used the World Health Organisation’ (WHO) surgical safety checklist. At our last inspection of the service in 2016, we found use of the checklist inconsistent and routine practice not embedded. In addition, two never events involving wrong site surgery had occurred at the location in May 2017 and June 2017. At our recent inspection, we saw a WHO Safer Procedure Checklist and the Correct Surgical Site Marking Policy and Standard Operating Procedure was in place (dated to July 2018).

During our inspection, we directly observed a robust WHO safety checklist culture. All staff we spoke with were aware of the importance of safety checks to reduce risk. During observation of procedures, we noted the WHO checklist was appropriately completed on 10 occasions at the location. We saw good engagement from the clinical team, which provided assurance that this was an effective process.
In addition, we saw that accountable items were reviewed and recorded on whiteboards. The trust provided us with theatre and PACU safety data for the period August 2017 to August 2018. Data was at trust-wide level and showed use/completion of accountable items whiteboards had been audited from August 2018; with a 92.5% compliance score recorded.

At the service, completion of the safer surgery checks was audited continuously by the theatre management system, and regular reports were produced. The trust provided who safer surgery checklist audit data specific to St James’s University Hospital, for the period August 2017 to July 2018. We saw that audits were undertaken for one week (Monday to Sunday) of every month, and six key metrics were measured: team brief, team debrief, average staff satisfaction score (with a maximum score of 5), sign in, time out, and sign out.

From August 2017 to July 2018, aggregated data at this location showed:

<table>
<thead>
<tr>
<th>WHO safer surgery checklist metric</th>
<th>Average compliance/ result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Brief</td>
<td>57.6%</td>
</tr>
<tr>
<td>De-Brief</td>
<td>53.1%</td>
</tr>
<tr>
<td>Average Staff Satisfaction Score</td>
<td>3.3</td>
</tr>
<tr>
<td>Sign In</td>
<td>99.7%</td>
</tr>
<tr>
<td>Time Out</td>
<td>99.7%</td>
</tr>
<tr>
<td>Sign Out</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

We analysed team brief and de-brief data further and found that average weekday (Monday to Friday) compliance was considerably better than average weekend compliance (Saturday to Sunday), with Sunday being particularly poor; as shown in the table below:

<table>
<thead>
<tr>
<th>WHO safer surgery checklist metric</th>
<th>Average weekday (Mon-Fri) compliance</th>
<th>Average weekend (Sat-Sun) compliance</th>
<th>Average Saturday compliance</th>
<th>Average Sunday compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Brief</td>
<td>73.2%</td>
<td>18.8%</td>
<td>28.1%</td>
<td>9.6%</td>
</tr>
<tr>
<td>De-Brief</td>
<td>68.0%</td>
<td>15.7%</td>
<td>24.5%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

Following our inspection, the trust informed us that the data they provided did not take account of non-elective (acute) surgical lists, which were more likely to be performed on weekends; compared to elective surgery. They said that their electronic theatre management system (TMS) did not allow for individual patient team brief/debrief data to be captured, and that paper records were held. They noted that this was to be addressed by the theatres and anaesthetic CSU.

Nevertheless, we saw that overall compliance with brief and debrief checks was internally recognised to be an issue at the trust. This was reflected in the trust’s 2017/18 WHO safer surgery checklist audit; which was presented to the Clinical Audit and Learning Forum (March 2018), and the Safety and Outcomes Sub-Group (April 2018). Findings described that there had been a decrease in ‘down-tools’ (brief and debrief) checks when compared to 2016/17 data; with the lowest compliance seen in the de-brief check, which had decreased from 76% in 2016/17 to 56% in 2017/18.

The trust provided us with theatre and PACU safety audit data for the period August 2017 to August 2018. Data was presented at trust level. We analysed a 12-month period of data from
August 2017 to July 2018. As shown below, high scores were observed across metrics, with a total average score of 90%. The lowest scores were observed for correct information display of patient safety boards as expected standard (82%) and evidence that the team de-brief from the previous theatre list was completed (82%).

<table>
<thead>
<tr>
<th>Theatre and PACU safety metric</th>
<th>Average compliance (%) August 2017 to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence that team brief completed for that day and all team recorded?</td>
<td>96.26%</td>
</tr>
<tr>
<td>Evidence the team de-brief from their previous list was completed?</td>
<td>82.08%</td>
</tr>
<tr>
<td>Is the theatre/PACU environment is clean, tidy and clutter free?</td>
<td>99.38%</td>
</tr>
<tr>
<td>Have four theatre staff members been allocated to the list?</td>
<td>91.14%</td>
</tr>
<tr>
<td>Is the patient safety board is displaying correct information as expected standard?</td>
<td>81.67%</td>
</tr>
<tr>
<td>Is there an identified Practitioner in charge displaying sticker?</td>
<td>88.20%</td>
</tr>
<tr>
<td><strong>Total: average across metrics</strong></td>
<td><strong>89.8%</strong></td>
</tr>
</tbody>
</table>

**Nurse staffing**

The trust told us that staffing on each ward or department was assessed using a range of tools, such as safer nursing care tools, and 1:8 ratios, to agree both their safe staffing levels and their establishment staffing levels (as part of a four-year plan). The trust measured nurse staffing by three levels, minimum, current and optimum. The minimum levels were considered to be the lowest level of staff numbers to maintain safety. Current levels were what the current establishment of staffing was set at. Optimum staffing was the ideal numbers of staffing for the ward or area. Prior to our inspection, the trust provided us with information that detailed they used the term ‘current’ to denote staffing to establishment. The trust acknowledged that many wards and departments had not yet achieved establishment staffing levels, specifically in registered nursing posts, due to local and national shortages.

However, staff at all levels who we spoke with during our inspection expressed difficulty articulating the difference between ‘optimum’ (establishment) and ‘safe’ (minimum) staffing levels; and how these had been agreed upon.

To mitigate for a shortage of registered nurses, the service described they had adjusted the skill mix to reflect a more diverse range of roles within the ward workforce. This, they said, included investing in the knowledge and skills of the un-registered workforce to ensure patients received high quality care. The trust had expanded the number and increased the skills of senior Clinical Support Workers (trained to level 3) and Assistant Practitioners (Level 5 Foundation Degree), and had introduced Nursing Associates (Level 5 Foundation Degree). We saw evidence of these mitigating actions implemented on surgical wards during our visit.

There was a clear escalation process for staffing concerns (Actions to Be Taken When the Numbers of Nurses or Midwives Per Shift Falls Short of The Agreed Roster Template, updated August 2018); and staffing was discussed at daily operational performance (DOP) meetings.

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.

Following our inspection, the trust told us that the Abdominal Medicine and Surgery CSU was the first CSU to introduce a daily review of staffing numbers and pressures presented by differing levels of acuity on their wards, and this model had subsequently been rolled out trust-wide.

We reviewed CSU risk registers for surgical service areas and found risks relating to registered nurse staff shortages featured prominently. However, we saw most of these risks had been downgraded over the last 12 to 24 months following mitigating actions being put in place, as described earlier.

Prior to our recent inspection, the trust provided information about staffing levels on wards and in specific core service areas they were concerned about. Of the four areas described, two related to the surgical core service areas; and at this location included nurse staffing across the abdominal medicine & surgery CSU.

During our visit, we saw staffing on ward J83 did not meet planned levels. On the early shift, five registered nurses and six clinical support workers were planned, but only three registered nurses and four clinical support workers were on duty. On the late shift, five registered nurses and six clinical support workers were planned, but only three registered nurses and four clinical support workers were on duty. On the night shift, three registered nurses and six clinical support workers were planned, but only two registered nurses were on duty; the planned level of clinical support workers (six) was met.

On ward J47 we saw that registered nurse staffing did not meet planned levels. On the early shift, four registered nurses were planned, but only three registered nurses were on duty. On the late shift, four registered nurses were planned, but only three registered nurses were on duty. On the night shift, three registered nurses were planned, but only two registered nurses were on duty. However, we noted that clinical support worker shifts were over planned levels (by one each) on early and late shifts (four per shift), and clinical support worker levels were met on the night shift (three).

On ward J44 we saw that registered nurse staffing did not meet planned levels for two shifts. Registered nurse (four) and clinical support worker (three) shifts were filled as planned for the early shift. The late shift had four registered nurses planned, but only three on duty; clinical support worker shifts were met. The late shift had three registered nurses planned, but only two on duty; however, clinical support worker shifts were over filled by one (three planned, four on duty).

In the surgical assessment unit, we saw that staffing did not meet planned levels. On the early shift, three registered nurses and four clinical support workers were planned, but only two registered nurses and three clinical support workers were on duty. On the late shift, five registered nurses and four clinical support workers were planned, but only three registered nurses and three clinical support workers were on duty. On the night shift, three registered nurses were planned, but only two registered nurses were on duty; the planned level of clinical support workers (two) was met.

During our inspection, several nursing ward staff we spoke with remarked that although mitigating actions had made a positive difference in some respects (for example, in delegating some workload, and with the monitoring of patients at risk of falls), they felt the shortage of registered nurses within the service had a detrimental impact on staff wellbeing and patient care. This appeared especially prevalent on wards where there were comparatively higher proportions of medical outliers.
For example, on J83 (a general surgery, liver and transplant ward) we saw that there were three medical outliers, one of whom was an elderly medicine outlier. Staff on the ward told us that the acuity of some medical outlier patients meant they struggled to deliver care. Staff commented that medical outlier patients were meant to encompass those whose condition was improving or who were nearly ready to be discharged home. However, staff said that medical outlier patients often presented with complex needs and discharge problems were commonly experienced. For example, one medical outlier patient who was resident on the ward at the time we visited had Parkinson’s disease and required medications administered eight times per day between the hours of 6am and 9.30pm.

We reviewed the trust’s Risk Management Committee Meeting minutes (July 2018) and saw that nurse staffing within the abdominal medicine and surgery CSU was discussed, and continued to be closely monitored by the CSU. A senior member of staff noted that the key risk regarding staffing was in the surgical assessment unit. The minutes described that 31 registered nurses were due to qualify in September and these would be supported through the apprenticeship programme. It was further noted, that there was a number of patients with complex needs on surgical wards, and the CSU was encouraged to escalate these patients to the Risk Management Team for advice where this was required in a timelier way.

Following our inspection, the trust provided us with a surgical assessment unit action plan (dated September 2018). This highlighted problems with reduced nurse staffing levels leading to inability to provide care to inpatients on the assessment unit, leading to patient complaints. Actions to be taken included: a proposal being taken to the corporate operational team to reduce the bedded patients overnight, this was intended to reduce the burden of nursing care. Further actions were to continue with specific adverts and recruitment for surgical assessment unit roles, and to explore the use of rotational post from the emergency department to support the surgical assessment unit.

The trust reported their staffing numbers for March 2017 and March 2018, as shown in the table below. These refer to establishment staffing levels:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>33.2</td>
<td>35.2</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>304.5</td>
<td>381.7</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>400.2</td>
<td>521.3</td>
</tr>
</tbody>
</table>

In March 2018 there were 740.7 WTE nursing staff in post in surgery services compared to a planned WTE establishment of 944.9 WTE staff, giving a fill rate of 78.4%. This was similar to the previous year’s fill rate of 78.7%.

The fill rate at St James’s University Hospital improved from 76.8% in March 2017 to 80.5% in March 2018. However, there was actually a small reduction in the number of actual nursing staff in post at this site over the period (400.2 WTE staff in March 2017, compared to 394.0 WTE actual staff in March 2018).

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a nursing staff vacancy rate of 21.8% in surgery. The trust did not have a target for vacancy rate.
At St James’s University Hospital, the nursing staff vacancy rate in surgery was 20.1%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a nursing staff turnover rate of 11.0% in surgery. The trust did not have a target for turnover rate.

At St James’s University Hospital, the nursing staff turnover rate in surgery was 11.1%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported an annual nursing staff sickness rate of 4.2% in surgery, which was higher than the trust’s target of 3.5%.

At St James’s University Hospital, the annual nursing staff sickness rate in surgery was 4.3%, which was higher than the trust’s target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, the trust reported that 1.0% of qualified nursing shifts in surgery at St James’s University Hospital were filled by bank staff and 3.2% of shifts were filled by agency staff. In addition, 7.1% of shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 7.2% of nursing assistant staff shifts in surgery at the hospital were filled by bank staff, 6.0% of shifts were filled by agency staff, and 4.0% of shifts were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>3,093</td>
<td>7.2%</td>
<td>865</td>
</tr>
<tr>
<td>Agency</td>
<td>2,590</td>
<td>6.0%</td>
<td>2,893</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,727</td>
<td>4.0%</td>
<td>6,393</td>
</tr>
<tr>
<td>Total</td>
<td>43,032</td>
<td></td>
<td>89,604</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Medical cover was available on-site 24 hours a day. Consultants were available 24 hours a day, and were on site between 8am and 6pm; on-call cover was provided at evenings and weekends.

Resident consultant and speciality registrar anaesthetic cover was provided 24 hours a day, with on-call consultant cover provided out of hours.

On-call consultants were supported by on site registrars, and foundation level doctors supported wards.

We observed both formal medical ward rounds and safety brief meetings. Formal medical rounds took place in the morning to facilitate patients’ ongoing care or discharge plans. The ward rounds
and safety huddles were thorough and efficient with all information clearly communicated. All staff members had the opportunity to contribute to the meetings.

As shown in the staffing skill mix diagram below, 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 8% compared to 11%.

However, the proportion of registrar doctors at the service (38%) was higher than the national average (29%). In addition, the proportion of consultants (52%) was slightly higher than the national average (49%).

Gaps in middle grade rotas and insufficient levels of junior doctor cover on wards were highlighted on relevant CSU risk registers. This was discussed with the senior management team, who informed us that gaps were covered using locums; with some internal cover from consultants for middle-grade gaps. The team also cited other mitigating actions, such as increasing staffing on the senior fellows’ programme and the Medical Training Initiative (MTI) programme. The MTI is a national scheme designed to allow a small number of doctors to enter the UK from outside the EU for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries. In addition, we saw that the service had increased the Advanced Nurse Practitioner workforce; which also helped support the junior doctor workforce.

Junior medical staff we spoke with said they felt supported working in the trust and felt able to raise concerns as required.

The trust has reported their medical staffing numbers for March 2017 and March 2018 as shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>27.1</td>
<td>21.5</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>448.0</td>
<td>472.6</td>
</tr>
<tr>
<td>St James's University Hospital</td>
<td>135.5</td>
<td>148.4</td>
</tr>
</tbody>
</table>

In March 2018, there were 630.5 WTE medical staff in post in surgery services compared to a planned WTE establishment of 645.6 staff, giving a fill rate of 97.7%. This was similar to the previous year's fill rate of 95.0%.

St James's University Hospital had a higher fill rate in March 2018 (96.3%) than in March 2017 (91.3%).

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From June 2017 to May 2018 the trust reported a medical staff vacancy rate of 2.2% in surgery. The trust did not have a target for vacancy rate.

At St James’s University Hospital, the medical staff vacancy rate in surgery was 3.5%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
**Turnover rates**
From June 2017 to May 2018 the trust reported a medical staff turnover rate of 40.7% in surgery. However, the inclusion of trainee grades in the data is likely to have inflated the rates. The trust did not have a target for turnover rate.

At St James’s University Hospital, the medical staff turnover rate in surgery was 40.8%. However, as stated, the inclusion of trainee grades in the data is likely to have inflated the rates.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**
From June 2017 to May 2018 the trust reported an annual medical staff sickness rate of 1.3% in surgery, which was lower than the trust’s target of 3.5%.

At St James’s University Hospital, the medical staff sickness rate in surgery was 0.5%, which was lower than the trust’s target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

**Trust level**
From April 2017 to March 2018, St James’s University Hospital reported that 698 shifts were filled by bank staff and 389 shifts were filled by locum staff in surgery. There were 66 shifts not filled by either bank or locum staff.

A breakdown of bank and locum usage by staff type at St James’s University Hospital is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Shift type</th>
<th>Consultant</th>
<th>Doctor in training</th>
<th>Middle grade</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank shifts</td>
<td>57</td>
<td>534</td>
<td>107</td>
<td>698</td>
</tr>
<tr>
<td>Locum shifts</td>
<td>234</td>
<td>155</td>
<td>0</td>
<td>389</td>
</tr>
<tr>
<td>Unfilled shifts</td>
<td>0</td>
<td>65</td>
<td>1</td>
<td>66</td>
</tr>
</tbody>
</table>

There was a higher number of shifts filled by bank and locum staff to cover doctor in training shifts at St James’s Hospital, with 689 shifts covered compared to 291 consultant shifts covered.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**
As of December 2017, the proportions of consultant staff and junior (foundation year 1-2) reported to be working at the trust were similar to the England averages.
Staffing skill mix for the whole time equivalent (WTE) staff working at Leeds Teaching Hospitals NHS Trust

Total WTE (674.4)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>38%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Paper records were available for each patient that attended the wards and departments; the trust also used electronic patient management (PPM) to record key information about the patient’s hospital stay. Electronic whiteboards were used on all wards we visited, the boards recorded key information about patient risks and treatment including flags for living with dementia, NEWS scores, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Concerns around the secure storage of records had been raised at our previous inspection of the service in 2016. At our recent inspection we saw that patient records were all stored in areas that were secure or observed and we did not see any patients notes left unattended.

We reviewed nine sets of complete records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. In the nursing notes there were different assessments and care plans for a variety of conditions that had been actioned and evaluated. The vast majority of risk assessments were appropriately completed. We saw evidence of the enhanced care risk assessment completed for patients that required additional support.

We saw that electronic discharge summaries were completed for patients and a copy sent to their GP.

Monthly ward Health-check data for the Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 93% compliance for documentation.

The trust provided us with Health Record Keeping Standards (Medical) Analysis of specialty level audits for quarter 3 of 2017/18 (October to December 2017). The trust provided a sample of record keeping audit results of surgical wards at this location. Review of the data revealed mixed results. Results for upper GI and pancreatic surgery (undertaken October 2017, ward J82/83) and found...
good results overall. However, results for Colorectal surgery (undertaken June 2018, wards J44 and J45) showed relatively poor results overall.

**Medicines**

We saw the trust had an up to date medicine policy. Staff described how the pharmacy team carried out spot checks at ward level on the storage, management and administration of medicine. A clinical pharmacy service was available to inpatients; this was focused primarily on patient flow and medicines reconciliation. Dispensary services were provided for inpatients and discharge prescriptions. The ward clinical pharmacy service was available on the admissions units ten hours a day, seven days a week.

The electronic patient record (whiteboard, PPM+) allowed staff to record allergies and the trust also used a red wristband to alert staff that a patient had an allergy.

We checked the storage of medicines on the wards we visited. Medicines were stored in a locked room that required access from designated staff members. On wards, we found nurses in charge carried the keys to gain access to locked controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) cabinets and locked drugs fridges.

Pharmacist colleagues who accompanied us on our inspection found controlled drugs were stored securely and access was restricted to authorised staff. Our checks of controlled drugs showed balance checks were carried out in accordance with trust policy and there were no discrepancies. We were told that omnicell (electronic technology that communicates directly with pharmacy) roll out had improved efficiency of controlled drugs management and quality of recording on wards where this has been implemented.

The trust provided us with evidence of controlled drugs audits; which formed part of their rolling programme of controlled drugs review. Data was presented at individual ward level, and not by CSU. We reviewed checks of controlled drugs for quarter one of 2017/18 (date stamped to June, July and August 2018) and sampled results for eight surgical wards at the location. We noted five of the eight wards were found 100% compliant across all metrics (wards J83, J43, J44, J46 and J47). Issues with quality of controlled drugs record keeping were identified on wards J82 (UGI and HPB surgery) and ward J42 (short stay elective surgery). Issues with patients own controlled drugs were identified on ward J45 (male colorectal and urology). However, these wards scored positively for all other domains, including the storage and monitoring of controlled drugs. We saw findings from audits were fed back to matrons and individual ward leads.

Monthly ward Health-check data for Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 93% compliance for medicine management.

During our inspection, we found all emergency medicines reviewed were readily available and in date. We also observed oxygen cylinders stored correctly and in date.

We reviewed guidance from Leeds Medicines Information Services at the trust, entitled Management of Medicines stored in fridges in Clinical Areas (dated to February 2018). The guidance detailed, “Any fridge that continues to deviate from 2 to 8°C, or where the cause of the deviation is not known must be investigated further. Seek advice”. Contact details for sources of advice were detailed within the guidance. Within the guidance it was also noted, “Medicines Management or Medicines Information should always be involved if there are persistent temperatures outside 2 to 8°C, or any temperatures outside 1 to 14°C”.

We were advised by the pharmacy team that if wards reported an out of range fridge temperature then this was logged onto an enquiry form with action required and advice by the pharmacy team. We were informed that, once altered, the pharmacy team would check storage temperature ranges and the drugs effected, and drugs would be destroyed as necessary.

During our inspection we saw medications that required refrigeration were stored appropriately in secure fridges. We observed there was a process was in place to check and minimum and maximum fridge temperatures daily, and reset thermometers. We saw temperatures for all days were recorded. However, we found a number of fridges observed to be consistently out of temperature range with no record of action taken being recorded. For example, on ward J47 we observed fridge temperatures had been out of range for 11 days in July 2018, and nine days in August 2018. On ward J83, we observed out of range fridge temperatures recorded for seven days in August 2018, with temperatures reaching 12.9°C. However, in both cases, we saw no evidence of actions being taken. Instances were reported to senior ward staff at the time of inspection.

Medicines were prescribed and dispensed using e-med medication charts. These contained the relevant information such as date, known allergies and electronic signature of the clinician. We reviewed seven medicine records and noted medicines were prescribed and administered within national guidance. There were three main code reasons why medication was not given, these were: delay, withheld or missed. We saw that codes were recorded on the electronic system stating the reason why they were not administered.

During our inspection, a review of patient records showed that where patients had been assessed for risk of blood clots, appropriate treatment was given. The Corporate Audit Report for VTE Appropriate Thromboprophylaxis Audit, quarter four of 2017/2018 (produced May 2018) detailed that 92.5% of patients on prophylactic LMWH (199 out of 215 audited) had an appropriate dose based on weight and renal function. These results show a marked improvement on the 2017/18 results where 89.5% of patients were on appropriate thromboprophylaxis.

There was a Medicines Risk Management Group in place at the trust. We reviewed meeting minutes for June 2018, which stated medicine audit results and action plans were presented to the group.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported four incidents classified as a never event for surgery. The details of the never events are shown below:

- Retained foreign object – reported in June 2017. The incident occurred in April 2017 at Leeds General Infirmary and took 55 days to report.
- Unintentional connection of a patient requiring oxygen to an air flowmeter – reported in May 2018. The incident occurred in May 2018 at Leeds General Infirmary and took eight days to report.
Wrong site surgery – reported in June 2017. The incident occurred in May 2017 at St James’s University Hospital and took 30 days to report.

Wrong site surgery – reported in July 2017. The incident occurred in July 2017 at St James’s University Hospital and took four days to report.

Incidents where medical air was administered rather than the intended oxygen were identified as a never event in the revised NHS Improvement (NHSI) framework in January 2018. One such never event had occurred at surgical services at the trust in the 12 months prior to inspection (May 2018), although not at this location. The trust informed us that they had undertaken took required steps to comply with the NHSI Patient Safety Alert, issued in October 2016. At trust level, risk elimination by the removal of medical air/medical air flow meters in appropriate areas was agreed to be the most robust risk control. During our recent inspection, staff discussed learning from the never event and changes to practices. Staff we spoke with identified the removal of medical air/medical air flow meters in appropriate areas, and we saw evidence of this.

Staff we spoke with described learning from never events that occurred in surgical services at the trust. Of relevance to this location, theatre staff often discussed the two wrong site surgery never events that had occurred in May 2017 and July 2017. They were able to describe the context in which the never events had occurred, and stressed learning points from the events, which included use and documentation of the WHO safer surgery checklist. They also recounted learning events that had previously occurred at the trust in relation to wrong site anaesthetic block; and the ‘stop before you block’ programme of learning that had been implemented as a result. Ward staff tended to discuss a recent never event that had occurred at Leeds General Infirmary, which involved unintentional connection of a patient requiring oxygen to an air flowmeter. Staff reiterated learning points and described removal (‘capping’) of medical air/medical air flow meters in appropriate areas and use of electronic nebulisers to mitigate the risks.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018.

Trust level

A breakdown of all incidents reported in surgery is shown below:

- Pressure ulcer meeting SI criteria – 10 (35.7%)
- Slips/trips/falls meeting SI criteria – eight (28.6%)
- Surgical/invasive procedure incident meeting SI criteria – seven (25.0%)
- Treatment delay meeting SI criteria – two (7.1%)
- Sub-optimal care of the deteriorating patient meeting SI criteria – one (3.6%)

St James’s University Hospital

At St James’s University Hospital there were 10 serious incidents reported from June 2017 to May 2018. A breakdown of incidents reported is shown below:

- Slips/trips/falls meeting SI criteria – four (40.0%)
- Surgical/invasive procedure incident meeting SI criteria – three (30.0%). Two of these incidents were the never events described above
- Pressure ulcer meeting SI criteria – two (20.0%)
The Trust used Datix to report and capture incidents, complaints, PALS queries, claims and inquest information. Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. Staff informed us that they received feedback following incidents which assisted with lessons learnt and actions taken to prevent recurrence.

Lessons from incidents were triangulated at CSU level and by the corporate lessons learned group at trust level. Each CSU had a named patient safety and quality manager who worked between CSU and corporate levels to share learning. Groups identified key learning from these sources and produced various learning resources including newsletters, bulletins, videos and SBAR alerts. NHSi patient safety alerts were circulated to all areas of the trust, and displayed on the trust intranet.

The most commonly reported serious incidents in surgical services at the location related to slips, trip and falls, and pressure ulcers. We saw from data this was consistent with the types of incidents reported in the wider trust.

We reviewed a sample of completed serious incident root cause analysis (RCA) reports and associated actions plans, which identified areas of good practice and areas of concern, contributory factors and recommendations.

We reviewed NRLS (incident) data at the location for a four-month period (reported between May 2018 and August 2018). We analysed the data and found most of the 64 falls reported occurred in general surgery and colorectal surgery service areas. Of the falls reported during this timeframe, 55 resulted in no harm, six resulted in low harm, and three resulted in moderate harm. Of the low and moderate harm falls, four occurred in urology, three in general surgery, and two in thoracic surgery service areas.

Staff we spoke with described a variety of mechanisms in place to share lessons learned. Senior staff discussed dissemination of fortnightly safety briefs (‘Quality and Safety Matters’) and learning points bulletins; which had focused on a series of topics arising from serious incidents and complaints at trust level. Others mentioned the trust’s lessons learned intranet pages and social media videos produced by CSUs. Surgical staff who attended a focus group also discussed the development of a lessons learned application for smart phones, for staff to download and instantly receive lessons learned from incidents.

Matrons reported they met regularly with their ward leadership and the head of nursing for the surgery division to discuss learning from incidents. Matrons were responsible for sharing lessons learnt at ward level with the senior and junior sister within each ward and their staff. Staff we spoke with on the wards and in the theatres described lessons that had been learnt.

Ward and theatre staff described various ways in which learning was shared about incidents, such as at safety huddles, handovers, and during monthly ward meetings. They described that there were communication folders or monthly bulletins displayed on wards, for staff to see and read; and we saw evidence of these.

Staff in theatres described learning that was shared through “hot topics” team briefs. For example, around flushing and removal of lines and cannula after procedures, and who safer surgery checklist refresher information; and we saw documented evidence of these. They also discussed
learning shared through the monthly theatres newsletter “risky business.”

We were often told on the wards about changes that had been made to assess and observe patients who were at risk of falls, slips and trips, and pressure ulcers (see Assessing and responding to risk section for more detailed information).

We saw that the trust had developed a bespoke RCA document for investigation of falls resulting in fracture, serious head injury or death (dated February 2018); and an associate panel meeting template. The trust had developed a falls prevention action plan (most recent version seen dated to May 2018), which outlined ongoing objectives to reduce falls.

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 demonstrated an awareness of the duty and the importance of being open and honest when delivering care. RCA reports we reviewed demonstrated the duty of candour.

Mortality and morbidity was discussed at regular mortality sub-committee meetings, minutes for which we reviewed. We saw that deaths were screened via the trusts 'Mortality Screening Tool', accessed electronically via on the electronic patient record (PPM+). Screening tool criteria had been extracted from NHSi 'Learning from deaths'. A positive response to any of the criteria (one of which is an unexpected death) triggered a structured judgement review, and reviews presented at departmental mortality meetings. Post mortem results, coroner’s reports and incident investigation findings were used in conjunction with structured judgement review by clinical services to inform learning. Learning from meetings was fed into governance meetings and to the Mortality Improvement Group to extract any themes.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 84 new pressure ulcers, eight falls with harm and 13 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for surgery.
The prevalence rate of pressure ulcers in patients surveyed generally remained similar over time, except in June 2017 when a higher prevalence rate was recorded. Trends in total falls and CUTIs cannot be commented on due to the small numbers reported.

(Source: NHS Digital)

The trust submitted safety thermometer data; however, the results were not on display to the public. Instead, each ward displayed ward health check dashboards. Senior staff told us that safety thermometer results were usually displayed in the rooms used at ward level by staff. Staff informed us that safety thermometer results were discussed at clinical governance meetings and information fed back at ward level.

**Is the service effective?**

**Evidence-based care and treatment**

We saw trust policies and pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

The surgical division had care plans and pathways for a number of conditions including stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis; based on the acute Bufalo toolkit screening tool and care protocols.
Integrated pathways were in use for patients undergoing day surgery procedures including documentation to assess risk such as venous thromboembolism (VTE). Enhanced recovery pathways were in place, for example for patients undergoing elective joint replacement surgery.

The safety and outcomes sub-group received a six-monthly report giving an overview of the trust’s compliance with NICE guidance. Any non-compliance had to be presented to the safety and outcomes sub-group, prior to approval by the quality assurance committee.

New guidance was monitored through clinical governance meetings and we saw evidence of this through a review of clinical governance reports. For each piece of guidance, a nominated lead within the CSU completed an assessment of the trust’s compliance, and actions were put in place to achieve compliance with any recommendations not met.

Staff accessed policies, procedures and other guidance through the trust intranet. We reviewed policies and found them to be in date with version control and a named author.

Audits were undertaken for the completion and accuracy of care bundles, the use of NEWS, medication and documentation such as those which related to infection prevention and control. The results were collated monthly for all ward and reported via the ward metrics system. We observed results on display on all wards inspected. Individual wards would choose a hot topic monthly to review practice to ensure all training was embedded and the ward culture was consistent surrounding learning.

The surgical division participated in a number of national audits.

**Nutrition and hydration**

We reviewed care plan documentation and risk assessments of nine patients and found the majority (eight in each instance) of fluid balance charts and nutritional risk assessments completed appropriately.

Monthly ward Health-check data for Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 92% compliance for nutrition, and 97% compliance for hydration.

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Staff used the Malnutrition Universal Screening Tool (MUST) tool to identify adults who were malnourished or at risk of malnutrition. Patients were assessed regarding their nutritional needs and these were recorded in care plans; patients were referred to the dietician for additional advice if required. We observed protected meal times were in place and saw patients supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking.

Patients typically gave positive feedback about the variety and quality of food choices available. Individual multicultural patient needs were catered for including, vegetarian, vegan and halal choices. Drinks were readily available and in easy reach of patients. Patients assured us that food was warm, fresh and of good quality.

However, a patient who had been admitted to the surgical assessment unit told us they had been on the ward for 28 hours and had not been given any food. In addition, that none of the nursing staff or doctors had explained why to them. We also spoke with a diabetic patient in the surgical assessment unit who had not had anything to eat or drink for six hours. Both instances were raised with senior staff.
We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that St James Hospital scored 96.94% for ward food assessment.

Current guidance recommends fasting from food for six hours and fluid for two hours. Records we reviewed showed patients had adhered to fasting times prior to surgery going ahead. Staff on some wards mentioned recently gaining access to fasting link nurses, who attended study days and offered teaching around fasting on the wards.

We saw records in notes for patients who received nutrition via nasogastric tubes, including the day and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained.

We saw that the theatres and anaesthetics CSU had led a ‘Think Drink’ campaign, aimed at reducing pre-operative fluid fasting times. This was being rolled out across the trust, who reported it had significantly reducing fasting times in the areas in which it had been launched. We saw patient information leaflets during our inspection advertising the campaign.

Data provided by the trust showed that of patients surveyed, most patients had been provided fasting information in written and verbal form, or in written form; a minority (two) reported only receiving verbal information. 98.8% of patients were aware they had to fast before surgery. Most patients (86%) found the information clear and helpful enough; 10% were unsure, and 4% disagreed. Following the ‘think drink’ campaign, most patients (69%) reported they did not feel thirsty (24%) or a little thirsty (45%); 17% reported they still felt thirsty, and 14% reported they felt very thirsty.

The trust provided us with fasting audit data, collected in July and August 2018. We saw that audits noted the last time the patient drank, and time to anaesthetics. We selected 20 cases at random from specialities at the location reported in August 2018 and found the majority appeared within reasonable range. Time since last food was not recorded, so this could not be assessed.

Pain relief

Staff used a pain-scoring ladder tool to assess patient’s pain levels; staff recorded the assessment on paper and electronic records. We saw evidence of pain scores in patient documentation reviewed.

Some surgical patients received intravenous patient controlled pain relief post-operatively. This was in line with national best practice guidance from the British Pain Society.

We reviewed care plans related to pain management. Pain assessments were carried out and recorded in patient notes. Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief was accessed through medical staff, if required.

Most patients we spoke with had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. Most patients we spoke with informed us they had been told by staff that if they felt they need additional pain relief to raise this immediately.

Two inpatients we spoke with told us they had informed staff they felt they needed additional pain relief which was immediately given. We were assured about the assessment of pain for those patients who may not be able to communicate were in pain.

However, during our visit, some patients waiting in the surgical assessment unit expressed that they had not received, nor had they been asked about pain relief. For example, we spoke with one patient who said they had been waiting for six hours to be seen and needed pain relief, but had not been seen by staff to raise this. We raised this with staff. We also spoke with another patient
who had been admitted to the ward who explained they had been given morphine for their pain but felt they needed additional pain relief. However, because no staff had enquired as to their wellbeing they had been unable to raise this with anyone.

Staff on some wards (for example, acute surgical wards) said that pain link nurses were available to contact for advice and support, and the pain management team was available Monday to Friday.

Monthly ward Health-check data for the Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 97% compliance for pain management.

**Patient outcomes**

From February 2017 to January 2018, all patients at St James’s University Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Patients in all of the top three specialties (based on count of activity) at the hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - St James’s University Hospital**

![Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

All patients at St James’s University Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Two of the top three specialties (based on count of activity) at this hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average (general surgery and urology) but thoracic surgery had a higher than expected risk of readmission.

**Non-Elective Admissions - St James's University Hospital**

![Non-Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics)
In addition to national audit action plans described below, we reviewed action plans resulting from ‘Getting It Right First Time’ (GIRFT) audit and review activities for a range of specialities. Many of these incorporated patient outcome findings from national audits. The trust provided us with a sample of GIRFT action plans for general surgery; urological; thoracic (including resection); vascular; ear, nose and throat; oral and maxillofacial, oncological; and ophthalmological surgery. Actions plans detailed a summary of issues identified, actions to be taken, named individuals responsible, review dates, and updates as of July 2018. These are described where relevant.

National Bowel Cancer Audit

The National Bowel Cancer Audit (NBOCA) was published December 2017, and reported results for patients diagnosed between 1 April 2015 and 31 March 2016.

In the 2017 NBOCA report, 72.3% of patients undergoing a major resection at the trust had a post-operative length of stay greater than five days. This was worse than the national aggregate. However, better than the 2016 report performance figure, which was 76.6%.

The risk-adjusted 90-day post-operative mortality (2017 report) rate was 3.8% which was within the expected range.

The risk-adjusted two-year post-operative mortality (2017 report) rate was 16.8% which was within the expected range. The 2016 figure was 28.1%.

The risk-adjusted 30-day unplanned readmission rate was 12.8% which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma (2017 report) rate in rectal cancer patients undergoing major resection was 63.7% which was a negative outlier; and an increase on the 2016 report rate of 62.1%.

(Source: National Bowel Cancer Audit)

The NBOCA indicated for two subsequent reporting years that the trust was an outlier for 18-month stoma rates. The trust submitted information that detailed the specialty had conducted a detailed review of individual cases, taking into account the complex referrals to the specialist centre and have revised their local governance arrangements, including weekly review of cases.

It noted that the national analysis calculated an adjusted stoma rate of 64% and an unadjusted rate of 67%. The findings noted that if the 13 tertiary referral cases were excluded from the analysis the service’s 18-month stoma rate would be 57%. Overall, the findings indicated that the procedures undertaken were reasonable when considering case presentation. However, it was noted that this was something the service planned to monitor and try to improve.

We saw that the ‘Getting It Right First Time’ action plan for general surgery highlighted concerns that the trust’s role as a regional centre resulted in higher than average rates of formation of permanent stoma. This was reported on and reviewed by the trust’s Quality Committee. In June 2018, the service also reported on the NBOCA (2017) at the trust's Safety and Outcomes meeting, where it was proposed that a further case review would be undertaken in areas where the trust was identified as an outlier.
National Emergency Laparotomy Audit (NELA)

We reviewed a summary of learning from the National Audit Report: National Emergency Laparotomy Audit (NELA) published July 2016 (covering year two data inputted from December 2014 - December 2015; based on 681 cases).

NELA is a mandatory national audit covering all patients undergoing emergency bowel surgery. In Leeds this equates to approximately 400 patients per year; the trust being one of the largest in England for patient case numbers.

Overall, data showed the service partially met many key standards of care; with evidence of improved performance over the two-year period. Data showed the service was a positive outlier for final case ascertainment (100%), risk documentation (72%), length of stay (median 10.2 days), and 30-day mortality (10.2%). However, the service was identified as an outlier for medical care of the older person (5% compared to a national average of 10%), arrival in theatre in time appropriate for urgency (78%), consultant delivered preoperative assessment for mortality risk of greater than 5% (45% compared to a national average of 57%), and direct consultant supervision in theatre for mortality risk of greater than 10% (53%).

We observed an action plan dated to Jan 2017, presented to quality management group in February 2017. Actions taken included, implementing a coordinator role; involvement with regional hospitals in the Northern Collaborative to share learning; and liaison with medical care of the older person colleagues.

We also reviewed a summary of learning from the National Audit Report: National Emergency Laparotomy Audit (NELA) published October 2017 (covering year two data inputted from December 2015 - December 2016). We saw that outcomes had typically improved or within range compared to the previous reporting year. For example, in relation to: adjusted 30-day mortality rate (9%), final case ascertainment (90%), risk documentation (72%), arrival in theatre in time appropriate for urgency (84%), consultant delivered preoperative assessment for mortality risk of greater than 5% (44%), direct consultant supervision in theatre for mortality risk of greater than 10% (58%), and median length of stay (11 days).

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA) report, the age and sex adjusted proportion of patients diagnosed after an emergency admission at the trust was 5.5%.

Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 7.9%.

The 90-day post-operative mortality rate was 5.3%. This was within the expected range. The 2015 rate was 6.1%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.3%. This was significantly lower than the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit report 2016)

In the 2017 National Oesophago-Gastric Cancer Audit (NOGCA) report (which reports on patients diagnosed from 1st April 2014 to 31st March 2016), the age and sex adjusted proportion
of patients diagnosed after an emergency admission at the trust was 1.2% (an improvement on the previous year’s figure of 5.5%).

The 90-day post-operative mortality rate was 4.2% (2017 report), an improvement on the previous year’s figure of 5.3% (2016 report).

The 2017 report showed that the proportion of patients treated with curative intent in the Strategic Clinical Network was slightly lower than the national average of 38.7%; but an improvement on the previous year’s figure of 34.3% (2016 report).

**Lung Cancer Clinical Outcomes**

The location is home to a high volume stand-alone thoracic unit undertaking 302 resections for primary lung cancer in 2015, the most recent year with validated data submitted to the Lung Cancer Clinical Outcomes Publication, 2017. This made the unit the firth largest in the country in terms of patient numbers. Notably, Yorkshire has one of the highest resection rates for primary lung cancer in England (second highest according to 2015 data).

Excision of lung within the thoracic surgery department was flagged up as a potential excess mortality following a planned audit project on enhanced recovery. This was later verified by the service’s regular review of the Dr Foster database which the trust uses to benchmark outcomes. In the 12-month period to January 2017, 13 deaths were observed in this group of patients. This equated to a mortality rate of 2.8%. The expected number of deaths was 5.3 (1.2%).

Following the alert, we saw that data was presented to the Thoracic Surgery Mortality and Morbidity meeting on 26 April 2017.

In addition, a report on findings from the Dr Foster mortality outlier alert for ‘excision of lung’ the trust was presented to the Mortality Improvement Group in October 2017. The report detailed that the result was externally reviewed, and the results of this review were that there was no evidence of any particular concerns and all aspects of surgical care were carried out to a high standard.

We saw that a detailed case note review for patients who died following surgery has been undertaken, prompted by an increase in the number of deaths over that expected. An interim mortality case record review for each patient was shown, followed by a table summary of cases.

Findings showed that some cases were incorrectly classified due to coding error. In other cases, it was noted that patients were felt to be at higher than average risk of death when taking into account their individual risk factors. The report concluded that it was perhaps inevitable that the approach led to operating on more high-risk patients (and hence the higher mortality rate).

Recommendations from the review included a targeted smoking cessation service to reduce Postoperative Pulmonary Complications, and multidisciplinary management and universal assessment of high risks patients at a specialised clinic.

**Patient Reported Outcome Measures**

In the patient reported outcomes measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance was similar to the England performance for all metrics relating to hip replacement, knee replacement and varicose vein.

Performance on groin hernias was about the same as the England average for improvement in patient outcomes. Performance was better for the proportion of patients who had reported worsened outcomes for groin hernia according to the EQ VAS indicator.

(Source: NHS Digital)

**Competent staff**

**Appraisal rates**

At St James’s University Hospital, all staff in surgery had an appraisal completion rate of 88.0% as at June 2017 and 98.0% as at June 2018. A breakdown of appraisal completion rate for nursing and medical staff is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th></th>
<th>Rate</th>
<th>June 2018</th>
<th></th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Required</td>
<td></td>
<td>Completed</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>368</td>
<td>422</td>
<td>87.2%</td>
<td>403</td>
<td>408</td>
<td>98.8%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>86</td>
<td>91</td>
<td>94.5%</td>
<td>94</td>
<td>99</td>
<td>94.9%</td>
</tr>
</tbody>
</table>

Both nursing staff and medical staff met the trust target for appraisal rate as at June 2018. Nursing staff had a higher appraisal completion rate as at June 2018 compared to the previous year, as at June 2017. The appraisal completion rate for medical staff remained similar between the two years.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Staff told us that they received appraisals and found them effective and reflected on their performance and career. They told us that colleagues encouraged them to undertake further courses to develop their skills and knowledge. Staff told us they had completed competency based training, mentorship training and academic degrees.

We spoke with several student / apprentice nurses who had developed through working in the trust. All those we spoke with said that they had been well supported by their mentor, that staff were friendly and approachable, and that they had enjoyed their placement at the hospital.

We also saw that clinical support workers were taking on more responsibilities for patients; which included completing patient records and evaluating their ongoing care. These staff told us that they felt competent in their roles and had received training and competency packages. They felt they were well supported by the registered nurses within the ward environment.

Preceptorship packages were in place for new staff and they were supernumerary for a period of time. Along with this staff were provided with competency packages to ensure the correct skills were observed.

The trust had a clinical education team that provided training and development to staff; and clinical educators were available in surgical specialities.

Staff on ward J83 described undertaking an annual training specific to caring for patients with liver disease; which they said was designed to meet RCN competences (Caring for people with liver disease: a competence framework for nursing, 2015) and NHS England requirements.

Theatre staff described a monthly theatre induction was in place. They also discussed the use of specialist induction packs for new starters. Staff told us that in-house link practitioners ensured members of the team completed the specialist induction pack within six months of starting; and this was checked and revisited by the education team. Established staff said they received priority training according to speciality, and described competencies were refreshed a minimum of every two years.

The trust provided us with falls theory and competency assessment training data at CSU level, for May 2018 to July 2018. The Falls Prevention Group Action Plan (dated May 2018) stated that 85% compliance was required by July 2018, 09% compliance by August 2018, and 95% compliance was required by September 2018. Data reviewed showed that relevant CSUs were close to meeting or had surpassed targets by July 2018.

Within the Abdominal Medicine and Surgery CSU, data showed compliance for completion of falls theory & competency assessment training was 82%, and compliance for falls theory training was 95% as of July 2018.

Within the Theatres & Anaesthesia CSU, data showed compliance for completion of falls theory & competency assessment training was 85%, and compliance for falls theory training was 96% as of July 2018.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision with regular meetings.

**Multidisciplinary working**

Nursing and medical staff reported good multidisciplinary (MDT) working and all surgical wards participated in multidisciplinary ward rounds. This, they said, resulted in a co-ordinated approach to treatment plans and decisions. We observed MDT working on inspection; teams worked collaboratively together using clear, concise communication.
There were established MDT meetings for discussion of patients on specific pathways or with complex needs; this included attendance from consultants, specialist nurses and radiologists. Multidisciplinary safety huddles took place each morning to discuss patient care and identify risks as well as to share other information. Physiotherapy, occupational therapy staff and discharge planners supported wards throughout SJJUH and helped with continuity of care.

Specialist and link nurses were available to review patients in specialties, such as respiratory and diabetes, physiotherapy, tissue viability, speech and language, pharmacy, child and adolescent, critical care outreach nurse (CCOT) and adult mental health liaison.

Allied health professionals confirmed there was good multidisciplinary working and offered training to nursing staff where appropriate. Dieticians completed daily reviews of those patients referred for their input.

There was a multidisciplinary approach to assessment and discharge, which was facilitated by dedicated discharge co-ordinators. A discharge planning meeting was held each morning, Monday to Friday supported by the ward manager, physiotherapist, occupational therapist and a discharge coordinator. Individual patient needs were discussed and discharge planned accordingly with support of a social care charity (the Red Cross).

**Seven-day services**

Surgical services ensured there was a seven-day consultant rota providing dedicated and on-call cover.

Staff had 24/7 access to a full range of diagnostic services such as, x ray, computed tomography (CT) scans or magnetic resonance imaging (MRIs); and no services we visited reported issues with seven-day access to diagnostic services.

The critical care outreach team covered both hospital sites, providing 24 hours cover every day. The team supported patients stepped down from critical care and reviewed deteriorating patients that had been referred to them.

The speech and language therapy team worked Monday to Friday 08:30 to 16:30; however, there was no cover at weekends.

The physiotherapy and occupational therapy services offered a five-day service with some dedicated presence at weekends. Teams worked with care support workers on the wards to continue rehabilitation over the weekend. Staff told us that they had contact details of out of hours support.

A pharmacy service was available 24/7: the dispensary was open 8am - 8pm Monday to Friday, with an on-call pharmacist available outside these hours.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, seven days a week with all adult patients.

**Health promotion**

Health promotion information was available on all wards we visited. This included display boards and information leaflets. We saw information displayed on topics such as smoking cessation, healthy eating, drugs, and infection prevention and control.
A range of patient information leaflets were available for patients and families. These included those on preventing blood clots, preventing bed sores and pressure ulcers, and medicines management. However, we noted that a number of these had past their review date.

Support was available for patients with smoking cessation which was discussed with patients as appropriate. There were also procedures in place to support patients withdrawing from drugs or alcohol, and the pharmacist gave advice and support when necessary.

We also saw a smoking cessation programme was in place for liver transplant candidates, which began at pre-assessment. Tailored information about the increased risks for smokers undergoing surgery as well as the increased cancer risk in immunosuppressed patients post-transplant was provided.

The liver transplant team had also increased their focus on supporting patients to remain well while they were awaiting transplant, and increase their level of fitness (if appropriate). Patients were encouraged to exercise in a way that is within their capacity and are provided with an exercise journal to document this.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that as of June 2018 Mental Capacity Act (MCA) training was completed by 90.6% of staff in surgical care at St James’s University Hospital compared to the trust target of 80%.

MCA training was completed by 95.4% of nursing and midwifery staff in surgery services. A breakdown of MCA training modules for nursing and midwifery staff at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act level 1</td>
<td>198</td>
<td>205</td>
<td>96.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>172</td>
<td>183</td>
<td>94.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

MCA training level 2 training was completed by 63.9% of medical staff in surgery services. Only level 2 MCA training was completed by medical staff as shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>99</td>
<td>155</td>
<td>63.9%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We saw that the trust had an up to date policy dealing with consent and mental capacity.

Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. At our previous inspection in 2016, we found that consent to surgery was
most often done on the day of surgery, and that patients didn’t always get a copy of their consent form. At our recent inspection, records we reviewed showed that patients had given both verbal and written consent to surgery in line with trust policies and procedures and best practice and professional standards; however, we observed that patients were not always provided with a copy of their consent form when discharged (as these sometimes remained in patients notes).

We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients. First and second stage consent was adhered to for both elective and acute admissions.

The trust provided us with the corporate audit report, consent audit for quarter two 2017/18 (dated to November 2017). It was expected that each specialty identified 10 cases where consent had been obtained from patients in relation to the care and treatment provided to them using the trust consent form 1, 2 or 4 (patient agreement to investigation or treatment). As of November 2017, 31 (76%) specialties uploaded findings to the Clinical Audit Database.

The trust provided a sample of consent audit results. However, only one related to surgical services at this location. Upper GI and pancreatic surgery specialty consent audit results showed good performance overall (for example, in relation to health professional completion, evidenced discussion of risk and benefits, and patient signature). However, some patients (20%) did not date the form or sign their name (40%). In all cases, consent was taken by the person performing the procedure (70%) or someone qualified to do so (30%).

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff we spoke with were able to give a clear explanation about capacity assessment and the importance of recognising how ill health can impact on a patient’s capacity. Staff we spoke with were aware of the legislation around Deprivation of Liberty Safeguards (DoLS); and how to make a referral. Staff said that support was available from the safeguarding team if required.

From April 2017 to March 2018, 166 deprivation of liberty safeguard referrals were made from surgical core services areas across the trust. Of these, 47 were made from surgical core services areas at St James’s University Hospital.

Staff told us that there was often a delay once the DoLS application was submitted, and local authorities struggled to meet the timeline of reviewing the patient between seven and 14 days. The trust had implemented a flowchart for staff to follow for if this occurred.

Staff we spoke with said that they had access to mental health referral pathways and would use these if they had concerns about any patients.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of care records in line with national best practice.

The trust informed us that they have implemented a new digital way to ensure patients’ wishes about their care in an emergency are known, shared and respected. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is an emergency care plan to support conversations and record recommendations arising from discussion between clinician and patient or those close to the patient. The trust informed us that the data is easily accessible by all clinicians at Leeds Teaching Hospitals, and by other healthcare organisations in Yorkshire.
Is the service caring?

**Compassionate care**

We spoke with 23 patients in assessment units, and on surgical wards and in theatre areas at the location. Almost all in-patients with spoke with on the wards and patients in theatre areas said they were happy with their care; and many expressed that staff were working exceptionally hard to deliver good quality care.

The vast majority of these patients we spoke with told us staff frequently enquired as to their wellbeing and comfort. On the wards, patients explained they would be asked if they were in pain, if they wished to be sat up or laid down and how they were generally feeling.

Most patients we spoke with said that staff were very caring, kind and attentive. For example, staff were described as “respectful and courteous” “polite” “very accommodating” “can’t praise [staff] enough”, and “amazing staff, kept me going”. Similarly, they often commented that the wards were a nice environment to be in; “comfortable”, “best ward I’ve been in, and I have extensive experience!”. Many also expressed they were “very happy with care”, and there was “good quality of care”.

We observed staff in these areas caring for patients and saw that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.

Of the very few patients within these areas who expressed (minor) negative opinions of their care (for example, “bit rushed”), most caveated responses with comments that indicated staff were performing well under pressure; for example, “not many staff but give impression of coping well”.

However, during our unannounced visit several patients waiting to be seen in or admitted to the surgical assessment unit expressed dissatisfaction with the quality of care received.

During one of our visits to the surgical assessment unit, we observed several patients waiting to be triaged by the duty doctor. Many of the patients we spoke who were waiting felt they had been waiting a long time, and were not clear why, or how much longer they would have to wait.

Staff informed us that the night shift had been extremely busy with two high priority patient admissions with ischaemic bowel diagnosis, which required urgent assessment and treatment.

Following our inspection, we received information from a member of the public who had attended the surgical assessment unit around the same time as our inspection. The person described that the assessment unit was not sufficiently staffed to cope with the numbers of patients it was dealing with, and did not have the physical capacity to respond in a dignified manner to the needs of sick patients; some of whom were at times literally sitting on the floor for want of proper seating and beds. The result, they said, was that staff were over-whelmed and stressed, whilst the standard of patient care fell to low levels.

We spoke with patients who had been admitted to the surgical assessment unit about the care they had received. We found not all the patients we spoke with told us they felt safe on the ward because no staff had been to enquire about their wellbeing. One patient we spoke with was expressing concern as to where her husband was because they had not seen them since they had been admitted, and they had no mobile phone or money with them to make a phone call to contact them. The patient told us no members of staff had spoken to them to how they were, or they would have mentioned this.

In addition, not all the patients we spoke with in the surgical assessment unit felt the staff on the
ward treated them with kindness and were compassionate, courteous and respectful; because of a lack of explanation as to why they were not being provided with food and drink (for example, see nutrition and hydration section), or what their treatment would entail. All patients did tell us that all healthcare professionals within the unit introduced themselves by name and confirmed what the patient would want to be called.

Following our inspection, the trust provided us with a revised standard operating procedure for the surgical assessment unit and a surgical assessment unit action plan (both dated September 2018). The action plan detailed that the number of attenders to the surgical assessment unit had increased by 34% over the previous 12 months, leading to increased waits for patients and a poorer patient experience. Documents included review of pathways for admission, capping of patients admitted overnight (to a maximum of 15) and escalation procedures to be followed should patient waiting / triage times exceed defined limits, and should more than 27 patients be waiting to be seen in the department.

Across all areas of surgical services at the location patients told us that their call buzzers were answered quickly (for example, “bells are answered quite quickly”, “prompt”) and we observed staff use doors and curtains to enhance patient privacy and dignity. Patients admitted to the surgical assessment unit described that when they had used their call bell, staff responded quickly and dealt with their concerns.

Staff we spoke with or observed in all areas displayed an understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Monthly ward health-check data for the Abdominal Medicine and Surgery CSU showed that from July 2017 to July 2018, wards achieved 98% compliance for patient dignity.

We saw that the Theatres and Anaesthetics CSU had trialled a new patient feedback form that included written comments from patients, to gain more insight and detail into patients’ experiences and perspectives. This included deeper dive survey work that showed all patients (100%) felt comfortable during their time in theatre, and all (100%) indicated they were treated with dignity and respect. Written responses were overwhelmingly positive and included comments such as: “Staff very understanding efficient, polite & caring. Thank you all very much!”, “treated very well, very pleased.”, and “kind and helpful staff all round”.

Friends and Family test performance

The friends and family test (FFT) response rate for surgery at Leeds Teaching Hospitals NHS Trust was 40% which was better than the England average of 28%.

A breakdown of response rate by site can be viewed below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total responses</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapel Allerton</td>
<td>1,233</td>
<td>34%</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>7,867</td>
<td>38%</td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>11,813</td>
<td>42%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)
Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

From May 2017 to April 2018 the overall percentage of patients that would recommend the service was over 90% on every surgical ward at St James’s University Hospital, except for the surgical assessment unit (JSUA) which had a lower overall recommend rate of 83%. Wards J45 (colorectal surgery) and J23 (breast surgery) had the highest overall recommend rates at 99%.

(Source: NHS England Friends and Family Test)

We reviewed the Abdominal Medicine and Trauma Governance Meeting minutes for April, June and July 2018. We saw indications that FTT response rates, comments and themes were discussed. However, the minutes did not offer any specific detail about these discussions.

Emotional support

We saw that ward managers and other more senior members of ward staff were visible on wards and relatives and patients were able to speak with them.

During our inspection we observed staff on wards and in theatres providing emotional support and reassurance to patients to minimise their distress. Overwhelmingly, patients, families and carers told us that they felt they received good emotional support from staff; for example, they felt “supported” and “reassured”.

However, several patients we spoke with waiting to be seen in or admitted to the surgical assessment unit told us that staff had not enquired about their wellbeing (as described in the Compassionate care section, above); so, we were not assured patients in these areas were always offered good quality emotional support.
A multi-faith chaplaincy service was available for patients. The chaplaincy team had members from the Christian, Jewish, Muslim, Hindu, Sikh, Buddhist and Humanist faith and belief traditions. We also saw there was a variety of chapels, prayer and quiet rooms available to meet the needs of different spiritual beliefs.

There was a bereavement service in place at the trust, who worked alongside the chaplaincy team and faith communities to help ensure the needs of patients and their families were met.

Staff explained that each ward has a mental health link nurse. Staff reported that although mental health link nurses might not be based on the same ward, that they were available for advice and support when needed.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, seven days a week with all adult patients.

A variety of clinical nurse specialists were available within the surgical service, and attended wards to provide additional support and advice to patients.

At handover meetings we observed, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

As part of an ‘always event’ campaign in 2017/18, the Theatres and Anaesthetics CSU had examined feedback from PALS, complaints data & Picker inpatient survey to develop a patient feedback questionnaire around ‘before and while you sleep’ themes. We saw that the Theatres and Anaesthetics CSU had trialled a new patient feedback form that included written comments from patients, to gain more insight and detail into patients’ experiences and perspectives. Written responses were overwhelmingly positive and included comments such as: “I was very nervous & the theatre staff were very sensitive to that & put me at ease & the whole operation experience was much easier. Thank you everyone!”, and “the staff in both anaesthetic & recovery rooms were very friendly & reassuring”.

We were informed of the Red Cross charity service (social charity) which staff said was an invaluable source for discharge facilitation. The service assisted with arranging meals, house key retrieval service, shopping assistance, and befriending; this supported and provided reassurance for patients nearing discharge. We were also given examples of how the service had gone above and beyond for patients, for example, by arranging to feed the pets of patients in hospital, who had no one else to do this for them.

Understanding and involvement of patients and those close to them

We observed at staff handovers and from interactions staff had with patients that staff discussed patient needs and the needs of those close to them.

We did however, observe an interaction on a general surgery ward in which a patient’s relative approached staff during a safety huddle and ask for an update. Staff informed the relative they were “just huddling” and to “wait there”. The relative looked visibly awkward and could hear private and confidential information that was being discussed by the team. We spoke with the patient’s relative later, who said that they were not impressed by the lack of warmth shown by the team, had received a poor update, and were made to feel very awkward waiting.

We saw dementia awareness boards in a number of areas at the location (including surgical wards) that displayed information about the care needs of people living with dementia.

We saw evidence in patient records that patients and their relatives had been involved in making
decisions about their care and treatment. Where applicable, we saw that relatives were involved in care planning and discharge arrangements for patients.

When we spoke with patients on wards and in theatres the majority told us that they knew what their planned care was for, had been informed in a way they could understand, had felt involved in decision making, and were given the opportunity to ask questions. For example, “ask rather than tell, always listen to ideas … kept informed” and “feel involved in decision making”.

Patients we spoke with who had been admitted to the surgical assessment unit told us staff always asked if they understood what had been said when discussing their treatment and confirmed if they were happy to be examined. One patient told us they felt they had been involved in the decision-making processes in relation to their treatment because doctors had provided them with a range of options to consider and explained these to them. However, two patients we spoke with said they did not feel they had been involved in the decision-making processes in relation to their treatment because staff had not explained what treatment they were proposing.

We saw that the Theatres and Anaesthetics CSU had trialled a new patient feedback form that included written comments from patients, to gain more insight and detail into patients’ experiences and perspectives. This included deeper dive survey work that showed 95% of patients surveyed said that medical procedures were explained in a way they understood; and 100% said they felt comfortable asking for explanations of anything they did not understand.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Surgical service CSUs provided elective (planned) and non-elective (acute) surgical treatments for patients.

The leadership team described a number of ways in which the service had been designed to meet the needs of local people following discussions with local commissioners; and the trust was home to a number of tertiary referral centres for the region.

There was collaborative working between NHS trusts, universities and the local authority to improve patient outcomes.

We also saw the trust had been working with charities to supply the hospital with clothing for patients to wear during their stay. In Bexley wing, there was a boutique where patients could also use clothes that had been donated.

**Average length of stay**

**St James's University Hospital - elective patients**

From March 2017 to February 2018, the average length of stay for all elective patients at St James's University Hospital was 4.5 days, which was similar to the England average of 3.9 days.

All of the top three elective specialties (based on count of activity) had a length of stay similar to the England average.
Elective average length of stay - St James's University Hospital

Note: Top three specialties for specific site based on count of activity.

St James's University Hospital - non-elective patients

The average length of stay for all non-elective patients at St James's University Hospital was 5.7 days, which was similar to the England average of 4.9 days.

Two of the top three non-elective specialties (based on count of activity) had a longer length of stay than the England average (general surgery and urology). The non-elective length of stay for thoracic surgery was similar to the England average.

Non-elective average length of stay - St James's University Hospital

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

Assessments took place on admission and during pre-assessment to identify individual patient’s needs and this information was used to inform care planning. We were assured that staff were aware and responsive to the needs of different people.

We saw a wide range of literature and resources available for people living with and caring for people with a dementia. The trust had a lead nurse for dementia and patients were screened on admission for dementia, depression or delirium.

Wards and patient areas were accessible for people who used a wheelchair or walking aids. Disabled toilets and showering facilities were available in all the areas inspected.

The trust’s electronic systems permitted staff to flag patients with a learning disability. In addition, symbols were used on boards next to patients’ bedsides to identify patients’ needs, such as learning disabilities or living with dementia.
The trust told us they had a lead professional for learning disabilities and autism. Staff we spoke with felt confident in caring for patients who may need additional support.

Side rooms were used for patients who were particularly anxious, living with severe autism or a learning disability, or those patients who needed isolation. Staff told us a MDT meeting was held to plan these admissions. This minimised distress to the patient as far as possible.

Staff on wards gave examples of reasonable adjustments made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients’ care and emotional needs. This was confirmed through feedback from patients and relatives during the inspection.

One patient we spoke with on an acute surgery ward described he was the main carer for his wife, who had dementia. He explained that when he was admitted he was very worried about how his wife would cope. The patient described that staff had facilitated the placement of his wife into respite care on the same day. We discussed this with staff and they said that they had identified that it appeared unsafe for the gentleman’s wife to be left at home alone, and they had contacted the medical social worker who arranged the placement.

We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted that St James Hospital scored 88.43% for the disability domain, and 91.37% for the dementia domain. However, results were at hospital level, and not necessarily related to surgical services.

Each patient had a board at their bedside which indicated their preferences, for example what they liked to be called and dietary requirements. Different food choices and chaplaincy for different religions and faiths were available.

Staff were proactive in planning for the needs of bariatric patients. This was identified at pre-assessment and all necessary equipment was obtained in advance of surgical procedure.

Patients with diabetes were put on a specific insulin care plan and there was mandatory training on insulin administration.

A discharge team worked with other agencies and social services to develop packages of care, taking mental health needs into consideration.

Translation services were available and staff knew how to access these. Information leaflets were available for patients; however, we could not see these readily available in languages other than English. Nevertheless, we were informed that the trust had an online system where patients could request translation of information.

Members of our team visited the surgical admission unit at the location on three occasions during our inspection. On the second occasion we visited, we observed a woman housed in a four-bedded bay with male patients, and felt this compromised their privacy and dignity. We also noted that there was a spare bed available in a female bay. We requested the attendance of the senior management team to the ward. They talked to us about the process of declaring mixed sex accommodation breaches. Following this discussion, we were not assured there was a formal process in place to record the decision to admit time or to consider the possibility of mixed sex accommodation breaches in this area.

Following our inspection, the trust provided us with a draft ‘Same Sex Accommodation Procedure’ (this was dated to 07 September 2018, and showed the procedure was awaiting Executive Director approval; planned for October 2018). The trust also provided us with a revised standard operating procedure for the surgical assessment unit and a surgical assessment unit action plan.
(both dated September 2018). The SOP detailed that all patients in bedded areas on the assessment unit must always adhere to same sex accommodation; and an action plan to support this was provided.

When we visited the David Beevers Unit, we were concerned that the unit housed male and female patients (post-operative day case and surgical outlier in-patients) on the same ward. Although male patients were situated at one end of the ward, and female patients at the other, we saw that patients were in clear sight of each other; and we were concerned about the privacy and dignity of patients in this area. Following our inspection, we reviewed a document entitled “Issues and Actions raised following the CQC visit August 2018 in DBDU.” We saw that the management team had agreed to trial two ‘Kwick Screen’ “duo” screens that would provide greater privacy for the sub wait area, and one “pro” screen for the ward, for a one-month period. If this was successful, then two screens were to be purchased.

Access and flow

We carried out a focused inspection in December 2017, due to concerns raised regarding the safe use of additional beds in non-designated areas during times of increased demand at the hospital. During our recent visit, we observed beds in non-designated areas; however, we did not see any of these in use. Staff told us that they had not recently had any extra patients in non-designated areas since the winter months.

Patient flow coordinators were in place to help manage the flow through the wards. Representatives from surgical services at the location attended a daily operational (DOP) meeting. This was a multidisciplinary forum, where access and flow throughout the location was discussed; for example, in relation to surgical ward capacity. Representatives from the theatres and anaesthetics CSU also attended to discuss emergency lists, and strategies to manage elective and non-elective surgical capacity. We saw that some patients were in surge beds (for example, in the David Beevers Day Unit); however, no patients were in non-designated areas.

We spoke with patient discharge clerks at the location, who helped facilitate the flow and discharge of patients. Several ward staff we spoke with commended their work, and commented that their appointment had been of tremendous benefit to help improve flow within the system.

We also observed other initiatives to improve patient flow and discharge planning and facilitation in the service. For example, staff we spoke with discussed the use of electronic discharge advice notes (EDAN), which included patient tablets to take out (TTO) on discharge and a GP discharge summary letter. We saw that an initiative called the ‘golden patient’ had been implemented, which worked toward patients being discharged before 12 midday. We were also informed of the Red Cross charity service (social charity) which staff said was an invaluable source for discharge facilitation.

We saw that a multidisciplinary team in the Liver Unit had implemented an enhanced recovery in liver surgery initiative. This had focused on improving prehabilitation and patient education, reducing the physical stress of the operation, a structured approach to post-operative management, early mobilisation, early feeding, and setting daily goals. Results showed that implementation of the programme, there was a 20% decrease of post-operative complications, a decrease in overall length of stay of 28%, and a decrease in overall length of stay for patients over 70 years of age of 35%.

However, during our inspection, we observed a number of medical outlier patients’ resident on surgical wards. For example, on J83 (a general surgery and transplant ward) we saw that there
were three medical outliers, one of whom was an elderly medicine outlier. Staff on the ward told us that the acuity of some medical outlier patients meant they struggled to deliver care.

Our colleagues who were inspecting medicine services at the location visited surgical wards where there were patients who were classed as medical outliers. They reviewed 12 patient’s medical notes which identified that they had received daily reviews from the medical team and consultant reviews between one to two times a week. A patient referral criterion was in place to ensure the correct patients were moved, and patients with cognitive impairment or risk of falling were expected not to be moved. However, they saw some patients had been transferred who were at risk of falls and suffered with confusion.

In addition, we visited the surgical admissions unit at the location during our unannounced inspection. On our first visit to the unit not all the patients we spoke with told us they had seen a doctor in a timely manner. One patient told us they had waited 12 hours in the waiting areas to be admitted on to the ward. We looked at three patients records in more depth and saw that one patient (diagnosed with ischaemic bowel) was admitted and seen immediately. However, we observed two patients had waited for long periods of time. One patient had arrived at accident and emergency, and approximately four and a half hours later was registered on the unit; but was not seen by a doctor for a further seven hours. Another patient was referred by a GP, and once registering on the unit waited 10.5 hours to be seen by a doctor.

Following our inspection, the trust provided us with a revised standard operating procedure for the surgical assessment unit and a surgical assessment unit action plan (dated September 2018). The action plan detailed that the number of attenders to the surgical assessment unit had increased by 34% over the previous 12 months, leading to increased waits for patients and a poorer patient experience. Actions included review of pathways for admission, capping of patients admitted overnight (to a maximum of 15) and escalation procedures to be followed should patient waiting / triage times exceed defined limits, and should more than 27 patients be waiting to be seen.

When we visited the David Beevers Day Unit we saw that the ward (second phase recovery area) housed both day case and inpatients. We saw that there were six surgical outlier patients who had been admitted from the surgical assessment unit. The trust provided us with data detailing the number of non-elective (outlier) stays on the ward (see Access and flow, outlier data, further below). This confirmed frequent housing of outlier patients on the ward; in the data sampled, this was most often for more than 24 hours - and sometimes for up to five days. Most patients sampled were transferred from the Surgical Assessment Unit.

Following our inspection, the trust provided an interim SBAR to describe the use of “David Beevers Day Unit (DBDU) for inpatients requiring an overnight stay” (dated 10 September 2018). The trust also provided a document entitled, “Admission/assessment criteria for patients to be cared for in the David Beevers Day Unit” (including escalation protocol) (October 2018). It stated that in-patient transfers to DBDU should have a discharge plan to leave within 23 hours of their admission and adhere to the DBDU transfer criteria. In addition, that no acute admissions from Emergency Department or Surgical Assessment Unit were to be admitted to DBDU. It said that only a General Manager on call (out of hours) could override the transfer criteria. It also stipulated that any patient who may be required to stay as an inpatient for additional nights would require escalation to the appropriate CSU lead.

We reviewed surgical service CSU risk registers (dated to June 2018) and saw entry and monitoring of risks relating to medical outliers in the surgical bed base, surge capacity in the David Beevers Unit, and Surgical Assessment Unit capacity. The risk was entered in April 2017 and scored as 20 (high), and remained scored at 20 at the time of inspection.
Bed occupancy
The trust provided data that showed the number and proportion of beds at the location occupied at midnight, as of 24 August 2018. Data showed a 93.6% midnight occupancy rate at the site.

Theatre Utilisation
The trust provided data that showed average theatre utilisation at the location from August 2017 to July 2018; average monthly session usage was 91%, and in-session utilisation 78% over the period.

Referral to treatment (percentage within 18 weeks) - admitted performance
From June 2017 to December 2017, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average and from January 2018 to May 2018 was better than the England average.

The trust’s performance was generally consistent over time. In the most recently reported month (May 2018) 76% of patients were treated within 18 weeks compared to the England average of 67%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
A breakdown of RTT rates for surgery broken down by specialty is below. Of these, five specialties were above the England average:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>93.7%</td>
<td>80.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>88.3%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>87.9%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>76.8%</td>
<td>70.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>64.9%</td>
<td>63.4%</td>
</tr>
</tbody>
</table>

Four specialties had RTT rates that were below the England average. Two of these, urology (10.1% below England average) and general surgery (14.5% below the England average), related to services provided at the location.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>79.3%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.8%</td>
<td>76.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.3%</td>
<td>72.8%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>58.3%</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Leeds Teaching Hospitals NHS Trust**

The percentage of patients whose operation was cancelled and were not treated within 28 days was consistently higher than the England average from April 2016 to March 2018. Performance deteriorated over time with particularly poor performance reported from October 2016 to March 2017 and from January to March 2018.

**Cancelled Operations as a percentage of elective admissions - Leeds Teaching Hospitals NHS Trust**

Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust was consistently above the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

We reviewed the corporate risk register (June 2018). An entry described that there was a risk that the trust does not achieve the 28-day cancelled operations target due to acute activity pressures,
critical care capacity, availability of theatre time, patient flow and elective bed availability.

At our last inspection of surgical services at the trust, we were told by several staff that a lack of critical care beds had had a significant impact on theatres. Following our recent inspection, we requested cancelled operations data from the trust. As shown below, data showed that from August 2017 to July 2018, 0.3% of all operations at the location were cancelled due to critical care capacity. We also saw that critical care bed capacity had been substantially increased at the location since our last inspection of the service. The most common reasons for cancelled operations were theatre scheduling (5.4%) and ward bed capacity (3.4%).

From August 2017 to July 2018, data showed that 10.9% of all operations at the location were cancelled.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Number or proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cancelled operations</td>
<td>2502</td>
</tr>
<tr>
<td>Total operations completed</td>
<td>20365</td>
</tr>
<tr>
<td>Total percentage cancelled operations</td>
<td>10.9%</td>
</tr>
<tr>
<td>Critical care capacity</td>
<td>0.3%</td>
</tr>
<tr>
<td>Failure of equipment</td>
<td>0.4%</td>
</tr>
<tr>
<td>No anaesthetist</td>
<td>0.2%</td>
</tr>
<tr>
<td>No operator</td>
<td>0.5%</td>
</tr>
<tr>
<td>Ran out of theatre time</td>
<td>0.5%</td>
</tr>
<tr>
<td>Scheduling</td>
<td>5.4%</td>
</tr>
<tr>
<td>Theatres</td>
<td>0.2%</td>
</tr>
<tr>
<td>Ward bed capacity</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Out of hours operations

At our previous inspection of the service in 2016, we observed that routine operations out of hours were taking place at the location (SJUH). Following our recent inspection, we saw a standard operating procedure for acute surgery out of hours was in place at the trust (published March 2017, amended/reviewed August 2018). We also requested out of hours operation data for a 12-month period; this was provided for the period March 2017 to March 2018.

We reviewed data provided by the trust and found 304 out of hours operations had taken place at the location from March 2017 to March 2018. Data showed the categories of procedures undertaken. We saw categories of operations listed appeared to relate to immediate and urgent procedures only.

Outliers

Following our inspection, the trust provided us with data that showed the number of patients (spells) where the patient was an outlier at any point during their spell (when the 8am snapshot was taken) for a 12-month period (August 2017 to July 2018). When a patient had multiple outlier stays within the spell, only the first spell was counted. Data was based on the first outlier period (spell). Therefore, it does not show outlier data pertaining to second spells (for example, multiple moves), nor does it tell us how long the outlier stay was for.

The data below shows surgical outliers on non-surgical (medicine) wards for the period August 2017 to July 2018. Data shows on which CSU (medicine ward), and at which location, surgery patients were placed.
The data below shows outliers on surgical wards for the period August 2017 to July 2018. These relate to patients under the care of other service areas who were based on a surgical ward. Data showed the CSU, and location, from which 'non-surgical' area (CSU) the patient came. As can be seen, 3538 ‘non-surgical’ patients were placed on surgical wards at this location over a 12-month period; according to the criteria described earlier (8am ‘snap shot’, ‘first spell’).

At this location, most ‘non-surgical’ patients placed on surgical wards came from emergency and speciality medicine (n2534, 72%) and acute medicine (n530, 15%) CSUs.

Further investigation of the data showed that, the greatest number of (‘first spell’) ‘non-surgical’ patients were placed on surgical wards J42 (short stay elective surgery) (12%), J98 (oncology) (12%), J46 (acute surgery) (11%), and J84 (thoracics and general surgery) (11%).

<table>
<thead>
<tr>
<th>CSU</th>
<th>LGI</th>
<th>SJUH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Medicine and Surgery</td>
<td>5</td>
<td>69</td>
<td>74</td>
</tr>
<tr>
<td>Cardio-Respiratory</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Centre for Neurosciences</td>
<td>15</td>
<td>28</td>
<td>43</td>
</tr>
<tr>
<td>Chapel Allerton Hospital</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>36</td>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>Institute of Oncology</td>
<td>1</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Trauma and Related Services</td>
<td>64</td>
<td>23</td>
<td>87</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>123</td>
<td>138</td>
<td>261</td>
</tr>
</tbody>
</table>

Further investigation of the data showed that, the greatest number of (‘first spell’) ‘non-surgical’ patients were placed on surgical wards J42 (short stay elective surgery) (12%), J98 (oncology) (12%), J46 (acute surgery) (11%), and J84 (thoracics and general surgery) (11%).
### SJUH surgical ward/unit

<table>
<thead>
<tr>
<th>SJUH surgical ward/unit</th>
<th>Number of ‘first spell’ outliers ‘8am snap shot’</th>
<th>Proportion of ‘first spell’ outliers ‘8am snap shot’</th>
</tr>
</thead>
<tbody>
<tr>
<td>J42</td>
<td>420</td>
<td>11.9%</td>
</tr>
<tr>
<td>J98</td>
<td>413</td>
<td>11.7%</td>
</tr>
<tr>
<td>J46</td>
<td>398</td>
<td>11.2%</td>
</tr>
<tr>
<td>J84</td>
<td>387</td>
<td>10.9%</td>
</tr>
<tr>
<td>J23</td>
<td>336</td>
<td>9.5%</td>
</tr>
<tr>
<td>J47</td>
<td>309</td>
<td>8.7%</td>
</tr>
<tr>
<td>J44</td>
<td>222</td>
<td>6.3%</td>
</tr>
<tr>
<td>J45</td>
<td>216</td>
<td>6.1%</td>
</tr>
<tr>
<td>J82</td>
<td>202</td>
<td>5.7%</td>
</tr>
<tr>
<td>J50</td>
<td>160</td>
<td>4.5%</td>
</tr>
<tr>
<td>J83</td>
<td>146</td>
<td>4.1%</td>
</tr>
<tr>
<td>J49</td>
<td>120</td>
<td>3.4%</td>
</tr>
<tr>
<td>J24</td>
<td>114</td>
<td>3.2%</td>
</tr>
<tr>
<td>J43</td>
<td>74</td>
<td>2.1%</td>
</tr>
<tr>
<td>JAL</td>
<td>20</td>
<td>0.6%</td>
</tr>
<tr>
<td>JVRT</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3538</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Following our inspection, the trust provided us with data that detailed the number of non-elective outlier patient spells at the David Beevers Day Unit from April 2018 to August 2018. The tabulated data provided showed the following:

<table>
<thead>
<tr>
<th>Patient spells</th>
<th>April 18</th>
<th>May 18</th>
<th>June 18</th>
<th>July 18</th>
<th>August 18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>98</td>
<td>80</td>
<td>64</td>
<td>68</td>
<td>47</td>
<td>357</td>
</tr>
</tbody>
</table>

We reviewed raw data provided by the trust (March to August 2018), and limited admission status to patients transferred to David Beevers Day Unit ("TransferredtoJDWD"), and where pathways were non-elective, and intended pathway management was as an inpatient. Data showed 135 patients met these criteria. Of these patients, data showed that patients had most commonly been transferred from the Surgical Assessment Unit (79), from ward J46 (acute surgery) (37) and from JAL (surgical admissions lounge) (8).

Data showed the number of days spent as an inpatient on the unit: where 0 equated to less than 24 hours, 1 equated to 24 to 48 hours, 2 equated to 48 to 72 hours, and so on. We saw that 36 patients spent less than 24 hours on the ward, 62 patients spent between 24 to 48 hours on the ward, 21 patients spent between 48 to 72 hours on the ward, 10 patients spent between 72 to 96 hours on the ward, 4 patients spent between 96 to 120 hours on the ward, and one patient spent 120 to 144 hours on the ward.

**Bed moves at night**

From April 2017 to March 2018, the trust reported 2447 ward moves at night (between 22:00 and 08:00) within surgical services at St James’s University Hospital. As shown in the table below, the greatest proportions of these occurred from the surgical assessment unit (JSUA) (33.5%), on acute general surgery wards (J46 9.2% and J47 6.3%), and the admission lounge (JAL) (6.7%).
<table>
<thead>
<tr>
<th>SJUH surgical ward/unit</th>
<th>Number of ward moves at night</th>
<th>Proportion of total ward moves at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>JSUA</td>
<td>820</td>
<td>33.5%</td>
</tr>
<tr>
<td>J46</td>
<td>225</td>
<td>9.2%</td>
</tr>
<tr>
<td>JAL</td>
<td>165</td>
<td>6.7%</td>
</tr>
<tr>
<td>J47</td>
<td>155</td>
<td>6.3%</td>
</tr>
<tr>
<td>J83</td>
<td>126</td>
<td>5.1%</td>
</tr>
<tr>
<td>J43</td>
<td>118</td>
<td>4.8%</td>
</tr>
<tr>
<td>J42</td>
<td>105</td>
<td>4.3%</td>
</tr>
<tr>
<td>J84</td>
<td>102</td>
<td>4.2%</td>
</tr>
<tr>
<td>J82</td>
<td>92</td>
<td>3.8%</td>
</tr>
<tr>
<td>J23</td>
<td>76</td>
<td>3.1%</td>
</tr>
<tr>
<td>J49</td>
<td>74</td>
<td>3.0%</td>
</tr>
<tr>
<td>J50</td>
<td>72</td>
<td>2.9%</td>
</tr>
<tr>
<td>J45</td>
<td>70</td>
<td>2.9%</td>
</tr>
<tr>
<td>J44</td>
<td>69</td>
<td>2.8%</td>
</tr>
<tr>
<td>JDWD</td>
<td>67</td>
<td>2.7%</td>
</tr>
<tr>
<td>J98</td>
<td>61</td>
<td>2.5%</td>
</tr>
<tr>
<td>J24</td>
<td>43</td>
<td>1.8%</td>
</tr>
<tr>
<td>J25</td>
<td>5</td>
<td>0.2%</td>
</tr>
<tr>
<td>JDL</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>VRT</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2447</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Delayed discharges**

From April 2017 to March 2018, the trust reported 0.6% of discharges across surgical services at St James’s University Hospital were delayed. Abdominal medicine and surgery wards (J44, J42, J45, and J46) experienced the greatest proportion of delayed discharges, which ranged from 0.8% to 2.6%.

<table>
<thead>
<tr>
<th>SJUH surgical ward/unit</th>
<th>Discharges</th>
<th>Delayed discharges</th>
<th>Proportion of discharges delayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>J44</td>
<td>772</td>
<td>20</td>
<td>2.6%</td>
</tr>
<tr>
<td>J42</td>
<td>1221</td>
<td>15</td>
<td>1.2%</td>
</tr>
<tr>
<td>J45</td>
<td>722</td>
<td>7</td>
<td>1.0%</td>
</tr>
<tr>
<td>J46</td>
<td>1373</td>
<td>11</td>
<td>0.8%</td>
</tr>
<tr>
<td>J84</td>
<td>1655</td>
<td>10</td>
<td>0.6%</td>
</tr>
<tr>
<td>J23</td>
<td>1501</td>
<td>9</td>
<td>0.6%</td>
</tr>
<tr>
<td>J47</td>
<td>1188</td>
<td>5</td>
<td>0.4%</td>
</tr>
<tr>
<td>JDWD</td>
<td>1392</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>J43</td>
<td>2460</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12284</strong></td>
<td><strong>79</strong></td>
<td><strong>0.6%</strong></td>
</tr>
</tbody>
</table>
Learning from complaints and concerns

The trust had a complaints policy which was located on the intranet for staff to access if needed. We saw that wards and areas we visited had a complaints process that addressed both formal and informal complaints.

We saw posters and information leaflets displayed in ward areas about how to raise a concern; and information was also available on the trust website.

We spoke with staff who could tell us about the complaints process and how they would manage a complaint. Staff we spoke with told us about some complaints and lessons learnt from these; although, they said many of the complaints tended to relate to waiting times and appointments for surgery. Staff said that when complaints arose they would try to handle these locally, where possible and appropriate; escalating them as necessary.

We saw that the Theatres and Anaesthetic CSU had worked to thematically analyse and act on patients’ complaints and concerns. ‘Always events’ involve those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system. As part of an ‘always event’ launch (September 2018), the Theatres and Anaesthetics CSU had examined feedback from PALS, complaints data & Picker inpatient survey to develop a patient feedback questionnaire around ‘Before and while you sleep’ themes.

We reviewed the Abdominal Medicine and Surgery Governance Meeting minutes for April, June and July 2018. We saw indications that FTT comments and themes were discussed. Similarly, we saw indications that complaint themes, numbers and response rates were reviewed. However, the minutes did not offer any specific details; so, we could not assess the depth or quality of these discussions.

Ward managers we spoke with were aware of themes and trends from complaints. Staff we spoke with said that learning from complaints was shared within teams through various methods, these included team meetings and safety huddles.

Summary of complaints

From May 2017 to April 2018 there were 185 complaints about surgical care at the trust. Where the complaint had been closed the trust took an average of 60.0 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 40 days.

St James’s University Hospital

From May 2017 to April 2018 there were 125 complaints about surgical care at St James’s University Hospital. Where the complaint had been closed the trust took an average of 56.3 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 40 days.

The trust has allocated multiple subjects to each complaint received. It is therefore not possible to provide number of complaints per subject.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From May 2017 to April 2018 there were 53 compliments within surgery. A breakdown by location is shown below:
There were 27 compliments within surgery. The most common specialties receiving compliments were:

- Breast surgery – seven (25.9%)
- Urology – five (18.5%)
- General surgery - four (14.8%)
- Ophthalmology – three (11.1%)

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Each CSU was led by a clinical director, general manager and head of nursing; the clinical director had overall responsibility for the CSU. We met with members and representatives of the senior leadership team from three CSUs at this location: Abdominal Medicine and Surgery, Oncology, and Theatres and Anaesthetics.

Due to the sizes of CSUs, there were various matrons that covered different speciality areas. With the exception of those in the Theatre and Anaesthetics CSU, many covered both surgical and medical wards. Staff within CSUs worked closely with other units, and we spoke with some matrons who told us they would cover and support other matrons within their CSU.

Matrons we spoke with during our visit told us they provided support to clinical areas and would visit wards daily to review the staffing and identify any issues that required to be escalated.

Matrons said they attended the daily staffing meetings and provided feedback to the director of operations chairing the meetings.

Ward managers and charge nurses said they had constructive and positive relationships with matrons and that they visited wards daily. Staff felt ward managers communicated well and kept them informed about the management of the wards and service changes.

Staff were encouraged to undertake professional development and received annual appraisals. We saw there was a workforce strategy and people strategy in place at the trust. These outlined development opportunities and pathways for clinical staff; including leadership development.

At ward level, most staff said they were well supported by their managers, they were visible and provided clear leadership.

Most staff told us they would be confident to raise a concern with their managers, and were confident this would be investigated appropriately.

Vision and strategy

CSUs strategies adhered to the trust’s main vision, which was commitment to delivering the highest quality and safest treatment and care to every patient, every time.

The trust vision was supplemented by the five trust goals: to be the best for patient safety, quality and experience; to be the best place to work; to be a centre of excellence for specialist services, research, education and innovation; to offer seamless, integrated care; and to be financially sustainable.
Vision and strategies were supported by the ‘Leeds Way’ values; offering patient centred care, and being fair, collaborative, and accountable. We saw posters throughout the wards and areas outlining the ‘Leeds Way’ were on display giving information to patients and staff about the trust’s values and expected behaviours.

We saw each CSU had its own 2017/18 clinical business strategy, each outlined key quality measures and current performance. We saw each contained a vision for service delivery, subdivided by speciality. In the Abdominal Medicine and Surgery CSU’s clinical business strategy, each speciality had a stated vision, aims/objectives and a strategy to achieve these. For example, hepatobiliary and transplant surgery aimed to increase the rates of both liver and kidney transplants over the next 5 years, and set forth current challenges and ways to overcome these following the UK strategy, ‘Taking Organ Transplantation to 2020’.

The Theatres and Anaesthesia CSU’s 2017/18 clinical business strategy detailed its strategic aim was to “develop a responsive service which delivers a safe, high quality patient experience that is respectful of patients, staff and colleagues”. The service planned to achieve its aims by focusing on the following key areas: Ensuring every patient experiences a safe and quality service, providing a responsive service; which allows flexibility and supports developments in surgery, growing an innovate workforce, and developing the CSU’s research portfolio.

The trust had implemented the Leeds Improvement Method (LIM), working in conjunction with the Virginia Mason Institute and partner organisations, and had supported senior clinicians and managers to undertake the ‘lean for leaders’ programme.

Members and representatives of the senior management team we spoke with were proud of the LIM and how they had used implemented this. For example, members discussed how urology had examined key theatre access and flow metrics and performance indicators, and had reduced length of stay. The work in turn led them to review transurethral resection of the prostate (TURP) operations, robotic surgery and urology pathways; and they now have criteria led discharge. They all shared their involvement in the nutrition project undertaken on orthopaedics and the increased hydration of neck of femur patients.

Members spoke with us about the work they had started to do using the Leeds improvement method in relation to surgical assessment unit. They explained they were in early stages of data collection.

Following our inspection, the trust told us that Abdominal Medicine and Surgery CSU leaders were early graduates of ‘Lean for Leaders’ training, and had supported other CSUs in developing and implementing this.

Members said they shared the improvement work with other CSUs at Friday meetings. They spoke about other rapid improvement projects that had been implemented across services; for example, electronic discharge advice notes (EDANs), information sharing between flow teams, and board rounds. They commented that any staff member can attend the Friday meetings, and they also shared information through a twitter page and on the trust intranet. They also said that this information was shared trust wide through team briefs and audit meetings.

**Culture**

We saw that staff had a positive culture with staff being open, honest, and willing to share information with us on inspection. Most staff told us the division had strong leadership, and senior managers were visible and engaged with staff.
When we spoke with the senior management team, they said the culture was one of working together. They also spoke about improvements in the operating theatres, which had improved standard behaviour and collaboration of teams. This said, had a positive impact on prioritisation of patients.

Charge nurses and ward managers told us that they had appropriate access to senior staff members. The senior management team were proud of staff working within the directorate and their resilience during ‘winter pressures’.

Staff typically expressed that more senior ward staff and managers were approachable and supportive; however, their comments sometimes indicated that senior management did not recognise the impact of staff shortages or added workload of medical outliers in the surgical bed base on the ‘shop floor’ (see Safe, nurse staffing section for further information).

Staff reported there was a strong culture of learning and improvement and training and development was actively encouraged. Senior ward staff were able to access support and leadership courses to help them in leading their services. Student nurses said that they felt supported by their colleagues, mentors and peers.

However, at pre-inspection focus groups some clinical support workers said there was lots of documentation to complete within 18 months for the front-loaded course. They told us there was inconsistent assessment with the provider, and staff often felt unsupported to complete the work necessary. They also told us that when overstaffed, clinical support workers relocations were sometimes not communicated well by managers, which impacted on staff culture.

Junior doctors said they felt supported by more senior staff and peers; however, some felt that the induction process could be improved upon, and several expressed frustrations with rostering.

Despite the challenges, staff generally spoke positively about the service they provided for patients and delivering high-quality care was a priority. All staff were clear about their roles and responsibilities, described delivering patient-focused care, and working well together.

**Governance**

Each CSU had monthly governance meetings, which fed into the executive management group meeting. Senior management teams we spoke with felt that senior leaders were aware of their CSUs risks, concerns and improvements; and we saw evidence of CSU risk discussions and action planning in Risk Management Committee Meeting minutes.

Staff in leadership roles had access to dashboards looking at performance, finance, governance and staff engagement.

CSU governance performance meeting minutes reviewed showed monitoring of mortality and morbidity, performance dashboards, ward metrics, audit progress, and patient outcomes. We reviewed a selection of recent Abdominal Medicine and Surgery, and Theatres and Anaesthetics CSU governance meeting minutes. In the Theatres and Anaesthetics CSU meeting minutes we saw there was a record of attendance, minutes were sufficiently detailed, with ownership of subjects discussed, and who was taking forward any actions. However, the Abdominal Medicine and Surgery CSU minutes we reviewed were not always sufficiently robust; with attendance, date for completion, and who was responsible for leading on particular actions not always clearly recorded in the main meeting minutes. Following our inspection, the trust told us that separate attendance sheets and an action tracker were maintained, however, these were not provided.
Speciality level governance and clinical audit meeting minutes we reviewed showed discussion of ward dashboards, clinical outcomes, best practice guidance and national audit reports, policy and procedure updates at speciality level.

We saw mortality and morbidity was discussed at regular speciality-led governance and clinical audit meetings (for example, at the Joint HPB/Upper GI and Colorectal Governance and Clinical Audit Meeting). We saw discussion of new and pending generic and individual cases for review and learning points. Minutes detailed that actions arising from reviews were monitored through mortality and morbidity action tracking tools.

We saw that ward managers and matrons attended monthly meetings, these were Connecting Leaders In Care meetings (CLIC). The meetings were approximately for three hours where staff received feedback from the chief nurse. Professional briefings and education sessions on patient care topics were discussed. We saw from the chief nurse briefings that positive feedback was received and information shared regarding incidents. In June 2018, we saw that information was circulated about the use of medical air instead of oxygen.

Ward sisters, senior managers and clinical leads displayed knowledge, skills and experience. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.

**Management of risk, issues and performance**

We reviewed risk registers for all CSUs where there was a surgical base at the location. Each risk had an initial, current and a target risk rating. The date that risks were added were included, and review dates were seen. Each risk had existing controls, gaps and mitigating actions. We saw that key risks identified by ward managers we spoke were included on the risk registers; for example, in relation to staffing, medical outliers, cancellations, and increased length of stays.

Senior staff and management teams were aware of risks facing services, and had plans in place to improve patient care. For example, they discussed various workforce strategies (such as band four practitioners) to mitigate registered nurse staff shortages, and the appointment of advanced nurse practitioners.

The management teams discussed the demand for surgical assessment and the need to see patients in a timely way, and they spoke with us about the effects of cancellations on patients and the service over the winter period. They also discussed patient ward moves at night, outlier patients, and constrained capacity within the surgical bed base.

We spoke with senior management teams about the David Beevers Day Unit and a head of nursing said that the unit was currently working on a duel basis, and patients were staying longer than the agreed 23 hours. Following our inspection, the trust shared an updated standard operating procedures and criteria for admission; to limit the number and acuity of patients placed on the unit.

We also discussed the Surgical Assessment Unit, access and flow, criteria for admission, and triage processes. Following our inspection, the trust provided us with a revised standard operating procedure for the surgical assessment unit and a surgical assessment unit action plan (dated September 2018); which detailed revised pathways for admission, limiting the number of patients admitted overnight and escalation procedures to be followed should patient waiting / triage times exceed defined limits.

However, on balance, we were not always assured there was sufficient oversight of action plan implementation within the service; and that decisions made at senior level translated into tangible and sustainable changes on the ground. For example, with respect to the number and type of
patients admitted to the David Beevers Day Unit, access and flow in the surgical assessment unit, consideration of the possibility of mixed sex accommodation breaches in the service, ensuring compliance with VTE assessment within 24 hours of admission, deviations in WHO surgical safety checklist compliance, and monitoring of the refrigeration of medicines. We noted that many of the issues highlighted had been raised at our previous inspection of the service, or following subsequent monitoring and engagement activities.

Medical leads we spoke with discussed risks around gaps in established training rotas and deanery pressures; and cited mitigating actions such as increasing staffing on the senior fellows’ programme and the Medical Training Initiative (MTI) programme. Senior management teams spoke with us about other local developments to improve performance that the trust had been involved in, such as local deanery training, trust based surgical rotations, and physician’s assistants.

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

Following our inspection, we asked the trust to provide us with risk management strategy documents for surgical clinical service units or specialities in the service. However, these were not provided. Therefore, we could not be assured that these were in place.

**Information management**

Information management systems were used effectively for patient care and for audit purposes; to monitor and improve quality.

Computerised whiteboards were in use in clinical areas, these contained patient information that staff could be reviewed instantly. They showed when observations were required to be completed, and provided indicators and flags when these were not managed appropriately.

Computers were available on surgical wards. During the inspection, all computers were locked securely when not in use. Staff accessed information relating to polices and guidance electronically. The system was easy to navigate.

Concerns around the secure storage of records had been raised at our previous inspection of the service in 2016. At our recent inspection, we saw that patient records were all stored in areas that were secure or observed and we did not see any patients notes left unattended.

Staff received training on information governance and were aware of the importance of managing confidential patient information. Information provided by the trust showed that 75.9% of medical staff and 98.2% of nursing staff at the location had completed information governance training. Medical staff training compliance rates were slightly below the trust’s target level of training of 80%.

We saw that increasing the use of information technology was part of the trust’s vision. The Leeds digital way provided a summary what this would include. Further risk assessments had been launched onto the patient’s electronic record, these included nutritional screening tool for malnutrition. We saw at our inspection that staff completed this online and communications to support staff to complete it electronically.

The trust informed us that they were one of six demonstrator sites for ‘Sacn4Safety’; an electronic programme that utilises standards to associate and track patients, products, places and processes. December 2017 saw the completion of the two-year programme phase; and the trust informed us implementation was ongoing to ensure maximum benefits are realised.
Engagement

The trust conducted an annual staff survey, which had informed a staff survey action plan for 2018/19. Leadership teams and managers told us they provided regular updates to staff regarding staffing levels, and how these were progressing.

The trust had an annual awards event where staff were nominated and received awards. Each of the CSUs also held events to celebrate the successes within the units. For example, a member of the Abdominal Medicine and Surgery CSU had been nominated for nurse of the year, and the Urology team won a time to shine award for sustainable service.

We saw that staff were involved in changes at the trust and within the CSUs; and were engaged with different Leeds Improvement Method workstreams. Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.

People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and the Patient Advice and Liaison Service were available in all ward and reception areas. Internet feedback via NHS choices was gathered along with complaint trends and outcomes.

The trust participated in the friends and family test, and we saw results displayed on surgery wards. The friends and family test (FFT) response rate for surgery at Leeds Teaching Hospitals NHS Trust was 40%, which was better than the England average of 28%. Ward managers on surgical wards assured us that they continually reassess FFT response rates, and encouraged ward staff to drive this initiative.

We saw the Theatres and Anaesthetics CSU had implemented a “think drink” campaign, and had engaged with patients to assess the usefulness of the information, and impact of the campaign.

The Theatres and Anaesthetics CSU had also held an always event. ‘Always events’ involve those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system. As part of an ‘always event’ campaign during 2017/18, the Theatres and Anaesthetics CSU had examined feedback from PALS, complaints data & Picker inpatient survey to develop a patient feedback questionnaire around ‘Before and while you sleep’ themes. The survey ran for three weeks and gained 144 responses. The CSU also invited 12 patients who responded to the survey to attend a focus group with staff (December 2017). As described elsewhere in the report, four core themes were developed (see, Caring section).

Learning, continuous improvement and innovation

Senior management teams, and staff on the ground, were proud of the breadth and quality of learning, continuous improvement and innovation that took place within surgical services at the trust – and St James University Hospital.

The trust had an improvement work stream to reduce pressure ulcers. Staff had implemented a stop the line: bedside pressure ulcer incident review. This involved reviewing the care that had been given to ensure all appropriate actions had been taken. We saw that collaborative work around pressure ulcers had been carried out in the abdominal medicine and surgery CSU. For example, wards J45 and J47 had piloted new tools such as ‘purple clock’, which used a turn clock to cue patient repositioning for pressure ulcer prevention. Ward J45 had also instigated ‘react to red’ campaign.

The senior management team spoke about the increase in robotic surgery, the increase in tertiary referrals and specialisms (such as transplants), and collaborative initiatives to improve patient care
and outcomes (such as integrated spinal surgery; with neurology and orthopaedics specialists working together).

The trust was involved in completing a number of clinical trials and local academic studies related to surgical services. We spoke with staff involved in research studies who were well supported in completing the trials.

On inspection we were informed by staff on J44 (acute colorectal unit) that they had recently completed a pilot trial of a new heart monitor product called sensium, which captured patients’ temperature and pulse data. Data was captured via an underarm sensor/monitor which sent information at five-minute intervals via a telephone applet. The nurse carried a telephone to view deteriorating patients during the trial; ensuring immediate action was taken.

We saw a New Interventional Procedures Group had been created to provide the trust with assurance that new procedures involving either an implantable medical device or a new interventional procedure are safe, effective and affordable. We were informed that 46 applications had been approved in past two years. These included: new orthopaedic joints to give patients greater stability and range of movement, robot assisted gynaecological, urological and thoracic surgery, insertion of biodegradable stents for frail patients with bile duct blockage, a bench top incubator for preserving livers before transplantation, and various cardiac implants and invasive techniques for patients with conditions that would otherwise have been rapidly fatal.

Within the Abdominal Medicine and Surgery CSU, we saw that four teams had been shortlisted for Nursing Times 2018 awards.

We also saw that the national emergency laparotomy team had won the national Perioperative and Surgical Care Award for improving care for emergency laparotomy patients (July 2018); and had been shortlisted for the Nursing Times 2018 Awards ‘Surgical Care’ category (to be announced October 2018).
Facts and data about this service

The trust has 164 critical care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Leeds Teaching Hospitals NHS Trust and England.**

### This trust

- **Ward name**
  - Adult critical care - J53/54
  - Adult critical care - J81
  - Total

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Services provided</th>
<th>Bed numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult critical care - J53/54</td>
<td>Intensive Care Unit</td>
<td>23</td>
</tr>
<tr>
<td>Adult critical care - J81</td>
<td>High Dependency Unit</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Sites tab)

St James’s University Hospital has 37 critical care beds across two wards:

- **Ward name**
  - Adult critical care - J53/54
  - Adult critical care - J81

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Services provided</th>
<th>Bed numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult critical care - J53/54</td>
<td>Intensive Care Unit</td>
<td>23</td>
</tr>
<tr>
<td>Adult critical care - J81</td>
<td>High Dependency Unit</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Sites tab)

St James’s University Hospital has a 23-bedded level two and three intensive care unit (ICU) based on wards J53 and J54. This provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three care (patients who require advanced respiratory support or a minimum of two organ support). The unit is split into three areas, each with a combination of bay’s and single rooms. The beds were flexed between level two and level three as required.

This site also has a separate 14-bedded high dependency unit (HDU) J81, which provides level two care. This unit comprised of bays and two single rooms. This unit was predominantly nurse led with support from an advanced critical care practitioner, however consultant led ward rounds still took place.

The critical care outreach team (CCOT) provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The outreach team offer a twenty-four-hour service, seven days a week.

The critical care service is part of the West Yorkshire Critical Care Network. Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 31
March 2018 on ICU at this site, there were 1,218 admissions with an average age of 57 years. Of these:

- 32% were from ward areas
- 28% were unplanned admissions from the emergency department or outside of the hospital
- 21% were admitted following emergency surgery
- 9% were transfers from another critical care unit
- 4.5% were planned admissions from theatre following elective surgery
- 4.5% were unplanned admissions from theatre following elective surgery
- 1% were transfers from another hospital
- 1% were planned admissions from the emergency department

The average (mean) length of stay on the unit was 2.4 days.

The units did not accept paediatric admissions as there was a dedicated paediatric intensive care unit at the trust.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

We reviewed mandatory training information on site with senior nurses which showed high levels of compliance consistent with the tables below.

The staff we spoke with all confirmed there were no issues in accessing mandatory training. Medical staff reported ‘hot days’ were helpful as they allowed a number of mandatory training modules to be completed on the same day. Training on sepsis was mandatory and was part of the trust induction programme. It was also formed part of other training courses such as the ALERT course training for nursing staff.

There were systems in place which enabled individual staff and their managers to be alerted when training was due for renewal. Mandatory training comprised of face to face and online learning.

**Mandatory training completion rates**

The trust set a target of 80% for completion of mandatory training.
A breakdown of compliance for mandatory training courses from as of June 2018 for qualified nursing staff in the critical care department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation training basic awareness</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 3 advanced life support</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>170</td>
<td>170</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>170</td>
<td>170</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>170</td>
<td>170</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>170</td>
<td>170</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>169</td>
<td>170</td>
<td>99.4%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>165</td>
<td>167</td>
<td>98.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>164</td>
<td>166</td>
<td>98.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>157</td>
<td>159</td>
<td>98.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>165</td>
<td>168</td>
<td>98.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>166</td>
<td>170</td>
<td>97.6%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>155</td>
<td>170</td>
<td>91.2%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At St James’s University Hospital critical care department, the 80% target was met for all 14 mandatory training modules for which qualified nursing staff were eligible. Nursing staff had an overall training completion rate of 97.2% and 13 of the 14 modules had completion rates above 90%.

A breakdown of compliance for mandatory training courses as of June 2018 at St James’s University Hospital for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation training level 2 intensive life support</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>18</td>
<td>21</td>
<td>85.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>20</td>
<td>24</td>
<td>83.3%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>19</td>
<td>24</td>
<td>79.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
At St James’s University Hospital critical care department, the 80% target was met for 12 of the 15 mandatory training modules for which medical staff were eligible. Medical staff had a training completion rate of 83.2%, higher than the trust target. Nine modules had completion rates above 90.0%. Three modules did not meet the trust target, although the module fire safety (all staff) had a completion rate of 79.2%, just short of the 80% trust target. The two modules with the lowest completion rate were resuscitation training advanced and resuscitation training advanced (update), both with a completion rate of 42.9%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Trust protocols and guidance on safeguarding were easily accessible. There was a safeguarding team who reviewed and investigated individual notifications and provided expert advice, support and training to staff.

Staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. Senior nurses were confident about staff’s understanding of safeguarding.

Staff had an awareness of female genital mutilation (FGM). The mandatory process of reporting and recording newly identified cases of FGM was part of the trust’s safeguarding policy.

There was a trust policy for when sedation was used in treatment. This was based on regional critical care network guidance.

Safeguarding training completion rates

The trust set a target of 80.0% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of June 2018 for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>21</td>
<td>24</td>
<td>87.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>19</td>
<td>24</td>
<td>79.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>5</td>
<td>8</td>
<td>62.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the 80.0% target was met for one of the seven safeguarding training modules for which medical staff were eligible. Medical staff had an overall training completion rate of 75.0%, not meeting the trust target. The trust target was not met for six training modules, of these four had completion rates 75.0% or above. Safeguarding vulnerable adults - level 2 and safeguarding children level 2 had the lowest completion rates, at 62.5% and 37.5% respectively.
A breakdown of compliance for safeguarding training courses as of June 2018 for qualified nursing staff in the critical care department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>160</td>
<td>170</td>
<td>94.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>160</td>
<td>170</td>
<td>94.1%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>104</td>
<td>144</td>
<td>72.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>103</td>
<td>144</td>
<td>71.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>16</td>
<td>24</td>
<td>66.7%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>16</td>
<td>24</td>
<td>66.7%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At St James’s University Hospital critical care department, the 80.0% target was met for three of the seven safeguarding training modules for which qualified nursing staff were eligible. Nursing staff had an overall training completion rate of 82.9%. Three modules had completion rates above 90.0%, while a further two modules had completion rates above 70.0%. Safeguarding vulnerable adults - level 3 and safeguarding children level 3 had the lowest completion rates of 66.7% for both modules.

A breakdown of compliance for safeguarding training courses as of June 2018 for medical staff in the critical care department at St James’s University Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>21</td>
<td>24</td>
<td>87.5%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>19</td>
<td>24</td>
<td>79.2%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>5</td>
<td>8</td>
<td>62.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the 80.0% target was met for one of the seven safeguarding training modules for which medical staff were eligible. Medical staff had an overall training completion rate of 75.0%, not meeting the trust target. The trust target was not met for six training modules, of these four had completion rates of 75.0% or above. Safeguarding vulnerable adults - level 2 and safeguarding children level 2 had the lowest completion rates, at 62.5% and 37.5% respectively.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**

Ninety eight percent of nursing staff and 92% of medical staff had completed mandatory training in infection control and prevention. The exceeded the trust target of 80%. There were identified link
workers within the nursing team for infection prevention and control who received additional training.

Intensive Care National Audit and Research Centre (ICNARC) data showed there had been 6.5 unit acquired infections in blood per 1000 patient bed days between 1 April 2017 and 31 March 2018 at St James’s University hospital. This was significantly higher than similar units who had 2.6. The data from 1 April 2018 to 30 June 2018 showed a slight improvement, with the unit acquired infections at 9.2 against 4.1 in similar units. Both of these figures were within national averages, however were flagged within the trust’s ICNARC data.

Information on hospital acquired infections was collated per ward in a monthly dashboard. We viewed this data on site, it contained details of the number of days since the last infection. For example, on ward J54, this was 40 days.

Hospital acquired infections were also a standing agenda item on the monthly departmental governance meetings. Any recent cases and investigation outcomes were discussed. The service also had monthly stewardship meetings with the microbiology team.

Hydrogen peroxide vapour (HPV) technology was used to disinfect patient areas following use. This system uses micro-condensation to eliminate pathogens from the environment; proactively preventing infections. We saw this system in use during our inspection.

We were told by the infection prevention team that RCA investigations were undertaken for all hospital acquired infections including ventilator associated pneumonia. There were quality improvement protocols in place to reduce the incidence of bloodstream infections. Key to this was the introduction of the blood stream infection bundle in December 2017. This included the introduction of ‘Buggles’ to both units. These were an adaptation of safety huddles and focused on infection prevention and control concerns.

Between 1 April 2017 and 31 March 2018 there had been one unit acquired case of methicillin resistant staphylococcus aureus (MRSA) and five cases of unit acquired clostridium difficile. This was in line with similar units.

On J54 there had been four cases of Clostridium difficile between May 2018 and June 2018. Root cause analysis (RCA) investigations were undertaken. There were no themes identified. However, the service still investigated further and held a meeting to discuss if there had been any potential lapses to prevent a reoccurrence.

The units were all visibly clean, tidy and free from clutter. The only exception to this were the blood gas machines on J54 and J53 which both had several dried blood stains on them.

Hand hygiene points were visible at the entrance of the critical care reception areas and the critical care units. Signage was visible regarding infection control across the unit. We observed clear signage in place on single rooms for patients requiring isolation.

Hand wash facilities were available in each bay and alcohol gel was available at every bed space.

We spoke with domestic and housekeeping staff who were aware of policy and processes for cleaning the ICU environment and we saw daily cleaning schedules for specific areas had been completed. Empty bed spaces also had terminal clean checklists completed to indicate they were clean and ready for the next patient.

Monthly cleaning audits were also in place ward health checks results displayed in ward areas. Each of the areas on this site had achieved 100% in their hand hygiene audits for the previous three months.
We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene, personal protective equipment (PPE) and isolation. Staff told us the unit had link nurses for infection prevention and control. We saw information on display about preventing legionella and how to manage blood spills.

The unit had facilities for respiratory isolation and we found appropriate waste segregation and disposal systems in place.

**Environment and equipment**

Both units were compliant with health building notice (HBN) 04-02 and had windows allowing natural light into the bed space. Access was via intercom with a security camera. Central monitoring was in place on both units, to allow oversight of patients.

Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance and managed in line with agreement with commissioners. In the main bay, bed spaces were separated by curtains to maintain patients’ privacy and dignity.

There was direct access to theatres via a corridor from the units. All units had a central dirty utility, blood laboratory storing point of care equipment (POCT), central store, pantry area and a pharmacy store/clean utility. All storage areas were well maintained and stock levels were managed by a dedicated central stores team and pharmacist technician. Stock was replenished by the stores department daily.

The replacement of equipment was part of the trust wide capital replacement programme. There was adequate equipment in the unit to meet the needs of patients. We saw that specialist equipment was available for patients with a high body mass index (BMI) when required. A standard hoist and bariatric hoist were available on the units.

We checked 18 pieces of equipment, including blood pressure machines, pumps and hoists; and found evidence of up to date electrical safety testing. There was a clear process of assurance for the maintenance of medical equipment and estates management.

The maintenance performance report from the medical equipment inventory which included in-house and external maintenance was updated daily. This was the responsibility of the medical physics department. Assurance work in medical physics was undertaken using a registered quality management system (ISO9001), and was audited regularly.

Training for new equipment introduced to the unit was provided by the manufacturer and refresher training and competency checks were carried out by clinical educators annually. There were key trainers across the critical care clinical service unit (CSU). At the previous inspection, training compliance rates for high risk equipment were a concern. Equipment training compliance was recorded on a system called MELVIS. We requested training compliance figures and current compliance for the critical care CSU was 78%. This was an improvement from the last inspection.

Appropriate emergency equipment was available at each bed space and there were resuscitation trollies centrally located on each unit. Each trolley had an information folder with check lists and stock availability. We saw evidence of daily checks being completed. Contents were checked and found to be sealed and in date.

We reviewed the records of checks for the difficult airway trolley on ICU. The checklist indicated checks should be completed once a month. We saw that checks had been completed in January
2018, then no further checks were documented until September 2018. We raised this with nursing staff who informed us the trolley was not used very often. Following the inspection we were provided with information that following investigation, it was discovered the record had been inadvertently destroyed during an extensive deep cleaning programme. The tag that was in situ at the time of inspection did not match the number of the most recent check. With permission, the tag was removed and contents checked, these were found to be in date and sealed.

We reviewed the contents of the chest drain trolley on ICU. The contents were aligned with the British Thoracic society insertion of chest drain process. The trolley was secured with an audit of completed daily checks.

The ICU had four internal patient transfer bags and one external patient transfer bag. Transfer bags were clearly labelled and we saw they were checked daily, together with transfer medicines requiring fridge storage. This was in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS). Qualified nurses completed transfer training as part of the step one competency training package.

**Assessing and responding to patient risk**

The critical care outreach team (CCOT) provided cover twenty-four hours a day, seven days a week. This level of provision had been in place since May 2017. At the inspection in 2016 CCOT out of hours cover had been provided by staff on the ICU.

The CCOT played a vital role in supporting staff on the wards when patients became unwell. They had a number of other roles including, attending cardiac arrest calls and providing support for patients with tracheostomies or requiring non-invasive ventilation. They also reviewed patients who were discharged from ICU to ward areas.

The trust used the national early warning score system (NEWS) as a tool for identifying deteriorating patients. The wards had an electronic system for recording patient observations which formed part of the electronic record system. This allowed the CCOT to remotely view any patients with elevated NEWS scores. There was a clear escalation policy in place for when patients had an elevated NEWS score. During inspection we observed the escalation process and how the CCOT nurse team managed deteriorating patients. This included patients on wards who required admission to critical care and patients on HDU who may deteriorate and require transfer to the ICU.

Sepsis screening tools and pathways were in use. The service had developed grab bags for sepsis screening as part of the BUFALO screening tool. These had been introduced throughout the trust. They included equipment for blood cultures with a clear process of reporting and escalation. Staff could demonstrate awareness of sepsis and the pathway supporting this.

We saw that daily bedside safety checks were in place. Staff completed relevant risk assessments and care bundles, for example, for venous thromboembolism (VTE) and pressure areas. These were completed in the ten sets of records we reviewed. We also saw a flow chart in use for invasive lines to ensure they did not remain in place for longer than required.

The electronic whiteboards in the units would ‘flag’ when any assessments were due for renewal as a reminder for staff. We observed ward clerks reminding staff about any alerts.

Staff reported that developments such as sepsis grab bags and the chest drain trolley meant more timely interventions for patients. For example, prior to the chest drain trolley being introduced it
could take around 15 minutes to collect all the required equipment. The trolley meant all the required equipment was readily available in one place.

Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

**Nurse staffing**

Nurse staffing was based on guidance and standards from D16 NHS standard contract for adult critical care and Guidelines for the Provision of Intensive Care Services 2015 (GPICS). We observed staffing levels during our inspection, reviewed staffing rotas and spoke with several members of nursing staff. We were assured that nurse staffing levels met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients’ ratio for level two patients.

On the ICU (ward J53 and J54) there were two supernumerary coordinators and the HDU (J81), had a supernumerary coordinator. This was also in line with GPICS recommendations.

The CCOT had increased its numbers to 19.5 whole time equivalent (WTE) staff to enable twenty-four hours a day, seven days a week provision.

Senior nurses told us vacancy rates and sickness did make staffing a challenge. However, no concerns were fed back from nursing staff with regarding to staffing levels. Any movement of staff was recorded on the electronic rostering system and was also noted in the file carried by the supernumerary co-ordinator.

Gaps in staffing were covered by agency staff or bank staff. Many of these shifts were filled by the unit’s own staff working additional bank shifts, meaning the units did not utilise greater than 20% of registered nurse from bank or agency on any one shift which weren’t their own staff.

Planned and actual staffing numbers were displayed and were achieved during our inspection. Planned nurse staffing levels for the ICU were 12 nurses and two health care support workers. Planned nurse staffing levels for HDU were six nurses and two health care support workers in a morning and seven nurses and two health care support workers in an afternoon and at night. Electronic rostering was in place and this enabled ‘rules’ to set up to further support safe staffing levels. For example, two band six nurses would always be on duty during the day on HDU.

Since the last inspection the service had implemented a critical care patient flow team. Part of their role was looking at nurse staffing across all critical care areas. The team consisted of six band six critical care nurses who worked 12-hour shifts from Monday to Saturday. There was a patient flow coordinator based at each site.

The flow coordinator looked at staffing and patient acuity and any agency requirements. This mean that the coordinators on ICU and HDU could then focus on the clinical aspects of their role and were not spending significant time overseeing staffing issues.

On one of the days during the inspection critical care was in (red) escalation due to staffing and patient acuity. The inspection team sat in on the morning patient flow call. This was attended by the flow coordinators from each site, the site coordinator, matron and general manager. We were
shown a flow chart which was red, amber and green (RAG) rated to clearly identify the level of escalation for the service. This determined who attended the patient flow call.

Staffing was managed across both sites and all of the critical care areas to ensure nurse staffing levels met the needs of the patients. During the patient flow call it was assuring that despite staffing challenges the supernumerary coordinators were not utilised to support any gaps.

The service had adapted clinical emergency medicine books (CEM books) typically used in accident and emergency departments. This live system enabled the service to look at the demands within their department, share this information and make better informed decisions.

We viewed the system whilst on site. There were eight parameters which each had a weighted scoring system to give an overall RAG rating for the service. The system was updated at regular times during the day and included information on staffing levels for nurses, the CCOT, advanced critical care practitioners (ACCP) and medical staff. This ensured a consistent and risk based approach was used when making decisions about staffing.

We observed nurse handovers in each of the areas. They were comprehensive and detailed. The handover was led by the nurse in charge who then allocated staff to patients to ensure continuity of patient care and skill mix was considered. Nurses then completed a one to one handover at the bedside.

There was a specialist critical care pharmacist who visited all units Monday to Friday to check prescriptions and reconcile patient medicines.

From speaking with physiotherapy staff and reviewing patient records, we were assured that physiotherapy provision was sufficient to deliver the respiratory and rehabilitation elements of patient care.

The trust reported their staffing numbers below as at March 2017 and March 2018:

**St James’s University Hospital**

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th></th>
<th>March 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>St James's University Hospital</td>
<td>148.1</td>
<td>191.6</td>
<td>77.3%</td>
<td>155.7</td>
</tr>
</tbody>
</table>

St James’s University Hospital had a staffing fill rate of 83.1% in March 2018, higher than the fill rate of 77.3% in March 2017, although the trust has decreased planned WTE staff by 4.2 between March 2017 and March 2018. The service had to operate with 43.5 less WTE staff in post than what was planned for in March 2017 and with 31.7 less in March 2018. This site however had 7.6 more WTE staff in post in March 2018 than in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 9.9% in critical care. The trust did not set a trust target for vacancy rates.
A breakdown by site is shown below:
- Leeds General Infirmary: 10.6%
- St James’s University Hospital: 8.9%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

As from June 2017 to May 2018 the trust reported a turnover rate of 7.4% in critical care. The trust did not set a target for turnover rates.

A breakdown by site is shown below:
- Leeds General Infirmary: 8.7%
- St James’s University Hospital: 5.6%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018 the trust reported a sickness rate of 2.9% in critical care, lower than the trust target of 3.5%.

A breakdown by site is shown below:
- Leeds General Infirmary: 2.7%
- St James’s University Hospital: 3.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

St James’s University Hospital

From April 2017 to March 2018, St James’s University Hospital reported 1.1% of qualified nursing shifts filled by bank staff and 0.8% shifts filled by agency staff in critical care. There were 0.1% of shifts not filled by either bank or locum staff.

Over the same period, 18.2% of nursing assistant staff in critical care at St James’s University Hospital was filled by bank staff, 2.2% of shifts were filled by agency staff and 4.4% of shifts were not filled by either bank or agency staff to cover staff absence.

A breakdown of agency and bank usage by staff type at St James’s University hospital is shown below. Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff, as this information is not stored on their electronic rostering system and is held locally within each department. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th></th>
<th>Qualified nurse</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Bank</td>
<td>510</td>
<td>18.2%</td>
<td>237</td>
<td>1.1%</td>
<td>747</td>
</tr>
<tr>
<td>Agency</td>
<td>62</td>
<td>2.2%</td>
<td>171</td>
<td>0.8%</td>
<td>233</td>
</tr>
<tr>
<td>Not filled</td>
<td>124</td>
<td>4.4%</td>
<td>33</td>
<td>0.1%</td>
<td>157</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,808</td>
<td>4.4%</td>
<td>22,488</td>
<td>0.4%</td>
<td>25,296</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
**Medical staffing**

Critical care unit had two designated clinical leads. Two consultants were available during week days from 8am to 8pm, and at weekends from 8am to 6pm for ICU. In addition, there was a named consultant for the week for HDU. Overnight cover was provided by an on-call consultant who was able to attend within 30 minutes. Consultants were supported by a registrar who was available twenty-four hours a day.

On HDU an ACCP provided cover during the day seven days a week. The service was working towards this provision being twenty-four hours a day by November 2018.

It was identified from reviewing medical rotas and speaking with consultants that consultant work patterns provided continuity of patient care as block working was in place. This was in line with GPICS recommendations. The consultant to patient ratio on ICU was also in line with the recommended range of 1:8 to 1:15.

We observed consultant wards rounds, and in the ten patient records we reviewed we saw that twice daily consultant led ward rounds took place from Monday to Friday in ICU. Daily ward rounds took place at weekends in both units.

On HDU consultant led ward rounds took place in the morning. A consultant also visited in the evening, they would see any patients staff were concerned about but may not do a full ward round. This did not fully meet GPICS guidance, however the majority of patients on this unit were elective and were on care pathways with criteria led discharge plans in place. All the nursing staff we spoke with confirmed a consultant was always available when needed, including out of hours.

The trust has reported their staffing numbers below for the period as at March 2017 and March 2018:

<table>
<thead>
<tr>
<th></th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site</strong></td>
<td><strong>Mar-17</strong></td>
<td><strong>Mar-18</strong></td>
<td></td>
</tr>
<tr>
<td>St James’s University Hospital</td>
<td>21.0</td>
<td>24.1</td>
<td>87.1%</td>
</tr>
<tr>
<td></td>
<td>21.1</td>
<td>19.9</td>
<td>106.3%</td>
</tr>
</tbody>
</table>

St James’s University Hospital had a staffing fill rate of 106.3% in March 2018, higher than the fill rate of 87.1% in March 2017, although the trust has decreased planned WTE staff by 4.2 between March 2017 and March 2018. The service had to operate with 3.1 less WTE staff in post than planned in March 2017 and with 1.2 more in March 2018. This site however had a similar number of WTE staff in post in March 2018 as in March 2017.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From June 2017 to May 2018 the trust reported a vacancy rate of -9.5%, in critical care, indicating that the service was overstaffed.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

From June 2017 to May 2018 the trust reported a turnover rate of 37.3% in critical care. However, the inclusion of trainee grades in the data is likely to have inflated the rates.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018 the trust reported a sickness rate of 0.3%, critical care, well below the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust did not use any bank or locum staff to cover medical shifts from April 2017 to March 2018.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Records

The service used an electronic records system, however paper records were also still in use. The ICU observation charts were also paper based. There was a project team in place who were working towards a paperless system.

Nursing and medical records were stored in a trolley at the end of each bed space or outside the room of those patients requiring isolation. On the HDU records were stored securely in trolleys with keypad access. Information provided by the trust showed that 98% of nursing staff and 83% of medical staff at this site had completed information governance training. This exceeded the trust target of 80%.

With support from staff, we reviewed ten sets of nursing and medical records in detail looking at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Care bundles and pathways were in use for pressure area care and indwelling lines. There was evidence in the notes we reviewed of holistic assessment which focused on details other than physical health needs, for example, mental health conditions.

Medical records were completed in line with trust and professional standards. We saw that patients were reviewed by a consultant within 12 hours of admission to critical care.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. This was done electronically and viewed on the trusts electronic patient management system.

CCOT staff confirmed that discharge information was thorough with clear escalation plans for individual patients. Step down from critical care was managed effectively, patients were reviewed by the CCOT team following step down and ward staff were aware of the CCOT referral process.
Medical records were completed in line with trust and professional standards, for example we saw evidence that patients were reviewed by a consultant within 12 hours of admission and daily MDT input.

We saw the physiotherapy team completed records that met with NICE Guideline CG83 (rehabilitation after critical illness) requirements during a patient’s stay in critical care.

In the records we reviewed, we saw admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) Guideline CG50 (acutely ill patients in hospital). CCOT staff told us discharge information was thorough with clear escalation plans for individual patients.

**Medicines**

During our inspection we found medicines were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records and saw that accurate records and checks were completed in line with trust policy. Controlled drugs stock was checked at each handover shift by the nurse in charge and a quarterly audit was completed by the pharmacy team.

The trust had a central system to monitor fridge temperatures in line with trust policy to ensure medicines requiring refrigeration were stored safely. We saw daily temperature checks had been completed. Staff could explain the process and protocol surrounding escalating fridge temperatures if outside of the safe temperature range and we saw evidence of appropriate action being taken when this occurred.

Medicine prescription charts were on an electronic system. With support from staff we reviewed ten electronic charts. We found they were completed in line with trust and national guidance. Each prescription had been reviewed by the pharmacist and allergy status had been completed. Clinical indication and start and stop dates for antimicrobials was also evident. The medicines charts we reviewed had antibiotics prescribed in line with national guidance.

We found oxygen was prescribed and preventative treatment for venous thromboembolism (VTE) was routinely prescribed both chemically and physically, for example, anti-embolism stockings.

The units had ACCP’s who were non-medical prescribers, staff reported particularly on the HDU that this saved time in getting medications prescribed. The electronic system also meant that medications and intravenous fluids could be prescribed remotely which saved time.

There was consultant pharmacist leader for antimicrobial stewardship, parenteral nutrition, thrombosis and anticoagulation.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

‘Druggles’ had been introduced on ICU as a trial to explore further ways of sharing information specifically around medicines.
Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for critical care.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. Incidents relating to pressure ulcers, falls and medication errors were monitored through the ward health check metrics.

Information provided by the trust stated the number of device related pressure ulcers had reduced by 50% in 2017/2018.

The HDU had been one of the wards at the trust which started the Improvement Academy work in 2013 to develop patient safety huddles. Since then the structure and purpose of these huddles had been expanded and embedded and rolled out across the trusts well as other trusts in the area. The trust had won a Health Service Journal award for this work and were put forwards for an NHS parliamentary award. The service was also supporting other trusts to implement safety huddles.

We observed safety huddles in the HDU and in ITU. They were attended by various members of the multidisciplinary team, including the consultant on call, the nurse in charge, patient flow coordinator and therapy staff. The safety huddles were supported by a standard operating procedure (SOP). Areas covered included staffing and capacity, any infection control issues and any communications to be shared.

At the start of the nursing handovers we observed there were team briefings. These had a checklist and included any information about patient safety incidents. For example, information was shared about an incident involving an infusion of parenteral nutrition.

There were various other systems in place to feedback learning from incidents. This included team meetings and a closed social media group for staff which included ‘messages of the week’. We also observed lessons learned in safety briefing documents which staff made reference to.

We reviewed monthly departmental governance meeting minutes and found incidents were a standing agenda item. A ‘tracker’ was used to monitor progress and themes of incidents and there was evidence of discussions around this in the minutes we reviewed.
There was a Quality Improvement (QI) programme in place in relation to the timely identification of the deteriorating patient. A number of different measures were in place to monitor the effectiveness of the QI programmes, such as the monitoring of the occurrence and harm levels of associated incidents and numbers of cardiac arrest calls. At CSU and unit level this was monitored through ward metrics. This included information on the number of days since the last patient falls/pressure ulcer etc. We saw this information displayed on the units we visited.

The electronic incident reporting system included a prompt on the duty of candour. This 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 demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Monthly critical care specific mortality and morbidity meetings took place, which was in line with GPICS recommendations. Feedback from consultants we spoke with was this process was embedded within the service. Structured judgement reviews took place, from reviewing meeting minutes it was evident that discussions took place and any actions required were taken forward. For example, a delay in antibiotic administration potentially due to a transition from paper to electronic medication charts as the patient moved from the emergency department to ICU was flagged to risk management.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Both units submitted data for the patient safety thermometer. We reviewed this data which showed for ICU between July 2017 and July 2018 harm free care ranged from 78% to 100%. On HDU for the same time periods percentages ranged from 85% to 100%.

This information was not publicly displayed as the trust incorporated this information into their ward health check dashboards.

Is the service effective?

Evidence-based care and treatment

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Policies and guidance were accessed on the trust intranet which was easy to navigate. We reviewed ten policies and found them to be in date with an author and version control. Many of the policies had flow charts and links to other guidance to inform staff. For example, the sepsis
management policy linked to the sepsis screening tool and antibiotic guidelines for adults with severe sepsis.

The recent introduction of CEM books was still being developed. As part of this policies, SOP’s and guidance documents for critical care were to be uploaded to aid quick access for staff. Governance meeting minutes from September 2018 informed staff that single page guidance on tracheostomy speaking valves had been uploaded to CEM books.

We saw from critical care meeting minutes that there was an agenda item for sharing knowledge from conferences and review of articles from the critical care journal.

The HDU had consultant oversight but ran predominantly as a nurse led unit. Care pathways and criteria led discharge documents were in place to support decision making.

The trust was part of the West Yorkshire Critical Care Operational Delivery Network (WYCCODN). This group met six times a year to representatives from each trust in the network. They shared and reviewed critical care specific guidance from their units. This included areas such as pain, sedation, delirium, prone positioning and nutrition. Each area was marked against a standard framework and given a score. The unit with the highest score shared their guidance with the rest of the group. If it was identified that there was an area or topic for which there was not guidance available, the group would develop some.

We saw evidence of screening for delirium in the ten patient records we reviewed in line with NICE guidance. Staff we spoke with gave an example of managing a patient with delirium when sedation was withdrawn and were aware that patients should resume their usual medication while sedated. The service had a SOP for delirium screening and diagnosis. The trust policy identified non-pharmacological treatments and approaches to use prior to looking at pharmacological interventions.

We saw evidence of screening for sepsis in the patient records we reviewed in line with NICE guidance. Staff we spoke with were aware of sepsis and the referral process to follow. The trust used BUFALO sepsis screening protocol. Sepsis blood culture grab bags were available on all units.

We asked staff about managing conflict and aggression on the ward and staff gave examples of where they had used distraction techniques from their training. For example, staff were aware to use individual patient personal information in challenging situations such as personal preferences, likes and dislikes.

We saw admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. We saw evidence of outreach team activity data collection. This included heat maps to monitor activity and the number of referrals to the team per patient speciality.

We found evidence of care being delivered in line with NICE CG83 rehabilitation after critical illness. Since the last inspection significant improvements had been made. A critical care rehabilitation team had been established based at the St James’s University Hospital site. The team visited other hospitals to see what work they had done and utilised the WYCCN quarterly rehabilitation forum to look at what the service was doing in comparison to the rest of the region.

There was a system in place to identify patients requiring rehabilitation. This was supported by a critical care rehabilitation pathway which was used by members of the multidisciplinary team. We saw from our observations and reviewing patient records that 45 minutes of therapy was delivered to patients each weekday. This involved both the physical elements of rehabilitation but also
psychological rehabilitation, for example, taking time to talk to patients about their time on the unit and what has happened to them.

The service had also developed information leaflets for patients and relatives which were shared with the WYCCN.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in the ten patient records we reviewed.

The unit had an emergency feed protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

There was access to a dietitian and they would attend the unit each day and on call support was available at weekends. We observed them reviewing patients during our inspection. Staff told us a speech and language therapist attended the unit when staff referred patients. Provision was therefore in line with GPICS recommendations.

During our inspection we saw that water was available for those patients able to drink. Assistance was provided as required for those patients able to eat, red trays were used to highlight patients who required assistance with eating and drinking. We found fluid balance charts were fully completed in each of the ten records we reviewed.

The completion of nutritional assessments was monitored through the ward health check metrics. Completion rates from April 2018 to June 2018 were 98-100%.

**Pain relief**

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team and attended the morning safety huddles. Pain relief was discussed on ward rounds and during one to one handovers between nursing staff. The pharmacy team would also review pain relief during their visits.

From the notes we reviewed we found evidence of pain scores being completed and appropriate action taken in response to any indicating a patient was experiencing pain. The trust used a pain scale of one to three which was recorded on the patient observation tool at the patient bedside. Pain observation tools were available for patients who could not verbalise they were experiencing pain. Staff could describe how they would assess pain for patients who were not able to verbalise, for example, by looking at facial expressions and body language.

The patients and relatives we were able to speak with reported pain control being effective and that it was provided in a timely way. One patient described how one type of pain relief was not effective but an alternative was quickly arranged to ensure their pain was controlled.

**Patient outcomes**

From May 2018 ICNARC data was collected by a team of data clerks who were based in the same office. Previously they had been on different sites. They worked closely with the clinical team to collate information to ensure accuracy.

At this site both units contributed to the Intensive Care National Audit Research Centre
HDU had only been collating data for two months prior to the inspection so did not have any reported data.

We reviewed the annual report data from April 2017 to March 2018 and the quarterly report from April 2018 to June 2018.

Hospital mortality (all patients)

St James's University Hospital

At St James's University Hospital, the risk adjusted hospital mortality ratio for the intensive care unit was 1.07 in 2017/2018 reducing to 1.04 in the most recent data from April 2018 to June 2018. This was within the expected range. The figure in the 2017/18 annual report was one.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>2017/18 National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,197 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1</td>
<td>1.07</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)

St James's University Hospital

At St James's University Hospital, the risk adjusted hospital mortality ratio for patients in the intensive care unit with a predicted risk of death of less than 20% was 1.2. This was within the expected range. The figure in the 2016/2017 annual report was one.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2016/17</th>
<th>2017/18 National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>739 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>1</td>
<td>1.2</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The unit had an unplanned readmission rate within 48 hours of 1.1% for the period of 1 April 2017 to 31 March 2018. This was just below (better) than the rate for similar units which was 1.2%, and was within the expected range when compared to the England average.

Between January 2018 and March 2018, the trust achieved 92% compliance for sepsis screening. There had been a focus on improving the timeliness of antibiotic treatment for suspected or confirmed sepsis. Between January 2018 and March 2018, data showed that 77% of patients had received antibiotics within an hour.

We were provided with a copy of the services clinical audits for best practise and quality improvement projects plan. This included four work streams, including best practice audits on policies and guidelines, trust mandatory audits and national audits.
These work streams were reflected in the annual audit plan for the service. A wide range of areas were covered, including target setting for oxygen use, consent and medical handover.

**Competent staff**

**Appraisal rates**

**St James’s University Hospital**

Appraisal rates for both nursing and medical staff had improved since our last inspection. As at June 2017 and June 2018, 90.7% and 100.0% of staff, respectively, within critical care at St James’s University Hospital received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>June 2017</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed</td>
<td>Individuals required</td>
</tr>
<tr>
<td>Nursing and midwifery staff</td>
<td>142</td>
<td>158</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>14</td>
<td>14</td>
</tr>
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</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. There was a preceptorship programme in place and new staff would initially be supernumerary and were allocated mentors to work alongside. We spoke with some new staff members who said they felt well supported in their role.

Clinical supervision had been introduced for nursing staff in 2016. Clinical supervision provides staff with an opportunity to reflect and review their practice. This may involve looking at individual cases, changing individual practice or looking at learning needs.

Staff had an hour of clinical supervision every three months. Staff were provided with training on how to facilitate supervision.

The units supported student nurse and midwife placements. Student nurses were mentored closely with one to one supervision. The student programme whilst strongly educationally focused to ensure placement requirements were met, also aimed to get students keen and excited to work in ICU.

We observed a medical student who was invited to join a ward round. Time was taken to explain the patient’s condition and the procedure they had undergone to aid their training.

For non-registered staff there were opportunities to progress to apprentice support workers then on to advanced support workers. The ACCP’s we spoke with reported good support from medical colleagues and that support and advice was always available when needed.

There were clinical educators for each unit in dedicated roles in line with GPICS standards. They provided a variety of education inputs and maintained central records for equipment training, mandatory training and post-registration training on the units.

Staff told us that training was openly encouraged and professional development was a key priority for the trust. Staff reported being given protected time allocated to enable training attendance. All the work around staff development and training was clearly outlined and supported by the adult critical care education and training strategy.
Training additional to mandatory requirements was provided in areas such as epidural care and tracheostomies. The units also had a ‘focus of the month’. For example, at the time of inspection this was renal care. This could be new learning for more junior staff or a refresher for experienced staff.

The CCOT were also involved in delivering training. They delivered an introduction to the deteriorating patient as part of the introduction to professional practice programme.

All registered nurses in critical care are required to complete Step one of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the unit. Support to complete this was provided by the critical care clinical education team. Step one competencies have been designed to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor and/or practice educator. The education team logged the type of experience nurses were gaining, for example with level two and three patients to track progress and facilitate skills development. They reported on ICU 71% of staff had completed step one competencies.

The unit had link nurses, for example, in nasogastric feeding, end of life care, tissue viability and infection prevention and control.

Information provided by the trust showed that as of May 2018 21% of staff on ICU and 13% of staff on HDU had a post registration award in critical care nursing. This was below the GPICS minimum recommendation of 50%. Staff turnover had contributed to this. However, data on site showed that 65% of staff had completed their step two and three competencies. Step three competencies are used to underpin academic critical care programmes of study.

Due to national problems with accessing post registration award in critical care nursing, the trust had developed an inhouse critical care course in partnership with a university. The current academic level was six and there were plans to increase this to level seven which is equivalent to master’s level. The first cohort of staff were shortly due to start the course, on completion the service would make progress in achieving the recommended GPICS standard of 50%. The West Yorkshire critical care network peer review report from December 2017, identified the service had made significant progress towards achieving the 50% standard.

**Multidisciplinary working**

We observed good multidisciplinary team working; this was supported by the staff we spoke with. We saw evidence of this in the patient records we reviewed. There was a lead pharmacist, physiotherapist and dietitian for critical care at band 8a. Access to speech and language therapy, a specialist nurse in organ donation and other nurse specialists was available when required.

There were clear internal referral pathways to therapy and mental health services for patients which staff were aware of.

Multidisciplinary staffing was in line with GPICS recommendations; however, on HDU it did not meet the full recommendations. Although therapy did not always accompany medical staff on the ward round, there was regular, structured MDT input and evidence of this factored in to planning and decision making. In the patient records we reviewed, we saw there was daily input from the pharmacist, physiotherapist, microbiology and dietitians.

We spoke with physiotherapy staff who confirmed that in line with GPICS recommendations they were able to provide the respiratory management and rehabilitation components of care.
We observed handovers taking place and the completion of transfer documents for patients going to ward areas. This was in line with NICE CG50 acutely ill adults in hospital. The critical care outreach team followed up all patients discharged to the wards from intensive care.

There were policies and procedures in place to support patients who would benefit from admission to critical care. As previously mentioned the HDU was predominantly nurse led and had criteria led discharge pathways.

**Seven-day services**

Consultant cover was available twenty-four hours a day, seven days per week, in line with GPICS standards.

A specialist critical care pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients’ medicines. An antimicrobial pharmacist also attended the unit on week days. There was access to pharmacy on-call service at other times.

Medicines supply services operated twenty-four hours a day, seven days per week with a core inpatient service provided over extended weekday and weekend hours between 8am and 10pm on this site.

Physiotherapists provided treatment seven days a week with an on-call service available overnight.

Speech and language therapy was offered Monday to Friday.

X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

**Health promotion**

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required.

The multidisciplinary team provided health and self-care advice to patients as appropriate to support them to manage their own conditions.

A range of patient information leaflets were available for patients and families. This included information such as preventing blood clots and pressure ulcers.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

**St James’s University Hospital**

The trust reported that, as of June 2018, Mental Capacity Act (MCA) level 1 and 2 training was completed by 99.4% of nursing staff in critical care at St James’s University Hospital, compared to the trust target of 80.0%.
The trust reported that, as of June 2018, Mental Capacity Act (MCA) level 2 training was completed by 71.4% of medical staff in critical care at St James’s University Hospital compared to the trust target of 80.0%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

The staff we spoke with demonstrated an understanding of the mental capacity act and deprivation of liberty safeguards. Staff were able to describe the processes they would follow when using any type of restraint. Staff could access specialist safeguarding nurses for advice. However, we were told where possible the use of physical restraint would be avoided.

There was an up to date adult critical care policy for deprivation of liberty safeguards. This included a flow chart which gave clear guidance on when an application should be considered.

Staff told us the trust used the regional critical care network guidance for sedation and we saw there was a flow chart to help staff decide if sedation holding was appropriate. The trust policy outlined the phases of sedation and target Richmond Agitation-Sedation Scale (RASS) scores, linked to the status of the patient and ventilator settings.

In the records we reviewed there were prompts to undertake RASS scores twice a day and screening using the Confusion Assessment Method (CAM) for ICU. These tools are used to measure the agitation, sedation or delirium levels of a patient.

It was recognised that gaining consent within ICU in particular could be difficult due to the patients they cared for. However, staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients. Where patients were able to verbalise, we observed staff seeking consent before undertaking any interventions.

Is the service caring?

Compassionate care
The patients and relatives we could speak with were consistently positive about the care given. Feedback was that staff were caring and compassionate to both patients and their relatives.

We observed all members of staff providing care for patients’ in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.

Patients and relatives we were able to speak with described staff as ‘fabulous’ and ‘angels’. One relative explained how they were pleased that staff were sensitive to her grandmothers hearing problems and that staff always checked to ensure she had understood and heard what had been said. Another family said they couldn’t have asked for better care.

We observed at the entrance to the unit’s pictures of the staff who worked there and their roles and an explanation of what the different uniforms were.

Patient boards at each bedside told staff about to any individual information relevant to that patient using magnetic symbols. This included any needs related to their care but also information about the person. For example, ‘I have a child attending school’ or ‘I have procedure anxiety’. These were particularly helpful for visiting staff who may only interact with patients for a short time, such as pharmacists or visiting consultants.

The use of these symbols was monitored through the ward metrics. Data showed an increase in compliance from 80% in April 2018 to 100% in May and June 2018.
During this inspection both units were busy, we observed staff calmly providing patient care and attending to the needs of their patients. The privacy and dignity of patients was maintained when care and treatment was being delivered by pulling curtains round.

On HDU we observed buzzers being answered promptly and patients we could speak with confirmed a timely response to any calls for assistance.

We saw thankyou cards displayed on the ward information board in HDU. Unlike some critical care units, the service collected friends and family test (FFT) data. For April 2018 to June 2018, HDU had won a trust award as 100% of respondents said they would recommend the service.

Across the service there had been 100% of respondents recommending the service, with a response rate of 21%, this was only slightly below the England average response rate of 28%. Staff told us the trust were focused on improving FFT response rates, as an incentive prizes were being offered to areas with the highest response rate.

Staff spoke about the important of patient feedback and how in addition to FFT data collection, iPads had been utilised to ask two questions and take any comments about patient care. This was done at the point of discharge; an online survey could also be completed by patients once they were at home. Data supplied by the trust showed there had been 60 responses, 97% of these were positive.

Patient dignity was monitored through the ward health check metrics; compassion audits were also completed. The most recent data from June 2018 showed 100% at this site for both units.

The service had a previous occasion where a dog visited a dying patient with profound benefits. In response to this each Wednesday a pet as therapy (PAT) dog, Maggie visited the units to interact with both patients, visitors and staff.

The service had critical care specific patient experience meetings. These were attended by unit managers, matrons, consultants and the patient experience team. We reviewed minutes of the June 2018 meeting. Items discussed included, FFT feedback, a patient story and patient update information, including patient diaries and unit information leaflets.

**Emotional support**

Staff completed patient diaries. Patient diaries can help patients to understand what has been happening whilst they have been critically ill. Patients who have been in a critical care environment often report memory loss and some may suffer from psychological problems. Diaries have been found to help fill in some missing gaps and have also given the patient understanding as to how poorly they have been. Relatives told us they found the patient diary information booklet was helpful.

One family described how even though it had been an extremely difficult time the staff on the unit had helped make it more manageable and they were made to feel ‘at home’ on the unit.

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. Contact information was available in the main reception on each unit.

Nonphysical risks were included in the critical care rehabilitation pathway document. This included prompts for patients in areas such as reoccurring nightmares and expressing a wish not to talk about their illness.
The intensive care psychological assessment tool (IPAT) was also used as part of the rehabilitation pathway. A score of seven or more would indicate a level of risk and a referral would be made for ongoing support.

During MDT critical care meetings, reviews of journal articles took place to update staff. From reviewing meeting minutes, we found the types of articles reviewed were not just focused on clinical interventions. The minutes from April 2018 review an article about ‘intensive care survivor reported symptoms’. This was about the prevalence of anxiety, depressions, fatigue and post-traumatic stress symptoms for ICU patients at three months and one year after discharge, and the importance of early recognition and appropriate support.

**Understanding and involvement of patients and those close to them**

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment. Staff spoke about the use of advocates and involving carers and relatives to aid communication.

We observed medical and nursing staff taking time to explain what was happening to relatives so they understood the care and treatment.

The relatives we spoke with said they felt well informed. One said they were ‘made aware of the treatment plan and next steps’. Another explained the nursing staff had given access to open visiting and had taken the time to fully explain care plans to them in words that they understood.

Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. The units had a lead organ donation specialist nurse, who was available twenty-four-hours a day seven day a week. Staff made referrals via the team manager.

There were information leaflets and information boards for relatives in the main reception in visitor waiting areas such as; pressure ulcer prevention, blood transfusion, hand decontamination, infection prevention, Methicillin Resistant Staphylococcus Aureus (MRSA), C Difficile, and deep vein thrombosis (DVT).

A visitor information folder gave information about the unit, including facilities on the unit, patient property, parking permits, patient diaries, hand hygiene, restaurant facilities, multi faith centre and shuttle bus information.

On ICU there was an information board for relatives with pictures showing and describing common interventions and treatments. For example, endotracheal tubes and continuous positive airway pressure hoods.

On HDU the waiting area had illustrations and a description to show the patient journey through the unit on their day of surgery.

In June 2018 the service developed and launched a website called ICU unwrapped. This was an information source for families to provide support and explain what things happen on ICU. It included pictures and explanations of the different staff and teams involved in delivering care as well as easy to understand clinical information. People who visited the website could also leave any feedback.
Is the service responsive?

**Service delivery to meet the needs of local people**

The service was actively involved in the regional critical care operational delivery network.

Critical care provision on the ICU flexed to meet the differing needs of level two and level three patients. The HDU provided level two care, there were clear pathways between the units if patient care needed to be stepped up or down.

The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

There was an Advanced Respiratory Unit based at this site. The unit supported patients requiring home ventilation. Any patients with complex weaning problems were referred to the respiratory team. A patient who was anticipated to have weaning problems was discussed during one of the handovers we observed. A long-term plan had been put in place by physiotherapy staff and the family had been heavily involved with this.

Overnight rooms for relatives were available, however on inspection we noted there was limited access to shower and changing facilities. The visitor rest areas on individual units also had pull out bed settees in able to offer overnight accommodation. There were vending machines for relatives and visitors to access hot drinks in waiting areas.

The service had a follow up clinic in place which was medically focused. Patients were offered an appointment three months after discharge from the unit. The clinic was run by the critical care outreach team; if patient needs were identified referrals were made via their general practitioner.

Service users were a key element of the adult critical care vision. Key to this was a focus on FFT, complaints management, carer input and literature and online support. Our inspection findings provided assurance that these plans had been implemented.

**Meeting people’s individual needs**

Staff we spoke with knew how to access interpreting services for patients whose first language was not English and gave example of where this had recently been used. Patient information leaflets were available in many differing languages.

There was a loop system available on reception for people who used a hearing aid, although there was no sign to alert visitors. Staff told us they would contact the vulnerable adults team or senior staff for advice and support if they were working with someone with a learning disability.

Staff recognised the importance of involving relatives and carers e.g. if someone had dementia or a learning disability. Staff told us that when caring for someone with a learning disability, they would also seek support from the trust safeguarding team, which included a specialist learning disability nurse. Patients with a learning disability were encouraged to share with the team their learning passport needs. The care we observed and the patient records that we reviewed reflected that individual needs were assessed and care planning was informed by this.

During handover we observed a conversation about a patient who was expected to have weaning problems. There had been significant family involvement and outings from the unit to support the long-term discharge plans.

Staff we spoke with told us they could access equipment to care for bariatric patients and had not experienced delays to patient care.
A visitor’s information booklet was available in the reception / waiting areas on individual units which included information about the on-site multi-faith chapel and trust chaplaincy service and menu options e.g. vegan, vegetarian and halal.

Patients and relatives were encouraged to contribute to patient diaries to record the pathway and care within critical care. Staff explained that they discussed this alongside individual patient likes and dislikes as an engagement tool.

Patient diaries were also discussed at the follow up clinic to identify individual patient needs post discharge.

A feedback form had been devised to ask patients about their views on the critical care rehabilitation team. This specifically asked about the transition from critical care to ward based care which can be a difficult period of adjustment for patients.

The Trust had recently introduced an initiative where all CSU’s attended the Patient Experience Sub Group, to present the improvements they have made in response to patient feedback. Critical Care presented information on patients who experienced having a tracheostomy and how frightening this could be. Patients also fed back one of the hardest things for them was not being able to get any fresh air. In response, the service was developing patient information to help patients understand more about having a tracheostomy. They also found a way for patients with tracheostomies to leave the department and go outside.

The trust recognised a key opportunity to obtain patient and relative feedback was through the FFT programme. Steps had been taken to make this more accessible to patients and their relatives using text messaging and providing access to a FFT app. The app enabled the FFT survey to be translated into over 90 languages. For patients not able to read, it is also enabled people to speak to them in their own language.

**Access and flow**

At the last inspection in 2016 issues had been identified in terms of access and flow, in particular around delays in getting patients admitted to critical care and out of hours discharges.

Access and flow remained a challenge for the service as it provided specialist critical care provision for a large geographical area. However, a number of actions had been taken to try and make improvements.

One key aspect had been the development of the cross-site patient flow team and the use of CEM books to strengthen escalation processes. This team of critical care nurses provided 12 hour cover six days a week. They met with bed managers and matrons at regular times throughout the day managing access and flow across all the units at the trust.

CEM books held data on the number of available beds, any expected admissions, acuity and staffing. A 24-hour flow chart had been developed for the patient flow bleep holder, included in this were the key times that data needed to be inputted into CEM books. This ensured consistency with the type and time of information added to the system to support informed decision making.

Two metrics within CEM book that significantly impacted the level of escalation for the units were, ‘available beds now’ and ‘predicated beds’. Predicated ‘step downs’ from either unit were
highlighted at the morning safety huddles which were attended by the flow coordinator for the day. Within CEM books there was also the ability to add free text to share information but also evidence why decisions were made. For example, we saw that on one day there were four level three patients with no beds plan being cared for outside of ICU. This impacted decisions made about staffing and elective patients as the priority was to move those patients into an ICU bed.

A matron of the day was also available to support the escalation process in terms of access and flow. They attended the patient flow meetings. An escalation process had also been implemented for cancelled operations, these were also discussed as part of the patient flow meetings. We were told by matrons that work was ongoing to try and standardise the flow of elective admissions. This would help reduce any ‘peaks and troughs’ during the week in terms of patient numbers.

We were provided with a high-level patient pathway for those needed adult critical care. This was used as a starting point to help the service in their aim of admitting 20 more patients to critical care each month following surgical treatment. Analysis and root cause investigations took place. An action plan was developed supported by metrics to measure progress. This included things such as, the number of cancelled operations and the length of delays for elective patients.

The ICU dashboard monitored the number of cancelled elective operations due to no critical care bed being available post operatively. Data from January 2018 to March 2018 showed the percentage was 7.69, this was better than the National average of 9.07%.

On HDU during handover we observed that any patients who would not be suitable for criteria led discharge were identified and highlighted to ensure they were reviewed first on the ward round and that plans were in place.

Bed occupancy

From May 2017 to April 2018, Leeds Teaching Hospitals NHS Trust's adult bed occupancy rates were lower than the England average from May to October 2017 before increasing in November 2017 to above the average for England. The rates were similar to the England average from December 2017 to April 2018.


Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
Delayed discharges

St James's University Hospital

We were provided with the most recent ICNARC annual quality report. This showed that between 1 April 2017 and 31 March 2018 there were 8,395 available bed days in ICU at this site. The percentage of bed days occupied by patients delayed more than eight hours was 4.2%, this was better than similar units which had an average of 4.9%.

The quarterly report from 1 April 2018 to the 30 June 2018 showed this had improved further. The percentage for this site was 2.2% compared to 3.2% in similar units.

We observed the process for when a patient was declared fit to transfer to a ward and that staff were very proactive in managing this. If delays were encountered consideration was given to mix sex breaches.

Non-clinical transfers

St James's University Hospital

ICNARC data from 1 April 2017 to 31 March 2018 showed that of 1,297 admissions to ICU 0.5% had a non-clinical transfer out of the unit. This was in line with similar units and was improved from their 2016/2017 data where the figure was 0.9%.

The data from the most recent quarterly report from April 2018 to June 2018 showed this had improved further and was below the percentage for that of similar units.

Non-delayed out of hours discharges to the ward

St James's University Hospital

At the previous inspection it was highlighted that there was a high percentage of transfers occurring out of hours (between 22.00pm and 07.00am).

ICNARC data from 1 April 2017 to 31 March 2018 showed that the proportion of admissions that were non-delayed, out-of-hour's discharges to the ward was within expected limits, however was still higher when compared to similar units. Based on 622 admissions, 2.9% were discharged out of hours, compared to similar units who had a percentage of 1.6. the graph below shows despite this there was an improving picture within the service.

The data from the most recent quarterly report from April 2018 to June 2018 showed this position had deteriorated, however the figure remained within expected limits.
At the previous inspection the percentage of unplanned readmission to the unit was higher (worse) when compared to similar units. ICNARC data from 1 April 2017 to 31 March 2018 showed that the percentage was 1.1% which was slightly better than similar units who had a percentage of 1.2%.

The unit had an admission and discharge policy. The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. From the ten sets of notes we reviewed all the patients had been reviewed by a consultant within 12 hours of admission. For acute admissions we saw evidence from records that they were admitted to critical care within four hours of the decision being made. This met GPICS standards.

The previous report highlighted some concerns over ventilated patients being cared for outside of ICU, notably in recovery. We requested data on this and found between April 2018 and September 2018 there had been seven ventilated patients cared for in recovery. Each of these were kept in recovery for two hours or less. This supported what we were told by staff during our inspection. This being patients would stay in recovery for a maximum of four hours. We were also told they would be cared for by an anaesthetist.

The process to follow when a critical care bed was not available and when a patient was cared for in recovery was supported by very clear flow charts. These had been updated in May 2016 and replicated what staff told us the process was.

Learning from complaints and concerns

Summary of complaints

From May 2017 to April 2018 there were eight complaints about critical care. The trust took an average of 61.4 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 40 days.

Two complaints were partially upheld, five were fully upheld and one was still under investigation.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>St James’s University Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Leeds General Infirmary</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
</tr>
</tbody>
</table>

The trust had allocated multiple subjects for each complaint received. It was therefore not possible to provide a breakdown of complaints by subject.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From May 2017 to April 2018 there were three compliments within critical care. The three compliments were all about to St James’s University Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We saw information available for patients and families about how to contact the Patient Advice and Liaison Service (PALS) and on how to make a complaint, for example on posters and in the visitor information folder in reception and in the relatives’ overnight stay rooms.
Staff were aware of the policy for managing concerns. However, all staff said they would try and resolve any concerns at the time they arose. Often this may be dealt with by the nurse in charge.

We saw from reviewing a number of different meeting minutes, complaints were a standing agenda item. These included governance meetings, patient experience and team meetings. As with incidents, a tracker was used to monitor complaints in terms of responding to them and identifying any themes.

We spoke with the senior management team about the data we had with regards to complaint response times. We were told the complaints received were complex and involved a number of the trusts CSU’s and ICU generally formed a small part of the complaint. They reported they provided a response to the critical care aspects in a timely way, however as other services were involved, providing a full response was a challenge and as such trust timeframes may not always be met. This was reflected in their overall response times and something they had little control over.

Is the service well-led?

Leadership

Often within trusts critical care sits with other specialities in terms of structures. At this trust the service had its own CSU which meant all aspects of management and the care and treatment of patients could be specifically focused on critical care.

Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. There were two lead consultants and a quality lead. The HDU and ICU each had a designated matron and had supernumerary coordinators in place for each shift in lines with GPICS.

The service had utilised the Leeds Improvement Method (LIM), in conjunction with the Virginia Mason Institute and partner organisations in various workstreams to make improvements, for example, with access and flow. Senior clinicians and managers had undertaken the Lean for Leaders programme, this was part of the trust’s Quality Improvement Strategy.

The CCOT had a clinical lead and each unit had its own clinical educator.

The leaders we spoke with were experienced and knowledgeable. There was strong nursing and medical leadership on the unit. From our observation and from speaking with staff, it was clear that staff had confidence in the leadership at all levels. The service ensured that there were experienced staff on every shift including night and weekends. Staff consistently reported feeling very supported by their teams and managers.

From discussions with the leadership team it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. There was clear evidence of actions taken and processes put in place to mitigate these.

Areas for improvement identified at the previous inspection has been addressed and built up on. Staff of all levels could tell us about the improvements made and we saw clear evidence to support this.

The West Yorkshire critical care network peer review report from December 2017 found a clear MDT commitment to providing safe and effective care to patients. The service demonstrated
improvements in a number of areas, with the senior management team being fully sighted on areas where further work was needed.

There was a significant focus on developing and training for staff at all levels to ensure effective leadership and drive continuous improvement. This was evident from training and appraisal records and from discussions with staff during the inspection. Overall training was supported by the trust’s workforce and people strategy.

The focus on training and development supported succession planning within the service. This was supported by the talent and leadership chapter in the trust’s people strategy.

The leadership team and senior staff were highly visible and approachable. Matrons were often on the units and involved in daily safety huddles and patient flow meetings. Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

**Vision and strategy**

The critical care CSU was aligned to the trust’s vision of commitment to delivering the highest quality and safest treatment and care to every patient, every time. Along with this the trust had five goals. These were; to be the best for patient safety, quality and experience; to be the best place to work; to be a centre of excellence for specialist services, research, education and innovation; to offer seamless, integrated care; and to be financially sustainable.

Since the last inspection the vision for critical care had been refreshed. An engagement exercise had been undertaken to develop a vision and statement to support the directorate to operate as one unit. The key focus had been on quality and safety with an overall vision of delivering outstanding care. We saw the strap line, ‘outstanding critical care’ throughout the units and headlining meeting minutes and documentation.

There were posters throughout the units illustrating the eight elements integral to the unit’s vision. These were; quality, research and innovation, environment, education and training, service users, governance/risk, finance/business and people. Each of these areas was linked to specific outcomes and strategies. For example, linked to quality was; pressure ulcers, handovers and transfers out of the unit.

The vision also involved external partners, staff and service users.

In the areas we visited there were posters outlining issues from the previous inspection and what actions had been put in place. From our discussions with staff from all disciplines it was evident there had been a team approach to the changes implemented as all staff could articulate them.

The values of the ‘Leeds Way’ were; offering patient centred care, and being fair, collaborative, and accountable. These were seen displayed in the areas we visited. Staff felt they were reflected in the values and behaviours of staff within the service.

The overall approach to strategy was taken through services working closely with NHS and social care partners in the Sustainability and Transformation Partnership and the West Yorkshire Association of Acute Trusts to identify the best pathways for sub-acute care, acute care, integrated and specialist care within the area.

The strategy had extensive consultation with staff and partners in other NHS organisations and social care. As part of this meetings were help in public places and crowd-sourcing techniques via
the internet were used. At CSU level a key theme was the “bottom up” involvement of clinical teams.

We reviewed the Quality Improvement Strategy for the service for 2018-2020. This was stretching and challenging looking at innovative ways of working to achieve the highest standards of care for patients. The stagey was based on the five domains in the National Outcomes Framework (2012) and the CQC framework. Each domain within the strategy had clearly identified areas of focus within it. For example, within safe there was, preventing and reducing skin damage, managing pain and developing the nursing and medical handovers using patient passports.

The service also had a Clinical Business Strategy (2017) which we reviewed. This outlined progress since the last inspection and had timelines for improvement up to 2022.

The service had also used the Leeds Improvement Method. Most recently this had been done in a lean for leadership project. This had five stages; sort, simplify, sweep, standardise and self-discipline. Currently the service was at stage two with an aim to be at stage three within a month.

The service recognised the importance of knowing how they were doing in relation to the goals and aims within their strategy and vision. The Quality Improvement Strategy outlined metrics to evidence this. They included, the number of patients with a hospital acquired infection and the number of incident compared to the number of patients being cared for.

During our inspection we found evidence that a number of areas identified in the strategy had already made significant progress. For example, in relation to rehabilitation after critical illness and in terms of access and flow.

Culture

Staff we spoke with told us they felt proud of their work and the care they provided to patients and their relatives. They said they felt able to raise concerns and were aware of the importance of being honest and open. They were able to explain the duty of candour and the need to apologise to patients and relatives in line with trust policy if there had been a mistake.

A recruitment and retention strategy had been devised. We reviewed this document which covered a wide range of areas from retiring and returning staff, education and adult critical care branding.

We found high levels of staff morale within all the teams we spoke with. There was a genuine view of critical care being one unit across the two sites. The language used by staff supported this as well as the systems and processes in place to manage staffing and access and flow.

Staff were highly engaged and we found effective systems in place for sharing information across teams. Safety huddles were embedded and were attended by members of the MDT. Safety briefings were another method of sharing information.

The service used closed social medic groups as another way of sharing information with staff. Staff told us often messages were posted thanking the team on particularly busy or challenging shifts. These made staff feel valued and appreciated. We saw a number of incentives to show staff were valued. These included an appreciation boards, with notes staring ‘I just had to say…’ and ‘a shout out to…’. We saw several of these had been completed by staff.

Staff well-being was a key focus for the service. Staff played a key part in the strategy and vision for the service and there was a strong focus on valuing staff and their well-being when we spoke with senior staff and the leadership team.
Debrief took place for staff following particularly difficult or challenging shifts and the trust had employed a psychologist on the team. Staff told us they could approach the psychologist for advice. The trust acknowledged staff emotional well-being and offered one to one support via regular mentor meetings and offered senior management support if a need was evident.

There was targeted work being done in relation to well-being for new starters and education was being provided to senior nurses on how to undertake debriefs.

**Governance**

Critical care had its own CSU. We were provided with the adult critical care ward to board flow chart. This clearly showed how information was shared and escalated. All elements of governance within the service reported into monthly critical care, governance, triumvirate and senior managers meetings. Sub groups fed into these meetings each producing a summary of any risks for discussion, for example, medicines management, falls, and patient experience.

We reviewed governance meeting minutes, which were well attended. Meetings had a standard agenda and covering staffing and updates for each of the units. Performance dashboards and metrics were reviewed, as well as trackers for monitoring incidents and complaints.

There were clear governance structures which were outlined in the Quality Improvement Strategy. There were escalation pathways and effective systems for disseminating information to all staff. Staff were able to describe these during our inspection. As previously mentioned safety huddles and briefings were key to this.

Individual staff at all levels were clear about their role and responsibilities and the systems for escalating any concerns. Matrons and senior managers were very visible on both units and had an 'open door policy' for staff.

The West Yorkshire critical care network peer review report from December 2017 showed ICU had achieved 100% compliance with GPICS standards regarding governance and data. This section of the report related to areas such as incident reporting, clear operation policies and evidence of implementation of evidence based care.

**Management of risk, issues and performance**

There was a critical care risk register which contained 14 risks. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating. Each of the risks had an initial RAG rating, a current score based on mitigation already in place, and a target score when further mitigation had been put in place.

There were clear descriptions of each risk and dates for review, each had associated controls and action plans attached.

The risks related to medical and nurse staffing, defibrillation equipment needing replacement, finance, hospital acquired infections, compliance with CG83 rehabilitation after critical illness and access and flow.

From our discussions with the leadership team they were clear about key risks to the service and mitigating actions and the risk register reflected this.
The service had a dashboard to monitor performance month on month compared to national averages. This included graphs to enable trends to be looked at.

The service contributed to ICNARC and since the last inspection the service had begun to collect data for HDU.

The service had a robust audit plan which was aligned to best practice guidelines to monitor quality.

Areas identified as requiring improvement at the last inspection had received significant focus and work. An access and flow team had been put in place and work in this area was reflected in improved outcomes in the service’s ICNARC data.

Significant work had been done in relation to CG83 rehabilitation after critical illness, above what was recommended by NICE.

The Quality Improvement Strategy for the service pulled all these elements together with a focused plan for oversight, monitoring and delivery of the objectives.

**Information management**

Electronic patient records and medication charts were in use. The computers we saw had screens locked when they were not in use.

Computerised whiteboards were used on the units. They contained patient information that could be viewed instantly. They alerted staff when any assessments needed reviewing.

Information technology was used in a number of ways to both monitor and audit the quality of care, and as tools for data collection from patients and their relatives.

Staff accessed information relating to policies and guidance electronically. The system was easy to navigate. The admission, discharge and transfer documentation was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information. We found that records were stored securely within the unit.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients’ bedside.

**Engagement**

Within the critical care service there had been a focus and recognition of the importance of engagement of both staff and patients and their relatives. There were a number of improvement projects using the LIM which staff were actively encouraged to engage with. Examples of these included, pressure ulcer collaboratives and work around deteriorating patients.

The trust conducted an annual staff survey, this showed an overall improvement in staff engagement scores from 2016 to 2017. The information was reviewed and the critical care team made commitments to staff based on the outcomes of this survey. This included; proactively sharing patient feedback with staff and investing in high quality staff training.

An important element of staff engagement was by recognition and reward of their work. This included things such as, an annual awards event where staff were nominated and received awards, quality improvement forums and the use of social media to thank staff.
We saw question boxes in staff rooms where staff could anonymously ask anything of leaders in the team. The responses were posted for everyone to see. Examples of things asked included, why do we double check drugs that are single checks in other parts of the trust. The response was to ask this of the medicines management group.

The service had a staff engagement group and a band five staff council. At this a variety of issues could be discussed with proposed solutions. For example, self-rostering was being explored through this group in response to issue with rotas.

There was good support for staff in terms of well-being and mental health awareness. The leadership team recognised the pressures of the roles. There was information on the trust intranet about how to deal with stress and what support was available for staff, this included access to a clinical psychologist.

There was evidence of staff engagement throughout the units. This had contributed to the progress made since the last inspection. Staff across the service felt part of team with a shared purpose.

Examples of this included, the development of the Quality Improvement Strategy. The infection control team spoke with us about working closely with quality improvement team. They described an approach of collegiate engagement involving staff at all levels supported by link and key workers. This resulted in staff being interested an engaged.

There were information boards on the unit to share information about the service with staff and visitors. They were titled, ‘how are we doing?’. This included performance data as well as training opportunities and successes within the units.

The service proactively engaged with patients and families through a number of different ways to plan and improve services.

There was some access to clinical psychology for patients on ICU through the patient follow up clinic. There was access to mental health liaison services for all inpatients.

The service had a critical care patient experience group, as part of this complaints were reviewed to look at ways of improving services. Within the MDT meeting minutes were reviewed we saw that one of the purposes outlined by the group was patient experience.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network.

The service had 12 advanced critical care practitioners (ACCP’s) and others in training. By November 2018 they aimed to have twenty-four-hour cover by ACCP’s on HDU. Senior management told us they were a proud workforce who were writing protocols and investigating devices to change practice.

The service was holding the National Adult Critical Care conference in 2020 to describe their journey and the progress they had made.

Supporting and seeking innovation was part of the services Quality Improvement Strategy. Research and innovation were one of the eight elements linked to the critical care vision. This was aiming for twenty-four hours a day seven day a week research capability. This was supported by work with the Institute for Critical Care and plans to build the North East Critical Care research network. There was an adult critical care research strategy and the service had a goal of being recognised nationally as a lead in research.
We spoke with the research team who were all intensive care nurses. They had strong links with education and told us about current projects such as lung protective ventilation strategies and a trial of new inotropes.

A significant amount of work had been by the service since the last CQC inspection. In particular regarding patient access and flow, and work related to rehabilitation after critical illness. Progress continued to be made with further improvement planned.
This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Leeds Dental Institute

Facts and data about this service

Leeds Dental Institute is a partnership between the trust and the University of Leeds. The institute provides routine dental care, specialist treatment and advice to the population of Leeds and the surrounding region. The institute only admits patients electively, following referral by a dentist or doctor.

The specialties provided are Oral and Maxillofacial Surgery, Oral Medicine, Paediatric Dentistry, Orthodontics, Restorative Dentistry, Dental & Maxillofacial Radiology.

The institute has an oral and paediatric dentistry day case unit with 5 trollies and a sedation unit with 4 dental chairs and 2 recovery chairs. Neither unit is open overnight.

The institute supports the training of medical and dental staff, dental hygienists, dental therapists, dental technicians and dental nurses and carries out research.

There are also three outreach teaching centres in south Leeds, Bradford and Hull that are run by the institute to provide dental care in the community and as part of the student’s learning experience.

(Sources: Trust website; Routine Provider Information Request (RPIR) Sites tab)

The institute had 1,574 admissions from March 2017 to February 2018. These were split between 889 admissions to oral surgery and 685 admissions to paediatric dentistry.

The admissions consisted almost entirely of day case admissions (1,567). There were only seven admissions that were not day cases. These were a mixture of admissions to oral surgery and paediatric dentistry, all of them elective.
The institute accounted for 76.1% of the trust’s combined inpatient oral surgery and paediatric dentistry admissions over this period (1,574 out of 2,068 admissions). It accounted for a much higher proportion of the trust’s admissions to oral surgery (88.1%) than to paediatric dentistry (64.7%).

Leeds General Infirmary accounted for almost all other inpatient dental admissions to the trust over this period, apart from a very small number of oral surgery admissions to St James’ University Hospital (fewer than six).

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training.

Leeds Dental Institute

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

A breakdown of compliance for mandatory training courses as of June 2018 for qualified nursing staff at Leeds Dental Institute is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine safety - 3 years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>PRTD paediatric life support level 2 update</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>7</td>
<td>9</td>
<td>77.8%</td>
<td>80.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Leeds Dental Institute the overall compliance rate for mandatory training for qualified nursing staff was 97.1%.

The 80% target was met for 11 of the 12 mandatory training modules for which qualified nursing staff were eligible. Although technically the target was not met for resuscitation training level 2, in fact this equated to only two nurses not completing the training.

A breakdown of compliance for mandatory training courses as of June 2018 for medical and dental staff at Leeds Dental Institute is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number trained</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>4</td>
</tr>
<tr>
<td>Dignity at work</td>
<td>140</td>
</tr>
<tr>
<td>Equality &amp; diversity general</td>
<td>140</td>
</tr>
<tr>
<td>Medicines safety - once only</td>
<td>126</td>
</tr>
<tr>
<td>Moving &amp; handling lower risk</td>
<td>139</td>
</tr>
<tr>
<td>Risk &amp; safety matters</td>
<td>139</td>
</tr>
<tr>
<td>Fire safety - all staff</td>
<td>135</td>
</tr>
<tr>
<td>Personal safety - lower risk</td>
<td>135</td>
</tr>
<tr>
<td>Information governance</td>
<td>131</td>
</tr>
<tr>
<td>Infection prevention &amp; control specialist clinical</td>
<td>125</td>
</tr>
<tr>
<td>Resuscitation training advanced</td>
<td>45</td>
</tr>
<tr>
<td>Resuscitation training advanced update</td>
<td>45</td>
</tr>
<tr>
<td>Prescribing standards - once only</td>
<td>28</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>32</td>
</tr>
<tr>
<td>Safer blood transfusion</td>
<td>14</td>
</tr>
<tr>
<td>Resuscitation training level 2 PMST</td>
<td>3</td>
</tr>
<tr>
<td>Resuscitation level 1 in hospital CPR</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitation training level 2</td>
<td>23</td>
</tr>
</tbody>
</table>

At Leeds Dental Institute the overall compliance rate for mandatory training for medical and dental staff was 72.7%.

The 80% target was met for six of the 18 mandatory training modules for which medical and dental staff were eligible. There were five modules with less than 50% compliance (though it should be noted that only three members of staff were eligible for resuscitation level 1).

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff told us they were encouraged to complete mandatory training. This included infection prevention and control, information governance, fire safety and how to deal with a medical emergency. Training was either completed online or by means of face to face training. Staff told us they had good access to training and could book it through the trusts electronic training system. We were shown by staff how this system worked.
Training was monitored at all levels of the service. Staff were sent an e-mail on a monthly basis which advised them of what training needed to be completed. This would flag up if a member of staff was due to complete training three months before it was due. Staff showed us evidence of these e-mails and confirmed they were fully aware of when they needed to complete training.

The clinical leads and dental nurse leads for each department also had oversight of training which had been completed. Any gaps in training would be discussed at staff meetings and at appraisals. This ensured that staff were all up to date with their mandatory training requirements relevant to their role.

Updated records as of October 2018 demonstrated that the overall compliance for the dental core service was 90%.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 80% for completion of safeguarding training.

**Leeds Dental Institute**

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

A breakdown of compliance for safeguarding training courses as of June 2018 for qualified nursing staff at Leeds Dental Institute is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent (WRAP)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 3</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 1</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults level 2</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
<td>80.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Leeds Dental Institute the overall compliance rate for safeguarding training for qualified nursing staff was 94.1%.

The 80% target was met for all seven safeguarding training modules for which qualified nursing staff were eligible.
A breakdown of compliance for safeguarding training courses as of June 2018 for medical and dental staff at Leeds Dental Institute is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number trained</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>35</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 3</td>
<td>35</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 1</td>
<td>135</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>125</td>
</tr>
<tr>
<td>Prevent (WRAP)</td>
<td>25</td>
</tr>
<tr>
<td>Safeguarding vulnerable adults - level 2</td>
<td>83</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>74</td>
</tr>
</tbody>
</table>

At Leeds Dental Institute the overall compliance rate for safeguarding training for medical and dental staff was 71.7%.

The 80% target was met for two of the seven safeguarding training modules for which medical and dental staff were eligible. The lowest completion rates were for Prevent training (65.8%), safeguarding vulnerable adults level 2 (64.8%) and safeguarding children level 2 (57.8%).

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had a safeguarding policy which was readily available on the trusts intranet page. There was a dedicated safeguarding team who could advise and support staff if they had concerns about a child or a vulnerable adult. Staff we spoke with were aware of the trusts safeguarding team and said that they were always available for advice and spoke very highly of them. Contacts for the trusts safeguarding team and local safeguarding team were available in the policy. In addition, there were two safeguarding leads (one for adults one for children) as well as four safeguarding dental nursing champions (two for adults and two for children) within the Leeds Dental Institute who staff could contact for advice.

As part of mandatory training the consultants and registrars were required to complete level three safeguarding training. In addition to the level three training consultants and registrars were required to complete additional training about safeguarding. These included topics such as domestic abuse, forced marriage and female genital mutilation. During the inspection we noted that mandatory safeguarding training for dental nurses was level one. We raised this during the inspection. We were later sent evidence that the organisational learning and safeguarding teams had been contacted and the mandatory training for dental nurse had been updated to level two. The dental nurses were currently completing this training.

An audit of staff awareness of safeguarding procedures was carried out in December 2017. This had identified some gaps in staff knowledge about who the safeguarding link nurse or champion was for the service. An action plan had been formulated as a result of this audit.

Staff described examples of safeguarding referral which had been made. We were told as a result of a recent concern, a paediatric consultant had put together a single sided basic guide for dental staff of what to do and who to contact in the event of a safeguarding concern. This paediatric consultant had also developed a trust wide protocol for children who present at any other service within the trusts with bite marks. This included the appropriate method to take photos to ensure they were accurate. They also told us they could liaise with forensic odontologists who could provide additional support for these cases involving bite marks.
In the paediatric department they had a morning huddle to discuss any patients who were deemed to be “high risk”.

There was a process in place for children who were “not brought” to appointments. Initially a letter is sent to the parent or carer, referring clinician and the patients GP. The parent or carer would be given a time limit in which they could contact the service to re-book an appointment. If a child is repeatedly not brought to appointments then a risk assessment would be carried out on the patient taking into account physical, emotional, social and medical needs. A decision would then be made whether to refer the patient to the local safeguarding team. Other healthcare professionals such as the referring dentist, GP, health workers and school nurses would be fully informed of any decisions made.

Cleanliness, infection control and hygiene

Decontamination of contaminated dental instruments and equipment was not carried out within Leeds Dental Institute. Instead, an offsite decontamination facility was used. Staff described the process for the storage and transportation of contaminated dental instruments and equipment. Sterile dental instruments were stored in a dedicated clean room and were passed to the clinicians or students when required. Once instruments had been used they were returned to a dirty utility room where they were placed in robust storage containers to be sent to the off-site decontamination facility. Staff told us there was a 24-hour turnaround of instruments and there were four collections each day for these instruments.

There was a process in place for the tracking of each individual kit of instruments. This involved scanning in and out each kit. In addition, when a kit was used it would be scanned into the patient’s dental care records. This enabled the service to track which instruments had been used on each individual patient. There was a process in place for staff to identify and return faulty or unclean instruments. We were shown a log sheet which was filled in and attached to any kits of instruments which were either incomplete, faulty or unclean. These would then be returned to the off-site decontamination facility. Staff completed checks on sterilised instruments to ensure they did not pass their use by date. Any instruments found to be past their use by date would be returned to the off-site decontamination facility for re-processing.

Hand washing facilities, liquid soap and alcohol hand gel were available throughout the clinic areas. Personal protective equipment (PPE) such as gloves and masks were readily available throughout the clinics. We observed staff followed the “arms bare below the elbow” guidance.

Clinics and general areas were clean, uncluttered and well maintained. There was a healthcare associated infection action plan in place to ensure the risks to patients were kept as low as possible. In addition, hand hygiene audits were carried out every month. The results of these audit were generally good. Where any issues had been identified these had been discussed with staff and re-checked later in the month to ensure compliance.

The trust had a safe use of sharps policy. We saw that safer sharps were routinely used throughout the service. We saw evidence of sharps injury protocols for staff to reference in the event of a contaminated sharps injury. These contained details of the local reporting procedure for contaminated sharps injuries. We saw sharps bins were wall mounted and correctly assembled.

Staff described to us how they managed dental unit water lines (DUWL) to reduce the incidence of Legionella or other bacteria developing. They told us they flushed the DUWL at the beginning of each session and in between patients. A water conditioning agent with reverse osmosis water was used in the DUWL to reduce the incidence of the development of a biofilm. We saw evidence of
water temperature testing was carried out on sentinel outlets. When the temperature was not in the correct range action was taken to address it.

We were shown evidence of water sampling tests which had been conducted on the dental chairs within the Leeds Dental Institute. Many of these identified the existence of a colony forming units. Any chairs identified as showing the existence of colony forming units were treated with a disinfectant. In many instances this had been unsuccessful. We were shown the service had put in place a process to identify certain chairs which had demonstrated the existence of colony forming units. We were told by staff that these chairs would not be used for patients who were deemed to be immunocompromised. All staff we spoke with were familiar with this arrangement. We were shown several e-mails between the staff at the Leeds Dental Institute and the estate team about this issue. The issues had also been discussed at the most recent water safety group on 12 September 2018 and the concerns had been highlighted. In addition, the general manager showed us that this issue had been recorded on the services risk register in 2016 and there had been a capital bid put in recently to replace all the dental chairs in the institute.

Environment and equipment

We observed that dental equipment was clean and well maintained. Staff told us that here was sufficient equipment to support safe and effective care. These included dental handpieces and other dental instruments. We were shown evidence that the dental compressors were serviced and maintained appropriately in accordance with the Pressure Systems Safety Regulations 2000. We saw evidence that equipment was portable appliance tested (PAT) on a rolling basis. There was a system in place to ensure it was completed as required.

Emergency medicines and equipment were readily available throughout Leeds Dental Institute. These were held on specially designed resuscitation trolleys. These included an automated external defibrillator (AED), emergency medicines and oxygen. Each was organised in the same manner with dedicated draws for drugs and miscellaneous items. Each trolley was tamper resistant with plastic tags. The senior dental nurses on each clinic were responsible for the regular checking of the resuscitation trolleys. The contents of the trolleys were in line with guidelines issued by the British National Formulary (BNF) and the Resuscitation Council UK.

Leeds Dental Institute has a dedicated radiography department. An electronic radiation protection folder was held. We saw evidence that all X-ray machines were serviced and maintained appropriately in line with the Ionising Radiation Regulations (IRR 2017). There was a rolling scheme of maintenance of all X-ray machines within the department. This helped ensure all X-ray machines were safe to use. Monthly quality assurance checks were carried out on the cone beam computed tomography machines. Local rules were available for each individual machine and these were currently being updated with help from the trusts Medical Physics Expert (MPE) and Radiation Protection Advisor (RPA).

Assessing and responding to patient risk

During the inspection, we looked at examples of dental treatment records. We found that the clinicians and students always recorded patient safety alerts. For example, medical histories were always taken by the clinicians and updated when patients attended for treatment. These medical histories included any allergies and reactions to medication such as antibiotics. Any relevant medical alerts were highlighted on the patient’s individual dental care record.
Local Safety Standards for Invasive Procedures (LocSSIPs) were routinely used. These are used for extractions to reduce the chance of wrong site surgery. We saw evidence of completed LocSSIPs in dental care records.

We observed a general anaesthetic session. Staff told us they had a group huddle before each session. We observed this huddle before the session which we attended. This included any discussion about any possible complications, the treatment being provided and the order in which they would see the patients. Younger patients or those with physical or medical needs would be seen first to reduce the waiting time for them. Staff ensure that the patients were appropriately fasted prior to the anaesthetic. The patient’s identification was checked at each stage of the process. This included before induction of anaesthesia and prior to any treatment being carried out. We saw evidence of completed World Health Organisation (WHO) surgical safety checklists completed. Staff completed checks to ensure all instruments were accounted for before the patients was woken up after the anaesthetic. This ensured that no foreign objects were left. The patient was monitored appropriately pre and post operatively by competent qualified staff.

Staff ensured that patients and carers received appropriate pre and post-operative instructions about treatments. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage or infections. Patients and carers were also provided with pre and post-operative information conscious sedation and general anaesthesia.

There was a process in place for patients who became acutely unwell during dental treatment. If a patient required emergency resuscitation, this would be carried out by trained members of staff. If the patient did not respond to initial treatment then they would be transferred by an emergency 999 ambulance. Staff were fully aware of this emergency process. In addition, the service had produced training videos relating to medical emergencies. These were about the orientation of the medical emergency trolley and an introduction to the medical emergencies quick reference guides.

The trust had a policy relating to sepsis. In addition, we saw that there were quick reference details on the computers about sepsis. This included the signs, symptoms and the pathway to follow if sepsis is suspected. Staff on the Acute Dental Care (ADC) department were familiar with the issues surrounding sepsis and the pathways to follow.

Rubber dam was always used in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available in all clinics which we visited.

The service had a process for receiving national patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

**Nurse staffing**

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

The trust reported their registered dental nursing staff numbers at Leeds Dental Institute as below as of March 2017 and March 2018.
<table>
<thead>
<tr>
<th>Service</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Leeds Dental Institute</td>
<td>6.9</td>
<td>6.2</td>
</tr>
</tbody>
</table>

*The exact figures were 7.85 WTE actual staff and 7.92 WTE planned staff. Hence the fill rate was 99.2% rather than 100%.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of 6.9% for qualified nursing staff at Leeds Dental Institute. The trust had no target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 13.6% for qualified nursing staff at Leeds Dental Institute. The trust had no target for turnover rate.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 1.4% for qualified nursing staff at Leeds Dental Institute. This was lower than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, the trust used no bank or agency nursing staff at Leeds Dental Institute.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

The trust reported their medical and dental staffing numbers at Leeds Dental Institute as below as of March 2017 and March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2017</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Leeds Dental Institute</td>
<td>100.0</td>
<td>115.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Vacancy rates
From June 2017 to May 2018, the trust reported a vacancy rate of 14.6% for medical and dental staff at Leeds Dental Institute. The trust had no target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From June 2017 to May 2018, the trust reported a turnover rate of 31.7% for medical and dental staff at Leeds Dental Institute. The trust had no target for turnover rate. However, the inclusion of trainee grades in the data is likely to have inflated the rates.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From June 2017 to May 2018, the trust reported a sickness rate of 1.1% for medical and dental staff at Leeds Dental Institute. This was lower than the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From April 2017 to March 2018, the trust used no bank or locum medical and dental staff at Leeds Dental Institute.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix
As of December 2017, the proportion of consultant staff reported to be working in dental specialties at the trust was lower than the England average for dental specialties. The proportion of junior (foundation year 1-2) staff was also lower than the England average.

Staffing skill mix for the 70 WTE medical and dental staff working at the trust
Note: the workforce statistics data published by NHS Digital cannot be broken down by hospital site. Therefore the charts below are based on data for all medical and dental staff working in dental specialties across the trust as of December 2017.

However, as noted in the facts and data section, the majority of the trust's inpatient dental activity takes place at the institute.
The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Staffing levels were monitored by the general manager. Dental students generally assisted each other whilst treating patients. We saw that the dental students were appropriately supervised by a tutor.

We were told that there used to be four senior dental nurses to cover the two restorative student teaching clinics and the specialist restorative clinics. This had now been reduced to two senior dental nurses.

There had recently been an issue with the number of paediatric consultants which had caused the waiting time for children to be seen to reach 62 weeks. There were now four paediatric consultants working at the service supported by postgraduate staff. This had reduced the waiting list to 38 weeks.

**Records**

The service used an electronic record keeping system called Salud. We were told any paper documents were scanned into Salud to ensure they were available for future reference. Computers were password protected and backed up to secure storage to ensure information was properly protected.
Records were completed to a good standard. These included an updated medical history (including social history), an oral health assessment and any treatment proposed. Dental student’s records were checked by a qualified dentist to ensure they were complete and accurate.

Audits of record keeping were carried out. These were part of the services mandatory annual audits. These were done for each department within Leeds Dental Institute. All these audits had action plans and learning outcomes. We saw that these audits had identified that the clinicians often used abbreviations for certain conditions and tests. We were told that as a result of these audits the service had requested certain dental specific terminology to be added to the trusts approved list of abbreviations.

The clinicians we spoke with told us when X-rays were taken they were justified, reported on and quality assured every time. Dental care records which we reviewed supported this. This ensured that the service was acting in accordance with the Ionising Radiation (Medical Exposure) regulations IR(ME)R and protected staff and patients from receiving unnecessary exposure to radiation.

Results of tests ordered by the oral medicine department were available on the electronic requesting system known as Integrated Clinical Environment (ICE). The service had carried out an audit of the timeliness at which these test results had been “actioned”. It had identified that only 50% of results were actioned with the gold standard of one week. An action plan had been formulated to improve this compliance and circulated to staff. This included ensuring there was cover for clinicians if they were on leave. The follow up audit carried out in August 2018 showed 100% compliance with the gold standard of one week.

Medicines

Medicines used in the provision of intravenous sedation (Midazolam) were stored securely in locked wall mounted metal cabinets. A controlled drug log was maintained by staff. This showed the amount used on each patient and the volume which was disposed of. The trust pharmacy department carried out a quarterly audit on the use of midazolam and flumazenil.

Portable oxygen cylinders were readily available on each clinic in case of a medical emergency. These were checked daily by a dental nurse to ensure there was sufficient oxygen available.

Prescription pads were stored in locked cabinets. These were trust specific prescriptions and could only be dispensed from the trusts internal pharmacy. Logs were maintained of prescriptions provided to patients. In addition, there was a small stock of antibiotics used for when certain types of surgery were carried out. There was a stock control system to ensure these did not pass their expiry date. We checked the stock and found all antibiotics to be in date.

Audits of prescribing were carried out. The most recent audit demonstrated that the dentists were following nationally recognised guidance for the prescription of antibiotics. It had identified that improvements could be made to the process for following up the patient after two to three days. This had been discussed with staff and would be re-audited.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From June 2017 to May 2018, the trust reported no incidents classified as never events at Leeds Dental Institute.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) at Leeds Dental Institute which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

There had not been any never events at Leeds Dental Institute in the previous 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. An example of a never event in dentistry is a wrong tooth extraction.

Staff were familiar with the concept of a never event and described to us the process for reporting these.

Staff told us about a never event which occurred approximately 18 months before the inspection. This related to wrong site surgery. As a result of this, the dental safe surgery checklist had been reviewed. Previously there were different checklists for students and qualified clinicians. The checklist had been simplified. In addition, a training video explaining how to use the new safer surgery checklist had been implemented.

Staff described to us how they reported significant events, incidents and accidents. These were reported on the trust's electronic reporting system. Significant events, incidents and accidents were graded according to their severity. Staff described to us examples of significant events which had been reported. These included missing equipment and IT issues. Staff told us that learning from significant events was regularly discussed at departmental meetings. In addition, learning from other departments was cascaded to all departments if necessary.

The managers had oversight of the incidence of significant events, incidents and accidents. These were discussed at the clinical governance meetings where any trends could be identified and decisions made to prevent re-occurrence.

Is the service effective?

Evidence-based care and treatment

The dentists followed national guidelines to ensure patients received the most appropriate care. These included guidance set out by the National Institute for Health and Care Excellence, British Orthodontic Society, British Society of Periodontology and the Faculty of General Dental Practice. The dentists we spoke with were knowledgeable about these guidelines and the standards that underpinned them.

The dentists providing conscious sedation followed the standards set out by the Scottish Dental Clinical Effectiveness Programme “Conscious Sedation in Dentistry” 2017. There were policies and procedures which supported the clinicians to follow this guidance.
We were shown examples of sedation checklists which demonstrated the clinicians carried out checks in line with guidance. These included monitoring the patient’s oxygen saturation and blood pressure throughout the sedation procedure.

Rubber dam was routinely used when clinicians were carrying out root canal treatment in line with guidance from the British Endodontic Society.

**Nutrition and hydration**

Patients undergoing general anaesthesia were given appropriate information by staff of the need to fast before undergoing their procedure. The patient, parent or carer were given a pre-operative instruction sheet emphasising the importance of fasting prior to the procedure. Advice about fasting prior to conscious sedation was given on an individual basis according to the patient’s medical needs.

The clinicians and dental nurses gave patients healthy eating advice in line with the Department of Health’s ‘Delivering better oral health – the evidenced based toolkit on the prevention of dental disease’.

**Pain relief**

The dentists assessed patients need for pain relief on an individual basis. They took into account patients age, co-operation and the complexity of treatment required. For example, for a nervous, young child requiring multiple extractions where local anaesthesia was not possible then a general anaesthetic was used as an alternative.

Patients were given advice about post-operative pain. This included advice about appropriate analgesia. Patients were advised to avoid taking aspirin after any surgical procedures as this could precipitate post-operative bleeding.

Information about post-operative analgesia was available within patient information leaflets. Patients undergoing general anaesthesia were given appropriate pain relief after the procedure.

**Patient outcomes**

**Relative risk of readmission**

*Leeds Dental Institute – elective admissions*

From February 2017 to January 2018, patients at Leeds Dental Institute had a lower than expected risk of readmission for elective admissions when compared to the England average:

- Patients in oral surgery had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Patients in paediatric dentistry had a lower than expected risk of readmission for elective admissions when compared to the England average.

The institute only admits patients electively.
Quality assurance processes were embedded within the culture of the service to improve patient outcomes and ensure quality and safety were not compromised. Many clinicians within the service were involved with audit and research projects which had been published in national and international journals for wider dissemination and learning. For example, we were told that the institute had been involved in a clinical trial looking into the effectiveness of hyperbaric oxygen for the prevention of osteoradionecrosis (HOPON). The results of this trial are currently awaiting publication.

The maxillo-facial team also used three-dimensional scans to assist with the planning of surgery for patients requiring resection of part of their jaw as a result of cancer. They used the scans to create a three-dimensional model of the patient’s jaw. A pre-bent sterilised bone plate would then be made on the model. This was used to guide the surgeons about where to place the bone graft. This reduced the amount of time required under general anaesthetic and greatly improved the final aesthetics of the procedure.

An audit of dental implants placed to facilitate rehabilitation of head and neck cancer patients had been carried out in June 2018. This included 297 dental implants which had been placed in 88 patients. The results showed that 97% early implant survival and 94% of these cases had been fully restored. This audit would be repeated to check on the long-term success of these implants.

The orthodontic department had completed an audit of unscheduled orthodontic appointments. These included patients presenting with de-bonded orthodontic brackets. This had identified that 3.8% of orthodontic clinical time was spent treating these patients. This was less than figures reported in other published audits. It also showed that 90% of these patients were seen within one hour. The service aimed to improve on this figure and it was hoped that as a result of increased staffing levels this would be done.

Members of the orthodontic department told us that they were using three-dimensional scans using cone beam computed tomography to create stents to assist with orthognathic surgery.
These were for patients who required surgery to correct the alignment of their jaws. We were told that this work had improved the clinician’s ability to plan the surgery and reduced actual surgery time and recovery time.

The institute was also involved in a current project looking at the effectiveness of low-level laser therapy for preventing or treating oral mucositis caused by radiotherapy. The National Institute for Health and Care Excellence had recently published some guidance about this in May 2018. The clinicians were currently involved in the trial of this procedure. Initial indications showed that this intervention reduced the incidence of oral mucositis and reduced the need for analgesia.

The Leeds Dental Institute had an on-site dental laboratory which made dental prosthesis for patients receiving treatment at the institute. They had a dedicated area of this laboratory for construction of maxillo-facial prosthesis. We were told and saw evidence of cases where they had used modern digital technology to print highly realistic prosthetic eyes for use in maxillo-facial prosthesis. We were shown numerous examples of when these had been used. To achieve these outcomes, they worked closely with the medical imaging department at the institute. The medical imaging department had also recently won accreditation from the Institute or Medical Illustrators.

**Competent staff**

**Appraisal rates**

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

Leeds Dental Institute had an appraisal completion rate of 99.1% across all staff as of June 2018. The trust target was 95%.

The breakdown for registered nurses and medical/dental staff is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who</td>
</tr>
<tr>
<td></td>
<td>received an</td>
</tr>
<tr>
<td></td>
<td>appraisal</td>
</tr>
<tr>
<td>Registered nursing staff</td>
<td>9</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
</tr>
</tbody>
</table>

Please note that the number of medical and dental staff shown as requiring an appraisal is much smaller than the number that worked in the Leeds Dental Institute in March 2018 according to the total staffing tab of the Routine Provider Information Request (see the medical staffing section above). This should be queried with the trust. (Note to inspectors: the last paragraph can be removed once confirmation from trust has been received).

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

There was an effective skill mix within the service. Staff were encouraged to complete additional training relevant to their roles. Many dental nurses had competed extended duty training. These included oral health education, impression taking and sedation. We were told that they were able to use these extended duties in their day to day roles.

Leeds Dental Institute developed the Yorkshire Orthodontic Therapy Course in 2007.
This is a yearlong course aimed at qualified orthodontic nurses and dental care professionals who wish to become involved in the provision of orthodontic treatment. Since the development of the course several orthodontic therapists had become integrated within the orthodontic service. The use of orthodontic therapists enables the specialist orthodontists to concentrate their time on diagnosis, treating more complex cases, whilst still maintaining a specialist led service for more routine cases.

Staff received regular appraisals. They told us that these appraisals were worthwhile and useful for reflecting on performance, talking about training needs and highlighting any concerns. The Leeds Dental Institute was the top core service unit within the trust for staff appraisal rates.

**Multidisciplinary working**

Multidisciplinary team (MDT) working was used throughout the service. We were given numerous examples of when MDT were used. Several departments worked together to improve the outcomes for patients. The orthodontic clinicians worked collaboratively with many other departments such as paediatrics, restorative, oral and maxillofacial surgery, oral surgery and the cleft lip and palate team. We were told the orthodontic and paediatric departments had a clinic every month dedicated to premolar transplantation. This is where a patient’s premolar tooth is removed (if the tooth was deemed not essential for aesthetic or function reasons) and then transplanted into the anterior region. This was used in cases where trauma to a patient’s anterior tooth had reduced its long-term prognosis. This enabled the patient to retain a natural tooth and avoid the need for a denture. This work had been published in dental journals. A publication in 2017 demonstrated an overall success rate of 87.6% and a 94.4% survival rate. An article published in 2013 which looked at patient and parent satisfaction with the treatment demonstrated that most 92% of patients and 88% of parents would recommend this treatment.

The maxillo-facial clinicians held weekly meetings with the oncology and pathology departments to discuss upcoming cases and treatment plans. These clinics were to discuss a joined-up approach to improving patient outcomes. For example, the orthodontic and paediatric joint clinics they would discuss the most appropriate times to remove teeth so not to compromise the outcome of orthodontic treatment.

The paediatric department could liaise a patients GP or paediatricians prior to a general anaesthetic. This was to check if there were any other treatments were required such as blood tests. These could be done whilst the patient was under the general anaesthetic.

**Health Promotion**

Dental staff used the Department of Health’s ‘Delivering Better Oral Health’ toolkit 2013 when providing preventative advice to patients on how to maintain a healthy mouth. This is an evidence-based tool kit used for the prevention of the common dental diseases. Staff told us they discussed dietary advice, toothbrushing instruction and smoking cessation with patients. There were numerous health promotion leaflets available throughout the institute for patients to reference. High fluoride toothpaste was prescribed for patients at high risk of developing dental caries. These included children with a high incidence of caries, patients with a dry mouth and those undergoing radiotherapy.

We were told that many dental nurses had received additional training to provide oral hygiene advice. They were used to provide intensive oral hygiene advice to patients prior to and during orthodontic treatment. This was to reduce the likelihood of the patient developing dental caries during orthodontic treatment.
We were told that the paediatric department gave out free toothbrushes to children to take home. We also saw evidence of patients who attended for sedation who had dental caries were referred to an oral hygiene educator to receive detailed oral hygiene and dietary advice about how to prevent further dental caries.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

The trust reported that, as of June 2018, registered nursing staff at Leeds Dental Institute were 100.0% compliant with Mental Capacity Act (MCA) training.

MCA level 1 training had been completed by all five eligible registered nursing staff. MCA level 2 training had been completed by all four eligible registered nursing staff.

The trust reported that, as of June 2018, medical staff at Leeds Dental Institute were 79.5% compliant with Mental Capacity Act (MCA) training. The breakdown by training module is shown in the table below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number trained</td>
</tr>
<tr>
<td>Mental capacity act level 1</td>
<td>4</td>
</tr>
<tr>
<td>Mental capacity act level 2</td>
<td>124</td>
</tr>
</tbody>
</table>

Deprivation of Liberty Safeguards training data was not provided in the routine provider information request. This data should be requested during inspection or it should be determined if this training is included in Mental Capacity Act (MCA) training. (Note to inspectors: the last sentence can be removed once confirmation from the trust has been received).

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the importance of obtaining and recording patients' consent to treatment. Staff described to us the process which they went through to obtain informed consent. This included informing the patients or carers about the different options available and the risks and benefits associated with each treatment option. We saw good evidence that dentists documented the consent process in the patient records and utilised NHS consent forms to support this. These consent forms were signed by both the patient, parent or career and the clinician. Staff showed us examples of signed consent forms.

For complex treatments such as joint maxillo-facial and restorative cases the patient would also be sent a letter highlighting the risks associated with the proposed treatment. We saw evidence of such a letter.

Where patients were undergoing treatment under conscious sedation then consent was always obtained at a pre-assessment appointment following standards set out by the Scottish Dental Clinical Effectiveness Programme “Conscious Sedation in Dentistry” 2017. This was then re-confirmed on the day of treatment. Patients undergoing conscious sedation were also informed that the treatment plan may need to change during the treatment.
This may be because a tooth may be deemed unsalvageable and may need to be extracted as a result.

Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005. However, we were told that they infrequently treated patients who lacked capacity. If they did ever need to provide treatment to a patient who lacked capacity, then they would check if any other person had a lasting power of attorney. They would also involve an Independent Mental Capacity Advocate (IMCA). Staff told us that the trust had a dedicated Mental Capacity Act who could provide advice and support.

Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

### Is the service caring?

#### Compassionate care

**Friends and Family test performance**

From May 2017 to April 2018 the friends and family test (FFT) response rate for Leeds Dental Institute was 81.3%. This was based on 1,273 responses.

According to the FFT data, only patients in the specialty oral surgery at the site were eligible. The response rate was higher than the England average response rate of 32.9% for the specialty oral surgery.

The overall percentage of patients who said they would recommend the institute to friends and family over these 12 months was 98.4%. This was similar to the overall England performance of 98.1% for the specialty oral surgery.

A breakdown of FFT performance by month for the period from May 2017 to April 2018 is below. The institute consistently scored 97% or above on a monthly basis over this period.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Respondents</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds Dental Hospital Day Unit</td>
<td>1,273</td>
<td></td>
</tr>
<tr>
<td></td>
<td>81%</td>
<td>May-17</td>
</tr>
<tr>
<td></td>
<td>90%</td>
<td>Jun-17</td>
</tr>
<tr>
<td></td>
<td>90%</td>
<td>Jul-17</td>
</tr>
<tr>
<td></td>
<td>93%</td>
<td>Aug-17</td>
</tr>
<tr>
<td></td>
<td>93%</td>
<td>Sep-17</td>
</tr>
<tr>
<td></td>
<td>93%</td>
<td>Oct-17</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Nov-17</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Dec-17</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Jan-18</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Feb-18</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Mar-18</td>
</tr>
<tr>
<td></td>
<td>93%</td>
<td>Apr-18</td>
</tr>
<tr>
<td></td>
<td>98.4%</td>
<td>Ann. Perf.</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

We observed staff treating patients with dignity and respect. Patients told us that staff were friendly, understanding and sensitive to health and personal circumstances.

Staff focussed on the medical, physical and social needs of patients. We observed positive interactions between staff and patients. For example, we witnessed dental students working on the restorative department greet patients in the waiting area, escort them to their hub and engage in conversation with them.

Privacy and confidentiality was maintained in the reception area. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy they would take them into another room.
The reception computer screens were not visible to patients and staff did not leave patients’ personal information where other patients might see it.

The student teaching clinics were open plan. This provided a challenge for maintaining confidentiality. However, we witnessed staff speaking quietly whilst on the open plan clinic to ensure no personal conversations could be overheard. Patients confirmed that there was sufficient privacy when they were being treated.

Staff respected peoples’ individual preferences, habits, culture, faith and background.

**Emotional support**

Staff were clear on the importance of emotional support needed when delivering care. They took into account patients emotional needs when providing treatment. Patients told us that staff were helpful and listened to them about any concerns which they had.

The waiting area in the paediatric department was designed to be child friendly. There was a fish tank and child friendly literature to keep children entertained before their appointment. Staff on the paediatric department were developing a sensory box for patients with autism. This involved introducing the patient to different items used in the dental environment such as drills, hand instruments and materials.

The oral medicine department had a dedicated quiet room which was used for breaking bad news. We were told that when bad news was delivered this was done in conjunction with a Macmillan nurse to provide support for the patient and family.

Staff told us that appointment times and lengths could be tailored to individual patient needs. For example, longer appointments may be required for patients who were particularly nervous or for those undergoing sedation. This enabled the clinicians to meet the emotional needs of patients undergoing treatment and ensure they were not rushed.

**Understanding and involvement of patients and those close to them**

Patients and their families were appropriately involved in and central to making decisions about care options and the support needed. Patients we spoke with confirmed they were fully involved in decisions about treatment.

Staff described to us the different methods they used to help patients and their families to understand treatment. For example, on the orthodontic clinic there was a specific patient journey. This involved an initial appointment on a consultant led clinic. The treatment plan was formulated and discussed with the patient and parent or carer. Models, books and pictures of different appliances were used to help explain the treatment. Staff explained to patients how these work and the need for appropriate maintenance. They would also discuss the need for possible extractions as part of the treatment process. We were shown a book which had been developed by the speciality registrars and orthodontic therapists which had colour pictures of the different stages of orthodontic treatment. Patient undergoing orthodontic treatment were also provided information leaflets produced by the British Orthodontic Society to help patients understand the proposed treatment.

Other methods to help patients understand treatment included the use of X-rays. The clinicians would use X-rays to demonstrate to patients a problem with a tooth or teeth. This may include dental caries, fractures in roots or issues with bone levels. In addition, three-dimensional scans
were taken for more complex treatments such as orthognathic or maxillo-facial surgery. These could be used to demonstrate to patients the surgery.

The service had developed a series of information leaflets about different types of treatment available at the service. These included root canal treatment, immediate dentures, crowns, dental implants and apical surgery. These were readily available throughout the institute.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Average length of stay**

**Leeds Dental Institute - elective patients**

From March 2017 to February 2018 there were seven overnight admissions from Leeds Dental Institute to Leeds Teaching Hospitals NHS Trust. All of these were patients who were admitted for one night and discharged the following day.

These admissions were split between oral surgery and paediatric dentistry, with fewer than six admissions to each of these two specialties.

There were 1,567 day case admissions to the institute over the same period.

The institute only admits patients electively.

(Source: Hospital Episode Statistics)

The dental service was commissioned by NHS England. The service provides specialist treatments and advice following a referral from a dentist or doctor.

They also offer routine dental treatments carried out by undergraduate dental students, dental therapists and orthodontic therapists.

Emergency appointments were available for patients experiencing pain or had trauma. This service was provided by undergraduate dental students carrying out treatment under the supervision of qualified clinicians and operated twice a day from Monday to Friday during term time. Appointments were allocated on a first come first served basis. Patients were triaged by trained dental nurses using a locally developed protocol. If the clinic was not able to see a patient, then they were signposted to the NHS111 service.

Patients requiring emergency treatment who were currently in a course of treatment at the institute were provided with information about what to do in an emergency in patient information leaflets.

**Meeting people’s individual needs**

The service was configured to reflect the needs of vulnerable people. It was fully accessible for wheelchair users, patients with push chairs or patients with limited mobility. Adjustments which had been made included automatic doors, wide corridors accessible toilets, lowered reception desks and hoists. There was a list of staff who were trained in the use of hoists to assist patients in wheelchairs. We were also informed that the dental chairs could be modified to enable patients to
be treated in their wheelchair.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas, written in languages other than English, informing patients that translation service were available. In addition, induction loops were available for use by patients with hearing aids.

There were adequate seating facilities in the waiting areas in all the departments. Parking spaces for blue badge holders were available outside the front entrance of the institute.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Oral surgery is the only specialty relevant to dentistry that is included in the admitted referral to treatment data. Paediatric dentistry and maxillofacial surgery are not included as separate specialties in this data set.

The referral to treatment data set does not include a breakdown by hospital site. Therefore the data below is at trust level. However, as noted in the facts and data section, the majority of the trust’s inpatient dental activity takes place at the institute.

From June 2017 to May 2018 the trust’s referral to treatment time (RTT) for admitted pathways for the oral medicine/oral & maxillofacial surgery department was consistently better than the England average. Over this time period, 87.4% of patients at the trust were referred for treatment within 18 weeks compared with the England average of 62.2%.

There was a trend of improvement from 82.3% in June 2017 to 95.2% in December 2017. This was followed by varied performance between January and May 2018. Over these five months the institute’s performance varied from 85.4% to 92.3%.

(Source: NHS England)

**Cancelled operations**

The cancelled operations data set published by NHS England cannot be broken down by hospital site or specialty. Therefore it is not possible to calculate data for Leeds Dental Institute.

(Source: NHS England)

General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long term continuing care to the community dental service. Once
a course of treatment had been completed the patient was referred back to primary dental care for ongoing care with their own dentist.

Waiting times were actively monitored by the dental service manager and discussed at trust performance meetings.

Referrals for oral surgery, oral medicine and maxillo-facial surgery were received through an online digital referrals system. These referrals were initially triaged by a specialist and allocated to the most appropriate waiting list. We saw evidence of this system. Staff told us that this system had improved the efficiency of the referral system.

We were told that a new “one stop” minor oral surgery clinic had been set up. This was a consultant led clinic. Referrals were received through the online digital referrals system and triaged by a specialist. The next available appointment would then be booked for the patient. The clinic was reserved for patients with two or fewer comorbidities and in line with guidance set out by the National Institute for Health and Care Excellence. This clinic offered an assessment and treatment at the same appointment. This reduced the need for multiple visits. This had helped reduce the waiting list.

We were told that there was a current waiting time of 38 weeks from referral to treatment for the paediatric department. This had been reduced from 52 weeks previously. We were told this was as a result of historic staffing issues. The staffing levels on the paediatric department were now better and the waiting list was now reducing.

The referral to treatment (percentage within 18 weeks) for September 2018 were:
- Oral surgery 96%
- Restorative dentistry 88.2%
- Paediatric dentistry 52.3%
- Orthodontics 96.1%
- Dental medicine 98.2%

Learning from complaints and concerns

Summary of complaints

The following analysis excludes research activity and the paediatric cleft lip service which falls under services for children and young people.

From May 2017 to April 2018 the trust received 10 complaints about the Leeds Dental Institute. For those complaints that had been closed, the trust took an average of 52.6 working days to investigate and close these complaints. This was not in line with their complaints policy, which states that complaints should be responded to within 40 working days.

The breakdown of complaints by subject is shown below. Because one complaint can have multiple subjects, the total below exceeds the total number of complaints.

- Clinical treatment: six
- Appointments (including delays and cancellations): four
- Communications: four
- Waiting times: three
- Access to treatment or drugs (including decisions by commissioners): two
- Admissions: one
- Consent to treatment: one
- Patient care: one

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From May 2017 to April 2018 the trust received three compliments about Leeds Dental Institute.

In their RPIR the trust did not provide a breakdown by subject or theme for compliments in each core service or location. Their overall summary of themes identified from compliments also does not specifically mention the institute.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The trust had a complaints policy and procedure which was readily available for staff to reference. Information leaflets about how to complain were readily available in patient areas and on the trusts internet page. These included details of the Patient Advice and Liaison Service (PALS). If a patient made a verbal complaint at the institute then they would be taken to a quiet room to discuss their concerns. If the patient was not satisfied with the response, then they were signposted to the PALS. The PALS team would identify the themes of the complaint and notify the general manager. The complaint would be investigated by a senior member of staff not linked to the complaint. Patients were invited in to discuss complaints in person with the senior member of staff. The service aimed to have a response ready by 21 days and get the response to the patient within 30 days. Complaints were discussed at the clinical governance meetings and the trusts performance meeting.

We looked at records relating to two complaints which had been received. These provided a detailed, open and honest response to the patient.

Is the service well-led?

Leadership

The general manager was responsible for the day to day running of the service. The clinical director provided overall clinical leadership for the service. The dental nurse manager provided support for the dental nursing staff within the service. There were individual clinical leads provided by consultants on each department.

Staff told us that managers were visible, and we witnessed positive interactions between them and staff throughout the inspection. Staff were clear about who their managers were and told us that they were approachable and felt they could contact them if they had any concerns.

We were told that six senior members of staff had recently been put on a leadership course by the trust. This was called “Lean for Leaders”. This course aimed to improve the leadership skills of senior members of staff. Staff who were on the course told us about systems and process which they had put in place to make the service safer and more effective. They attributed this to the leadership course. Examples included the use of a production board in in the oral medicine and maxillo-facial clinic. This was a white board which had details of staff who were working on each clinic, the number of patients expected, numbers of patients which had been seen and whether the clinic was running on time or not. In addition, the orthodontic department had re-organised their instrument drawers to make them identical. This made it easier for clinicians if they needed to work in a different area of the clinic.
Vision and strategy

The clinical director told us that the vision of the service was to be the best specialist dental centre nationwide. They aimed to achieve this by training staff to continuously improve themselves and provide a supportive environment for learning.

The trusts values were patient-centred, accountable, fair, collaborative and empowered. These values formed part of “The Leeds Way”. Staff we spoke with were aware of the values and “The Leeds Way”. The values were displayed on computer home screens and in prominent places around the service.

Culture

Staff were passionate and proud to be working within the service and providing high quality care to their patients. Staff morale was good across the service and it was clear they were committed to providing the best care possible for every patient. Many members of staff had worked at the institute for several years, spoke positively about the trusts and felt well supported.

Staff were aware of their responsibilities to raise concerns if the need arose. They were aware of the local whistleblowing process and felt comfortable to be able to raise concerns. There were details of how to raise concerns displayed in staff areas including details of public concern at work.

Staff told us that a dental nurse working on the restorative department had been appointed as a health and well-being lead. This member of staff maintained the health and well-being notice board on the department. They were also a point of contact if staff members had any concerns about their well-being.

Staff and managers were aware of the need to be open and transparent with patients in line with the duty of candour.

Governance

There were effective governance procedures in place to enable the smooth running of the service. The clinical director also held the role of clinical governance lead for the institute. Policies and procedures were readily available on the trusts intranet page and were updated regularly to ensure they reflected current guidance and legislation. These were a mix of trust wide policies and polices specific to the institute. Several members of staff were involved in the production of these polices. Staff told us they had good access to these polices and demonstrated how they could find them.

Monthly clinical governance meetings were held. This was chaired by the clinical director. This was attended by the heads of each department and a representative of the infection prevention and control team. At these meetings topics such as infection prevention and control, incidents, complaints and quality were discussed. There was a weekly triumvirate meeting involving the clinical director, general manager and the dental nurse manager. In addition to these meetings, consultant departmental meetings were held on a monthly basis. Information from these meetings was filtered down to staff through monthly department meetings.

Quality assurance processes were central to the culture and ethos of the service. We were shown the audit dashboard which included all the mandatory audits which the trust required the service to complete. These included audits of X-rays, record keeping and other clinical topics. We saw that all audits had documented outcomes and action plans to encourage continuous improvement.
Management of risk, issues and performance

The service maintained a risk register which was regularly reviewed by senior members of staff. Each risk was apportioned a risk rating. Mitigating factors were put in place to reduce the likelihood of the risk causing harm to patients or staff. The risk register was discussed at the monthly governance meetings to ensure that they were appropriately mitigated.

There were currently nine entries on the risk register. We saw that the issues surrounding the dental unit water lines had been identified and put on the risk register in 2016. The risk register entry highlighted the risk of patient infection due to contaminated water in the dental waterlines within dental chairs resulting in potential harm to medically compromised patients. This had been allocated a risk rating of 4. We discussed with the general manager during the inspection whether after our findings during the inspection whether this level of risk was appropriate. We were assured that this rating would be addressed. The issues with the restorative and paediatric waiting lists were also on the risk register.

Information management

The service collected, analysed, managed and used information well to support all its activities. Staff had completed training in information governance and were aware of the importance of protecting patients’ personal information. For example, staff locked computers when they moved away from their workstations, reception computer screens were not visible to patients and staff did not leave patients’ personal information where other patients might see it.

Dental care records were mainly computerised. However, there were still some records held on paper. They were aiming to become completely paper free in the near future. We saw computers were password protected and were told these were backed up to secure storage. Paper records were held in a secure room.

Engagement

One of the oral medicine consultants was involved in the development of the local managed clinical network (MCN) for oral surgery, oral medicine and maxillo-facial surgery. MCNs are groups of professionals from primary, secondary and tertiary care who work together to ensure the equitable provision of high quality effective services. These networks enable the clinicians to engage with general dental practitioners and other providers of secondary care about how services can be improved. We were told that this MCN had been instrumental in the development of a new referral pathway for oral medicine. They had produced a quick and a full referral guide to assist primary care dentists in deciding the most appropriate pathway to refer the patient. Details of the development of the MCN had been published in the British Dental Journal in November 2017.

The general manager also told us that the liaised with the NHS England local area team about waiting times and referral pathways. For example, they would work with NHS England to ensure a joined-up approach to informing primary care dentists about the new criteria for endodontic referrals. In addition, they were working with NHS England to develop a referral pathway for patients with tempo mandibular joint problems. The general manager also attended the local dental network meetings to discuss topics such as referral times with primary care dentists.
Learning, continuous improvement and innovation

Learning, continuous improvement and innovation was well embedded within the culture of the service. The service was heavily involved in research through the Dental Translational and Clinical Research Unit (DenTCRU). DenTCRU is a collaborative approach towards research between the University of Leeds and the Leeds Dental Institute. The aim of this unit was to expediate interdisciplinary translational research for patient benefit.

DenTCRU had recently done a project called “Don’t smile”. This was an innovative research project using theatrical performance to disseminate research to at-risk seldom-heard adolescents in areas of social deprivation and high oral health inequality. The purpose of this was to test whether theatre may impact knowledge, allow debate and improve oral health awareness in at risk adolescents. As a result of this project, students at a local secondary school were keen to become involved in providing oral health education and toothbrushing instruction with help from final year undergraduate dental students to primary school children at their school. In addition, because of this project one of the students at the school had recently started to train to become a dentist. This project had won the National Co-ordinating Centre for Public Engagement (NCCPE) prize in 2016.

Other research projects included work involving the use of digital imaging in dentistry, the genetic function in the development of enamel abnormalities, skeletal tissue repair and regeneration and looking at the link between periodontal disease and rheumatoid arthritis.

The Leeds Dental Institute provided training for undergraduate dental students from the University of Leeds. They had recently installed 30 haptic dental trainers. These provide the dental students with virtual cases where they can practice providing treatment in a safe environment to develop core surgical skills. In addition, scans of real teeth could be downloaded to these machines to allow the students to practice on a virtual tooth prior to carrying out the treatment on the real tooth.