

Leeds Teaching Hospitals NHS Trust

Quality Report

Great George Street
Leeds
West Yorkshire
LS1 3EX
Tel: 0113 2432799
Website: www.leedsth.nhs.uk

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

Ratings

Overall rating for this trust

Good 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Good 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

We inspected the following locations:

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

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

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

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

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

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

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

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

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

Our key findings were as follows:

- Since the last inspection, the trust had invested time, effort and finances into developing a culture that was open, transparent and supported the involvement of staff, and reflected the needs of the people who used the services.
- Changes such as the development of clinical service units and governance arrangements that were in their infancy at the last inspection had been further embedded and embraced by staff in the organisation.
- Each clinical service unit had clear direction and goals with steps identified in order to achieve them.

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- The leadership team had remained stable. Staff across the organisation were positive about the access and visibility of executives and non-executives, particularly the Chief Executive. There had been improvements to services since the last inspection.
- The leadership team were aware of and addressing challenges faced with providing services within an environment that had increasing demand, issues over patient flow into, through and particularly out of the organisation, including the impact this had on service provision; and the recruitment of appropriately skilled and experienced staff.
- The trust values of, 'The Leeds Way' were embedded amongst staff and each clinical service unit had a clear clinical business strategy, which was designed to align with the trust's 'Leeds Way' vision, values and goals. This framework encouraged ownership from individual CSUs.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.
- Staff reported across the trust that they were proud to work for the organisation and felt that they worked well as a team across the different sites.
- The trust invited all 15,000 staff to participate in the national staff survey, with a response rate of over 8,000 staff across the organisation. The survey showed that there was continuous improvement. The response rate for the NHS Staff Survey 2015 was 50%, this was better than the England average of 41%.
- At service level there were governance processes and systems in place to ensure performance, quality and risk was monitored. Each CSU met weekly and used the ward health check to audit a range of quality indicators including the number of falls, complaints, pressure ulcers, staffing vacancies and staff sickness. This information was then escalated to senior staff and through the trust's governance structure.
- There was a positive culture around safety and learning from incidents with appropriate incident reporting and shared learning processes in place. However, learning from Never Events was not consistent amongst all staff within theatres. All steps of the World Health Organisation (WHO) safety checklist were not consistently taking place: audit data and our observations supported this. The audit data provided by the trust did not assure us that national early warning score (NEWS) and escalation was always done correctly.
- There were occasions when nurse and care support worker staffing levels were below the planned number. Despite having a clear escalation process, non-qualified staffing levels did not always mitigate for the reduction in qualified nursing levels. Nursing, midwifery and medical staffing levels did not meet national guidelines in some areas, particularly surgery, theatres, critical care, maternity and children and young peoples' services. The trust was actively recruiting to posts and supporting a range of role development programmes to diversify the staff group, including supporting advance roles and role specific training for non-qualified staff.
- Arrangements and systems in place were not sufficiently robust to assure staff that the maintenance of equipment complied with national guidance and legislation.
- There were arrangements in place for assessing the suitability of patients who were appropriate to wait on trolleys on the assessment ward. However, these were not consistently applied, or risk assessments undertaken. There was a lack of robust assurance over the oversight of patients waiting on trolleys.
- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. In accordance with trust policy, a two stage consent process including two patient signatures was not consistently evidenced in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- There was a much improved mandatory training programme. However, there were still low completion levels in some training, particularly resuscitation and role relevant safeguarding.
- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated there was no evidence of risk compared to the England average.
- There were suitable arrangements in place for the prevention and control of infections, including

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policies, procedures and a dedicated infection prevention control team. Areas visited were clean and staff generally adhered to good infection control practices.

- The trust responded to complaints and concerns in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns.
- The trust took into consideration the needs of different people when planning its services and made reasonable adjustments for vulnerable patient groups.
- There was clear guidance for staff to follow within the care of the dying person's individual care plan when prescribing medicines at the end of their life. Patients' individual needs and wishes at the end of their life were represented clearly in the documentation.
- Policies and guidelines were based on the latest national and international guidelines such as from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine.
- On the whole, patients received pain relief in a timely manner and were able to access food and drinks as required.
- Arrangements were in place to alert staff when patients were in receipt of treatment or admitted with special needs or were vulnerable, including living with dementia and learning disabilities. Staff had received training on how to support patients and individualise care to meet specific needs.
- Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients, although there was some inconsistent practice over care of patients receiving rapid tranquilisation treatment.

We saw several areas of outstanding practice including:

- There were outstanding examples of record keeping in the care of the dying person care plan. We saw that staff recorded sensitive issues in a clear comprehensive way to enable safe care to be given.
- The development of Leeds Children's Hospital TV allowed families to explore the wards and meet the teams.
- Organ transplantation which included a live liver donation and transplant programme had been undertaken, which was the largest in the UK. Other aspects of the transplantation programme included Neonatal organ retrieval and transplantation, Life Port

Trial, Kidney Transplantation, QUOD Trial, Quality in Organ Donation National Tissue Bank, Revive Trial, Organ Care System and Normothermic perfusion, Support for Hand Transplantation.

- Procedures such as minimally invasive oesophagectomies were being performed. The colorectal team were using sacral nerve stimulation for faecal incontinence.
- There is a consultant led virtual fracture clinic. This allows patients to be assessed without attending the hospital and then have the most appropriate follow up. This reduces unnecessary hospital attendances.
- Revolutionary hand transplant surgery had taken place within plastic surgery.
- Nurse-led wards for patients who were medically fit for discharge had been introduced to allow the service to adapt their staffing model to meet the needs of patients.
- In response to patient carer feedback the acute medicine Clinical Service Unit had introduced John's campaign. This allowed carers to stay in hospital with patients with dementia.

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

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure all staff have completed mandatory training and role specific training.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.
- The trust must review the admission of critical care patients to theatre recovery areas when critical care beds are not available to ensure staff are suitably skilled, qualified and experienced.
- The trust must review how learning from Never Events is embedded within theatre practice.
- The trust must review the appropriateness of out of hours' operations taking place and take the necessary steps to ensure these are in compliance with national guidance.

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- The trust must review the storage arrangements for substances hazardous to health, including cleaning products and sharps disposal bins to ensure safety in line with current procedures.
- The trust must review and address the implementation of the WHO Five Steps to Safer Surgery within theatres.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must review the function of the pre theatre waiting area in Geoffrey Giles theatres and ensure that the appropriate checks and documentation are in place prior to patients leaving ward areas.
- The trust must ensure that all equipment used across core services is properly maintained and serviced.
- The trust must ensure that staff maintain patient confidentiality at all times, including making sure that patient identifiable information is not left unattended.
- The trust must ensure that infection prevention and control protocols are adhered to in theatres.
- The trust should review the availability of referral processes for formal patient psychological and emotional support following a critical illness.
- The trust should review the provision of post-discharge rehabilitation support to patients discharged from critical care.
- The trust should ensure that appropriate staff have access to safeguarding supervision in line with best practice guidance.
- The trust should continue to monitor the safe and correct identification of deceased patients before they are taken to the mortuary and take necessary action to ensure this is embedded in practice.
- The trust should continue to work towards improving the assessment to treatment times within the ED department. The trust should also continue to work towards improving ambulance handover times and reduce the number of handovers that take more than 30 minutes.
- The trust should ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.

In addition the trust should:

- The trust should review and improve the consent process to ensure trust policies and best practice is consistently followed.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Leeds Teaching Hospitals NHS Trust

Leeds Teaching Hospitals NHS Trust was formed in 1998 bringing together two smaller hospital trusts under a single management and direction for the first time.

Leeds Teaching Hospitals NHS Trust is one of the largest trusts in the United Kingdom and serves a population of around 780,000 in Leeds and up to 5.4 million in surrounding areas, treating around 2 million patients a year. The trust has a budget of around £1 billion.

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

Day surgery and outpatient services are provided at Wharfedale Hospital and outpatients services are also provided at Seacroft Hospital.

Leeds is the third largest city in England. The health of people in Leeds is varied compared with the England average. There were people living in a variety of communities. The age profile, health and level of deprivation of the population varied. Rural and semi-rural areas had a mix of people of a wide range of ages and backgrounds. Waterfront areas were made up of younger professionals. Inner city areas had mixed ages and larger culturally diverse populations.

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Julie Walton, Head of Hospital Inspection, Care Quality Commission

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

How we carried out this inspection

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

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

As this was a focused inspection we did not look across the whole service provision; we focussed on the areas defined by the information that triggered the need for the

focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected. At this inspection we did not ask whether services were caring as these had been rated good at the previous inspection.

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

organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG),

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NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisation.

We carried out the announced inspection visit from 10 - 13 May 2016, with an unannounced inspection on 23 May 2016. During the inspection we held focus groups with a range of staff including nurses, consultants, allied health professionals (including physiotherapists and

occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also held focus groups with community groups who had experience of the trust services.

What people who use the trust's services say

The NHS Friends and Family Test (FFT) results between February 2015 and January 2016 indicated the percentage of patients who would recommend the trust's services was consistently worse than the England average each month in this period.

The Care Quality Commission In-Patient Survey (2014) asks questions such as ; 'Did a member of staff answer your questions about the operation or procedure?'; 'Did you feel you got enough emotional support from hospital staff during your stay?' and; 'Did doctors talk in front of

you as if you weren't there?' The results showed this trust scored about the same as other trusts for all questions except for delays to discharge, where the trust was recorded as being within the worst performing trusts.

The Patient Led Assessments of the Care Environment (PLACE) showed the trust scored better than the England average from 2013-2015 in each of the four areas rated; cleanliness, food, facilities, privacy and dignity and wellbeing.

Facts and data about this trust

- Urgent and Emergency services: Between April 2014 and March 2015 the trust saw 222,968 patients in A&E. The conversion rate (percentage of those patients attending who were subsequently admitted) to a hospital ward at this trust was 18.4% in 2014/2015.
- Medical services: The trust has one of the highest numbers of admissions in the country. Between September 2014 and August 2015 there were 73,896 medical admissions to Leeds Teaching Hospitals NHS Trust (LTHT).
- Surgical services: The trust has one of the highest numbers of admissions in the country; between September 2014 and August 2015 there were 63,358 surgical admissions to LTHT.
- Critical care services: The total number of admissions to the critical care units within the LTHT between 1 April 2014 and 31 March 2015 was measured by the ICNARC case mix programme to be 1,153 patients. These numbers did not include all of the critical care units as data was not submitted by them all.
- Maternity and gynaecology services: The maternity service at St James's University Hospital delivered 4,726 babies between April 2014 and March 2015. The maternity service at Leeds General Infirmary delivered 5,014 babies between April 2014 and March 2015.
- Children's and young people's services: The trust had 18,868 episodes of care for children between July 2014 and July 2015, of which 42% were emergency admissions.
- End of life care: From September 2014 to August 2015 there had been 2851 deaths in the trust. Between April 2014 and March 2015 there had been 1255 referrals to the specialist palliative care team.
- Specialist services: The trust is one of the largest providers of specialist hospital services in the country, with almost 50% of the overall income from specialist commissioners, NHS England. Specialist services


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generally fall into five groups – specialist children’s services, cancer, blood and genetics, neurosciences and major trauma, cardiac services and specialised transplantation and other specialised surgery.

- Between January 2015 and January 2016 there were seven reported case of Methicilin-resistant Staphylococcus Aureus and 42 cases of Clostridium difficile.

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Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as requires improvement because:</p> <ul style="list-style-type: none">• Staffing across nursing and medical staff did not always meet the trust’s planned numbers or were in line with national best practice, particularly in surgery, theatres, critical care, maternity and children’s and young people’s services.• Not all staff had completed their mandatory training, particularly for resuscitation and role specific safeguarding training.• The arrangements in place did not give sufficient assurance that equipment across services were maintained and serviced in line with legislation and national guidance.• Arrangements were not robust to give sufficient assurance that patients were appropriately assessed as suitable for waiting on trolleys, had risk assessments completed and gave the management team accurate oversight information.• General Medical Council (GMC) guidance and the hospital consent policy were not consistently adhered to. In accordance with trust policy, a two stage consent process including two patient signatures was not consistently applied.• The World Health Organisation’s Five Steps to Safe Surgery were not consistently applied across the surgical services. There was inconsistent learning from Never Events in some theatre areas.• Generally, the identification of the deteriorating patient was well managed. However, there was some inconsistent practice identified at the LGI site. Within surgical services audit data showed that national early warning scores (NEWS) and escalation was not always correctly implemented.• Routine operations were regularly taking place out of hours. <p>However, we found that:</p> <ul style="list-style-type: none">• There was a good safety culture across the trust with learning from incidents shared and appropriate incident reporting.• The trust had processes and systems in place to comply with the duty of candour and staff confirmed that there was an open and honest approach to incident reporting and involving patients and their carers/relatives in any investigations.	<p>Requires improvement </p>

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- There were robust safeguarding arrangements in place across the trust and staff were aware of how to deal appropriately with safeguarding issues.
- There were arrangements in place for the prevention and infection and control of infection. Environments were clean and staff generally adhered to trust infection prevention and control practices.
- The trust was actively recruiting to vacant posts, assessing staffing needs on a daily basis and putting in contingency arrangements for shortfalls.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The Duty of Candour was introduced as a statutory requirement for NHS trusts in November 2014. Prior to the introduction of the regulation, communications were sent out by the trust explaining its introduction and included presentations to raise awareness. This was supported by a trust wide Quality and Safety Matters briefing, which was circulated in April 2015 and recirculated again in March 2016.
- An e-learning tool was available for all staff to complete on the trust intranet. Quality and Safety matters posters were displayed informing staff about the duty of candour.
- The duty of candour had been included as part of the 'Being Open,' and the 'Serious Incident' procedures. It was also being included as part of the Root Cause Analysis training and Lead Investigator training.
- Staff told us, they understood the need to be open and honest with families when things went wrong.
- The trust used its electronic reporting system to report and record incidents. Each incident was investigated using Root Cause Analysis (RCA) to establish the factors leading up to the incident and what learning would result from this. Following a RCA we saw evidence of duty of candour letters, including an apology were sent to families along with the outcome of the investigation.

Safeguarding

- The executive lead for safeguarding adults and children was the chief nurse/deputy chief executive. In addition there was a full time head of safeguarding; who led the trust's safeguarding

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adults and children's teams. The trust had moved to an integrated safeguarding team, which consisted of a named nurse for safeguarding children; two named doctors for safeguarding children; a named midwife; a lead professional for safeguarding adults and a lead professional for the Mental Capacity Act (2005), the Mental Health Act and vulnerable groups

- The safeguarding governance structures were robust. Policies reflecting the wider safeguarding agenda were in place, including training and plans on domestic violence and sexual exploitation.
- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015. The safeguarding children policy had been written in 2013 and was due to be reviewed in September 2016. Therefore, there was a risk that staff were not working to current guidance.
- There was no specific mention of Female Genital Mutilation (FGM) or Child Sexual Exploitation (CSE) in the safeguarding children policy. In October 2015 a mandatory reporting duty was introduced which requires health professionals to report known cases of FGM in under 18 year olds to the police. The Department of Health (DH) had produced updated statutory guidance on FGM in April 2016.
- All staff we spoke with told us they received some training on CSE in their safeguarding training but did not receive any on FGM. However, information provided by the trust suggested that FGM was included in the safeguarding training. It is unclear therefore how much knowledge staff had about their responsibilities with regards to FGM.
- We saw a standard operating procedure (SOP) that the trust had recently developed for recording and reporting FGM.
- The Royal College of Nursing Guidance: Safeguarding children and young people – every nurse's responsibility, 2014 states that regular high-quality safeguarding supervision is an essential element of effective arrangements to safeguard children. The trust child protection supervision policy stated that staff should access supervision once every three months. However, nursing staff told us that they did not receive regular safeguarding supervision but would access supervision if they were involved with a safeguarding case.
- The safeguarding team were involved in a range of work city wide in influencing safeguarding. Internally issues such as identifying and understanding patients' vulnerability from pressure ulcers on admission had been well embraced and their connection to safeguarding was understood.

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- There was good evidence of the trust reaching out to the diverse communities in maternity, addressing patients with mental health illness and services. Services were adapted to meet patients' needs to reduce safeguarding issues.
- The Savile action plan had one outstanding action regarding children age 16 – 18 years, which was on track for completion with a range of options being considered at Board level.
- All volunteers had a disclosure and barring service (DBS) check. Staff on wards were given information about the volunteers before they came onto the wards.
- Following the Savile Enquiry volunteers now wore green polo shirts and they were identifiable on the ward.
- Following the Savile Enquiry all charities now had offices in a non- patient area of the hospital.
- Staff completed risk assessments for visiting clergy and community leaders and they would not be left unattended on the ward.
- To meet safeguarding training needs the trust had adapted the induction and mandatory training programme. It was recognised that it was a challenge for staff to achieve face to face training with the safeguarding team so the trust was exploring other ways of delivering this. Some staff groups for example, in the A&E, found it difficult to attend training and supervision. The trust was aware and actively taking steps to address this.
- Safeguarding vulnerable adult's Level 1 and 2, and safeguarding children Level 1 were included in the trust mandatory training programme. The trust target for mandatory training was 80%.
- The trust collected training data by Clinical Support Unit (CSU) and not by individual locations. There was a mixed completion figure across services. Generally, Level 1 adult safeguarding and children's training was completed, often above the trust target. For example, at trust level, 97% of urgent care staff had completed safeguarding children Level 1 training, and 81% had completed safeguarding children Level 2 training, compared to the trust target of 80%. However, in some Clinical Service Units (CSUs) there was variation. For example in the cardio-respiratory CSU staff had completed safeguarding vulnerable adults Level 1 training and safeguarding children Level 1 training. However, only 65.5% of staff had completed safeguarding vulnerable adults Level 2 training. In the neurosciences CSU only 70.4% of staff had completed safeguarding vulnerable adults Level 2 training; 69% of staff in

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critical care had completed safeguarding vulnerable adults Level 2; 95% of maternity and gynaecology services had received Level 1 training and 74% had received Level 2/3 by the 9 May 2016.

- Training records submitted by the trust showed within the acute medicine CSU only 77% of staff had completed safeguarding vulnerable adult's Level 2 training; 72.5% of staff in the abdominal medicine and surgery CSU and 65.5% of staff in the cardio-respiratory CSU had completed safeguarding vulnerable adults Level 2 training. In maternity and gynaecology services 74.8% of staff had completed safeguarding adults Level 2 training. Relevant staff had face to face safeguarding training, which met both the requirements of the Level 2 and 3 training; 74% of staff had received this training. Most midwives we spoke with confirmed they had received Level 3 safeguarding training.
- The trust also confirmed midwives participated in initial case conference meetings with social care; follow up review meetings from case conferences; pre -birth planning meetings and strategy meetings on the wards. This participation contributed to the staffs' Level 3 safeguarding competencies.
- Figures provided by the trust showed that 95.3% of children's services staff had completed safeguarding children Level 1 training.

Incidents

- Never Events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Between October 2014 and September 2015 there had been four never events reported with three Never Events within surgery at the trust. Two were attributable to the SJUH site, one related to a retained swab following surgery and one related to a wrong site anaesthetic block. A second incident of wrong site anaesthetic block occurred within six months at Chapel Allerton Hospital. We reviewed the investigation reports and related action plans of the Never Events. They included a review of service delivery problems and contributory factors; a root cause was identified with associated recommendations and lessons learned. Areas of good practice were also noted and an action plan developed.

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- We reviewed the recommendations and action plans in relation to the retained swab Never Event. There was a focus on the impact of human factors and consistency with regards guidelines and processes within theatres. Accountable items and completion of the World Health Organisation (WHO) safety checklist were a particular focus.
- The staff we spoke with gave a mixed response with regards to learning from Never Events and some staff were not aware of any. However, other staff were able to give details of the different never events, saying never events were in the 'risky business' newsletter. Some staff also said their managers and team leaders attended monthly incident review meetings and following these they were provided with feedback about lessons learned.
- Whilst on inspection staff told us about a more recent never event of wrong site cataract surgery which occurred in January 2016. The investigation showed that appropriate processes had not been followed. Staff told us of changes in practice had been done and included in the development of standard operating policy guidance.
- Trust audit data and observation at inspection showed that the WHO safety check list had not consistently been embedded across the trust and more attention was needed to ensure that learning from Never Events prevented future re-occurrence of incidents.
- The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Serious incidents are incidents that require reporting and further investigation.
- There had been 100 serious incidents (SI) reported from October 2014 to September 2015, with pressures ulcers (those that met the serious incident criteria) being the main category reported.
- NRLS incidents per 100 admissions was higher than the England average. There had been 19,424 incidents for the same reporting period, 16,516 resulted in no harm to the patients and 2,598 resulting in low harm, 274 resulted in moderate harm.
- The most commonly reported incidents were pressure ulcers accounting for 1634 of all incidents reported. Falls, slips and trips accounted for 1435 of all incidents and staffing resources accounted for 309 incidents reported. Other themes of incidents included medication errors and access, admission, transfer and discharge.
- The trust had worked hard to reduce the number of falls. The service had introduced daily multidisciplinary safety huddles, educated staff on the importance of footwear, introduced falls bays to cohort high risk patients and increased the use of one

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to one staffing for high-risk patients. In 2014/15 the trust saw a 32% reduction in the number of falls. Information was displayed on 'how to prevent falls' and certificates were awarded to ward teams for fall-free days.

- Staff, including junior doctors, understood their responsibilities to raise concerns and near misses and to report safety incidents using the electronic recording system.
- Staff received feedback on incidents reported. Any lessons learned from incidents were shared at team meetings, via a 'safety matters' electronic bulletin and in safety huddles.
- The 2015 National NHS Staff Survey showed the number of staff reporting errors, near misses or incidents witnessed in the last month was less than the previous year. In 2014, 92% of staff had reported incidents; this had dropped slightly to 88% in 2015. The national average for the same time period was 90%.
- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thromboembolism (blood clots), and catheters and urinary tract infections (UTIs). The trust collected this data monthly. The results of which were used to inform decisions about improvements needed or progress made against any safety concerns.
- All wards we visited held daily safety huddles. All members of the multidisciplinary team were encouraged to attend including medical staff, domestic staff and clinical support workers. The safety huddles were used to share any learning from incidents and identify any patient safety issues including, pressure ulcers, falls, high national early warning scores (NEWS), patients under a deprivation of liberty safeguard (DOLs) and any patients with a hospital acquired infection. Staff spoke positively about the safety huddles and felt they had created a sense of ownership amongst staff to improve patient safety.

Assessing and responding to patients at risk

- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Modified Obstetrics Early Warning System (MOEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary.
- Children's services used the paediatric advanced warning score (PAWS) tool, an early warning assessment and clinical

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observation tool. The charts, PAWS guidelines and deteriorating patient policy included information to assist nursing and medical staff as to the action to take in response to deteriorating scores.

- The neonatal units did not use the Newborn Early Warning Trigger & Track (NEWTT) assessment tool. Staff told us there was a plan to introduce NEWTT in the surgical new born unit located within the neonatal unit. When asked how they were assured that deteriorating patients are identified at the earliest opportunity we were told that safety huddles were used as a method of recognising deterioration. Staff identified which patients they were most concerned about to ensure that clinical review focused on these patients and the whole team was aware of staff concerns.
- The national early warning score system (NEWS) was used in each adult ward area as a tool for identifying deteriorating patients. Staff knew how to identify and respond if a patient was deteriorating. The score from the NEWS acted as a trigger to escalate concerns to medical staff on the ward.
- Generally, the documentation we reviewed across all ward areas showed accurate completion of NEWS scores and we saw evidence of raised NEWS scores being escalated appropriately.
- We reviewed audit data on deteriorating patients from April 2015 to February 2016, which looked at eight aspects including correct NEWS scoring and referrals for 'at risk' patients. This data was per CSU. The data showed an overall improvement for the eight areas. However, at LGI in surgical services we reviewed audit data on deteriorating patients from April 2015 to February 2016. This looked at eight aspects including a minimum of twice daily observations and correct scoring of NEWS. The data was collated per CSU. Within the centre for neurosciences and trauma and related services CSUs, there were some areas RAG rated amber and red. These related to correct NEWS scoring, 24 hour cumulative fluid balance completed and referrals for 'at risk' patients. The data showed an improvement in December 2015; however in January and February 2016, the percentages dropped (worsened). For example, in neurosciences the percentage of referrals for 'at risk' patients in December was 90%. In January this had dropped to 67%. This meant that not all patients who were deteriorating were referred to the medical team as per hospital policy.
- We discussed deteriorating patients with the senior management team who felt NEWS scoring had improved and

Summary of findings

the deteriorating adult collaborative was having a positive impact. We were told patients with elevated NEWS were discussed at ward safety huddles and during handover. This was observed by the inspection team.

- The deteriorating patient intervention bundle was launched in June 2015 following collaborative working with 16 wards utilising the 'Model for Improvement' as a framework for testing new interventions. Following testing of these interventions and making changes in their areas the 'Deteriorating Patient Intervention Bundle' was launched in June 2015. This focused on patients with a serious infection (sepsis) and acute kidney injury. Part of the work with an external agency also focused initially on reducing the number of avoidable cardiac arrest calls by 70% on the pilot wards. This looked at things such as ensuring correct calculation and escalation of NEWS scores and timely identification of patients approaching end of life care.

Staffing

- The National Quality Board (NQB) published staffing guidance 'How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability' in November 2013. Within this document the NQB detailed ten expectations trust boards were expected to follow. We reviewed nurse staffing against these expectations.
- Reports were submitted to the Trust Board on a regular basis, which gave information on staffing levels, issues related to staffing and vacancy rates.
- On some wards, the actual number of staff on duty were lower than the planned number. We reviewed the planned and actual information for all the medical wards. We found qualified nursing levels for the wards were not always achieved. For example on ward 28, between the 23 March 2016 and the 22 May 2016, we found 5 days when registered nursing staff was over 100%, 44 days when the levels were between 80% and 100% and 14 days when registered nursing levels were below 80% with one day when the registered nursing level was below 62%. We looked at the non-qualified staffing levels between the 23 March and 22 May we found 56 days when non-qualified staffing levels were above 100% and 6 days when they were between 80% and 95%. For 6 days both the registered nursing levels and the non-qualified staffing levels were below 100%. For example on the 5 April 2016 the registered nursing levels were 70.7% and the non-qualified staffing levels were 81%. Therefore the non-qualified staffing levels did not mitigate for the reduction in qualified nursing levels.

Summary of findings

- In surgery services, with the exception of the ophthalmology ward, all areas we visited had some nurse staffing vacancies. For example within the AMS CSU there were 103.1 whole time equivalent (WTE) vacancies. However, the feedback from staff on the wards was that there had been an improvement with regards to staffing levels. Comments such as 'less use of agency' and 'staffing much improved' were made.
- We reviewed overall bank and agency fill rates for the wards at St. James's University Hospital (SJUH) for February 2016 to April 2016. They were between 93% and 94% for registered staff and 91% and 94% for unregistered staff.
- We reviewed data relating to staffing fill rates for individual wards at SJUH from October 2015 to January 2016. For registered staff these were between 92% and 130% with the exception of ward J82, which was between 81% and 87%. Fill rates for the same time period for unregistered staff were 82% to 185%. We were informed that the electronic rostering system did not take into account flexible working to support some staffing gaps. For example if a staff member was used from another area to help for a couple of hours, such as on the surgical assessment unit, where they had access to surgical nurse practitioners. These figures meant staffing levels were safe and where there were gaps in registered staffing additional unregistered staff were used.
- Staffing was co-ordinated by matrons during the day and nurse practitioners at night. We were told it was fluid throughout the day so could flex as needed. Staff on the wards we visited told us they help each other out and sometimes sorted out staffing issues between themselves. Electronic rostering was in use which enabled staff to easily view staffing in other areas. If a ward/department was short of staff or needed some help for a period of increased activity, staff could see if other wards could support them without needing to escalate to a matron. In a focus group we were told by health care support workers they could be moved regularly to support other areas but staff had no issues with this.
- Within theatres and anaesthetics there were 63.7 WTE vacancies, this data was for SJUH and LGI. Data on fill rates for registered staff in theatre from February 2016 to April 2016 was 38%, 90% and 55% respectively. Staff reported challenges particularly in the post anaesthesia care unit (PACU), however staff did say the recent increase in the number of band six nurses had improved staffing skill mix. We were told PACU was run on four staff for eight theatres. We reviewed rotas for April 2016 and found that actual staffing levels were only slightly below planned (4085 and 3869).

Summary of findings

- In David Beever theatres we were told five staff were currently going through induction and would soon be added to the rota.
- Staff confirmed that the majority of times, vacant shifts were covered. Staff also told us that the trust had their own secure intranet, staff social network site. They were able to send out a request at short notice for staff to cover shifts and they found this system was effective.
- The Board Assurance Framework for May 2016, showed the Trust Board had agreed and had in place, a five year investment plan for nurse staffing. They had identified the risks and had assurance and action plans to address the shortfalls.
- The A&E had recently employed a large number of newly qualified staff. To ensure that all staff had the appropriate skills to work in an A&E, the trust had designed a comprehensive 16 week induction programme, which consisted of theoretic and practical training. Staff were assessed by the two clinical educators in the department and had to demonstrate competency in key skills before being able to work unsupported. A number of nurses were undergoing training to become Advanced Care Practitioners.
- Between November 2015 and December 2016, an annual review of staffing was carried out by the Women's service Clinical Governance and Risk Management Forum. The Head of Midwifery presented it to the Maternity Services Clinical Governance, Governance, and Risk Management Forum. Six monthly further reviews were to take place in line with the National Institute for Health and Care Excellence (NICE 2014) guidance and staffing levels remained on the risk register.
- The data factored in the corporate guidance in terms of leadership, annual leave and study. The recommendations supported an increased establishment to 359 midwives and an increase of 10.8 maternity support workers to support a midwife to birth ratio of 1:28. Information provided by the trust stated the Trust Board had an agreed investment plan to support the midwifery staffing numbers incrementally, from a ratio of 1:33 in 2014, to the current average of 1:29.
- The RCN (2013) recommend a ratio of one nurse to three patients for under two's and one nurse to four patients for over two's. In the Children's Hospital these ratios were not achieved on every shift for some wards.
- For example on wards 31, 32 and 33 they should have had an establishment of three trained staff on an early and a late and two trained staff on nights. For April 2016 this establishment was met for 45 shifts. 17 shifts were one staff member below

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and 21 shifts were one staff member above the establishment. The risk register highlighted nurse staffing on some wards as a risk. Activities were ongoing to encourage retention and recruitment.

- The paediatric intensive care unit (PICU) and High dependency unit (HDU) had the required ratio of staff to patients as set out by the Paediatric Intensive Care Society (PICS 2015).
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the local and corporate risk register. Controls put in place by the trust to reduce the risk included a clear escalation process and discussion at daily operational performance (DOP) meetings, use of bank and agency staff, staff deployment from other clinical areas and projects focusing on recruitment, mentorship and the retention of staff.
- Staff were clear about the escalation process used if staffing levels fell below the planned number. Ward managers would book agency staff or offer staff additional shifts. Any unfilled shifts would be escalated to the matron and discussed at the DOP meetings. Matrons would review staffing throughout the day and move staff to support wards that were short staffed. Staff understood why this happened and appreciated the help they received from other wards when they were struggling.
- We saw evidence of the induction checklist agency staff completed.
- An executive was always accessible should any issues require escalation for senior advice or support. Staff reported that the DOP were highly productive meetings and communication had improved across all areas and between sites, which enabled them to work as one team and support each other. An adult inpatient pool had been developed, consisting of care support workers, mental health support workers and registered nurses. Feedback from staff was highly positive about this initiative.
- The NHS Staff Survey 2015 reported that the percentage of staff working extra hours was the same as the England average at 72%.
- Evidence based acuity tools were used in services across the trust applicable to the needs of the patients. In medicine the service used the Association of United Kingdom University Hospitals (AUKUH) acuity and dependency tool. The acuity and dependency tool was developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. In surgery,

Summary of findings

the service used three staffing acuity tools, including the safer nursing care tool, to review staffing establishments based on patient dependency. Professional judgement also formed an important part of this process.

- The maternity staffing levels were based on the birth rate-plus methodology and factored in the complex case mix of women in Leeds.
- A paediatric safer nursing care assessment tool was used to produce an overall recommended whole time equivalent for each area. However, service leads acknowledged that acuity and dependencies needed to be looked at again and staffing requirements reconsidered. There was no plan in place for this at the time of our inspection.
- Neonatal services used the DH toolkit for Neonatal Services (2009) and the British Association of Perinatal Medicine (BAPM) guidelines.
- There were twice daily DOP meetings where concerns could be raised about staffing levels and risks to patients.
- Staff shortages were reported on the trust's electronic incident reporting system. Staff confirmed and data examined showed that staff reported the occasions when staffing levels did not meet those planned.
- The NHS Staff survey 2015 reported that the score for staff satisfaction with the quality of work and care they are able to deliver was 3.85, which was worse than the England average of 3.93.
- Staff across the trust told us that they felt able to raise concerns with managers and there were a number of forums and meetings, where they could raise concerns.
- We found that there was consultation amongst different professionals taking place when discussing and identifying staffing levels.
- Staff reported that they struggled to access time to spend on administrative and managerial activities, particularly when they were short staffed. Managers and clinical educators were often part of the shift rota.
- There were twice yearly reviews of nursing and midwifery staffing in accordance with NICE guidance (2014). We saw Board reports from the Chief Nurse including the paper dated 26 January 2016, regarding details of areas where there were particular nursing workforce challenges / risks and Hard Truths (2014) data, which showed a summary of the number of wards where staff on duty were less than 80% of that planned.
- Information provided by the trust showed that considerable progress had been made in improving staff fill rates. Staffing data from March, April and May 2016 showed significant

Summary of findings

reductions in the number of wards with fill rates of less than 80 percent, with levels over this time being well below the threshold to report when 40 percent or more of wards have fill rates below 80 percent.

- Information on staffing levels were displayed on wards and in departments. The trust also published this data and made it available within Board papers, which were posted on the trust web site.
- The trust was actively recruiting both nationally and internationally. In addition, the trust was working with universities and other organisations to support training initiatives and the development of alternative roles such as apprentice programmes and advanced nurse practitioners.
- Staff told us the trust was advertising for staff, but were struggling to recruit.
- The trust was working with the universities in the sponsoring of staff, with a view to the encouragement of more staff to work at the Leeds hospitals.
- Some new staff had not yet started work at the hospitals as they were working through the recruitment checks.
- The trust had regular engagement with commissioners about planning and the delivery of services. These discussions included the staffing levels and challenges faced by the trust and the actions taken to address these.

Medical Staffing

- In surgery services we reviewed medical staffing and spoke with consultants, middle grade and junior doctors. Medical cover was available on-site 24 hours a day. Consultants were available 24 hours, with on-call cover provided at evenings and weekends. The on-call rota for surgery provided two consultants each day; one consultant specialising in upper gastrointestinal surgery and the other in lower gastrointestinal surgery. Each consultant was present for a minimum of ten hours per day and had no other clinical commitments whilst on call. The consultants were on call for several days at a time to ensure appropriate continuity of care.
- The on call consultants were supported by two specialist registrars. One was for acute patients only, the second helped to support theatres and cover referrals from Leeds General Infirmary.
- In addition there was a resident surgical officer (RSO) who was based on the surgical assessment unit (SAU) and provided 24 hours a day, seven days a week cover.

Summary of findings

- Foundation year doctors supported the wards and the SAU. Surgical nurse practitioners (SNP) were also available to provide support; a further four SNPs were due to qualify towards the end of the year (2016).
- The percentage of middle grade and junior doctors was below the England average. However the consultant and registrar group was higher. We discussed gaps in the middle grade rota with the senior management team as it had been highlighted as a concern from discussions with staff. We were assured gaps were covered using locums and some internal cover from consultants.
- We reviewed medical agency and locum use from January 2015 to March 2016 across the CSUs.
- Rates remained consistent, for example in theatres and anaesthetics percentages were between 7.4% and 12.4%.
- Medical staff were on the whole highly positive about working at the trust and appreciative of the work done by the executive team.
- Doctors reported concerns over level of medical staffing across some areas and in particularly filling junior doctor rotas. Concerns also included the impact of the cap on agency staff and use of locums on staffing levels in the trust.
- Some consultants expressed concerns over the split site working for maternity services and neonatal services, with the impact this had on medical cover arrangements.
- The CQC data pack showed there were 38% (82 WTE) consultants employed by the trust, compared to the England average of 35%. Three percent middle carer (at least 3 years at Senior House Officer (SHO) or a higher grade within their chosen specialty), 55% registrars and 4% junior doctors (foundation year 1-2). This compared with the England average of 8% middle grade doctors, 50% registrars and 7% junior doctors.
- From April 2014 to June 2015, the average number of hours per week consultant presence on delivery suite was 60 hours.
- At inspection consultants, doctors and midwifery staff confirmed there was 60 hours consultant presence on delivery suite each week.
- Cover was provided from Monday - Friday 8.30am to 6pm and an on-call consultant was present until 7pm each week day evening.
- Weekend consultant presence was from 8.30am until 12.30 mid-day. Outside of these hours, the consultants were non-resident on-call. However, the consultants told us that when on-call, several of them chose to provide onsite cover.

Summary of findings

- Insufficient consultant obstetric staffing levels had been recorded on the risk register. The risk register identified there should have been 98 hours cover. This was in line with the size of unit and the Royal College of Obstetricians & Gynaecologists (RCOG) best practice standard for consultant labour ward cover. The trust had identified there was a deficit of 3.5 WTE consultants.
- Appointments had been made for two consultants and following the inspection the trust notified CQC that the two consultants were now in post. They told us the consultant's job plans were being reviewed and the rotas redesigned to improve consultant cover; this was in the process of consultation. They said these changes would achieve 83 hours planned consultant presence per week from January 2017.
- In the children's and young people's services medical staffing had been identified as a risk on the risk register, with gaps in junior doctor rotas. Data provided by the trust showed a 0.5% vacancy rate in children's medical staff. Medical staff we spoke to said that doctors were feeling the pressure with the difficulties in staffing.
- Medical staffing on PICU met the standards set by the Paediatric Intensive Care Society (PICS) (2015).

Medicines

- The trust has a Medicine Management and Pharmacy Clinical Service Unit (CSU). The pharmacy teams work across all the other CSUs supporting directly with service delivery, education and development. At trust level 80% of acute medicine staff had completed their medicines administration and safety training; this was in line with the trust target of 80%.
- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges. However, we found that there was some variation on checking the temperatures of medication fridges. Medicines sensitive to certain temperature ranges may not be safe to use should they be kept outside of these ranges.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Generally, staff kept accurate records and performed balance checks in line with the trust policy. However, not all staff were following trust policy. We found that there was some inconsistent practice with obtaining signatures.

Summary of findings

- The chief pharmacist and the clinical governance pharmacist lead said there were robust systems in place for monitoring antibiotic use. We saw stickers in use to remind staff to review antibiotics on day three of them being prescribed. There were also prompts on the prescription charts.
- We saw information displayed on medicines in patient profile summaries (MAPPS) in ward areas. This is a way of accessing patient information about medication as well as providing them with reminders about when to take medications. This information could be printed off and given to patients on discharge.

Infection Prevention and Control (IPC)

- In the past 12 months there had been 4 cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and 42 cases of Clostridium difficile (C. difficile). The trust identified 15 of these cases as being due to a lapse in care within medical services at SJUH. There had been seven cases of MRSA within the trust during 2015/2016, and one case since April 2016, which was within surgery. This was above the trajectory of zero.
- From February 2015 to February 2016 there had been 10 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) within medical services across the trust.
- The trust had in place infection prevention and control (IPC) policies, procedures and an audit programme. The audit programme included hand hygiene, IPC practices, antibiotic prescribing, high impact interventions and surveillance data collection. There was a team, led by the director of infection and control (DIPC) dedicated to monitoring, supporting and training staff on effective IPC practices. The team had appropriate expertise and support from specialists such as microbiologists to ensure that appropriate steps were taken to prevent and control infection. IPC issues and progress against preventative measures were reported regularly to the Trust Board, sub-committees and with staff groups to foster shared learning and good practice. A root cause analysis was undertaken with each identified case of infection.
- Training on IPC was mandatory throughout the trust and there was good compliance with this.
- We found all areas visited visibly clean with appropriate cleaning and maintenance schedules in place. The patient led assessment of the care environment showed the trust scored 99% for cleanliness against an England average of 98% in 2015.
- A yellow tray system was used by staff when serving meals to identify patients that had a healthcare-associated infection.

Summary of findings

- Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited. However, we found that there was inconsistent practice with bins used for the disposal of sharps. Some were found to be accessible in patient areas and there was confusion in one of the operating theatres over the correct colour waste disposal bags to use.
- Each ward had an infection, prevention and control champion who was responsible for developing and sharing best practice in relation to infection prevention control.
- During the previous inspection concerns were raised about the number of cases of C difficile on ward 19. Between April 2013 and March 2014, 12 cases of C. difficile were reported. The trust investigated each individual case to identify any specific themes. Staff produced a video that was available on the trust intranet to share their experiences and discussing how lessons had been learnt. Changes to clinical practice included; a review of micro-bacterial prescribing, the introduction of stickers into medical notes to prompt a review of antibiotics after 3 days and discussion at daily safety huddles of patients with MRSA or C. difficile. Between 2014 and 2015, the number of cases of C. difficile on ward 19 had reduced to 2.

Equipment

- The trust had changed its appliance/equipment testing and servicing arrangements. These were now undertaken in house by the medical physics department. There was a replacement and procurement process in place for medical equipment; however, it was acknowledge that a back log had built up. There were systems in place for staff to obtain support for equipment or escalate concerns about specific pieces of equipment.
- Across services we inspected equipment for evidence of portable appliance testing (PAT) and found variable compliance with the testing of equipment.
- Across the trust we saw various pieces of equipment with out of date PAT. For example in Jubilee theatres at LGI we saw an intravenous contrast perfuser and an operating microscope which had a review date of December 2014. In the hands and plastics' day unit theatres, we found a fan dated January 2014 and a fridge dated 2011. This was raised with the trust at the time of inspection and we were told it would be looked at.
- In the neonatal unit at SJUH, 15 pieces of equipment had no indication of any testing having taken place at all. We could not be assured that testing had taken place.

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- There was a rolling programme of equipment replacement. However, neurosurgical theatre equipment was on the departmental risk register as a range of equipment had been identified as needed to ensure the continuity of the service.
- In one of the maternity theatres at LGI, there were several disposable instruments out of date. This was brought to the attention of the theatre staff who removed them immediately.
- On wards 9, 11 and 16 at SJUH the defibrillators on the resuscitation trolleys had all passed their due date for servicing.
- Some of the wards we visited had a lack of space for the storage of equipment such as hoists, chairs and mattress.
- The children's assessment and treatment unit (CAT) was based on ward L9. This meant that space on both wards L9 and the CAT was limited. Triage of patients took place in the corridor within the entrance to the unit, which meant there was no privacy. Equipment was being stored in one of the bed bays of the assessment unit, as there was a lack of storage space. Intravenous fluids were stored in an unlocked cupboard in the urgent medical assessment room.
- McKinley syringe pumps with safety features were supplied by the equipment 'pool' and maintained by staff in the medical physics department. (Syringe pumps are used to administer subcutaneous medications to patients). Staff told us there were no problems in obtaining syringe pumps.

Are services at this trust effective?

We rated effective as good because:

- Policies and care pathways were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance. The A&E department worked within up to date national and international guidelines and patient care pathways reflected these guidelines.
- Patients received pain relief in a timely manner. The medical service scored about the same as other trusts for staff doing all they could to help control pain in the CQC national survey of in-patients. In the A&E department pain levels were reviewed regularly as part of dignity rounds.
- Patients received care from competent staff who had received a comprehensive induction and were appraised regularly. There were processes in place to address poor performance and staff were encouraged to develop and improve their skills and knowledge.
- Staff were able to access information relating to patients and worked with other health professionals to ensure that patients received coordinated care and treatment.

Good



Summary of findings

- The A&E department provided a 24 hours, seven day a week service for patients.
- Patient outcomes were on the whole as expected or better than expected with only a few areas for improvement identified by national surveys and audits. Work was underway to make improvements and audits were planned and carried out to provide assurance of improvements.
- Staff understood the basic principles of the Mental Capacity Act (2005) and were aware of their responsibilities in relation to restraint and Section 136 of the Mental Health Act relating to detained patients. Patient outcomes were monitored through the CSU ward healthcheck.
- The trust participated in local and national audits.
- Multidisciplinary teams worked together to understand and meet people's needs.

However:

- The trust achieved an overall score of D (where A is the best and E is the worst) in the Sentinel Stroke National Audit programme (SSNAP).
- Fluid balance charts were not always fully completed.
- Staff were below the trust target for Mental Capacity Act (2005) Level 2 training.

Evidence based care and treatment

- Policies and care pathways were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance.
- Staff demonstrated awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward. We reviewed clinical guidelines on the intranet. Of the three that we reviewed all had identified author/owner and all had review dates.
- Policies and guidelines used by the A&E department were based on the latest national and international guidelines such as from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine. Local audits showed that patients received care that was in line with evidence based guidance.
- The trust provided us with evidence of participation in Royal College of Emergency Medicine (RCEM) audits and local audit activity. We saw that when standards were not met, action had been taken to implement changes and re-audits had been planned. For example, the Procedural Sedation Audit had

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identified poor completion of documentation and a new recording document had been designed and introduced. Similarly, the VTE (venous thromboembolism) Audit had led to the introduction of a new pathway of care for applicable patients.

- The IT system in the A&E had been adapted to ensure that consultants had final sign off of patients. This meant that patient cases were reviewed by a consultant before the patient was discharged from the system.
- Stroke pathways were in line with NICE guidance however, patients did not have access to a Neuropsychologist as recommended in NICE CG162 stroke rehabilitation.
- Each CSU had a yearly audit plan. We reviewed the audit plan for cardiology and found evidence of participation in a range of local audits from the trust's programme including audits of sepsis, consent and VTE thromboprophylaxis. The audit plan also included participation in national audits of guidelines and best practice for example stable angina, smoking and atrial fibrillation.
- The trust audited clinical coding for electrophysiology and device procedures. The trust identified that clinical coding for electrophysiology and device cases were inaccurate and had worked with the coding department to improve accuracy through introducing a tick sheet. The audit found that out of 95 devices, 77 (81%) were coded correctly and out of 76 electrophysiology procedures, 66 (87%) were coded correctly. The audit made recommendations to improve the results; however it did not have a timed action plan.
- All wards participated in the CSU ward healthcheck. Ward managers recorded and submitted data on performance and quality of care using nurse sensitive indicators including, incidents, falls, complaints, pressure ulcers, staffing vacancies, patient experience, healthcare acquired infections and staff sickness. Ward health check outcomes were red, amber, green rated. Staff reviewed the data at head of nursing and matrons meetings and at clinical governance meetings and results were shared with ward staff. Any wards that were rated red for three consecutive months were placed in escalation and got support from the corporate nursing team.

Patient outcomes

- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other

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factors including deprivation, palliative care and case mix. HSMR's are usually expressed using 100 as the expected figure based on national rates. Figures from May 2015 indicated no evidence of risk.

- The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level throughout NHS hospitals in England. The SHMI indicates the number of patients who died following being in hospital, compared to the England average of the number who would be expected to die looking at the characteristics. The figures are represented at trust level and data as of February 2016 indicated there was no evidence of risk. For the latest reporting period, July 2014 to June 2015 the SHMI rate was 1.006 and the HSMR rate was 96.39. Both the SHMI and HSMR rates had consistently fallen within the expected range for the size and type of trust.
- The trust SHMI and HSMR rates were closely monitored by the Trust Mortality Improvement Group. The trust was also participating in the Improvement Academy Avoidable Mortality Project, which involved case note reviews.
- Each CSU had monthly mortality and morbidity meetings, individual cases were discussed and required actions were documented with timescales. Any lessons learned from mortality and morbidity meetings were shared via a 'lessons learnt bulletin' and across other specialities.
- The standardised relative risk of readmission for all non-elective admissions was higher than the England average for cardiology and stroke medicine. The risk of readmission was lower than the England average for neurology.
- The standardised relative risk of readmission for elective admission was below the England average for gastroenterology, but above the England average for cardiology and neurology.
- The average length of stay was below the England average for elective admissions, and was below or equal to the England average for non-elective admissions. Stoke medicine was an exception, the average length of stay for patients was 17.2 days, this was higher than the England average of 11.3 days. The trust was planning on implementing an early supported discharge team to reduce the length of stay for stroke medicine.
- The trust took part in the National Diabetes Inpatient Audit in 2015, and performed above the England average in 9 of the 16 scored indicators. The trust scored worse than the England average for visit by specialist diabetes team, able to take control of diabetes care and insulin errors. The trust identified it had an under-developed service for the care of diabetes patients who were admitted with conditions not directly related

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to their diabetes. The trust identified a range of improvements including education and training for all front line staff, developing an IT system to flag all patients with known diabetes across the trust and introducing a diabetes in-reach service for wards.

- LGI took part in the 2013/14 Heart Failure Audit. The hospital had good results overall and scored above the England average for all but three of the indicators. The trust had the highest number of patients included in the audit (697 patients). 96% of patients had an echocardiography, 71% of patients were cared for on cardiology wards and 77% had input from a consultant cardiologist. The trust wanted to further improve the services and had appointed a third heart failure nurse and a full time consultant cardiologist who specialised in heart failure.
- LGI had good results in the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audit. The audit found that 100% of patients were seen by a cardiologist or member of their team, compared to the 94% England average, 97% of patients were admitted to a cardiac unit or ward, compared to an England average of 56% and 80% of patients were referred for or had an angiography, compared to the England average of 78%.
- In the MINAP audit, the trust was in the lower quartile for delivery of primary percutaneous coronary intervention (PPCI) within 150 minutes of a call for help. This reflected the geographical distribution of patients accessing the service and the complexity of patient's treatment. The trust said work was ongoing with the ambulance service to achieve rapid patient assessment and transfer to LGI.
- The trust took part in the Sentinel Stroke National Audit programme (SSNAP). Between July and September 2015, stroke services at the trust scored an overall score of D (where A is the best and E is the worst). One component, speech and language therapy remained at an E.
- Overall SSNAP data had improved from our previous inspection in 2014 when stroke services at the trust scored an overall score of E. Staff felt centralising the service at one site had helped improve the patient journey.
- The trust identified further areas for improvement including, introducing a new data collection tool that would allow for real time uploads of SSNAP data, putting together a business case for a neuro psychologist and implementing an early supported discharge team to improve patient flow and reduce patient's length of stay. A recent business case for an early supported discharge team had been turned down by the CCG's. The trust was meeting to discuss other options for providing the service.

Summary of findings

- The trust had a SSNAP user group whose role was to streamline data collection processes to ensure high quality data was submitted. The group discussed and identified any challenges in the collection of SSNAP data, developed practical solutions to gather data whilst patients were still in hospital and aimed to keep up to date with national SSNAP updates.
- The trust took part in the national audit of inpatient falls 2015. The trust scored above average for assessment for the presence or absence of delirium, assessment for medications that increase the falls risk, measurement of lying and standing blood pressure and assessment of vision. The trust scored below the national average for the number of falls and the number of falls that cause harm. The trust had worked hard to reduce the number of falls. The service had identified steps to reduce falls by introducing daily multidisciplinary safety huddles, educating staff on the importance of footwear and increasing the use of 1:1 nursing for high-risk patients. In 2014/15 the trust saw a 32% reduction in the number of falls. The inpatient falls audit identified further areas for improvement including ensuring that all patients over 65 years identified as having continence issues had a care plan.
- The trust achieved JAG accreditation in June 2015 and was due to be reviewed in September 2016. JAG accreditation is a formal recognition that an endoscopy service has demonstrated competence against specific standards.
- All wards participated in the ward healthcheck. Ward managers recorded and submitted data on performance and quality of care using nurse sensitive indicators including, incidents, falls, complaints, pressure ulcers, staffing vacancies, patient experience, healthcare acquired infections and staff sickness. Staff reviewed the data at head of nursing and matrons meetings and at clinical governance meetings.

Multidisciplinary working

- There was effective multidisciplinary team working in wards and the A&E departments, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted.
- There was good access to mental health clinicians within the A&E department with 24-hour telephone access to psychiatric liaison staff. In addition, there was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.

Summary of findings

- Allied health professionals such as physiotherapists and occupational therapists attended and worked closely with ward and department teams. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- The A&E departments worked closely with the ambulance trust, local GPs and the out of hours service to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.
- The A&E offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24-hour period.
- There was 24-hour seven-day access to diagnostic blood tests. The department had some point of care testing which meant that some blood tests could be carried out in the department. Radiology tests such as x-rays and scans were carried out as and when needed and were available 24 hours every day.
- All wards we visited held daily safety huddles. All members of the multidisciplinary team were encouraged to attend including medical staff, domestic staff and clinical support workers.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The General Medical Council (GMC) guidance on consent: Patients and doctors making decisions together, states: “Give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks”.
- We were told 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. From the 14 sets of notes we reviewed 11 of these required consent for surgery. We found three patient copies had been removed from the notes meaning they had been given to the patient. However, the remaining eight were still in the medical notes. All of the 11 patients had been consented on the day of surgery.
- We reviewed a further ten consent forms and all patients had been consented on the day of surgery. Six sets of notes contained patient copies of consent forms. Several of these patients were undergoing elective surgery.

Summary of findings

- We reviewed audit data provided by the trust on consent from October 2015 to December 2015 looking at 30 patients across three surgical specialities. It showed that two out of 30 patients were consented in advance of their procedure.
- We discussed this at the senior management meeting and with consultants. We were told elective patients were seen by a consultant several weeks prior to surgery and a follow up letter was sent explaining the procedure and associated risks. A full and frank discussion took place allowing patients to think about their intended procedure; there was no opportunity to provide a consultant at pre assessment to enable patients to sign their consent form. The trust felt assured that patients were adequately informed prior to surgery. However, the trust consent policy, which was a two stage consent process, was not consistently followed.
- We also discussed the observation regarding the majority of patients not being given copies of their consent form. The management team agreed this was something to be reviewed. The trust felt assured that the clinic letters patients were sent provided sufficient information about their surgery.
- Staff were aware of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice.
- In the A&E departments training figures for MCA training were at 98% for Level one and 80% for Level two across all staff groups. The trust target was 95%.
- Staff understood the need to obtain consent from patients to carry out tests and treatments and told us that they implied consent when the patient agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them.
- In the A&E departments an initial assessment of the patients' capacity was made at triage and where concerns were identified, a more detailed assessment would be made each time patients needed to make decisions.
- Wards and departments were able to access Independent Mental Capacity Advocates (IMCAs), independent patient advocates support patients who were deemed to lack or have fluctuating capacity.
- The trust policy on the use of restraint stated that staff would always use the least restrictive constraint and would only use physical restraint as a last resort. This was confirmed when we spoke with staff.

Summary of findings

- In the A&E departments staff underwent conflict resolution training as a way to de-escalate situations and reduce the need for either physical or chemical restraint.
- Some staff said medication would be used to calm the patient if they were at significant risk of harm to themselves or others. As a last resort staff would use intramuscular rapid tranquilisation. Staff reported inconsistencies in the frequency of recording patient observations. The National Institute for Health and Care Excellence guideline on violence and aggression: short-term management in mental health, health and community settings (2015) states: after rapid tranquilisation the side effects should be monitored including the patient's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. This should be monitored every 15 minutes if the maximum dose has been exceeded. Some staff said they would not change the frequency of patient observations from four hourly, some said they would do them hourly and others two hourly. All staff said they would have a staff member sitting with the patient.

Staff Training and Development

- The trust offered comprehensive mandatory training to staff. Modules included; equality and diversity, fire safety, infection, prevention and control, dignity at work, moving and handling, the Mental Capacity Act (2005) and risk and safety training. Staff could access their mandatory training record electronically. The training record used a traffic light system to notify staff when their training was due and staff received an alert. Managers received an email when staff had registered for training sessions.
- Mandatory training was highlighted as an area for improvement at the previous inspection. At this inspection, we noted significant improvements with most areas achieving above 90% compliance.
- The main exception to this was resuscitation training where compliance figures were between 69% and 74%. Some staff mentioned issues with availability of basic life support and immediate life support training. We were not told of a specific plan to address this, however we were told the training was provided by the hospital resuscitation team and the volume of people needing training was a challenge.
- Staff told us that the period between April and June was classed as appraisal season when the majority of staff

Summary of findings

underwent appraisal. Any staff absent were given their appraisal on return to work. They told us that the appraisal was meaningful, supportive and enabled them to identify any training needs they had.

Are services at this trust responsive?

We rated responsive as good because:

- Across the trust the majority of services were rated good for being responsive. Issues within this domain were limited to the core services of surgery and critical care.
- The services took the needs of people into consideration when planning and delivering services.
- The average length of stay was below the national average for the majority of elective and non-elective patients.
- The complaint policy and the procedures were well advertised and people told us they knew what to do if they were dissatisfied with the service. Concerns and complaints were investigated and responded to in a timely manner.
- We saw evidence of practices to meet individual needs of patients, such as those living with dementia or with a learning difficulty.
- Critical care services staff took into account the circumstances of each patient, their personal preferences and their coexisting conditions when planning and delivering care.
- Plans were in place to bring all of the children's services together in one location within the trust.
- A youth forum had been formed that promoted change within children's services. A teenage area was due to be opened shortly after our inspection.
- The CAT unit ensured that children could be assessed by a paediatrician without the need for admission. The Paediatric Ambulatory Near Discharge Area (PANDA) was an area that children and their families could wait, after discharge, for test results or medication. These units improved access and flow through the hospital.

However:

- Stroke medicine had challenges around patient flow. The average length of stay for stroke patients was significantly above the England average.
- Readmission rates for elective and non-elective admissions in surgery were higher than the England average.
- Only two specialities in surgical services were performing above 90% for referral to treatment time within 18 weeks.

Good



Summary of findings

- The trust provided specialist critical care services for a large geographical area therefore sometimes the demand for the service exceeded the resources they had, causing problems with the access and flow to the critical care units (CCUs). This resulted in cancellations of surgery and delays in admission to CCUs when patients were critically ill, discharging patients from the unit out of hours and the increase in the readmissions to the unit following discharge. The staff and the management held three times daily bed meetings within all the sites to enhance the flow and discharge of patients.
- In some children's specialities there were long waiting times for treatment.
- Some children requiring admission from the CAT unit waited a long time for an inpatient bed.

Service planning and delivery to meet the needs of local people

- Partnership working for service planning purposes included working with commissioners of services, the local authority, other providers, GPs and patient groups to co-ordinate care pathways. Integrated care was one aspect of the trust's five year strategy. This included working with the Health and Social Care Transformation Board looking at city-wide working to provide more 'joined up' care for patients.
- Another aspect of this was developing the Leeds Academic Health Partnership. This aimed to develop collaborative working between NHS trusts, universities and local authority, with the focus on improving patient outcomes.
- Minutes of meetings confirmed that regular discussions were held between the trust and the commissioners about the provision of services; for example this included the service level agreement for critical care services and the capacity for providing regional specialities.
- The trust worked closely with other stakeholders, patients and staff to plan and deliver services to meet the needs of local people.
- The trust strategy focused on developing ambulatory pathways, and avoiding unnecessary hospital admissions. The trust had held a workshop with key members across the organisation including lead clinicians, ward sisters, matrons and CCG's, to look at where medical assessments happen and look towards reorganising care pathways to improve efficiency.
- In a response to the increased demand on capacity and number of medical outliers, the trust worked closely with community partners. For a six month trial period, the trust took

Summary of findings

over the running of ward 31 from another trust. The aim was to cohort patients who were awaiting rehabilitation and reduce the number of patients who were outlying on other wards within the hospital.

- The trust made further attempts to reduce the number of medical patients outlying on other wards by designating two wards in the hospital as 'medically fit for discharge' wards.
- Data provided by the trust showed in March 2016 there were 310 medical outliers and in April 2016 there were 290 medical outliers. In May 2016 the trust held a workshop with staff to explore ways to reduce admission rates with the overall aim of reducing the number of medical outliers. The workshop identified a process to reduce admission rates through the development of a frailty assessment model. However, the workshop identified the need for further collaborative working with other organisations.
- In addition, the trust was building partnership arrangements with other surrounding hospital trusts to be able to offer specialist care to patients closer to home.
- The AMS CSU formed in June 2015 following the merger of the Digestive Diseases and Hepatorenal CSU's. This enabled more collaborative working between medicine and surgery. In turn, the care and experience for patients was better with timelier access to services.
- The trust had signed up with NHS England to be an early implementer of seven day services. A seven day service was already provided for acute services. This included a full range of diagnostics, consultant-directed interventions and ward rounds.
- The trust had invested in a team to strengthen patient experience. The team had been in development over the last 18 months. The team actively worked with local communities, clinical business units and had introduced systems for sharing learning at ward and department level.

Meeting people's individual needs

- Use of information technology allowed patient information to be accessed more easily, for example, information produced by GPs. This meant the hospital was alerted to any risks prior to a patient's admission so staff could begin to plan ahead. For example if a patient had previously had any safeguarding referrals made.
- There was a lead nurse for learning disabilities, who held information on patients identified as having learning disabilities and where they were in the hospital or which

Summary of findings

department they were receiving treatment in each month. This information then linked into the patient experience survey. On average the trust had around 16 in-patients a month with a learning disability.

- The trust had appointed 'Get me better' champions to support people with learning disabilities.
- There was an alert flag on the trust's electronic system to identify when a person had been admitted or was in receipt of treatment with a learning disability. This then sign posted staff to consider reasonable adjustments and to complete the 'hospital passport'. In addition, there was an information document that provided advice on what would be useful to consider supporting the person whilst receiving care and treatment, such as environmental issues, communication and individual needs. An advice document was also given to staff in wards and departments about what reasonable adjustments to consider. The trust also liaised with the community and GP services about patients' care and treatment.
- There were a range of good practices and arrangements in place to respond to the needs of patients with learning disabilities but there appeared to be little in way of monitoring how services were performing with these.
- To help identify patients with severe sensory loss, such as deafness or blindness, the A&E departments had a flag system; this was visible with subsequent patient visits to the department. All patients admitted were assessed and the documentation had specific triggers for deafness or blindness so that reasonable adjustments could be made.
- There were universal symbols used at the patient's bedside that identified patient safety needs or sensory loss. Information was available in large, easy read or braille typeset and there was an RNIB Eye Clinic Liaison officer available to support wards with aids, including audio aids. There was also an assisted listening device for use in an emergency for deaf patients. The trust had sign language interpreters available.
- The trust had set up a working group to develop a risk assessment for enhanced supervision for acute adult inpatients. Patients who were confused and wandering, and presented as a risk to themselves and others; displaying violent and aggressive behaviour; expressing intent to self-harm or were under a mental health section order were identified as high risk. Recommendations for these patients included, one to one care by either a care support worker, security or a mental health nurse. We saw examples of this taking place during the inspection across the trust.

Summary of findings

- The A&E teams worked effectively with other specialty teams within the trust. There was good access to mental health clinicians with 24-hour telephone access to psychiatric liaison staff. There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them. Allied health professionals such as physiotherapists and occupational health therapists attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently. The department worked closely with the ambulance trust, local GPs and the out of hours' service to ensure that unnecessary attendances and admissions to the department were avoided.
- A critical care outreach team was available 24 hours a day, seven days a week at SJUH to support staff with patients who were at risk of deteriorating, patients whose NEWS score triggered a review and patients on non- invasive ventilation. Staff said the team were very responsive and patients could be escalated to Level 3 beds if required. A 24 hour, seven day critical care outreach team was due to be implemented at LGI in October 2016. In the interim, out of hours cover for deteriorating patients at LGI was provided via the existing on-call clinical arrangements.
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. When a patient was identified as 'at risk' staff completed the appropriate care plan.

Dementia

- A head of nursing has the corporate lead, who worked with an operational head of nursing to provide clinical leadership for caring for patients living with dementia. Training and education across the organisation was provided by the clinical educators. Most wards had an identified dementia champion who promoted the 'Forget me not' scheme and the 'Know who I am booklet,' with associated symbols used at the bedside to alert staff to patients' needs. There was no electronic flagging system in place to identify patients living with dementia.
- Patients were assessed at admission; this entailed questions over the person's memory. A more in-depth screening process took place for patients who were admitted acutely, were over 75 years or with a length of stay over three days. This assessment was recorded in the medical notes and included in discharge information.
- In addition, the trust had two carer support workers who supported carers and provided information and advice. Staff

Summary of findings

said they could refer carers to the dementia carer support workers. They offered a variety of support including; listening to the carer, support with discharge and help with grants and benefits.

- The trust undertook carer surveys; the results of which were discussed at the dementia steering group and used to inform trust priorities over dementia issues across the trust.
- The trust had introduced a dementia audit as part of the 2016/17 audit programme, which was to be completed by the end of quarter 2.
- The trust was adopting the 'John's Campaign' and had undertaken a pilot with the support of NHS England to test if identifying patients by the use of coloured name bands reduced risk. John's Campaign, is a campaign that was developed in order to allow families and carers to stay on the ward with patients with conditions such as dementia. This was discussed at the older people's sisters meeting and was been rolled out across the wards.
- Some of the medical wards had been adapted to be dementia friendly.

Access and flow

- The trust was working closely with external partners and had good links with community services. The early discharge assessment team (EDAT) team worked on the acute assessment wards, seven days a week, to support discharges and identify patients who could be discharged with intermediate care.
- Wards had discharge coordinators to support discharge planning. Staff were proactive in commencing discharge planning and used daily board huddles to discuss patient discharges.
- Home planner documentation was being introduced to the wards. The document was completed by the discharge coordinator with patients and relatives and used to support hospital discharge.
- The trust had a team of hospital flow managers and bed managers who were responsible for patient flow throughout the hospital. The trust held daily operational performance meetings to discuss capacity within the hospital.
- In March 2016 the acute medicine CSU reported 140 delayed transfers of care. In April this had reduced to 129. Delayed transfers of care were patients who were medically fit for discharge and awaiting either a package of care, care home placement or further rehabilitation.

Summary of findings

- The trust had attempted to cohort delayed transfers of care. Ward 14 and 16 were allocated to patients deemed medically fit for discharge and who were waiting for a package of care or care home placement. Staff said the average length of stay could be up to six weeks.
- High bed occupancy levels, the high volume of medical outliers and patients who were medically fit for discharge with the impact on patient flow were identified on the acute medicine CSU's risk register.
- From the previous inspection in December 2013 concerns were raised about patients being transferred to wards prior to their bed spaces being ready. We found that all the assessment wards had 'trolley patients'. Each ward could take up to three patients. Patients were transferred to the assessment wards (wards 26, 27, 28 and 29) on trolleys and waited for a bed rather than waiting in accident and emergency.
- At a local level, ward 27 collected data on the number of patients waiting on trolleys and the length of time it took for patients to be moved into a bed space. The waiting time ranged from 2 to 3 hours. On the 10 May 2016, five patients waited on trolleys. The waiting times ranged from 2 hours 30 minutes to 5 hours. The clinical director was made aware of any trolley waits and all patients were discussed at the DOP meeting. We requested further data from the trust on the number of patients waiting on trolleys on the assessment wards and the length of time it took for patients to be moved in a bed space. The trust said they did not collect this data. However, the trust had established a task group to agree a process and governance framework to enable the trust to monitor and take any action.
- Between February 2015 and January 2016 the trust reported 73% of patients were not moved during their inpatient stay, 16% of patients were moved once, 6% were moved on two occasions, 4% were moved on three occasions and 2% were moved on four occasions or more. Staff said the number of bed moves reflected patient flow throughout the trust and was based on clinical need.
- The trust had 18 work streams focusing on improving patient flow. The work streams focused on reducing avoidable hospital admission, and reducing patient's length of stay. Two of the work streams had been completed and the remaining were ongoing. Examples of different work streams included concentrating consultant cover in the morning on the admission wards to improve timeliness of discharge,

Summary of findings

conducting an audit of readmitted patients over the age of 70 years to identify any key themes and auditing the common delays in patient pathways and implementing any recommendations.

- The average length of stay for patients at SJUH was above the England average for elective and non-elective admission. For elective admissions the average length of stay was 5.5 days compared with the England average of 3.8 days. For non-elective admissions the average length of stay was 8.6 days compared with the England average of 6.8 days.
- The target referral to treatment time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment time. Between December 2015 and February 2016 all but one of the medical specialties was performing at 90% or above for the RTT. Each specialty within the service individually achieved the target with the exception of gastroenterology which achieved 83%.
- The trust told us they had signed up with NHS England as an early implementer of seven day services; a commitment to achieve four priority standards (2, 5, 6 and 8) for services by April 2017. A baseline evaluation had taken place which showed that most of the standards were compliant in a number of clinical services, for example standard 5 and 6, emergency diagnostic services and consultant-directed interventions. Further audits and evaluations were planned.
- LTHT provides specialist critical care service for a large geographical area therefore sometimes the demand for the service exceeded the resources they had, causing problems with the access and flow to the critical care units. This resulted in cancellations of surgery and delays in admission to CCU when patients were critically ill; discharging patients from the unit out of hours and the increase in the readmissions to the unit following discharge.
- SJUH performed worse than expectations for two indicators in the 2013/14 ICNARC case mix programme. They were out-of-hours discharges to the ward and unplanned readmissions within 48 hours. A peer review audit of the service was undertaken in November 2015 identified patient flow to be a key challenge for the CSU operationally.
- SJUH performed worse than expectations in out-of-hours discharges to the ward and unplanned readmissions within 48 hours. This was seen as a result of being a specialist centre.
- Emergency theatres were accessible seven days a week and elective lists ran six days a week. The ophthalmology day unit had between four and six lists a day, Monday to Friday.

Summary of findings

- Theatre one in the Giles theatres suite was an acute theatre and ran 24 hours, seven days a week. Theatre two was also an acute theatre and ran from 8am to 6pm. Morning sessions Monday to Friday were 'ring fenced' for urology, gynaecology and thoracic procedures. This theatre was also shared with the transplant team. We were told operations often took place after midnight by middle grade doctors, as there was not enough time during the day.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) provides guidance and classification on surgical interventions. The categories are immediate, urgent, expedited and elective. The guidance is clear that these categories relate to the procedure being undertaken and not the theatre list which is being utilised.
- From the discussions we had and the data reviewed we were not assured that the operations being performed at night were always appropriate. We requested data from February 2016 to April 2016. The data showed 155 operations were performed between 10pm and 8am, 91 of which commenced prior to 1am. From 1am up to 7.59am, there were 64 cases.
- At SJUH 625 (1.5%) of the 42,331 scheduled operations between January 2015 and December 2015 were cancelled. This was higher (worse) than the England average of 0.8%. Of these cancelled operations, 63 were not treated within the 28 day target. At LGI, 553 (1.4%) of the 40,322 scheduled operations between January 2015 and December 2015 were cancelled. Of these, 39 were not treated within 28 days. Trust wide the percentage of patients whose operations were cancelled and were not treated within 28 days was better than the England average for Q2 and Q3 of 2015/16.
- We were told by several staff that a lack of critical care beds had had a significant impact on theatres. For example, operations being cancelled on the day and some patients requiring high dependency or intensive care having to remain in PACU. Twenty operations were cancelled due to lack of critical care beds from January to March 2016.
- The senior management team were aware of the issues with critical care capacity. There was a willingness to improve, however the ability to recruit nurses was identified as a challenge. The trust acknowledged the impact this was having on patient flow. Plans such as working with partners for repatriation, escalation and close team working had been implemented to work together to prioritise patient flow.

Summary of findings

- Overall trust performance for RTT for the surgery core service was 81.3%, which was above the England average of 75.8% in February 2016. RTT remained on the risk register for all CSUs with plans in place to review activity and report through trust performance meetings.
- Enhanced recovery programmes were in place for some elective surgical procedures such as hemicolecotomies (bowel resections). Enhanced recovery is a programme to improve patient outcomes and focuses on optimal recovery and discharge for patients. We were told about, and saw work in progress, in relation to enhanced recovery for prostate cancer surgery. This work was being undertaken with an external agency which supports health care transformation. A number of initiatives had been introduced in theatres to improve start times and efficiency within the departments. This was having some positive impact.
- A purpose built SAU was opened in 2015 which improved patient experience and flow through the trust. The SAU took admissions directly from GP referrals and from the emergency department at SJUH and LGI. A telephone triage system was in place for GP referrals; referrals from the emergency department were done via a telephone call with a member of the medical team.
- At LGI the length of stay within stroke medicine was above the England average because of the challenges around discharging stroke patients. Acute stroke patients who required further rehabilitation as an inpatient were transferred to ward 12 if they were over 65 years or to Chapel Allerton Hospital if they were under 65. Staff said there was a lack of rehabilitation beds in the trust. The service also did not have an early supported discharge team. Staff had raised this with the trust and a business case for an early supported discharge team had recently been turned down by the CCGs. The trust was meeting to discuss other options for providing the service. Staff said other challenges around discharging patients including delays in the provision of care packages and care homes.
- There had been no mixed sex accommodation breaches in the last 12 months.
- At the Children's Hospital located at LGI, children were seen on the CAT unit for an assessment by a paediatrician without the need for admission. Staff triaged children on arrival to the unit to ensure those requiring more urgent treatment were seen first. The Paediatric Ambulatory Near Discharge Area (PANDA) was an area that children and their families could wait, after discharge, for test results or medication. These units improved access and flow through the children's hospital.

Summary of findings

- Children needing admission from the CAT unit sometimes had a long wait for transfer to a ward. Staff told us that at times this could be 10 or 11 hours. We were unable to obtain any data about waiting times on the unit, as this information was not collected by the trust.
- Flow through the CAT unit could sometimes be difficult due to nurse staffing issues. Medical staff told us that the workload on the unit had been increasing over the past 18 months. Steps were taken to increase medical staff presence on the unit at peak times. However, nursing staff told us that increasing the number of doctors on the CAT unit increased the demand on the nurses. When there were only two nurses covering the unit it was difficult to manage the throughput at times and children had to wait longer.

Learning from complaints and concerns

- There were robust systems in place for dealing with complaints. All complaints were risk assessed by the complaints manager or their deputy when received using the trust's risk matrix. More complex complaints were discussed with the senior nurse for patient experience.
- The executive lead for complaints was the Chief Nurse with support from a non-executive director. Any complaints that have been identified as high risk were reviewed weekly at the quality meeting with the Chief Nurse and the Chief Medical officer.
- The complaints and Patient Advisory Liaison Service (PALs) department was run by the head of patient experience, supported by a lead nurse for patient experience.
- Information on complaints was reported at every Board meeting through the healthcheck data, which described the number of complaints received by each CSU. In addition, there was a formal complaint report and an annual report to the Board. The integrated risk report was seen by the quality assurance committee, which was a sub-committee of the Board. These reports pulled out themes from complaints. The monthly Quality and Performance Report routinely included CSU level data on complaint numbers versus activity.
- The patient experience sub-group reviewed how complaints had been handled and any themes or lessons learnt were reviewed at the lessons learned group as well as the patient experience and risk teams' forum. Learning from complaints was contained within the Trust Board Complaints reports, staff quality and safety briefings. The trust had also produced a

Summary of findings

number of films about patients' experiences. There was a lessons learnt group, which also included lessons from incidents, claims and any external recommendations such as Coroner Inquests.

- The trust consistently achieved the national standard for acknowledging complaints within three working days, although this varied with some specialities. In addition, the trust had introduced a new initiative by giving the CSUs the opportunity to record complaint resolution meetings as an alternative to providing a traditional response letter.
- According to the six monthly update to the Board 28 January 2016 the trust received 394 complaints between 1 April 2015 and 30 September 2015, the same number as received between 1 October 2014 and 31 March 2015. During the first two quarters there had been 16.5% less reopened complaints than the previous two quarters. There had been 7,733,863 patient contacts during this time giving a rate of 1.4 complaints per 10,000 patient contacts. The paper reported an improved position compared to the same period 2014/15 when there were 1.8 complaints per 10,000 patient contacts.
- There was a Complaints Improvement Plan (2015-17) based upon guidance in the PHSO report "My Expectations" and the recommendations contained within the CQC and Patient Association report following the joint inspection in April 2014. The top complaint subjects by volume received were communication, treatment and administration issues.
- Information on how to make a complaint was displayed in public areas. In addition, leaflets were available in patient areas and included easy read versions, as well as posters and leaflets aimed for children. Laminated sheets were located in patient folders at the bedside. Information on how to complain was on the trust intranet site. Posters encouraged patients and visitors to raise any concerns or questions.
- Staff were able to describe how they would deal with a complaint, and understood the role of the patient advice and liaison service (PALS) and formal complaints process.
- We reviewed complaints letters and found an apology was offered when care fell below the expected standard; the trust was responsive to concerns raised and staff met with the families concerned.

Are services at this trust well-led?

We rated well-led as good because:

Good



Summary of findings

- The trust values of, 'The Leeds Way' were embedded amongst staff and clinical service units had a clear clinical business strategy, which aligned with trust's five year strategy, priorities and goals.
- There was a range of overarching strategies in place to support service delivery and improvement. Clinical support units had their own business strategies; each aligned with the trust five year strategy, objectives and goals.
- There were robust governance processes and systems in place to ensure performance, quality and risk was monitored. The information and risks identified at service level and trust level were reflected in risk registers and the Board Assurance Framework.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.
- Staff engagement had improved and staff reported that they felt consulted with and engaged with trust service development. Communication had improved across the trust and up from the Board to the wards. Initiatives had been introduced to involve staff in clinical service development and staff achievements and successes were celebrated.
- There was increasing public engagement and involvement. Strategies, service planning and developments was undertaken in consultation and involvement of a wide range of stakeholders in the community, including patient groups.
- The culture in the trust was open and transparent. Staff reported that they were confident to raise concerns, were able to share lessons learnt and good practice and that the organisation was supportive of staff.
- The trust had introduced a large range of innovative practices and initiatives to benefit patient care.

However, we found that:

- Not all services had local vision or strategy. Critical Care services did not have any unit specific visions or strategies but they said that they took ownership of 'The Leeds Way' and applied it to their units.
- Further work was needed to strengthen some aspects of governance and assurance processes to ensure that the leadership team were confident that all changes to practice and improvements introduced were being adopted and embedded. For example, changes in practice following Never Events.

Vision and strategy

Summary of findings

- The trust used crowdsourcing technology to engage with its staff to develop its vision, values and goals. Collectively the outcome to this was known as the 'Leeds Way'. Staff were asked to describe the behaviours and leadership required to achieve the trust vision.
- The 'Leeds Way' was visibly promoted through trust documentation, practices and procedures used, training, appraisal and recruitment processes. Staff across the trust referred to this when discussing the values and goals and with particular reference to the care of patients. The 'Leeds Way' was promoted in posters across wards and hospital sites.
- The trust vision was 'to be the best for specialist and integrated care'. The values to underpin this were - Patient Centred, Fair, Collaborative, Accountable and Empowered. There were five trust goals to be – the best for patient safety, quality and experience, the best place to work, a centre of excellence for specialist services, research, education and innovation, hospitals that offer seamless, integrated care and to be financially sustainable.
- The trust had identified four priority areas for quality improvement. These were to be harm free, including reducing the number and harm from falls; improving patient experience; avoidable mortality and integrated care for partners where the trust was developing the care pathway with partners in health and social care so these work more effectively.
- The five year strategy (2014-2019) was designed to be delivered through the development of clinical service units (CSU) and their individual clinical business strategies. These related to the trust-wide business plan. The CSU business strategies detailed the services provided, measures used to check performance against clinical outcomes and patient feedback. The strategies were designed to align with the trust's 'Leeds Way' vision, values and goals. This framework encouraged ownership from individual CSU's. We found reference to the 'Leeds Way' in related documentation within these strategies.
- Ten corporate objectives had been agreed to drive the achievement of the goals, which included involving patients, delivering mandatory standards, staff engagement and working collaboratively with partners. An example of this was the development of the Leeds care record programme, for the better sharing of information between the trust, GPs and other professionals.
- Most services had developed strategic plans linked to the trust's five year strategic plan. For example in medical services the management team were able to explain the strategy for acute medicine. The focus included, more integrated working,

Summary of findings

developing joined up working between accident and emergency and acute medicine, admission avoidance and developing ambulatory pathways. This was evident when we looked at service planning for this service, which showed the active steps to work with partner organisations, commissioners, other stakeholders and trust staff to plan services. However, not all services had a local vision or strategy. Critical Care services did not have any unit specific vision or strategies but they said that they took ownership of 'The Leeds Way' and applied it to their units.

- The strategic plan for surgical services showed alignment to the trust's strategy, with a focus on quality and patient experience.
- Each CSU had clear direction and goals with steps identified in order to achieve them. For example within the AMS CSU the aim was to be a centre of excellence for organ transplantation; the use of technology and innovation featured highly in the strategy to achieve this.
- The trust was actively working with partner organisations, commissioners of services and other stakeholders including patient representative groups to plan and develop strategies to meet the needs of the patients using their services.
- The trust had a range of overarching strategies to support the delivery of services and achieve the trust vision and goals, these included an estates strategy, a people strategy and an organisational development strategy.

Governance, risk management and quality measurement

- The trust had a governance framework in place, which had matured and become more embedded since the last inspection. This supported the delivery of services and ensured effective reporting of safety, quality and performance information from ward to Trust Board.
- We examined a range of Board papers and found that these were aligned to the trust goals. Papers covered a range of operational and strategic issues from staffing updates, corporate and strategic risks and progress on performance, including patient experience feedback.
- The committee structure reporting to the Board of Directors consisted of six committees, including risk management, finance and performance and quality assurance. Non-executive directors chaired assurance committees. The assurance committees had moved from having a mix of operational and assurance elements to a position of dealing solely with assurance. When issues drew attention, additional assurance was required from executives on the situation. Deep dive

Summary of findings

examinations added more scrutiny for specific concerns, one example given was the repeat occurrences of Never Events. This involved looking at team management in theatres, lessons learnt and challenges faced.

- The Board Assurance Framework (BAF) had been revised in September 2015 and updated to reflect the trust's longer-term strategic risks. It had been agreed that this would be distinct from the Corporate Risk Register, address threats to the trust's strategic objectives and be linked to and inform the annual planning cycle. Risks were considered alongside corporate objectives.
- We viewed the Board Assurance Frame Work for May 2016; it identified a number of areas for improvement so that patients could experience safe and effective care. The areas highlighted for action to address gaps in controls and assurances were comparable to our findings at this inspection. These included: a five year plan for investment in nurse staffing levels to address the high number of vacancies, staff retention, sickness absence and changes to patient acuity and skill-mix: Effective monitoring to ensure staff compliance with infection prevention and control procedures to protect patients from healthcare associated infections; hospital acquired Clostridium difficile or MRSA bacteraemia: To make sure mortality and morbidity (M&M) reviews were systematically undertaken: Understand patients' needs and their experience of the services and demonstrate learning and change in response to patient feedback. Actions had been identified to address these as part of the trust action planning process.
- At service level there were governance processes and systems in place to ensure performance, quality and risk was monitored. Each CSU met weekly and used the ward healthcheck to audit a range of quality indicators including the number of falls, complaints, pressure ulcers, staffing vacancies and staff sickness. This information was reviewed at head of nursing and matrons meetings and at clinical governance meetings. Any issues from these would be reported up through the various sub-committee groups to assurance committees and eventually to the Board if appropriate.
- During the inspection, we found that there were still areas where assurance mechanisms were not sufficiently robust to identify and address concerns. For example, the embedding of lessons learnt from Never Event in operating theatres; the oversight of patients waiting to be admitted on trolleys (including inconsistent risk assessment); the use of theatres overnight and how staff from ward to Board could be assured

Summary of findings

that equipment was appropriately serviced and maintained. We found there were systems in place and work being undertaken, such as that done on understanding lessons from Never Events, but this had yet to fully address the issues.

- Corporate and CSU risk registers were in place and were regularly reviewed and updated. Risk registers were reviewed quarterly at clinical governance meetings and twice a year by the Risk Management Committee, chaired by the Chief Executive. If any risks were identified outside of this, they were added to the risk register. We reviewed the CSUs' risk registers. All risks were given a current risk rating. Key controls were in place to reduce the risk and assurances to assess if the controls were effective. We found that there were some long standing risks on some CSU risk registers for example, the longest standing risk on the acute medicine risk register was from April 2015 and was reviewed in March 2016. There were four risks from this date. One of the risks related to high occupancy levels, high numbers of medical outliers and patients who are medically fit for discharge and was given a risk score of 20. Controls put in place to mitigate the risk included the use of additional beds, an agreed approach to the management of medical outliers by consultants and relevant specialities and increasing pharmacy cover seven days a week to support discharges.
- Every six months, each CSU attended the trust risk management meeting chaired by the Chief Executive to discuss the CSU risk register.
- The ward healthcheck was used on wards to audit a range of quality indicators. Any wards that were rated red for three consecutive months were placed in escalation and got support from the corporate nursing team. Staff spoke positively about the team and said they supported staff to make changes and drive improvements
- The trust had a £1 billion turnover. According to the Trust Board Paper dated 26 January 2016 regarding 2015/16 financial position. The year-end forecast position was a planned £37.2 million deficit. The trust was moving from a £100 million overspend to a positive balance in three years. This had been achieved without significant transfer of capital and it was reported that this was helped through good relationships with the commissioning groups. £15 million had been secured by better coding and a positive response to cost improvement plans. The trust had invested in a patient-led costing system to

Summary of findings

provide better data for business services. Cash reserves stood at £3.2 million. Projections for April 2016 to March 2017 were income of £1,185.3, a surplus of £1.2 million with full costs at £1,184.1.

- Top concerns raised about achieving key objectives were the provision of specialist services, addressing the IT/informatics infrastructure issues, workforce, delivering performance targets in line with trajectory and achieving financial balance.
- The major issues with the estate was the large infrastructure. It would cost around £45 million for energy rationalisation and £40 million to bring the IT infrastructure up to date and enable a paperless process to be established across the trust. Other concerns around IT included issues over servers, aging computers and laptops and internet access. There had been an under investment in the clinical IT systems. The trust was looking at a range of solutions for these, one of which included working with IT partners; a business case had been submitted for consideration.
- Challenges over workforce were about recruiting to the necessary posts, succession planning for an aging workforce and the reliance on agency and locum use. Efforts had been made to reduce short term agency usage in non-clinical areas. There was a £26 million threshold for agency usage. The staff sickness/absence was at 3.89% at the time of the inspection. There were support mechanisms in place such as a helpline and attendance management coaching to enable staff to return to work.

Leadership of the trust

- There was a stable senior leadership team at the trust led by a Chief Executive who staff reported from across all areas of the trust to have brought about changes that improved the culture and delivery of services.
- Staff consistently reported a high level of confidence in the Chief Executive and his executive team. They were reported to be visible, accessible and committed to improving patient experiences and staff engagement.
- The Chair had been in post since 2013, with the seven non-executives directors ranging from one since 2012, two since 2013, three since 2014 and one person started in 2015.
- The Chief Executive commenced in post in October 2013, the Chief Nurse/Deputy Chief Executive in May 2013, the Chief Medical Officer in June 2013, the Director of Finance in January 2014, the Director of Strategy and Planning in May 2014 and the Director of Human Resources and Organisational Development in October 2014.

Summary of findings

- The trust operated a clinically led structure with 19 clinical service units, each having a clinical focus. Each CSU was led by a senior medical clinician, a senior nurse and senior manager.
- The trust was committed to the development of leadership, particularly in clinical areas and provided a 'Leading in Leeds' training programme to develop key leadership skills.
- The trust was one of five trusts to take part in the NHS Improvement Partnership working with NHS Improvement and an external agency. The programme is about ensuring the trust provides the highest quality care whilst reducing inefficiencies in the service. The five year programme focuses on learning from the experiences of others and empowering clinical teams to have continuous quality improvement across the organisation

Culture within the trust

- Staff felt that the senior leadership team had brought about a change in the culture within the organisation; staff described a new, proactive way of working.
- Staff of all disciplines and levels across the trust reported consistently that they were proud to work for the organisation. Even in areas with staffing challenges such as theatres, staff reported that morale was good.
- The score for the number of staff who would recommend the organisation as a place to work or receive treatment was 3.72, which was around the same as the England average of 3.76. The percentage of staff who experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months was about the same as the England average at 27%. The percentage of staff experiencing physical violence from staff in the last 12 months was the same as the England average at 2%.
- We observed good working relationships between nursing and medical staff across all sites of the trust. Junior medical staff said they felt supported by senior medical colleagues and consultants.
- Staff reported how small changes had made a big impact. For example the, 'hello my name is' campaign. To foster improved communication with patients and embrace patient centred care around a third of staff had signed up to the national campaign 'hello my name is', thereby introducing themselves to patients with an explanation of what they do.
- Staff gave positive feedback regarding the culture in the organisation and described the trust as a good place to work. They felt the culture encouraged staff to be open and honest

Summary of findings

and to report incidents and learn from them. Staff felt confident to raise any concerns about patient safety and that managers would listen and would take appropriate action. We saw posters displayed on wards providing information about how to speak to the sister or matron if people had concerns.

- The staff who had been involved in the learning from the wrong site cataract surgery never event told us there had been a 'no blame' culture in relation to this. Learning was undertaken with the involvement of staff in a supportive way.
- The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month was about the same as the England average at 32%. However, the percentage of staff reporting errors, near misses or incidents witnessed in the last month was 88%, which was worse than the England average at 90%.
- The trust had introduced the Leeds Improvement Method. The Chief Executive reported to the Board on 26 November 2015 how the Leeds Improvement Method placed the patient at the heart of everything done in the trust with greater productivity and efficiency.
- Ward managers told us that 'The Leeds Way' values were integral to staff appraisal.
- The trust and individual CSU held annual award nights to recognise and celebrate staff success.

Equalities and Diversity – including Workforce Race Equality Standard

- The Workforce race equality standard (WRES) aims to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The trust had benchmarked itself against the standard and indicators in June 2015.
- Information in this indicated that the percentage of BME staff had increased to 19.76% in March 2015 compared to 18.84% in March 2014.
- The trust had developed an Equality and Diversity strategy and a policy was in place. There was external scrutiny for the plans in place.
- There had been an increasing amount of work undertaken around patient experiences and equality groups in the trust.
- Equality and diversity was part of the mandatory training programme and the trust was rolling out 'Unconscious Bias' training.

Summary of findings

- The trust collected and used data to inform objectives and there were robust governance systems in place with senior leadership involvement. The trust was compliant with the publishing of required data.
- The percentage of staff experiencing discrimination at work in the last 12 months according to the NHS Staff Survey 2015, was the same as the England average of 10%.

Fit and Proper Persons

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had a standard operating procedure in place for the Fit and Proper Person. This included all executive and non-executive directors.
- We reviewed five files of executive and non-executive director's files and found they were compliant with the regulation.

Public engagement

- A patient experience (story) was heard at each meeting of the Trust Board with a view on lessons learnt from this for service delivery.
- The trust was one of 20 hospitals participating in a pilot scheme called 'open and honest care'. The information gathered was available on the trust's website for the public to view and was updated each month. It included data on pressure ulcers, falls, Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile rates. Patient and staff experience surveys and safety thermometer data was also shared.
- In addition the trust conducted compassion in care audits. This data was collected monthly and RAG rated for each area. Patients were asked five questions based on whether their care had been compassionate and if they had felt involved. Data for the head and neck CSU saw overall percentages to be between 91% and 100% between April 2015 and February 2016.
- The trust monitored and reported regularly to the Board its performance on the Family and Friends Test (FFT). The Board paper dated 28 January 2016, entitled 'Family and Friend Test' reported that based on their experience of care in quarter 2 2015/16, 91% of inpatient, day case, maternity and emergency department FFT responders would recommend the trust to friends. The performance for quarter 2 (2015/16) had exceeded the internal target of a 20% response rate in A&E departments

Summary of findings

(average response rate 28.1%). The total number of patients eligible to provide FFT feedback was increasing month on month as new services came on board and wished to engage in the process. However, the paper acknowledged that performance in established FFT areas had declined. The trust response rate for established FFT areas in quarter 2 was 25.74% (against an internal target of 30%). Actions had been put in place to address this. The Patient Experience Team were trialling the use of two Android devices that facilitated electronic FFT capture, meaning that the data was reported in real time and live.

- The trust was developing an overall Patient Experience Strategy, consultation with local communities and staff at the trust. In the meantime, there were separate strategies in place including equality and diversity and volunteers. Consultation was taking place with a range of groups to capture patient experience, particularly aligned to specific clinical services or patient conditions. For example consultation was taking place with people with sensory loss, advocacy services to ensure the patient voice was heard, and refugee resettlement and traveller groups.
- The trust recognised that there was more to be done to improve engagement with the public and patients. Processes had been developed to promote the patient voice, capture engagement and share experiences across the clinical areas.
- There was regular monthly engagement with Healthwatch

Staff engagement

- The trust invited all 15,000 staff to participate in the national staff survey, with a response rate of over 8,000 staff across the organisation. The survey showed that there was continuous improvement. The response rate for the NHS Staff Survey 2015 was 50%, this was better than the England average of 41%.
- Staff told us about monthly question and answers sessions with the trust's Chief Executive and improved communication between departments. Staff felt there was improved sharing of information with dedicated notice boards in clinical areas around performance.
- The trust produced a trust magazine called 'Connect', which contained details of news, developments within services, where innovative practice was taking place and a calendar of events for the year such as presentations, talks and discussions on particular health issues such as arthritis and dementia.

Summary of findings

- The Chief Executive communicated with staff weekly through a weekly bulletin, entitled 'Start the week'. In this contained information on updates on trust activities, what the executive team had been involved in that week and celebrated staff successes and contributions.
- Junior doctors told us the Chief Executive came to their trust induction which they thought was excellent practice.
- The trust had introduced a range of initiatives to encourage staff participation in trust service development. They included, nurses attending the urology audit day engaged well with consultants and were able to make them aware of specific nursing issues; link nurse roles had been developed to improve staff engagement within clinical areas; nursing teams were involved in the development and planning for the new surgical assessment unit.
- We were told that consultants led certain teaching days and these would, in the future, also be attended by staff nurses and health care support workers. This would provide an opportunity for ward and theatre staff to meet.
- Staff felt that the appraisal process was effective and it was a process which supported them in taking on additional roles and responsibilities. For example, the staff involved in the urology enhanced recovery programme received a full week of training which included looking at standardising the certain procedures, discharge planning, reducing length of stay and patient experience.
- The trust held Schwartz rounds. This was a forum for hospital staff from all backgrounds to come together to talk about the challenges of caring for patients. It offered staff a confidential and safe environment to share patient care issues and to offer support to each other.

Innovation, improvement and sustainability

- The trust was continuously introducing new innovations and improvements to services. Some enhanced patient care and treatments, others enabled improved sustainability within services and are reported in the location core service reports.
- Examples of innovative practice and areas the trust celebrated staff achievements include the following:
- Organ transplantation which included a live liver donation and transplant programme had been undertaken which was the largest in the UK. Other aspects of the transplantation programme included Neonatal organ retrieval and

Summary of findings

transplantation: Life Port Trial: Kidney Transplantation: QUOD Trial: Quality in Organ Donation National Tissue Bank, Revive Trial: Organ Care System and Normothermic perfusion: Support for Hand Transplantation.

- Work was ongoing in relation to Viral Hepatitis C and the trust is a designated site for implementation of Hep C eradication therapy.
- Procedures such as minimally invasive oesophagectomies were being performed. The colorectal team were using sacral nerve stimulation for faecal incontinence.
- There was a focus on research with 80 trials being run across all specialities by 20 research nurses.
- A Glaucoma Monitoring Unit had been established to ensure all follow up glaucoma patients had screening and a virtual follow up review.
- The trust is one of 14 'pioneer' health and social care economies working together to improve the provision of integrated care.
- The trust operated over 150 apprenticeship programmes, including pharmacy, clinical support workers and nursing support.
- The trust had been selected as an NHS Employers Equality and Diversity partner organisation for 2015/16.
- The trust supported Honorary Clinical Professors in partnership with University of Leeds supporting clinicians to provide leadership in research and education in their speciality.
- Ward J29 had won the Palladium Patient Safety prize at the Bristol Patient Safety Conference.
- The trust was one of the first to receive Safe Effective Quality Occupational Health Service Accreditation for occupational health services.
- The speech and language therapy team had won the National Royal College of Speech and Language Therapists Sternberg Clinical Innovation Award
- The trust had introduced the 'Leeds Improvement Method', which meant they were one of five trusts nationally working in partnership with the Virginia Mason Institute to improve quality and safety for patients through the implementing lean methodology, thereby working more efficiently. This was launched in elective orthopaedics in Chapel Allerton Hospital.
- The trust had developed a Quality Improvement Strategy in partnership with partner organisations and the trust's clinicians with the aim to improve quality and reduce patient harm.
- The trust was part of the West Yorkshire Association of Acute Trusts, working collaboratively to improve patient care services.

Summary of findings

- The trust had introduced 'Wayfinder'. This was an on line crowd sourcing platform for staff to share problems and look at possible solutions.
- The trust had introduced 'Get Me Better Champions' an involvement programme for people with learning disabilities to contribute to the development of services.
- To improve the engagement of children and young people in service development the trust had arranged a youth forum; views from this would help shape the Leeds Children's Hospital strategy.
- The Colorectal Cancer Multidisciplinary Team at St James's University Hospital was named the winner of the Cancer Research Excellence in Surgical Trials award for 2015.
- The trust is a key partner in the 100K Genomes project for Yorkshire and Humber.
- The trust is one of six centres for Precision Medicine Catapult used to accelerate learning from diagnostics and data.
- The trust has the Stereotactic Ablative Body Radiotherapy for the North Region.
- The trust has a funded hand transplant centre, following the first UK operation.

Overview of ratings

Our ratings for Leeds General Infirmary are:

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

Our ratings for Chapel Allerton Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	N/A	N/A	N/A	N/A	Good
Overall	Good	N/A	N/A	N/A	N/A	Good

Overview of ratings

Our ratings for Wharfedale Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	N/A	N/A	N/A	N/A	Good
Overall	Good	N/A	N/A	N/A	N/A	Good

Our ratings for St James's University Hospital are:

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

Our ratings for Leeds Teaching Hospitals NHS Trust

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

Notes

Key questions showing as N/A above were rated as 'good' at the comprehensive inspection in March 2014.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the trust MUST take to improve

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

Outstanding practice and areas for improvement

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

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

How the regulation was not being met:

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

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

This section is primarily information for the provider

Requirement notices

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

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

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

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

How the regulation was not being met:

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

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

Requirement notices

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

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

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

How the regulation was not being met:

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

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

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