

# Leeds Teaching Hospitals NHS Trust


## Quality Report

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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

<b>Overall rating for this trust</b>	<b>Requires improvement</b>	
Are acute services at this trust safe?	<b>Requires improvement</b>	
Are acute services at this trust effective?	<b>Good</b>	
Are acute services at this trust caring?	<b>Good</b>	
Are acute services at this trust responsive?	<b>Requires improvement</b>	
Are acute services at this trust well-led?	<b>Requires improvement</b>	

## Contents

<b>Summary of this inspection</b>	<b>Page</b>
Overall summary	3
The five questions we ask about trusts and what we found	10

# Summary of findings

What people who use the trust's services say	16
Areas for improvement	16
Good practice	17

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## Detailed findings from this inspection

Our inspection team	18
Background to Leeds Teaching Hospital NHS Trust	18
How we carried out this inspection	19
Action we have told the provider to take	22

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# Summary of findings

## Overall summary

### 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 about 752,000 in Leeds and 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 outpatients' services are provided at Wharfedale Hospital and outpatients' services at Seacroft Hospital.

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

We did not inspect Leeds Dental Institute as part of this review as this is a specialist service and outside the scope of the inspection. In addition, Leeds Teaching Hospital NHS Trust provides children's cardiac surgery services, which are also specialist services and therefore not included in this inspection.

We undertook an announced inspection of the trust on 17, 18, 19 and 20 March 2014. We also inspected Leeds General Infirmary and St James's University Hospital unannounced on the evening of 30 March 2014.

### Our key findings were as follows:

#### Accident and Emergency services

Leeds General Infirmary and St James's University Hospital provided accident and emergency services for adults. Children's accident and emergency services were provided at Leeds General Infirmary.

At department level, the service was well led, staff felt engaged and involved in service improvement and redesign work. Staff worked well as a team.

The accident and emergency departments at both hospitals were clean and well maintained.

Nursing and medical staffing levels were safe as the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practitioners and overseas emergency medicine training programmes.

Nursing handovers were comprehensive and thorough covering elements of general safety as well as patient specific information.

There was good ownership of risk and learning from incidents within the departments.

Not all staff had completed mandatory training particularly safeguarding children Levels 2 and 3 where appropriate.

Care and treatment was in accordance with nationally recognised best practice guidelines.

There was an effective Clinical Decisions Unit with access to a range of specialists 24 hours a day, including good access to mental health services, through the acute liaison psychiatry (ALP) service.

Patients were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department. The implementation of dignity rounds helped ensure that patients were as comfortable as possible, including ensuring that drinks and food was available.

The trust had been performing better than the national targets since June 2013 for 95% of patients waiting less than four hours to be admitted, transferred or discharged. Patient flow was maintained through the departments and was better than the national average.

The children's accident and emergency department was staffed by paediatric consultants and nurses, and the trust had recently recruited more staff. The service improvement team was reviewing staffing within the children's accident and emergency department as part of a wider piece of work looking at the effectiveness of the department. On most day shifts there was a nursery nurse on duty with one or two care support workers.

# Summary of findings

## Medical services

Both Leeds General Infirmary and St James's University Hospital provided medical services. Leeds General Infirmary provided specialist cardiology, neurology and stroke services for the region. It did not accept general medical patients (who were transferred to the St James's University Hospital).

Patients were admitted promptly to the appropriate ward, although some patients then had to be transferred to an 'outlying' ward once their acute phase of treatment was finished as there were some delays in transferring them back into the community.

There had been a concentration on improving the acute care pathway, which meant that the elderly care service had not developed as it should, particularly the care of patients living with dementia.

Medical wards at both hospitals were clean and well maintained.

Low numbers of nursing and medical staff in some areas, particularly out of hour's medical cover and anaesthetists meant that there was a risk that patients were not always protected from avoidable harm.

There was a good culture of reporting incidents among the nursing staff, but this was not seen as a priority for all clinical staff. The recent introduction of the 'safety board' on wards had been embraced by the staff and all spoke positively about it.

Not all staff had completed their mandatory training.

There was inconsistency with the quality and recording of the nursing and medical handovers, which meant important information may not always be passed on appropriately to the next shift.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Although there was an annual clinical audit programme and a central Clinical Audit Database on which clinical audits should be recorded, this was still in its relative infancy and thus although audits were undertaken there lacked clarity over what was being audited, the outcomes and how this information was captured.

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

Patients were treated with kindness and respect and patients were complimentary and full of praise for the staff looking after them.

## Surgical services

Surgical services were provided by Leeds General Infirmary, St James's University Hospital, Chapel Allerton Hospital and Wharfedale Hospital. Wharfedale Hospital only provided day case surgery. Staff reported a significant shift in culture in the organisation and the new management arrangements were working well, although the analysis and use of performance data was 'work in progress'.

Wards and theatres were generally clean across all hospital sites and there was evidence of learning from incidents in most areas.

There were arrangements in place for the effective prevention and control of infection.

Not all staff had completed their mandatory training.

The operating theatres used the World Health Organisation safety checklist, although improvements were needed as not all aspects such as the debriefing were embedded in practice.

At Leeds General Infirmary and St James's University Hospitals, we found that there were inadequate levels of staff, both nursing and medical in some areas, particularly out of hours' medical cover and anaesthetist availability. In response to this the trust had increased the use of locums to minimise risk.

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

Patients were positive about their care and treatment and were treated with dignity and respect.

There were systems in place to manage the flow of patients through the hospital and discharge dates and plans were discussed for most patients.

# Summary of findings

Staff were aware of how to support vulnerable patients. However, mental capacity assessments were not always documented in accordance with the Mental Capacity Act (2005).

There was good multidisciplinary working with coordination of care between different staff groups, such as physiotherapists, nurses and medical staff.

## Critical care

Critical care was provided at Leeds General Infirmary and St James's University Hospital. Staff were positive about the new leadership team and felt that communication had improved. However, staff were concerned about the increasing critical care bed pressures and increasing demands on the service.

We had concerns about the apparent 'us and them' culture between the two main hospital sites, the lack of engagement between senior medical staff and the limited planned cross-site working.

The critical care units were found to be clean with appropriate arrangements in place to prevent and manage infection, although there was some confusion over the use of some personal protective equipment.

Substantive nurse staffing levels were consistently below those required levels, which placed a reliance on nursing staff to work additional hours and a high use of agency staff. This was considered a risk by the permanent nursing team.

Mental capacity assessments and the deprivation of liberty safeguards were not embedded as part of the critical care process. Mandatory training completion was low and the mechanism in place for ensuring staff were up-to-date with their training appeared ad-hoc despite being co-ordinated by the Organisational Learning Department.

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

We had concerns about the medical cover, the quality of the handover and support on the high dependency unit on Ward L39 at Leeds General Infirmary, which was overseen by the surgical services unit rather than the critical care service in accordance with the Critical Care Core Standards (2013).

Staff were caring and respected patients' privacy and dignity. Patient's families and carers were kept informed and involved and felt able to discuss concerns with staff.

## Maternity and family planning

Maternity and family planning services were provided at Leeds General Infirmary and St James's University Hospital. There was consistency of leadership across the maternity services, regardless of the location.

Maternity service areas were clean and effective procedures were in place to monitor infection control.

Where incidents had been identified, staff had been made aware and action taken.

There was a shortfall in relation to midwifery and medical staffing; action had been taken to recruit midwifery staff and medical rotas were in place to cover the maternity services. Staff reported that despite the vacancies, systems were in operation to ensure safety at all times.

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

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

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

## Children's and young people's services

The Children's Hospital was located within the buildings and facilities of the main hospital site of Leeds General Infirmary and was not easily identifiable as a dedicated service. There was no formal executive lead and oversight of children's services, which were provided across other clinical service units in addition to those in the Children's Hospital.

Nurse staffing levels on the children's wards were identified as a risk and regularly fell below expected minimum levels, which placed staff under increased

# Summary of findings

stress and pressure. There were gaps at middle-grade and junior doctor level and some medical staff were covering paediatric specialties without any specific paediatric training.

Although Quality and Safety Matters briefings were issued to staff to encourage shared learning from serious incidents not all staff we spoke to were aware of recent serious incidents that had occurred within the trust.

Children's services were utilising national guidance, peer reviews and care pathways.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. Patients and their relatives were treated with compassion and felt involved in decisions about their care and treatment.

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

## End of life care

The trust had recently introduced new 'care of the dying patient' care plans to replace the Liverpool Care Pathway (LCP). We were told that a future audit of the use of these was planned to assess their effectiveness.

Staff involved people in their care and treated them with compassion, kindness, dignity and respect.

Staff were committed to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of care.

All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service.

Staff were positive about the management and support given with end of life care.

We saw some inconsistencies when assessing a patient's capacity when making decisions about whether a 'do not attempt cardiopulmonary resuscitation' was appropriate. The Mental Capacity Act 2005 was not being consistently applied or documented.

## Outpatients

Outpatient services were provided by all the hospital sites inspected.

There was consistency in leadership and governance from the clinical service unit at all sites. Staff at all levels felt encouraged to raise concerns and problems.

Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learned and improvements were shared across the departments and hospitals.

Clinics were generally clean and appropriately maintained. The infection control procedures were adhered to in clinical areas, which appeared clean and reviewed regularly.

Staffing levels were adequate to meet patients' needs.

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

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

A common theme from the analysis of patient feedback was that waiting times in clinics could be improved in terms of length of wait and patients being informed of why and how long they were expected to wait.

## Medication

There were appropriate arrangements in place the safe storage, administration and disposal of medication.

Medication storage areas were well organised and administration appropriately recorded, including the handling and disposal of controlled medications.

There was inconsistent prescribing of oxygen, which did not adhere to trust policy.

## Complaints management

When we carried out this inspection, colleagues from the Patients Association looked at how complaints were managed in the trust using the Patient's Association Good Practice Standards for Complaints Handling. A separate report has been provided to the trust with the outcome to this inspection.

# Summary of findings

From April to November 2013, the top three themes of complaints were with regard to communication, medical care and attitude. The trust's Patient Advice and Liaison Service received 2895 concerns during the period April to November 2013. The highest number concerned head and neck, neurosciences and trauma services, mainly relating to administration, appointment or waiting time issues.

In January 2014, a revised Complaints Policy was implemented across the trust with the strategic intention of improving the management of complaints, attitude to complainants and to provide all those involved in the complaint handling with training.

A new team had been established and this was impacting positively on the receipt and handling of complaints.

The executive team was found to be committed to a cultural change in the handling of complaints and an improved response to patients concerns.

Work was progressing, but further areas for improvement included the increased capacity of the Patient Advice and Liaison Service, embedding the monitoring and auditing of complaints including performance information and better sharing of lessons learnt.

## **We saw areas of outstanding practice including:**

The Macular Degeneration Clinic at St James's University Hospital and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.

The Disablement Service Centre at Seacroft Hospital had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.

The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.

## **Importantly, to improve quality and safety of care, the trust must:**

Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical elderly care wards children's wards and surgical wards, including anaesthetist availability and medical cover out of hours and weekends.

Ensure that staff attend and complete mandatory training, particularly for safeguarding and maintaining their clinical skills.

Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.

Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.

Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff are clear about the Mental Capacity Act and implement and record this appropriately.

Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.

Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.

Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.

Review the nursing and medical handover to ensure that the appropriate information is passed to the next shift of staff and recorded.

Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.

Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.

Review the arrangements over the oversight of L39 High Dependency Unit at Leeds General Infirmary to ensure

# Summary of findings

there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.

Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.

Review the clinical audit and auditing of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.

Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

## **However, there were also areas of practice where the trust should make improvements.**

Review the effectiveness of the recruitment of staff processes to ensure delays to recruitment are kept to a minimum.

Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.

Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.

Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.

Review the information available for people who have English as a second language and make written information more accessible including clinical decisions and end of life care.

Ensure that the provision of oxygen is appropriately prescribed.

Ensure that all staff involved in patient care are aware of the needs of people living with dementia and that the documentation used reflects these needs.

Ensure that all early warning score documentation is fully completed on each occasion used.

Consider displaying trend data over a period of time as part of the ward dashboards and that information is disseminated to staff.

Ensure that the windows on L26 are repaired and that the ventilation of the ward is appropriate to need.

Review the use of the Family and Friends Test results to improve consistency across departments.

Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.

Review the recruitment processes to ensure that they are efficient and timely.

Review the support and provision of the medical elderly care services with consideration of providing a seven day service and contribution to the monthly clinical service unit governance meetings.

Review the use of the World Health Organisation safety checklist for theatres to ensure that it includes all elements such as the team debrief.

Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.

Review the arrangements for surgery on the Clarendon Wing regarding their suitability and how performance, oversight and reporting were effective.

Review the bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems.

Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.

Review the security of the hospital in general, but specifically with regard to access to theatre departments.

Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.

Review the use of personal protective equipment on the critical care units to ensure consistent practice.

Implement a seven day a week critical care outreach team.



# Summary of findings

Review the IT system to ensure that all necessary information such as that identifying if a social worker is involved when 'Looked After Children' arrive in the hospital.

Review the consent process to ensure that where appropriate the child or young person is involved in decisions and signatures are obtained.

Develop facilities and recreational activities for older children and young adolescents in children's services.

Appoint an executive lead for children's services to ensure that there is consistent oversight and shared learning across clinical areas.

Review the frequency and effectiveness of the surgical morbidity and mortality meetings so that there is a more effective use of lessons learnt to improve patient outcomes.

Introduce a robust patient tracking system for surgical patients so that there is continuity of care at all times.

Review the effectiveness and care of patients following surgery on Bexley Wing in relation to the transfer post operation to Geoffrey Giles Theatres in Lincoln Wing, and potential multiple moves to fit in with service operating times.

Consistently apply patient feedback processes across clinical support services.

Review the waiting times in the outpatient clinics and information given to patients to ensure these are kept to a minimum length and patients understand what to expect.

Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

### Are services safe?

Overall, we rated the safety of services as requiring improvement. There were arrangements to assess, monitor and report risk with new governance and reporting structures in place. Areas visited were clean with systems to manage and monitor the prevention and control of infection. Attendance at mandatory training was low in some areas and staff did not always have access to the necessary training to maintain their skills. Not all clinicians involved in the care of children had undertaken appropriate children's safeguarding training. A safety culture was not yet fully embedded in the hospital. There was good reporting of incidents among the nursing staff, but this was not seen as a priority for all clinical staff. Lessons learnt from incidents were shared within departments or amongst the clinicians concerned, but there was limited sharing between clinical service units and other trust hospitals.

Nursing and medical staff shortages were experienced across a number of areas of the hospitals and meant that the necessary experience and skills mix did not always meet Royal College and national recommendations for best practice. Medical cover out of hours was a particular concern on the medical elderly care, children's and surgical wards. We had particular concerns over access to anaesthetists, particularly out of hours. The trust had taken a number of steps to address the shortfalls including increasing consultant cover. We found that mental capacity was not always being assessed in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards; where these were being undertaken, they were not consistently being recorded appropriately.

Requires improvement



### Are services effective?

Overall, we rated the effectiveness of services as good. Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. We observed commonly used care tools such as care bundles for the care and treatment of specific medical conditions. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

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

Good



# Summary of findings

active involvement or encouragement to be involved in clinical audit or quality improvements. Further work was required to monitor and audit the implementation of trust policies, guidelines and best practice recommendations.

## Are services caring?

Overall, we rated caring in the trust as good. We observed that staff were kind, caring and ensured that the patients' privacy and dignity were respected when attending to individuals' personal needs. Patients told us they had been involved in decisions about their care and treatment. Nurses introduced themselves to their patients at all times. Doctors explained to patients their diagnosis and made them aware of what was happening with their care. We did however, have concerns over patients' and their families involvement in end of life decisions, as records did not consistently demonstrate that discussions had taken place.

Analysis of patient feedback information showed that generally patients were positive about their experience, particularly in the accident and emergency department. End of life support was reported to be good and a specialist team was available to advise and ensure that patients were given, where possible the opportunity to be cared for in their place of preference.

Good



## Are services responsive to people's needs?

Overall, we rated the responsiveness of services as requiring improvement. Access to services was generally good; patients' needs were responded to appropriately and in a timely manner. The hospital had been performing better than the A&E national targets since July 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. The hospital was performing similar to hospitals in other trusts in both cancelled operations and delayed discharges. Generally, the hospital was performing well with access to appointments and waiting times, although there was an elevated risk with referral to treatment times under 18 weeks on the admitted pathway.

There was a focus on continuous quality improvement but further work was required on ensuring a consistent response to the needs of people living with dementia. Staff on the critical care units were concerned about the increasing bed pressures and increasing demands on the service, particularly because of the hospital's trauma centre status. Apart from the teenage cancer unit, there were no dedicated facilities including recreational for young people. Young people over the age of 16 were admitted to adult wards without an assessment of the appropriateness for their stage of development.

Requires improvement



# Summary of findings

## Are services well-led?

Overall, we rated the leadership within the trust as requiring improvement. The trust had recently introduced a new leadership and governance structure. Services were arranged within 19 clinical service units (CSUs) led by a senior doctor, nurse and manager. The clinical service unit structure crossed the different hospital sites and was yet to be fully established. There had been a change of leadership at trust level in 2013 and staff reported that there had been a shift in culture since this change. The Chief Executive in particular was visible and staff reported a positive lift in confidence within the hospital and trust as a whole.

At a local level, they felt supported by their managers. However, there were still areas that had not embraced the cross site ethos and different cultures were reported in some areas. Opportunities to improve the safety culture and quality of services were missed as good practice and learning from incidents was not consistently shared across clinical service units and reporting was not fully embedded across different staff groups. New systems and processes were still in their infancy and although improvements were being felt and reported by staff, there was still a need to embed these at local service level and within staff practices.

## Vision and strategy for this service

- The trust had recently published a five year strategy consultation document for 2014, which sets out the trust's values, culture and vision.
- The vision aims to deliver five goals – to be patient centred, fair, collaborative, accountable and empowered with 10 corporate objectives. The values and objectives had been developed in consultation with staff across the trust.
- The work developing the trust vision and strategy was in its infancy and the executive team was working hard to act inclusively with staff across the trust.
- In many areas, the trust's objectives and vision were displayed on wards, together with the names of Trust Board members. We heard the phrase – “The Leeds way”, which was being seen as a drive to create a high performing, patient centred organisation.

## Governance, risk management and quality measurement

- There had been a significant change to the governance structure across the trust. The previous five divisions had been split into 19 smaller clinical service units.
- Each clinical support unit was led by a triumvirate of a medical, nursing and manager leads. It was evident from interviews and discussion with staff that this structure was in its infancy and although positively received, the benefits had yet to be realised.

## Requires improvement



# Summary of findings

- Not all clinical service units were working across hospital sites effectively, there was a risk that ‘silo working’ would develop, for instance there was reported little ‘joined up working’ within and across the critical care units.
- The trust was in the process of re-developing risk management and assurance systems such as the Board Assurance Framework. However, it was too early to assess whether these would bring the robustness needed to ensure the timely and appropriate identification of risk. We found concerns such as the lack of appropriate mental capacity assessments, inconsistent application of the best practice guidance for ‘do not attempt cardiopulmonary resuscitation’ decisions, the lack of critical care oversight on the High Dependency Unit (L39) at Leeds General Infirmary and the lack of supervision for trainee anaesthetists had not been highlighted to the trust so that these issues could be addressed or mitigated against.
- There were systems in place for reporting incidents and events. However, lessons from the investigation of these had been in the main fed back to the clinicians concerned or the service involved. Staff reported that learning from lessons was improving, but that some of the formal processes in place such as a trust-wide Learning Points Bulletin, and fortnightly Quality and Safety Matters briefing were still in their infancy. There was reporting to the Trust Board about incidents, but it was not clear that the information from reporting was robust, consistent and information was not always timely.
- There was good incident reporting by nursing staff, but this was not seen as a priority for all clinicians. Therefore, there was a missed opportunity to improve the safety and quality of services and meant that a safety culture was not yet fully embedded in the trust.
- Accountability was increasing across the services with the introduction of the clinical service units and new initiative such as the ‘Ward Healthcheck’. This gave a three monthly oversight of individual ward performance against a multitude of performance measures, such as – staffing, the Friends and Family Test and safety measures such as the number of falls, pressure ulcers and infection rates.
- The Ward Healthcheck had only been in place one month prior to the inspection, as such it was too early to make any assessment of this initiative, but it was well received by staff and seen as an aid to drive improvement.
- There were regular governance meetings across the clinical service units. However, not all were fully attended. Notably,

# Summary of findings

elderly care was not always represented and it was acknowledged that there had been a concentration on improving the acute medical care processes and that attention was now needed on the elderly care wards.

- Mandatory training across many areas was not completed and the appraisal rate was poor in some areas.
- Staff shortages in some areas were a risk to patient care and the organisation. Recruitment was actively taking place and initiatives such as the emergency medicine practitioner programme had been introduced. However, recruitment processes were reported to be poor and lengthy. There had been investment in recruiting, but this was planned to take place over the next 30 months and consideration should be given to accelerating this process and ensure that there is a contingency plan if recruitment fails to provide the necessary skills.

## Leadership of service

- The Chair and the Chief Executive were appointed in 2013.
- Staff reported that morale had improved with the new team, and that the Chief Executive was visible.
- Staff reported that the new leadership had made significant changes in communication, governance and was seen to be driving a quality experience for patients in the organisation.
- There were some areas that would benefit from some specific lead roles. For example, there was no executive lead at board level for the oversight of children's services across the trust.
- The Quality Committee had previously been chaired by a non-executive director who had now left. An interim arrangement had been put in place for the chair of the Trust to provide non-executive leadership for quality until the new non-executive director takes up their post.

## Culture within the service

- Staff across the trust reported that there had been a significant change in culture with the commencement of the new executive and leadership team. Staff reported that the culture was more honest and open, that they felt well informed and involved.
- Many areas visited spoke of changes in culture putting the patient first and a drive for quality care.

## Public and staff engagement

- Staff engagement had increased recently, with more consultation across a range of issues and strategies such as the

# Summary of findings

trust's vision and values. Staff reported that they felt better informed than previously and communication came in a range of forms including the staff Bulletin (staff magazine), weekly emails from the Chief Executive and newsletters.

- A Patient Experience Strategy had been produced in January 2014, but it was too early to assess whether the initiatives for consulting and engaging with the public would improve communication.
- The Trust Board had patient's stories as part of their meeting agendas.
- It was acknowledged that the patient engagement strategies are in the process of development and as such it was too early to make an assessment of their effectiveness.

## **Innovation, improvement and sustainability**

- Innovation was encouraged from all staff members across all disciplines. Junior doctors and student nurses were involved in quality improvement projects. Staff were able to give examples of practice that had changed as a result.
- In recognition of the shortage of staff in some areas, the trust had developed training and development programmes such as the advanced practitioner programmes and the emergency medicine training programme for overseas medical students.
- There was a six-monthly 'innovation day', when staff displayed their recent projects.

# Summary of findings

## What people who use the trust's services say

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

Analysis of data from the Care Quality Commission's (CQC) Adult Inpatient Survey (2013) showed that the trust was rated as 'average' across all areas.

The Cancer Patient Experience Survey (CPES) 2012/13 - the trust performed 'better than other trusts' nationally for five of the 69 questions. The trust performed 'worse than other trusts' for 10 of the other questions in the survey.

CQC's Survey of Women's Experiences of Maternity services 2013 – Labour and Birth Data – the trust is performing the same as other trusts for two of the three areas of questioning. In comparison with the 2010 results, the trust is showing an upward trend in one of the eight questions asked.

Healthwatch shared their 2014 survey, where 183 people shared their views and experiences of services across all of the five hospitals at the trust. At trust level, approximately 44% rated the service outstanding, 24% were rated as good, 7% were rated as satisfactory and 26% were rated as requiring improvement.

## Areas for improvement

### Action the trust MUST take to improve

- Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical, surgical and children's wards, including medical cover out of hours.
- Ensure that staff attend and complete mandatory training, particularly for the safeguarding of adults and children and maintaining their clinical skills.
- Ensure that doctors are able to attend teaching sessions and this includes specialist medication regimes and other clinical areas they cover for including children's services.
- Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.
- Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.
- Review the handover procedure for medical and nursing staff to ensure that the necessary information is communicated appropriately and effectively.
- Ensure that there is a coherent and clear auditing system in place for the participation of national clinical audits and auditing of trust guidelines and that there is an appropriate recording system in place to capture this. Review the involvement of junior doctors in the audit process.
- Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.
- Review the arrangements over the oversight of L39 High Dependency Unit Leeds General Infirmary to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.
- Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.
- Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff act in the best interests of the patient and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.



# Summary of findings

- Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.
- Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.
- Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.
- Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

## Good practice

### **Outstanding practice**

The Macular Degeneration Clinic at SJUH and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.

The Disablement Service Centre at Seacroft Hospital had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.

The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.

# Leeds Teaching Hospital NHS Trust

## Detailed findings

### Hospitals we looked at

**Leeds General Infirmary; Wharfedale Hospital; St James's University Hospital; Seacroft Hospital and Chapel Allerton Hospital**

## Our inspection team

### Our inspection team was led by:

Chair: Dr Jane Barrett Consultant Radiologist

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

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

## Background to Leeds Teaching Hospital 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. The trust

treats around 2 million patients a year with a budget of around £1 billion per annum. The trust recognised it faces major financial challenges that will require significant action, particularly in improvements in performance.

There are approximately 86,000 attendances a year in the accident and emergency (A & E) department at St James's University Hospital and approximately 112,000 attendances in the A&E at Leeds General Infirmary, of which up to 31,000 are children (under 16 years old). Children are seen in the children's A&E, which is located next to the main A&E. The admission rate to a hospital ward at this site is about 33% for adults and 21% for children. At St James's University Hospital's A&E one emergency bay is equipped for children in case a child attended and not the children's A & E at Leeds General Infirmary.

Leeds General Infirmary provides cardiology, neurology and stroke services including percutaneous coronary intervention (for heart attacks) and thrombolysis (for strokes) service with a hyper-acute stroke unit. Ambulance services transport patients with suspected cardiological or neurological problems to this site. All other ambulance patients are taken to the St James's University Hospital

# Detailed findings

A&E. Any patient who walked into the A&E requiring medical input aside from cardiology or neurology would be stabilised first and then transferred to the other site under the care of the appropriate team.

St James's University Hospital provides acute and general medical care services. These include care of the elderly, respiratory, endocrine, infectious diseases, gastroenterology and acute medical wards. It also provides specialist oncology and renal wards, which were not inspected at this time.

Surgical services at Leeds General infirmary include trauma and orthopaedic surgery, ear, nose and throat (ENT), neurosurgery, spinal surgery, vascular, cardiac and plastic surgery. At St James's University Hospital there are a range of surgical services including general surgery, urological and gynaecological surgery, organ transplantation and day surgery. There is also a surgical admissions unit and a pre-assessment ward. Chapel Allerton Hospital provides orthopaedic and dermatology services and Wharfedale Hospital provides only day surgery services for general surgical, ENT, ophthalmology, gynaecology and vascular conditions.

Adult critical care services are provided across Leeds Teaching Hospitals NHS Trust, with 131 beds. The beds are split across two sites with three units at Leeds General Infirmary for general, cardiac and neuro-surgery and two units at St James's University Hospital for general intensive care and high dependency care. Critical care at St James's University Hospital comprise of 34 high dependency beds and 15 intensive care beds. There are 14 additional high dependency beds at St James University Hospital and six at Leeds General Infirmary, which sit outside the management of the critical care clinical service unit.

The trust provides obstetric/midwifery care at the St James's University Hospital and Leeds General Infirmary site, along with community midwifery care. It is a tertiary centre and therefore provides care for and advice to clinicians caring for women with complex needs. The service included pre conceptual care, early pregnancy care, antenatal, intra partum and postnatal care. The trust also had a tertiary Neonatal Intensive Care Unit at both sites, which provided medical neonatal care. At Leeds General Infirmary the service is for babies under 27 weeks gestation

and high risk pregnancies, and they had a total of 27 neonatal cots. At St James's University Hospital the service is for babies above 27 weeks gestation and with a total of 34 neonatal cots.

End of life care services are provided throughout the trust. The Specialist Palliative Care Team is located at the Robert Ogden Centre at St James's University Hospital. The team comprises of consultant medical staff, speciality doctors, matrons, specialist palliative care nurses, a palliative care discharge facilitator, end of life care facilitators, a social worker and a pharmacist.

The trust provided a range of outpatient clinics with nearly one million patients attending each year. At St James University Hospital over 390,000 patients attended outpatient clinics in 2012-2013, 307,000 patients attended Leeds General infirmary and 51,000 patients attended Seacroft Hospital. The trust has dedicated outpatient departments with dedicated outpatient staff. The trust employs 220 nursing staff (Registered and Unregistered) who are supported by approximately 350 administrative and reception staff to provide and support outpatient services.

## How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection, if they are provided by the hospital:

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

# Detailed findings

- Outpatients.

We inspected and reported on the following-

Leeds General Infirmary, which provided all eight core services. The Children's Hospital is located within the buildings and facilities of Leeds General Infirmary, and therefore the findings of the inspection of this hospital are reported in the children's and young people's core service of the Leeds General Infirmary report.

We inspected the outpatients' services located at Seacroft Hospital and the findings of this inspection are contained within the hospital report for St James's University Hospital.

St James's University Hospital, which provided seven core services – children's and young people's services were not provided at this hospital.

Wharfedale Hospital and Chapel Allerton Hospital only provide surgery and outpatients' core services.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits over a period of four days on 17, 18, 19 and 20 March and we undertook an unannounced visit to St James's University Hospital and Leeds General Infirmary on 30 March 2014.

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

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

## Facts and data about this trust

### Safety

The trust had five Never Events between December 2012 and November 2013. Three related to swabs being left inside a patient after surgery, one was due to a small piece of equipment being left in a patient and one was a result of a misplaced nasogastric tube.

Between December 2012 and January 2014, 38 Serious Incidents occurred at the trust and were reported to the Strategic Executive Information System (STEIS). Ward areas accounted for 44% with the remaining split across nine separate areas.

Leeds General Infirmary accounted for 50% of serious incidents between December 2012 and November 2013, with St James's University Hospital having the second highest.

Medical specialities had the highest number of patient incidents reported to the National Reporting and Learning System (NRLS) with 43%. Incidents with a moderate degree of harm were the most common at 51%. Death incidents accounted for 9% of incidents reported to the NRLS, but 0.001% of all incidents reported by the trust.

The trust's infection rates for Methicillin Resistant Staphylococcus Aureus were within statistically acceptable range for the size of the trust. However, there was an elevated risk for Clostridium difficile.

Medication errors were within statistically acceptable limits.

There were no concerns for this trust in the Schedule 5 (formerly Coroner's Rule 43) report.

New pressure ulcers – from November 2012 to November 2013 the trust had performed well above the national average for all patients and patients over 70 years acquiring a pressure ulcer after admission.

New Venous Thromboembolism (VTE) – The trust's performance of new VTE was significantly higher than the national average from November 2012 to March 2013. From April to September 2013 the trust's performance rapidly decreased to below the average by 0.6%.

Catheters and new Urinary Tract Infections (UTI) – The trust performed higher than the national average 10 months

# Detailed findings

between November 2012 and November 2013. For all patients the trust was below the national average in October 2013 by 0.3%. For patients over the age of 70 years the trust was below the average by 0.5% in October 2013.

Falls with harm – The trust's performance was higher than the national average for 10 months of the year for all patients between November 2012 and November 2013. In September 2013 the trust was below the national average by 0.4%. For patients over 70 years the trust was below the national average by 0.7% in September 2013.

## Tier 1 Indicators

For maternity and women's health - there was no evidence of risk for elective Caesarean Section, emergency Caesarean Section, Puerperal Sepsis and other puerperal infections.

For re-admissions there was no evidence of risk for maternal readmissions, neonatal readmissions, emergency readmissions following elective admission or emergency readmissions following emergency admissions.

PROMs - there was no evidence of risk for groin hernia surgery, hip replacement surgery, knee replacement surgery or varicose vein surgery.

Audit – there was no evidence of risk for the number of cases assessed as achieving compliance with all nine

standards of care measured within the National Hip Fracture Database, the number of patients scanned within one hour of arrival at hospital, the number of potentially eligible patients' thrombolysed.

For Mortality trust level – there was no evidence of risk with the Summary Hospital-level Mortality Indicator or the Dr Foster: Composite of Hospital Standardised Mortality Ratio indicators.

## Responsive

A&E Waiting Times – since June 2013 the trust has consistently been above the 95% target for the four hour waiting time. The percentage of emergency admissions via A&E waiting 4-12 hours from the decision to admit until being admitted, the trust is better than the national average. The trust scored worse than expected in the percentage of patients leaving A&E without being seen. The trust is tending towards better than expected for ambulance handovers.

Cancelled Operations – The trust is performing similar to other trusts in both cancelled operations and delayed discharges.

Referral to treatment time under 18 weeks: admitted pathway showed an elevated risk. For all other access to treatment measures, there was no evidence of risk.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii)</p> <p>(1)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of –</p> <p>(a)The carrying out of an assessment of the needs of the service user; and</p> <p>(b)The planning and delivery of care and, where appropriate, treatment in such a way as to –</p> <p>Meet the service user’s needs,</p> <p>Ensure the welfare and safety of the service user</p> <p>Nursing and medical handovers were not consistently ensuring that the appropriate information was passed to the next shift of staff and recorded, which put service users at risk.</p> <p>There was no oversight of the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.</p> <p>Systems to ensure that risk assessments were appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices were not effective.</p> <p>There was a risk to patients due to a lack of anaesthetic staff, which had resulted in unsupervised trainees anaesthetising patients. There was no peripatetic anaesthetist available to oversee trainees or provide emergency cover.</p>

Regulated activity

Regulation

This section is primarily information for the provider

## Compliance actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10: Assessing and monitoring the quality of service Provision

(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –

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

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

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

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

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

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

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

### Regulated activity

### Regulation

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This section is primarily information for the provider

## Compliance actions

The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in

relation to the care and treatment provided for them.

Staff were not always assessing the mental capacity of service users to ensure that the ability to consent was appropriately ascertained.

### Regulated activity

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing.

Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI, particularly on medical elderly care, children's services and surgical wards, including the availability of anaesthetists and medical cover out of hours and at weekends, in order to safeguard the health safety and welfare of service users.

### Regulated activity

### Regulation

Regulation 23 (1) (a) & (b) HAS 2008 (Regulated Activities)  
Regulations 2010 Supporting workers.

There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard.

Not all staff had completed their mandatory training or had the opportunity to attend training to enhance or maintain their skills or obtain further qualifications appropriate to the work they perform.

Not all staff had received an appraisal or had appropriate supervision.