Care Quality Commission

Calderdale and Huddersfield NHS Foundation Trust

Calderdale Royal Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Calderdale and Huddersfield NHS Foundation Trust is an integrated trust, which provides acute and community health services. The trust serves two populations; Greater Huddersfield which has a population of 248,000 people and Calderdale with a population of 205,300 people. The Trust operates acute services from two main hospitals - Calderdale Royal Hospital and Huddersfield Royal Infirmary In total; the trust had approximately 824 beds and 5,831 staff.

We carried out an inspection of the trust between 8-11 March 2016 as part of our comprehensive inspection programme. In addition, unannounced inspections were carried out on 16 and 22 March 2016.

We included the following locations as part of the inspection:

- Huddersfield Royal Infirmary
- Calderdale Royal Hospital
- Community services including adult community services, community services for children, young people and families and community end of life care

We inspected the following core services:

- Emergency & Urgent Care
- Medical Care
- Surgery
- Critical Care
- Maternity & Gynaecology
- Services for Children and Young People
- End of Life Care
- Outpatients & Diagnostic Imaging

Overall, we rated the trust as requires improvement. We rated safe, effective and well led as requires improvement and caring and responsive was rated as good. We rated the Huddersfield Royal Infirmary and Calderdale Royal Hospital as requires improvement and community services as good.

Our key findings were as follows:

- The trust had infection prevention and control policies, which were accessible, and used by staff.Across both acute and community services patients received care in a clean and hygienic environment.
- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, overall, they were content with the quality and quantity of food.
- The trust promoted a positive incident reporting culture. Processes were in place for being open and honest when things went wrong and patients given an apology and explanation when incidents occurred.
- Staffing levels throughout the trust were planned and monitored. There were shortfalls within medical care, children's services and adult community services however; it was addressing this through a range of initiatives including national and overseas recruitment.
- Medical staffing numbers did not meet national guidance in the emergency departments across both sites.

Summary of findings

- The accident and emergency departments' provision for paediatric patients was limited with only one paediatric qualified staff member on duty during our inspection across both sites and limited facilities available for children and young people.
- Not all staff within children's services had received safeguarding training at the appropriate level for their role in line with the requirements of the Safeguarding children and young people: roles and competences for healthcare staff Intercollegiate document (RCPCH March 2014).
- Patient outcome measures showed the trust had mixed performances against the national averages when compared with other hospitals with some outcomes performing better and some performing worse.
- The trust had consistently achieved the national standard for percentage of patients discharged, admitted or transferred within four hours of arrival to A&E in eight of the last 12 months. Between April 2015 and March 2016 the year to date percentage of patients achieving this target was 93.88% which was just below the target of 95%.
- The trust had consistently achieved the national indicators for patients on the admitted, non-admitted and incomplete referral to treatment pathways.
- The trust had a nurse consultant for older people and a learning disabilities matron. Across the trust 200 Matrons and Sisters had received training and were vulnerable adult's leaders to ensure the vulnerable adult care principles and process were embedded into practice. This included care of patients living with dementia.
- The estates and facilities team throughout the trust were focussed on improving the quality of patient care and experience and considered this when undertaking work to improve the environment.
- Across the services we found a variable understanding from staff regarding consent and mental capacity.
- The trust performance for responding to complaints within the relevant timescale was 48% against a target of 100%.
- The trust had an overall vision which was underpinned by behaviours, goals and responses to support the delivery of the vision. The trust vision was "Together we will deliver outstanding compassionate care to the communities we serve." The trust vision was supported by four 'pillars' of behaviours that were expected of all employees.
- There were a number of concerns within maternity services which included feedback from patients during the inspection, the numbers of large volume postpartum haemorrhages (PPH), third and fourth degree tears, the antenatal assessment of mums to ensure they delivered in the appropriate setting and the ability to open a second obstetric theatre.
- We found during the inspection that there were a number of patients on the clinical decision units (CDU) in the accident and emergency departments who had an extended length of stay on the units whilst waiting for a general inpatient bed.
- It was difficult to determine how the service had planned services to meet the needs of local children and young people at Huddersfield Royal infirmary. There was no clear rationale or model of care for the services provided on the paediatric assessment unit.

We saw areas of outstanding practice including:

- The development and growth of the ambulatory care service to support the hospital sites and meet local need. The trust had vulnerable adult's leaders to ensure the vulnerable adult care principles and process was embedded into practice.

Summary of findings

- Engagement support workers had been appointed to provide engagement, socialisation and companionship, cognitive and physical support for patients with dementia and/or delirium. The team supported patients during the day with either group or one-to-one activities which promoted sleep at night. Through providing suitable engaging activities during the day, less 1:1 care was required during the day and night. This also helped other patients experience by reducing sleep disruption on the wards.
- The trust had worked closely with local higher education facilities and offered an enrichment programme to 'A' level students to experience working in a hospital environment but particularly with patients living with dementia or experiencing delirium.
- The development of NEWS and 'Nerve centre' technology to identify deteriorating patients for prompt care escalation and intervention.
- The use by critical care outreach of the NEWS and Nerve Centre technology to drive effective identification of the deteriorating patient in ward areas. This supported early admission to critical care, and in turn better patient outcomes. The team could use the system to prevent readmission of critical care discharges.
- A proactive, positive and energised discharge coordination team together with an integrated MDT working to provide care to the patient in the most appropriate environment.
- Within community services multidisciplinary and multiagency working was completely integrated in some teams with staff having a good understanding of each other roles. This led to a seamless service for patients and there was a collective responsibility to meet patients' needs in the community.
- The diagnostic imaging department worked hard to reduce the patient radiation doses, and had presented this work at national and international conferences.
- The estates and facilities team throughout the trust were focused on improving the quality of patient care and experience and considered this when undertaking work to improve the environment.

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

Importantly, the trust must:

- The trust must continue to 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 continue to embed and strengthen governance processes within the clinical divisions and at ward level.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
- The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.
- The service must ensure staff have an understanding of Gillick competence.
- The trust must continue to identify and learn from avoidable deaths and disseminate information throughout the divisions and the trust.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role. The service must also ensure all relevant staff are aware of Female genital mutilation (FGM) and the reporting processes for this.
- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.
- The trust must ensure that interpreting services are used appropriately and written information is available in other languages across all its community services.

Summary of findings

- The trust must ensure that appropriate risk assessments are carried out in relation to mobility and pressure risk and ensure that suitable equipment is available and utilised to mitigate these risks.
- Within maternity services the service must focus on patient experience and ensure women feel supported and involved in their care.
- The trust must review the provision of a second emergency obstetric theatre to ensure patients receive appropriate care.
- The trust must continue work to reduce the numbers of third and fourth degree tears following an assisted birth and the incidence of PPH greater than 1500mls following delivery.
- The trust must review the admission of critical care patients to theatre recovery when critical care beds are not available to ensure staff suitably skilled, qualified and experienced to care for these patients.
- The trust must continue to review arrangements for capacity and demand in critical care.
- The trust must ensure that patients on clinical decision unit meet the specifications for patients to be nursed on the unit and standard operating procedures are followed.
- The trust must ensure there are improvements to the timeliness of complaint responses.
- The trust must ensure there is formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant
- The trust must review the model of care for the services provided on the paediatric assessment unit at Huddersfield Royal Infirmary.

In addition the trust should:

- The trust should review the availability or referral processes for formal patient psychological and emotional support following a critical illness.
- The trust should review the handover arrangements from the hospital at night team to the critical care team to ensure continuity of patient care across the hospital.
- The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.
- The trust should provide consultation opportunities and team collaboration in the development and completion of its business strategy and vision for end of life care.
- The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.
- The trust should ensure signage throughout the HRI main building and Acre Mills reflect the current configuration of clinics and services.
- The trust should ensure there is access to seven-day week working for radiology services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated urgent and emergency care as good overall because: The department had information available for patients which included waiting information screens and department information in each cubicle. There was good learning from incidents and complaints, including the sharing of findings and complainants were involved in the process. The immediate leadership team were well respected by staff and we were told that they were approachable, visible and supportive. However: During the inspection we had concerns around the use of the clinical decisions unit (CDU). Patients were being admitted for substantially longer than the 24-48 hours outlined in the trusts policy. There was confusion as to which medical teams were responsible for patients waiting for beds on inpatient wards were being treated on the CDU as well as ED patients. Patient flow through the department was confusing and meant that patients could wait longer than the national 15 minute target for initial assessment. This meant that patients were waiting for potentially long periods of time for analgesia or assessment. Staff shortages to both nursing and medical staff meant there was high usage of agency and locum staff. This had also affected training rates and mandatory training rates did not meet trust targets. Provision for paediatric patients was limited. There was not a dedicated paediatric area and the department only had one qualified Paediatric nurse. Paediatric staff from ward 3 within the hospital could provide support, and if available would attend the department to manage the care of paediatric patients.

Summary of findings

Medical care (including older people's care)

Good

We rated medical care (including older people's care) as good overall because:
Staff understood their responsibilities to raise concerns and report incidents. Senior staff managed staffing shortfalls proactively.
Staff delivered evidence based care and overall patient outcomes recorded in local and national audit were good. There was evidence of collaborative and effective multi-disciplinary team working.
Staff cared for their patients. Patients had individual care plans and felt safe. Staff considered physical, emotional and social aspects of wellbeing. Patients were positive about the care received and would recommend the service as a place to receive care.
The division was responding to the internal and external demands placed upon it. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.
Managers led the division well with an open and honest culture. Governance arrangements were set up to effectively identify, manage and plan service improvements, efficiencies and to implement actions to mitigate risks affecting upon service provision.
However:
We found the divisional management of patient safety incidents to require improvement, in particular, around incident grading and investigation. The division were consistently below national target for harm free care.
Medicines management needed to improve at ward level to ensure refrigerated medications remain stable and those past their expiry date are disposed of in a timely manner and in accordance with local policy.
There were noted delays in transferring patient care into non-hospital settings compounded by limited integration with community services in the Calderdale area. The division had bed occupancy pressures leading to a number of patients moving after 10pm at night. The division had reported mixed sex breaches.

Summary of findings

While staff were passionate about working in the division, a number felt as though there could be better communication from senior management and more attention to their well-being.

Surgery

Good

We rated surgical services as good because:
The trust had good systems and processes in place to protect patients and maintain safety. Staff understood the process for reporting and investigating incidents and there were good reporting and feedback processes at Calderdale Royal Hospital. Each ward recorded and displayed individual incidences of insignificant, minor and moderate falls, catheterized urinary tract infections (C.UTI's) and pressure ulcers. Staffing levels and skill mix had been planned and implemented at Calderdale Royal Hospital.
All patients reported their pain management needs were met in a timely manner. Care of patients' nutrition and hydration were being met as part of the surgical care pathway. We observed care that was coordinated and discharge and transfer planning took account of patient's individual needs. We observed patients being cared for with dignity, compassion and respect in all the surgical wards and departments we inspected.
Feedback from patients through the NHS Friends and Family Test consistently showed patients would recommend the hospital to friends and family.
The 'Five Steps to Safer Surgery' and completion of the World Health Organisation (WHO) checklist was consistently good at the hospital. Mandatory training was well attended and meeting overall training targets was in progress with action plans in place to meet year-end targets.
Surgical wards were modern in design with good provision of single room accommodation. The wards and departments were spacious, visibly clean and well organised. We saw evidence of regular audit with regard to infection control and cleanliness.
Patient care was personalised in line with patient preferences, individual and cultural needs and ensured flexibility, choice and continuity of care.

Summary of findings

Clear strategies were in place and implemented to improve the care of patients. For example, the appointment of link nurses, associate cancer physicians and engagement support workers.
The trust met the NHS operational target of 90% of patients waiting less than 18 weeks for treatment and rated second in the Yorkshire and Humber Region. The Trust was continuing to work on waiting times to improve services for patients.
Senior managers had a clear vision and strategy for the division and identified actions for addressing issues, the strategy clearly identified objectives for improving patient care and safety. There was good staff morale and staff felt supported at ward level.
There was a culture that supported innovative practice and improvement and the trust had embedded a number of ways of working and improvements in practice that were improving quality of care and experience for patients.
However:
There was no rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant. This had not been resolved at the time of our inspection and staff identified this as a risk to the safety of patients.
Daily temperatures for the storage of medications were not all within the correct limits on all wards and were recorded outside the margins for the safe storage of medicines. No action had been taken to check whether records were accurate or whether there was a fault with equipment.
Trust data showed only 45% of complaints were closed within target in the surgical division.

Critical care

Requires improvement

Overall we rated critical care as requires improvement. We rated the effective, responsive and well-led domains as requires improvement and safe and caring as good.
There was an inconsistent understanding of incident grading and reporting of incidents in critical care, there were processes to share learning from incidents however not all staff we spoke with were aware of this. Patient harm incidents were low and results for recent falls and pressure ulcers were displayed on a 'how are we doing' noticeboard.
Nurse and medical staffing was good at the time of inspection however we found areas of

Summary of findings

non-compliance with intensive care standards for all staff groups. Recruitment and retention of nursing staff had been challenging for the unit, however recruitment of nursing staff had been successful in 2015/16.

The unit submitted data to the intensive care national audit and research centre (ICNARC) case mix programme, and it was able to benchmark its performance against comparable units. Patient outcomes were generally good however; 41% of all patient discharges were delayed more than four hours after the decision to discharge.

Between January and March 2016 the theatre recovery unit had been utilised every week by critical care for admission of patients. This was not a safe arrangement; activity was not being planned, monitored or managed by the critical care senior team.

Thirty nine percent of nursing staff held a post registration award in critical care nursing and intensive care however national guidance recommends a minimum of 50%. There were plans for three staff to attend the course in 2016. In line with recent recruitment there was a high ratio of inexperienced nursing staff and an additional clinical educator had been appointed to provide support. Senior staff recognised that they needed to retain its current establishment of experienced nursing staff.

The vision and strategy for the critical care service was not shared or clear across the team. The senior team we spoke with from critical care and the surgical and anaesthetic directorate told us of the trust five year proposals for a single site unit in 2021 in order to improve achievement against GPICS (2015), however interim strategy or vision was limited to address some of the current issues in the unit

There was a governance structure in place under the surgical and anaesthetic division. We saw evidence in the management and divisional team meeting minutes that incidents and complaints were monitored and reviewed.

However:

Summary of findings

The unit was visibly clean, had good facilities and equipment for care of the critically ill patient. Infection control practices were good amongst staff and there was a low incidence of infection, better than national averages (ICNARC).
Care of patient's nutritional need was good. The dietitian was an integral part of the team to ensure good standards of patient assessment and support. There was evidence of good multidisciplinary working. Medicines management and record keeping was also good in critical care. Staff had attended a medical device competency training programme for all items of critical care equipment and a tracheostomy training programme delivered by the critical care outreach (CCOR) team.
We observed caring staff. Patients and relatives we spoke with were positive about their experiences in critical care. We saw individual care plans and good documentation around risk assessment, and patients and family needs were also documented well. There was a low number of patient complaints in critical care.
We observed good teamwork amongst staff however reports of staff satisfaction were mixed from the 34 staff we spoke with. The majority (7 out of 9) of junior nursing staff in band and five and six roles we spoke with told us of issues around limited cascade and communication of information, a lack of investment in professional development of experienced staff and staffing issues which had caused a negative impact on staff morale, particularly in 2015. The senior critical care team had also identified these issues, held staff 'listening events' and had developed an action plan which they were making progress against at the time of inspection.

Maternity and gynaecology

Requires improvement

Overall we rated maternity and gynaecology services as requires improvement.
Mandatory training figures were variable and figures were generally lower for medical staff and safeguarding training. Training was not provided on the mental capacity act and deprivation of liberty safeguards which left a gap in knowledge for staff.

Summary of findings

We were concerned over the numbers of women experiencing third and fourth degree perineal tears and postpartum haemorrhage following delivery. This had been flagged on the maternity dashboard as being higher than the regional average.
Staffing on the gynaecology ward was often below the planned level. The recommended ratio of midwives to births and supervisors of midwives to midwives was not being achieved.
We received negative feedback from some of the women we spoke with, which reflected comments seen in some of the serious incidents and complaints data.
We were concerned that the risk associated with the opening of a second emergency obstetric theatre and subsequent theatre delays were not a focus within the service.
However:
We saw the careful planning and support systems had been put in place when implementing the electronic patient record.
Handovers between staff were detailed and informative.
Clinical areas were clean and tidy with sufficient equipment to meet the needs of patients.
Care bundles and action plans had successfully reduced the number of stillbirths.
The preceptorship package for newly qualified nurses and midwives was comprehensive and on-going development of staff was supported through the 'clarity' project.
Staff spoke in a positive way about local leadership and visibility of the senior management.
Staff were patient focused and we observed compassionate care in the areas we visited.

Services for children and young people

Requires improvement

Overall we rated the service as requires improvement because:
Safeguarding training levels were far lower than the trust requirement of 100% compliance. Training in other areas, such as infection control, were also below the trust target.
There were examples of lack of oversight by leaders and the ability of staff to recognise safety issues, for example, resuscitation trolleys behind locked doors.

Summary of findings

Investigations into incidents, prior to inspection, using root cause analysis were not always comprehensive and were poorly documented.
Action plans to mitigate risks and issues in the service did not demonstrate timely action and response.
Audit data showed that patient outcomes were worse than the England average.
The neonatal unit were not undertaking universal precautions to reduce infection control risks.
There were no facilities to support the needs of older children and adolescents.
Some parents said communication about their child's care could be improved.
However:
The service had a system for reporting incidents. Incidents were reportedly in a timely manner. Staff provided examples of lessons learnt from incidents; however, staff did not always get direct feedback when they had reported an incident. There was an electronic system in use which alerted staff to deteriorating patients and the need to monitor patients closely. This system was introduced following learning from a serious incident.
The trust was a pilot site for the Child Protection – Information Sharing (CP-IS) project, an NHS England sponsored programme. The aim of this project was to provide timely information regarding safeguarding concerns across health care providers.
The service had processes in place to implement NICE guidelines and other best practice guidelines. The service also participated in national audits. The service implemented local audits such as infection control audits.
There was evidence of multidisciplinary working across all the children's services.
Throughout our inspection we saw patients and relatives treated with dignity, respect and compassion. We heard staff using language that was appropriate to patients' age and level of understanding. All the patients and families we spoke with were happy with the care and support provided by the staff.

End of life care

Good

We rated end of life care services as good overall because:

Summary of findings

Patients were provided with an end of life care service that was safe and caring. The mortuary was clean and well maintained.
Staff delivering end of life care understood their responsibilities with regard to reporting incidents and ensured information and lessons learnt were shared proactively with other colleagues within the hospital.
We saw clear, well documented and individualised care of the dying documents and appropriately completed DNACPR forms.
The referral process was clear and responsive and staff ensured that patient's wishes were central to the care planning process.
Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care.
However:
The end of Life Strategy / Vision was in draft form. It did not contain business objectives for the team and lacked robust definition of what the vision and outcomes would be for the team in the future.
There was a limited approach to obtaining the views of people who used the service and other stakeholders. There was no mechanism to ensure feedback was captured and actioned in a timely way.

Outpatients and diagnostic imaging

Good

We rated the service as good overall. We rated the responsive domain as requires improvement and the safe, caring and well-led domains as good. The effective domain was inspected but not rated. This was because we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic imaging.
Patients, visitors and staff were kept safe as systems were in place to monitor risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with the staff to improve services. There was a robust process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed.
The environment we inspected was visibly clean and staff followed robust infection control procedures. Records were stored electronically for X-ray images and OPD had a mixture of electronic

Summary of findings

and paper records. Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.
Outpatients and radiology nurse staffing levels were appropriate with a low number of vacancies. Radiographer vacancies were higher; a recruitment plan was in place and fifteen staff had been recruited, due to start in the summer of 2016. There were also recruitment issues with ultra-sonographers and breast radiologists. There was an on-going recruitment and retention plan in place.
There was evidence of service planning to meet patient need such as the agreement for purchase of a third MRI scanner. Diagnostic imaging waits were within targets for the national waiting times.
Staff had good access to evidence based protocols and pathways. The OP and radiology departments were very busy during the inspection but patients received good communication and support during their time there. Staff followed consent procedures and had a good understanding of the Mental Capacity Act (2005).
We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients living with a learning disability or dementia. Staff clearly demonstrated that they put the patient first.
The diagnostic imaging department had a local development plan in place to improve services and the environment. The plan gave a comprehensive review of the demand and capacity on the department to deliver a sustainable and high quality clinical service, taking account of seven-day working plans.
Governance processes were embedded across diagnostics and the pathology and radiology teams felt supported in the new directorate structure however governance processes in OP were less well developed.
However:
People were not always able to access OP services when they needed to. There were issues with appointment backlogs, waiting lists and appointment bookings. Patients experienced long

waiting times within the departments, appointment delays and cancellations. Outpatient clinics were often overbooked and we found issues with capacity and demand in all OP clinics. Actions taken to address these issues had not always been effective.
Staff we spoke with were aware of the complaints policy and told us most complaints and concerns were resolved locally. A high proportion of the total complaints received by the outpatients department (22%) related to appointment problems.
We did not see any evidence to show current trends and themes from incidents and complaints were monitored.

Calderdale Royal Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Calderdale Royal Hospital

Calderdale and Huddersfield NHS Foundation Trust provide a full range of acute hospital and community services. The main sites are the Huddersfield Royal Infirmary and Calderdale Royal Hospital and Community Services across the Halifax area.

The trust serves two populations; Greater Huddersfield which has a population of 248,000 people and Calderdale with a population of 205,300 people. The health of people in Kirklees and Calderdale is varied compared with the England average. Deprivation is higher than average and about 20.1% (8,200) children live in poverty in Calderdale and 18.6% (15,900) children live in poverty in Kirklees. Life expectancy for both men and women is lower than the England average.

The trust had 824 beds:

- 754 General and acute
- 57 Maternity
- 13 Critical care

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, community nurses, therapists, nurse directors and expert by experience.

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?

Detailed findings

The inspection team inspected the following eight core services at Huddersfield Royal Infirmary and Calderdale Royal hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostics

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

We held stalls at Calderdale Royal Hospital and Huddersfield Royal Infirmary on 29 February and 1 March 2016 and provided comment cards and boxes at a number of locations across the organisation. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

Focus groups were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services, community clinics, and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

Facts and data about Calderdale Royal Hospital

The CQC intelligence monitoring report placed the trust at Band 5 (May 2015), the second lowest risk summary band. The report identified two elevated risks for the proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database and Monitor - Governance risk rating.

There have been no never events reported during the period October 2014 to September 2015; there were a total of 157 serious incidents and 9,160 incidents reported for the same time periods. 97% of all NRLS incidents were categorised as low or no harm. Within maternity services there had been two never events reported in 2016 which related to retained swabs.

The number of reported NRLS incidents was lower (worse) than the England average at 7.5 per 100 admissions compared to the England average of 8.6.

Between April 2015 and November 2015, there were 3 cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) against a zero threshold and been 16 cases of Clostridium Difficile against a threshold of 17 cases.

Information in CQC's intelligence pack indicated the number of written complaints received by the trust had been relatively consistent between 2010/11 and 2014/15. Between December 2014 and November 2015 the trust had received 620 written complaints.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The Calderdale and Huddersfield NHS Foundation Trust had two Emergency Departments (ED's). One located at Calderdale Royal Hospital (CRH) in Halifax and one at Huddersfield Royal Infirmary (HRI) in Huddersfield. Not all data provided was specific to the individual departments. Unless specified, data below was trust wide.

Between December 2014 and December 2015 the department had 72,722Emergency Department attendances.

Between April 2015 and August 2015 an average of 20% of attendances resulted in an admission, which was lower than the England average of 22%. The proportion of attendances resulting in admission at this trust had been lower than the England average since 2013/14.

25 per cent of Emergency Department attendances between April 2014 and November 2015 were children aged zero to 16 years old. From April 2014 to October 2015 (the latest figures available) CRH ED was attended by 30,196 children aged 0-16.

Between July 2014 and June 2015 5,416 patients left ED units within the trust either prior to being seen or having refused treatment. In September 2015, 3.2% of people attending A&E left without being seen which was higher than the England average of 2.9% but below the national target of 5%. The performance over the year 2015 was consistently higher than the England average.

CRH was identified as the stroke centre for the Kirklees and Calderdale area and as such ED dealt with all suspected stroke patients from the area brought in by Ambulance.

The ED had an initial triage cubicle by the reception, a majors area that comprised of 13 cubicles, one paediatric cubicle, three minor injury assessment and treatment rooms, a physiotherapy room and an eye assessment room. The resuscitation area had four beds, three of which were for adults and one which could be used for adults or paediatrics. There was also a six bedded clinical decision unit, which was split with three beds to one side and two plus a side room to the other to divide the unit based on sex of the patient.

The department had a dedicated X-ray facility with separate waiting area within the department.

There was a main waiting area for assessment and two smaller waiting areas for patients awaiting treatment. There was also a separate area for children waiting in the department with a secure play area and separate toilet and changing facilities.

During the inspection we spoke with five patients and their relatives. We spoke with staff of all levels and roles including those working in reception, nursing, medical and senior management. We observed care and treatment as well as the daily running of the department. We reviewed 15 sets of patient records and information provided by the trust.

Urgent and emergency services

Summary of findings

We rated urgent and emergency care as good overall because:

- The department had information available for patients which included waiting information screens and department information in each cubicle.
- There was good learning from incidents and complaints, including the sharing of findings and complainants were involved in the process.
- The immediate leadership team were well respected by staff and we were told that they were approachable, visible and supportive.

However:

- During the inspection we had concerns around the use of the clinical decisions unit (CDU). Patients were being admitted for substantially longer than the 24-48 hours outlined in the trusts policy. There was confusion as to which medical teams were responsible for patients waiting for beds on inpatient wards were being treated on the CDU as well as ED patients.
- Staff shortages to both nursing and medical staff meant there was high usage of agency and locum staff. This had also affected training rates and mandatory training rates did not meet trust targets.
- Provision for paediatric patients was limited. Other than the paediatric waiting room and cubicle there is no dedicated paediatric area within the department. The Department only had one qualified paediatric nurse. Paediatric staff from Ward 3 within the hospital could provide support and would attend the department to manage the care of critically unwell patients.

Are urgent and emergency services safe?

Requires improvement

Despite some areas of good practice, we found that the CRH ED required improvement in the domain of safety.

- There were staffing shortages in both nursing and medical staff, and despite high agency, bank and locum usage there were still shortfalls on shifts. At night there was only one Consultant grade doctor on call for both sites, meaning if both hospital sites required a consultant level doctor in the department then patient safety may be compromised.
- There had been six serious incidents reported across the trust between October 2014 and September 2015.
- The trust had had nine black breaches (where arrival by ambulance to initial assessment was delayed by more than 60 minutes) in 2015; however this was trust wide and not specific to CRH ED.
- Mandatory training rates were lower than trust targets. Though work was in progress to improve on this, staffing shortages limited the amount of time staff could be given for completing training.
- The average time from arrival by Ambulance to initial assessment was consistent with the England average from January 2015 to July 2015.However, information supplied by the trust showed that the year to date average time to assessment for patients arriving by 999 ambulance was 20 minutes as of December 2015. This did not meet the national target.
- Patients were being admitted onto the clinical decisions unit (CDU) where there was not beds available on main wards. Staff on the unit were not always aware who was responsible for the care of these patients and did not always have the specialist skills to assess and treat these patients.

However, we found that;

- The average time from initial assessment to treatment was 20 minutes, which was consistently lower than the England average of 53 minutes.

- Incidents were investigated fully and findings were feedback to staff in an effective way to ensure learning was implemented. This included discussions on a one to one basis and at daily safety meetings and handovers.

Incidents

- The trust had a serious incident and never event policy, which outlined the responsibilities of the trust in managing incidents and to support staff in learning from serious incidents. This included recognising mistakes made and making changes to practice and policy to ensure these mistakes were not repeated.
- The trust had reported no never events in October to 2014 to September 2015. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented. Trusts are required to monitor the occurrence of never events within the services they commission and publicly report them on an annual basis.
- The trust had reported six serious incidents. Two of these were alleged abuse of an adult patient by staff members at the HRI site.. As part of the investigation, information was shared with the Police and the member of staff was prosecuted. In both cases, thorough investigations were carried out and staff were suspended pending investigation and disciplinary procedures were followed. Although these incidents did not occur at this site, lessons learned were shared across both Emergency Departments.
- Other serious incidents (SI) included one pressure ulcer, one slip/trip/fall meeting one premature discharge and an incident of self-inflicted harm.
- Staff understood their responsibilities to raise safety concerns, and report incidents and near misses. Staff told us that they would report concerns to senior nursing staff in the first instance and then information was recorded on the electronic incident recording system. This system was widely used throughout the NHS and was appropriate for the needs of the department.
- Where incidents had occurred, staff were involved in the investigation and findings where shared on a one to one basis. Where wider lessons had been learned, information was shared in staff handovers and in the daily safety huddle. Incident feedback was also shared in meetings and via notice boards where appropriate.
- Staff told us they had received satisfactory feedback following reporting an incident where they had requested it. Incidents and learning were discussed in monthly governance meetings. Findings following investigation and lessons learned were documented and this information was available to all staff.
- We found evidence of staff learning from incidents. Staff told us of recent incidents and how practice had been changed following these incidents, for example ensuring all observations were completed prior to transfer to a ward to avoid delays to treatment on admission.
- A representative of the department attended mortality and morbidity meetings when appropriate to discuss any potential learning opportunities from other directorates.

Duty of Candour

- The trust had a Duty of Candour policy in line with the requirements of the Health and Social Care Act 2014. Within each directorate, the matron was responsible for ensuring staff were aware of their duty of candour and to investigate and manage complaints on behalf of the directorate.
- We discussed the policy with the matron who had until recently had responsibility for both sites and they were able to give examples of duty of candour and how they had communicated with patients. For example, following a serious incident the family of the patient were made aware of the incident by the matron on arriving to visit and were informed that the member of staff involved had been suspended and had been reported to the Police.

Cleanliness, infection control and hygiene

- The ED had dedicated Housekeeping staff that maintained cleanliness and hygiene of the department. There were cleaning schedules and staff told us that these were followed; records were kept to confirm that cleaning had taken place and these were clearly displayed and up to date. Senior nursing staff told us that this was checked to confirm standards were being maintained.

Urgent and emergency services

- All staff in the department were observed as being bare below the elbow. We observed staff washing their hands between patient interactions and using alcohol gel dispensers that were situated by doors and outside cubicles. Hand hygiene audit results for CRH showed higher than 99% compliance in May, June, July, August, October and November 2015 (only these six months provided). Data displayed in the department showed that this trend continued into 2016.
- Cubicles were cleaned between patients by nursing staff, including changing bedding and clearing waste. If a cubicle was visibly soiled or empty for a period of time then it would be cleaned by the housekeeping staff including mopping floors, wiping surfaces and emptying bins as required.
- Infection prevention and control training was a part of the mandatory training for all staff. Completion rates were recorded across both sites and were below trust target of 100% completion. 38.5% of medical staff and 69.2% of nursing staff had completed infection control training.
- The 2014 CQC A&E survey identified the trust as being "About the same" as other trusts for cleanliness.
- Trust cleanliness audits indicated that there had been no incidents of MRSA (a bacterial infection that is resistant to widely used antibiotic treatments) or C. difficile, a bacterial infection that can lead to diarrhoea between April 2013 and October 2015.
- A local infection prevention quality improvement audit was carried out in September 2015 and this showed overall scores of 91% compliance for infection control, 93% for cleaning and 92% for estates.
- The curtains on the cubicles were disposable and the date of installation was recorded on the curtains. Senior staff told us that these were changed when visibly soiled or where there was high infection risk. Curtains were also changed when cubicles were deep cleaned.
- Sharps bins and waste bins were appropriately labelled and not over full. Clinical and domestic waste bins were located in each cubicle and were emptied regularly by housekeeping staff.

Environment and equipment

- The department consisted of a main waiting area by the reception, a second waiting area for patients awaiting treatment that had been cannulated, a small area for patients awaiting treatment, a clinical decisions unit and a four bedded resuscitation room. The department was modern and was easily accessible from a large carpark outside the department or from within the hospital.
- The department was well maintained and where repairs were required, these were carried out by the Estates division
- The layout of the department was straight forward as it formed a large square. Patients went from the reception area to a large waiting area.Assessment occurred either in a room next to the reception or a cubicle nearby. Following initial assessment, unless being admitted straight to a cubicle, patients would return to the main waiting area to wait for further treatment.
- There was a separate children's waiting area with a secure play area separate toilet and changing facility. This area was not directly observed by staff, however the doors were glass and assessment nurses would regularly be passing the waiting area. There was no specific provision for older children or adolescents.
- Equipment was well maintained. Electrical equipment we checked had current safety testing certificates. A database was made available which showed service intervals, last service dates and problems repaired on all trolleys and beds within the department. An in house medical engineering department carried out servicing and repairs on equipment as appropriate. Staff told us that equipment was well maintained and repairs were carried out promptly.
- All mattresses checked were in excellent condition with no tears in the covers or stains/marking on the inside foam.
- Where equipment required a daily check we found that this was carried out and documented appropriately.
- Resuscitation trolleys had been checked daily and records indicated the trolley had been consistently checked. Staff told us that they were responsible for checking the areas and equipment they were assigned to and that this was done throughout the shift to ensure

patient care was not interrupted. We observed all resuscitation trolleys and bays within the resuscitation area were suitably equipped and conformed to resuscitation council guidelines.

- There was an adequate supply of equipment during the inspection and staff told us that the department was well stocked with consumables and linen.

Medicines

- Medicines and controlled drugs were stored in a safe and secure manner. Cupboards were locked and the key was held by the nurse in charge. We found there were no omissions from controlled drug record books; all entries were complete and legible.
- During the inspection we found an unsecured medicine in the eye assessment area, the door was open and staff were not able to observe this area. We informed a staff member and this was rectified immediately on being made aware.
- Maximum, minimum and current fridge temperatures were checked and recorded daily for all fridges containing medicines except in the minor injury area, where only current temperature was recorded, despite the record sheet stating that maximum and minimum must also be recorded. The recorded temperatures were within the safe range.
- In the central area we observed information relating to administrating, recording and safety advice for specific medicines.
- Emergency medicines were in date and in sealed packaging.
- Patient group directives (PGD's) were reviewed and found to all be in date. Patient group directives are written instructions which allow specified health care professionals to supply or administer a particular medicine in the absence of a written prescription.
- A chart was available in the resuscitation area showing drug doses for paediatric patients to ensure that information was readily available in an emergency.

Records

- The majority of patient records are recorded electronically using the emergency department information system (EDIS). Observation charts and fluid balance charts are currently paper records.There was a separate national early warning score chart (NEWS) used to record clinical observations such as pulse and blood pressure. These observations were applied to specified criteria to create a score which could indicate deterioration in a patient's condition. The Trust were in the planning stages of introducing a Trustwide electronic patient record system. We reviewed 15 sets of patient notes from all areas of the department. We found that notes from the main area were completed to a high standard and we found most records to be complete, legible and accurate. Times of arrival, triage and treatment were documented in all records and names of nurses and doctors involved in the patients care were clearly documented. However, we did find two cases where pressure areas had not been assessed or assessments had not been recorded. Records did not record consent for assessment or treatment.
- Patient information was recorded on hospital admission forms rather than ED record sheets on the clinical decision unit. These forms showed that patients were routinely assessed for risk in relation to falling, pressure ulcers, nutrition and hydration. This was documented in care plans, however, we observed records where risk assessments had been carried out and patients were identified as being at risk of pressure sores, but this had not been acted upon

Safeguarding

- Systems were in place to ensure vulnerable adults and children were kept safe. Staff were aware of their responsibilities in relation to safeguarding, the processes to make referrals effectively and were confident in their knowledge of safeguarding concerns.
- Information supporting safeguarding referrals and decisions was available to staff on the intranet. Staff were aware of the location of this information and told us that they would refer to it when making safeguarding decisions.
- Staff completed safeguarding training at induction and this was included in mandatory training. 61.5% of nursing staff had completed safeguarding training. 35.9% of medical staff had completed adult safeguarding training. Clinical staff were trained to a minimum of Level 2 for safeguarding adults. Senior nursing staff and doctors were trained to Level 3 for

adults and children. However the Intercollegiate document published by the royal college of paediatrics and child health entitled 'Safeguarding children and young people: roles and competences for health care staff' States that "all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should be trained to Level 3 safeguarding.

- Staff could contact the paediatric department for support on child welfare issues whenever required.
- Staff were aware of female genital mutilation and were aware that this was a safeguarding issue; however, staff told us that this was not routinely assessed due to the nature of the work in the ED.

Mandatory training

- Mandatory training covered a variety of safety systems, processes and practices. Areas such as manual handling, safeguarding and information governance were provided to all staff. Staff also completed role specific training at induction that was mandatory such as medicines management and use of medical equipment.
- Trust mandatory training rates had a target of 100% compliance across all areas for all staff (clinical and non-clinical). ED nurse training rates were below target in all areas. ED medical staff were also below target in all areas.
- Mandatory training comprised of face to face sessions and e-learning packages. Staff had difficulty in accessing face to face sessions due to shortfalls in staffing. Staff told us that E-learning was completed in their own time and that access to computers could be challenging.
- We discussed these figures with senior staff and were advised that staff were struggling to complete mandatory training due to shortages of staff. There was a dedicated nurse responsible for training, and they were implementing several strategies to improve training rates including securing lap top computers that staff could take home to complete training in their own time. Some of the lowest areas of training compliance included PREVENT training (29.2% for all staff) and conflict resolution (46.6% for all staff).
- Advanced Life Support training was managed on a Trust wide basis, medical staff compliance was checked annually at appraisals.

Assessing and responding to patient risk

- A National Early Warning Score (NEWS) system was used for all patients, which supported the early recognition of patient's deteriorating. This aided early intervention and appropriate levels of observation based on risk.
- Patients who walked into the department were registered by the receptionist and directed to the assessment area waiting room, where they were called by a nurse who completed observations and gained a history prior to triaging the patient to relevant areas of the department. During this initial assessment any bloods, electrocardiography (ECG heart traces) or other diagnostic tests were carried out to ensure that information was ready for the treatment phase. Analgesia could be administered if required under PGD by the nurses on duty.
- Patients arriving by ambulance entered through a different entrance specifically for ambulances. They were handed over to a nurse co-ordinator who streamed the patient into the appropriate area unless the patient required immediate access to the resuscitation bay. Reception staff were called to the central area to complete the booking in process and the ambulance crew were responsible for transferring patients to hospital trolleys or chairs as appropriate.
- Once streamed, patients received further assessment and treatment by a doctor or emergency nurse practitioner.
- The College of Emergency Medicine (CEM) guidance states a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Patient records we reviewed indicated that 13 out of 15 patients were assessed within this time frame, however during the inspection information screens in the waiting area showed waiting times of up to one hour for initial assessment.

- For patients arriving by ambulance, the time from arrival to assessment was consistently below six minutes between July 2014 and July 2015 across the trust (site specific information was not available). During the inspection we did not witness a patient handover taking more than the 15 minute national target.
- From April 2015 to December 2015 the time to treatment target was 60 minutes or less. The trust achieved this target.
- CRH was designated as a stroke centre and all patients suspected of having suffered from a stroke in a pre-hospital environment who arrived by ambulance would be brought to the ED at CRH.The department had close ties with the stroke team. There was a video conference system that allowed consultants to discuss stroke patients remotely. .
- There was an escalation policy for dealing with severe staffing issues or high attendance to the department. This included contacting staff who were off duty or sending patients to other local ED's. If staffing levels fell below safe levels then the trust had decided that they would close the one of the ED sites and amalgamate all staff and patients at one site. However, this had never happened.
- Pressure relieving mattresses were not in use on the CDU and we observed patients within the unit showing signs of pressure damage. This was particularly important as patients were often staying on the unit much longer than the trust stated target of 24 hours.
- Nurses on the CDU told us that patients were staying on the unit who should have been admitted to specialist units. Although the admitting doctors were ultimately responsible for these patients, the CDU staff felt that sometimes it was hard to get hold of these doctors and the nurses were not always aware of specialist assessment or treatments required for these patients. Patients admitted via the ED were staying for prolonged times, in one case a patient had stayed for nine days. This contradicted the trusts policy for admission to CDU which stated that patients should stay for no more than 48 hours.
- Concerns were also raised around appropriate risk assessment of patients being admitted to CDU. Often patients had severe mobility problems and the staff on the unit regularly had to ask for help from the main area to transfer patients .This was reflected in the reported incidents, of which a large number related to patients on the CDU who did not meet the CDU specifications set out by the trust. This was an issue across the trust.

Nursing staffing

- Staffing ratios for Emergency Department were reviewed utilising the Royal College of Nursing's Emergency Care Association (ECA) Baseline Emergency Staffing Tool (BEST) which utilised the validated dependency tool for Emergency Departments.
- We were told a request to increase the number of qualified and unqualified nurses was supported by the Board and recruitment was ongoing.
- The current establishment was 38.93 whole time equivalent (WTE) qualified nurses, and 10.20 WTE healthcare assistants. The planned figures were 44.44 WTE for qualified nursing staff and 10.64 for unqualified.
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, the actual versus planned numbers of qualified and unqualified nursing staff on duty was displayed prominently in the reception area of the department.
- On the days of our visit, the actual numbers of registered and unregistered nurses on duty did match the planned numbers. However in December 2015 there were 39 shift periods that were short staffed, January 2016 50 shift periods and February 2016 52 periods that were not fully staffed. Staff were assigned to particular areas (Resus, CDU, majors etc.).
- During an unannounced visit the following week the staffing showed that the department was meeting planned staffing for qualified staff and exceeding the planned staffing for unqualified.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. Senior staff told us that there was one only registered children's nurse employed in the department.
- Staff without paediatric qualifications were encouraged to complete a 'Paediatric nursing for adult qualified nurses' module at a local university. At the time of the

inspection four members of staff had completed this training. There was no monitoring of staffing to ensure that each shift had a member of staff with additional paediatric training present. However, all senior nurses were trained in delivering paediatric advanced life support and there would be a member of staff with this qualification on duty at all times.

- Senior staff had also developed a training matrix whereby nursing staff could identify their skills and knowledge around treating and assessing paediatric patients. This would allow training to be targeted to areas of significant weakness and staff with higher knowledge could support colleagues in their development. Nursing staff also had access to a series of 'Care of children and young people' master classes. These are whole day face to face taught sessions on specific subjects relating to the care and management of children and young people.
- Staff told us that they could escalate concerns about staffing levels and would receive a response from management. This was supported by records of incidents reported by ED staff relating to staffing concerns.
- The department was overseen by a matron who provided local managerial support, and clinical support when necessary.
- The department had high usage of agency and bank nurses. The same bank nurses were re-booked providing familiarity to the department and many of the bank nurses were substantive staff.
- At the beginning of each shift, agency and bank staff were required to sign a form indicating that they had been made familiar with the department, understood their role and would conform to trust policies and protocols such as diversity and equality standards.
- We were told recruitment was on going but the trust had struggled to appoint new nurses. The trust had looked to recruiting nurses from other countries and had had some success with this approach.
- Nursing handovers occurred twice a day, at the start of the day shift and the start of the night shift. There was also a handover between shift coordinators. The department also ran once daily safety meetings which could be attended by any staff member. These would be used to discuss any safety issues presenting in the department and to update staff on any potential risks to the shift.

Medical staffing

- We examined the medical staffing rota and spoke with consultants and junior doctors. Medical cover was demand driven, so at busy times there was more medical cover. Rotas were complex and varied on a day-to-day basis. Junior doctor start and finish times fluctuated throughout the day and training was built into the rota.
- Across the trust, 24% of the medical staff were of consultant grade this was higher the England average of 23%. They had the same percentage of 52% middle grade and registrars as the England average and 24% junior Doctors which was also in line with the England average.
- According to the College of Emergency Medicine (CEM) (2015), an emergency department of this size should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend. There was Consultant presence on site from 8am-10pm Monday to Friday. There was additional ad hoc locum weekend on site cover by ED consultants and locum staff.
- Outside of these hours a single consultant was on-call for both sites with a contractual 30 minute response time. We asked how this would work if the consultant was required at both HRI and CRH ED's. We were told that in this situation the consultant would make a risk assessment of which site they would attend and would liaise with senior emergency medical staff and a middle grade doctor would travel to the other ED that had been left short to provide decision making assistance and liaise with the consultant by telephone. There were no reported incidents relating to this, however it was recorded on the risk register and continued attempts at recruitment had been made.
- There were 9.84 whole time equivalent (WTE) A&E consultants employed by the trust across both sites and the trust was advertising current vacancies.

Urgent and emergency services

- There were 10 WTE middle grades. This included full time posts and locum staff. Gaps were identified in advance and were filled by agency staff as required. Rotas were updated by hand so it was difficult to identify how many shifts were left unfilled.

Major incident awareness and training

- The trust had a major incident policy, this was accessible to staff on the trust intranet and staff completed awareness training as part of their induction.
- Staff we spoke with had an understanding of their roles and responsibilities with regard to any major incidents and understood how major incidents elsewhere could impact on the work of the department.
- Staff we spoke with had a good understanding of the types of major incidents that could affect the department such as severe weather events like recent flooding that had damaged bridges locally. Staff were aware of continuity plans for offering support to staff commuting in bad weather and advice was shared via the intranet and in meetings
- There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials. There was also patient decontamination equipment which included an inflatable tent and shower equipment.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- Staff had undertaken training and practice that included practice in wearing the protective suits and erecting the tent to use for contaminated casualties.
- Staff had received training on how to care for someone who may have symptoms of Ebola and personal protective equipment was stored in the department along with guidance in folders on how to manage a potential outbreak.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated urgent and emergency services as good in the domain of effective because:

- Policies and procedures were developed in line with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine (CEM), the National Institute of Clinical Effectiveness (NICE) and the Resuscitation Council UK.
- The department had an on-going audit programme that encompassed both local and national audits. Staff were encouraged to undertake audits on areas of interest and changes were made to practice as a result of these audits.
- Pain relief was available from initial assessment and pain scores were recorded in patient records.
- Training for nursing staff was linked to revalidation needs.

However,

- Annual appraisal rates were low.
- Access to training was limited by staffing issues.

Evidence-based care and treatment

- There were a range of pathways available for patients with specific needs or conditions such as Asthma in children, sepsis in adults and Paracetamol overdose; these complied with the NICE guidelines and the CEM clinical standards for emergency departments.
- The trust contributed to national audits so it could benchmark its practice against other emergency departments. This included collecting data on asthma, head injuries and fitting children.
- Nursing staff were encouraged to carry out local audits on various subjects, including record keeping, equipment usage and waste management. The findings of these audits were used to improve practice and services. For example, we were told how since a

member of staff had been monitoring the recording of pain scores and the recording of offering pain relief, compliance had increased and most records we observed had this information recorded.

- Care pathways had been established for conditions such as stroke, hypoglycaemia and sepsis to promote early treatment and improve patient outcomes. These included using specific patient record pages, to ensure the correct information was gathered and diagnostic tests were carried out. Compliance with these pathways was audited and current compliance with national standards was displayed on a white board in the staff communication room and these were discussed at daily safety briefings.
- Guidelines were easily accessible on the trust intranet page and there were paper copies of pathways. All pathways and guidelines we observed were in date. Where the expiry date was approaching, this was highlighted. Junior doctors were able to demonstrate the accessibility of these guidelines and they told us they found them clear and easy to use.
- Junior doctors attended weekly teaching sessions to ensure they were up to date with evidence-based practice and current guidelines. Topics covered included mental capacity act and management of head injuries.

Pain relief

- A nationally recognised pain score tool was used to assess pain. This involved patients assigning a number to the pain they were experiencing. Pain was scored as zero for no pain up to 10 for severe pain.
- We reviewed 15 sets patient notes for the completion of pain scores, offering of pain relief and timely administration of analgesia if appropriate. All records reviewed included a pain score, record of pain relief offered and pain relief was given quickly after assessment where appropriate.
- Patients told us that staff had asked about their pain and all of those patients who had pain said they were treated quickly.
- The CQC A&E survey 2014 showed that the trust was 'About the same' as other trusts in the response to patients feeling staff did all they could to help control pain and the waiting time between requesting and receiving pain relief.

Nutrition and hydration

- Sandwiches, hot and cold drinks and toast were available in the department. Patients admitted to the CDU had hot food available and cereals available at breakfast time. Hot food was available from the canteen and staff could request hot food for other patients as required. Specialist food was available on by request including Halal, Kosher, vegetarian and gluten free.
- Patients told us that they were satisfied with the food and drink provision in the department.
- We observed staff assisting a patient to eat during our inspection and staff told us that they would monitor what people were eating and drinking and offer support for any patient that was struggling. We observed records on CDU where this was documented.
- There was no set mealtime and food was available whenever it was requested.
- In the hospital entrance, there was a shop and café, which sold hot and cold drinks plus food. There were also drinks and snacks available in the ED waiting area.
- The CQC A&E survey 2014 showed that patients rated the availability of suitable food in the department as 'about the same' as other trusts.

Patient outcomes

- From October 2014 to October 2015 the unplanned re-attendance rate to the emergency department within seven days of discharge was consistently better than the England average and was around the national standard of 5%, scoring on average 4.9% these figures show that the number of people coming back to the department after treatment for further treatment or assessment was higher than national averages.
- The College of Emergency Medicine (CEM) had developed evidence based clinical standards to which all emergency departments should aspire. The emergency department had participated in a number of audits to benchmark their performance against these

CEM standards such as 'the initial management of the fitting child', asthma in children, cognitive impairment in older people (including dementia) and a severe sepsis and septic shock audit.

- Compliance to the treatment of severe sepsis was below the prescribed 100% compliance standard in all fields in the 2013 to 2014 audit and the department was in the lower quartile of England average for the measuring and recording of vital signs, the initiation of high flow oxygen and the measurement of serum lactate (an early indicator of septic shock).
- Most areas were in line with the England average except for evidence of blood cultures being obtained (a method of identifying the type of infection) which was in the higher quartile of the England average. An action plan was in place which included on-going training of medical and nursing staff. Audit findings were shared at the daily safety meetings and results were displayed the staff communication room.
- An internal sepsis-screening pathway was implemented. This meant that any patient with symptoms of sepsis or a NEWS of five or higher was automatically screened for sepsis. As a result of this pathway, compliance with the sepsis audit had improved and nursing staff told us that their awareness of sepsis screening had improved.
- In the CEM audit for asthma in children 2013/14, seven out of 10 indicators were between the lower and upper England quartile. Three of the indicators, peak flow measurement and two treatment routes were in the upper England quartile.
- The CEM audit for fitting child there was one indicator that was lower than the England quartile this was regarding discharging patients with written safety information which was 0%. However, the sample size for this indicator was low at 8 patients. The other indicators had high compliance percentages with 86% for the checking of blood glucose on arrival (7 patients) and 98% for eye witness history record (40 patients) and 100% for fitting children being managed in line with advanced paediatric life support algorithms (7 patients) and presumed aetiology recorded (40 patients).
- The CEM audit for cognitive impairment in older people three indicators out of six were in between the lower and upper England quartile. The trust was in the lower quartile for a cognitive assessment taking place of 50 patients in the sample only 2% had been assessed in this manner; however this was a developmental standard rather than a fundamental standard. No specific plans to improve on this were reported.
- The department closely monitored its performance against a range of clinical indicators and presented a current, real time report in a dashboard format. This presented a detailed and balanced view of the care delivered by the emergency department. It also reflected the experience and safety of the patients and the effectiveness of the care they received. This included ambulance handover times, time to treatment, four-hour breaches and attendance rates. This information was displayed in the staff communication room and in a limited form in the main waiting area.

Competent staff

- Medical and nursing staff had annual appraisals and staff we spoke with were positive about the process where they had received an appraisal; however some staff told us that they had not received an appraisal in the last 12 months.
- Across both hospital sites, ED appraisal rates were currently 53.8% for nursing staff and 17.9% for medical staff. Senior staff told us that there were plans in place to improve on this however staffing limitations impacted on this.
- New nursing staff received emergency department specific competency based training. A mentor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- Emergency nurse practitioners were used to assess and treat patients with minor injuries. These staff had completed advanced training courses and had increased skills.
- Agency staff was required to complete a form at the beginning of shift stating their competency and that they had completed a familiarisation of the department.
- We were told by senior medical staff that junior doctors received appraisal as part of their training package. These were not carried out annually as staff would

rotate to other departments, however, reviews at the beginning and end of the placement would take place and ED consultants contribute to the annual appraisal process through the Deanery.

Multidisciplinary working

- We observed good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency department.
- Care was delivered in a co-ordinated way using a number of different care pathways between the emergency department and the clinical decision unit. However, staff on CDU told us that sometimes communication between staff was poor, especially when patients admitted to other specialities were having prolonged stays on the unit whilst waiting for beds on main wards. During our engagement with junior doctors we were told that often staff from other departments found it hard to communicate with CDU staff.
- Occupational therapists and physiotherapists would come to the department to provide clinical expertise and review patients prior to discharge. They would also see patients on the clinical decision unit. There was a separate physiotherapy room within the department for patients returning to the department for follow up sessions.
- The mental health team was based on the hospital site providing timely assessment to patients with mental health needs.
- ED staff had good links with staff in the paediatric departments, who offered support and would, where appropriate assess paediatric patients in the department.
- Nursing and ambulance staff told us that they work well together and had high levels of mutual respect. The assessment and opinions of ambulance staff were valued within the department and ambulance staff told us that they could work well with the ED staff.

Seven-day services

- The department was open 24 hours a day seven days a week for all patients and had x-ray facilities within the department which could be accessed 24 hours, seven days a week.
- Consultant rotas demonstrated that a consultant presence in the department was between 8am to 10pm Monday to Friday, and for a minimum of six hours on a Saturday and Sunday. Outside these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available in the department at all times.
- There was availability of pharmacy and physiotherapy services seven days a week and an on call service was provided outside of normal working hours.

Access to information

- Patient records are recorded electronically using the emergency department information system (EDIS). There was a separate national early warning score chart (NEWS) used to record clinical observations such as pulse and blood pressure. These observations were applied to specified criteria to create a score which could indicate deterioration in a patient's condition
- A letter for patients General Practitioners (GP) was generated from the electronic patient record system. Administration staff print off the letters and send them to the patients GP.
- In the department, the nurse coordinators computer displayed the status and waiting times of all patients in the department.
- By using the trust's intranet, staff had access to relevant guidance and policies as well as updates and important information relating to their work. Paper copies were available in the communication room and information was also shared in daily safety briefings and by posters in staff areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that they understood the relevant consent and decision making legislation in line with the mental capacity act 2005 and deprivation of liberty guidance.

We were told that staff had completed training on this as part of the mandatory safeguarding training; however this is not one of the areas listed on the mandatory training package.

- Medical and nursing staff told us that they obtained verbal consent from patients before providing care and treatment. We observed staff explaining treatments and diagnosis to patients, checking their understanding, and asking permission to undertake examination and perform tests. However, this consent was not consistently documented in the patient records we examined (three out of 15 had consent formally recorded).
- When treating children, staff used Gillick competency principles in assessing a patient's ability to consent to treatment. Staff had support from paediatric services where they had concerns around a patient's capacity.
- Doctors gained written consent from patients who required sedation using standard hospital consent forms explaining risks and planned treatment. These forms included a simple capacity assessment to ensure a patient had the full ability to consent to treatment.

Are urgent and emergency services caring?

Good

We rated the domain of caring as good because:

- The department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.
- Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in the decisions about their care and treatment. Care was person-centred and staff were observed to provide care which maintained the dignity and privacy of patients.
- There was information available to patients in the waiting areas and cubicles to understand the care, assessment and treatment they would receive.

Compassionate care

- During the inspection we observed patients being treated with respect, privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed. Staff spoke in an appropriate volume to avoid being over heard by other patients. Staff were respectful when asking for personal information. When assessment required exposure of the patient, this was handled with dignity, allowing patient's privacy to change into a gown or assisting if required, with consent gained from the patient.
- We observed a number of interactions between staff and patients and relatives. Staff were always polite, respectful and professional in their approach. We observed a nurse dealing with a difficult patient who was swearing loudly. The staff member dealt with the situation in a caring manner, making an effort to understand why the patient was upset and they tried to resolve the problem that had upset the patient rather than just dealing with the situation as a problem.
- We spoke with five patients and relatives who all praised the care they had received. All described how they were treated with care, dignity and respect.
- The friends and family test results between November 2014 and October 2015 demonstrated a higher than England average of patients would recommend services in the department. However, the response rate to this survey was low.

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology and leaflets were given to patients about their condition or managing their symptoms where appropriate.
- We observed patients being given a clear explanation on discharge and advice was given on follow up care and how to manage potential complications.
- Patients and relatives we spoke with told us they were kept informed of what was happening and understood what tests they were waiting for.

Emotional support

- We observed staff offering emotional support to patients who were anxious or upset. They spent time

reassuring them and explaining what was happening and why. Patients told us that support staff were always happy to bring a cup of tea and have a chat, which made them feel less anxious and lonely.

- Staff took the time to treat patients in a caring and supportive way. However, we were told by staff that they felt limited in the amount of time they could sit with a patient to offer emotional support due to staffing limitations.
- Support was available from the multi-faith chaplaincy service who was available 24 hours a day to patients and family members in the event of a bereavement.
- In the CQC A&E survey 2014, the majority of caring related questions scored about the same as other trusts, however, two questions scored better than other trusts, these were in relation to patients ability to gain a staff members attention if they needed something and for continuity in what staff members were telling them.

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

(for example, to feedback?)

Good

We rated the emergency department as Good for responsive because:

- The trust had improved from September 2014 in meeting the target of 95% of patients admitted, transferred or discharged within four hours, and now fluctuated around the target which was better than the England average.
- Total time in ED was consistently lower than the England average and the percentage of patients waiting four to 12 hours from decision to admit to being admitted was lower than the England average, however, since February 2015 this had risen several percentage points however this was still below the England average and expected standard.
- Complaints were managed in line with trust policy, complainants were involved in investigations and feedback was given to staff.

However,

- The flow of patients through the department was limited by space in the department and patients waiting for beds on wards within the hospital.
- The time to treatment for patients was better than the national target but there were nine black breaches reported between January and December 2015.
- Provision for paediatric patients was limited with only one paediatric qualified staff member on duty during our inspection and limited facilities available for older children and young people.
- The department was often at capacity meaning the fracture clinic was used as an over flow.
- Staff were not aware of specific guidance for the care of patients with learning disabilities.
- The clinical decision unit was often not available to ED patients as patients waiting for beds on other wards remained on the unit for long periods of time.
- The trust had a higher than England average number of patients leaving the department before being seen.

Service planning and delivery to meet the needs of local people

- The management of the department were aware of the changing demand on services, a public consultation was due to be undertaken to consider the reconfiguration of services at the trust which included the ED departments. Clinical commissioning groups, stakeholders and public groups were involved in this process.
- The main waiting room had a number of notices which provided useful information to patients and visitors about the service. There was a screen which displayed up to date information relating to waiting times, number of patients in the department and time to treatment.
- Infection prevention and cleanliness scores were displayed along with current staffing and the names of the senior nurse and doctor on duty
- Senior staff told us that the facilities and premises were no longer appropriate to meet the needs to the local people. The department was often at capacity and there was not enough cubicles to treat the volume of patients attending.

Urgent and emergency services

Meeting people's individual needs

- Disabled toilets and were available in the waiting room and baby changing facilities were available in the children's waiting area. The department was wheelchair accessible and had good parking and drop off provision.
- The reception area had a designated hearing loop and a lowered desk to aid access.
- Staff told us they did not have any specific guidance to assist them on how to support patients with a learning disability. They told us they would encourage their carer to stay with the patient to help alleviate any anxieties the patient may have. A 'VIP' card had been introduced which contained medical and personal information which was used for patients with a learning disability.
- During the time of inspection we did not see a patient with a learning disability. However, senior staff told us that there was a matron for learning disability who could be contacted to offer support and care to patients with learning disabilities.
- There was no specific 'dementia friendly' cubicle; however, the 'Butterfly Scheme' was implemented, which at a glance created discreet identification via the Butterfly symbol for patients who had dementia-related memory impairment and wish staff to be aware of it. We did not see evidence of this in use as we did not see a patient with dementia during our inspection. Staff we spoke with were aware of the program and felt it was successful.
- Specialised bariatric equipment was available including a hoist and bariatric wheelchair if needed.
- A range of information leaflets were available for patients to help them manage their condition after discharge. Available leaflets were in English only, however a translation service was available either by use of telephone interpreters or by ordering leaflets from a central printing office; however this was not ideal for patients leaving the department or attending outside office hours.
- Staff told us they avoided using friends or family members for interpretation as much as possible to ensure information was accurate and to maintain patient confidentiality.
- There was a relative's room where people had access to telephones. Hot and cold drinks were offered and available on request. The room was comfortable, private and suitable for its purpose.
- There was a separate paediatric cubicle in the emergency department, this was decorated in a child friendly manner, had access to toys and other distraction methods and was away from the main area. There was also a separate waiting area for children with toys, games and a television away from the main area. There was a bay in the resuscitation area that was suitable for adults and children.
- The mental health team was based within the hospital site and provided a seven days a week service 24 hours per day. There was a small office that they could work from and carry out assessments if required.

Access and flow

- The national standard set out by the Department of Health's for emergency departments was to admit, transfer or discharge 95% of patients within four hours of arriving in the department. Between November 2014 and November 2015 the percentage of patients achieving this target was consistently around 95% which was higher than the England average.
- The median amount of time people could expect to spend in the emergency department before being discharged, admitted or transferred was consistently lower than the England average at approximately 130 minutes between September 2014 and September 2015 against the England average of approximately 137 minutes over the same time frame.
- The College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. During our inspection, the year to date median waiting time to receiving treatment for patients in the emergency department was 58 minutes.
- Once a decision to admit had been made, there had been no reported breaches of patients waiting more than 12 hours in the emergency department.
- The national average for the percentage of patients who leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of

time they have to wait), was between 2% and 3%.The trust wide figure was 3.86% between October 2014 and October 2015, this was better than the threshold of less than 5% but worse than the England average.

- The emergency department aimed to ensure patients who arrived by ambulance were kept waiting for no more than 15 minutes before patients were handed over to the care in the department. This was achieved for 90.6% of patients, which was better than the England average of 85%.
- Black breaches occur when the time from an ambulance's arrival to the patient being formally handed over to the department is longer than 60 minutes. The emergency department had nine black breaches between January 2015 and December 2015. The main reason for this was recorded as no cubicles available (six instances).
- We observed five ambulance handovers. Patients were handed over to the nurse coordinator and transferred to a cubicle within fifteen minutes on each occasion.
- During the inspection, we observed flow of patients and reviewed current information on waiting times. We observed the time patients waited in the waiting room and the longest the patients waited was 60 minutes.
- We observed a meeting of the bed management team, who observed flow within the emergency department. To understand the bed situation to enable planning for expected admissions and discharges, the team met frequently throughout the day. During these meetings it became clear that spaces in the CDU were considered as part of the hospital capacity and were not ring fenced for use by the emergency department for the treatment and observation of patients for up to 24 hours.
- The CDU was being used as a general ward. This was against the specification set out by the trust in June 2014. This was having an adverse effect on flow through the emergency department and was putting patients at risk as the unit did not have the facilities to care for patients who needed longer than 24 hours care.
- During our inspection we found records of patients who had been admitted to the unit for seven days and staff told us of patients that had been admitted for three weeks in the past. This meant the trust's own specification was not being followed which stated that patients should be discharged after 24 hours.
- There was an escalation policy. This provided guidance on when and how to implement the escalation policy, to ensure safe working when the department was full or the hospital bed state was preventing flow of patients through the department. This included plans for inadequate medical staffing, whereby one department would be closed and staff would migrate to the other site to provide emergency services form one site within the trust area.

Learning from complaints and concerns

- Between December 2014 and November 2015 there were 22 complaints made to the emergency department. The themes were associated with staff attitude, missed fractures, inappropriate discharges and communication.
- Staff told us they were aware of how to deal with complaints, trying in the first instance to resolve issues immediately. If this was not possible they would refer to the complainant to the nurse in charge. We were told that doctors would investigate complaints which involved medical staff or medical issues, and the matron would deal with complaints related to nurses or nursing care.
- Where appropriate, complainants were invited to speak at the patient experience group. Staff told us that this put a face to a complaint and helped them to understand how the patient had felt and what led to the complaint. The matron told us that they had had positive feedback from patients as a result of this and that patients felt that their voice could truly be heard.
- Response letters to complainants included an apology when things had gone wrong, an explanation of what had gone wrong and how the trust intended to investigate the incident. This was in accordance with the expectation that services operated under a duty of candour.
- Patients and relatives we spoke with were confident about how to make a complaint to the trust, though none of the people we spoke with had complained about the department.

- Feedback was given to staff face to face and any lessons learnt were discussed in handovers. There was also a monthly patient experience group where feedback would be given and complaints discussed. An example of this was a complaint about poor treatment in the ED and CDU. The issues were addressed with the individual members of staff and training was given where appropriate on CDU discharge procedure. The complainant was also invited to the patient experience group.

Are urgent and emergency services well-led?

Good

We have rated the CRH ED as good for the domain of well led because:

- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes.
- There was strong local leadership and management. Staff respected the senior staff in the department and felt that they were well supported.
- The provision of paediatric emergency care did not meet the standards set by The Royal College of Paediatrics and Child Health. However, this was identified as a national problem and senior staff had implemented plans to mitigate the risk of this.
- The patients' voice was seen as important and the department took part in patient experience surveys, invited complainants to patient experience meetings to share their thoughts and shared feedback with staff daily.
- There was a strong supportive culture of openness, transparency and honesty. Staff were proud of working in the department.

However:

- Issues with flow were not being adequately addressed and patients were being admitted to the CDU for inappropriately long times.
- Staff felt disconnected from board level management and did not feel that their work was appreciated by the trust.

Vision and strategy for this service

- The emergency department was part of the emergency care directorate and worked closely with the acute medicine division.
- The directorate is actively involved in a plan that includes a re-design of emergency and urgent care services.A public consultation was due to be undertaken to consider the reconfiguration of services at the Trust which included the ED.
- There was a clear strategy for achieving the trust vision of 'Together we will achieve outstanding compassionate care to the communities we serve.' The trust provided a five year strategy and a one year plan which included goals for transforming and improving patient care. These were 'Keeping the base safe' for example ensuring the trust meets national standards and targets, 'A workforce for the future' and financial stability.
- Staff told us of the trust values which were represented by four pillars. These were, 'We put the patient first', 'We go see', 'We work together to get results', 'We do the must do's'. These values were displayed prominently in several locations and all staff that we spoke with were aware of these and understood what it meant to them.
- Work had begun in developing the workforce and more staff nurses had been appointed and a new consultant had recently been appointed within the trust. Other vacancies were still being advertised.

Governance, risk management and quality measurement

- A governance system was in place and the agenda items of the patient experience group and the clinical effectiveness and outcomes group included discussions of incidents, complaints and lessons to be learnt. These issues were also discussed at handover and in daily safety meetings.
- A monthly senior leadership team meeting took place that discussed finance, performance data, changes to clinical practice and audit activity. Staff were clear about

the challenges the department faced and they were committed to improving the patients' journey and experience. Both these meetings fed into trust wide governance meetings.

- There was ongoing quality measurement through a real time dashboard available to staff, and in an edited form to patients outlining waiting times, number of patients in department and number seen that day. Staff were also encouraged to carry out regular audits on items such as record keeping, pathway use and referral rates.
- The department risk register was available and was continually under review to ensure it reflected current risks relevant to the operational effectiveness of the department.
- There were 13 risks recorded on the register at the time of our inspection. Each risk was graded, dependent on severity. There were four low risks, seven moderate risks and two high risks. Each risk was related back to the trust goals.A lead officer was assigned to each risk and descriptions of key controls to mitigate risks were given along with further actions to take and targets to achieve these by. Examples of the high risk were risk of poor decision making due to dependence on middle grade locum doctors at weekends and nights and poor patient experience due to staffing issues and flow through the department.
- The trust and senior staff were aware of the shortage of paediatric emergency qualified nurses and this not meeting the standards set out by The Royal College of Paediatrics and Child Health. There had been ongoing recruitment to this role which had not been successful. As a result, the department had close ties to the paediatric department within the hospital and staff were being supported to develop their skills in the management and treatment of children, with a target of working towards a post graduate qualification in paediatric care for adult qualified nurses.

Leadership of service

- The emergency department had a clear management structure at both directorate and departmental level including a clinical director, a general manager an operational manager and three matrons. The majority of the leadership team were from an emergency medical background and had experience of working in an emergency department prior to taking their current roles.
- We spoke with the leadership team at length and it was clear that they understood the challenges the service had and had identified actions needed to address these issues. This included the recent hiring of more nursing staff and plans to improve mandatory training compliance.
- The nursing team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability. Senior staff would be recruited form within the team and a large number of staff had been with the trust for a long time.
- Both the medical and nursing teams had responsibility for audits in the department. Medical staff told us there was a strong educational resource provided by the senior doctors and junior doctors felt supported and consultants.
- From our discussions with staff, the department leadership was strong, supportive and staff felt they were listened to. There was confidence in the management and staff told us they were proud to work in the hospital. Nursing staff we spoke with told us that they respected the immediate leadership team as they were visible, approachable and quick to take on clinical work when the need arose. There was a good working relationship between doctors and nurses.
- However, some staff commented that the chief executive and board level managers were not very visible on the department.
- All the staff we spoke with told us that the department was a good place to work. Staff were generally happy in their work and felt that they were a respected part of the team. Staff voiced concerns around staffing and the busyness of the department.
- The team appeared to be efficient and good teamwork was evident including working across different areas to cover short breaks and where patient care was taking longer than planned.

Culture within the service

- Staff told us that they felt respected and valued by the immediate leadership team and by the directorate management. Staff described the culture as open and transparent.
- Some staff we spoke with voiced concerns that they felt disconnected from the board level and some staff reported feeling disengaged since the announcement of plans to change emergency department services within the trust.
- Where behaviour or performance fell short of the expectations of the trust or were inconsistent with the trusts vision and values this was managed by the staff members direct manager.
- Staff felt that their safety and wellbeing was a high priority for the leadership team. Staff felt comfortable raising concerns and told us that they felt the department was a safe place to work.
- We observed staff working well together and staff told us that they worked closely with other teams. However, some staff told us that there were challenges in referring to other specialities sometimes as 'Everyone is stretched'.

Public engagement

- The department used several methods to understand the experience of patients. The trust took part in the national Friends and Family initiative and results were displayed prominently in the department. People who had complained were invited to attend patient experience groups, to speak with staff and explain the reasons for their complaint and how the incident had made them feel. This put a face to the issues raised and helped staff to understand the effects their actions could have.
- Service users and their carers were involved in decisions relating to care, however, a large number of complaints received by the department related to poor communication with service users and their families in relation to discharge.

Staff engagement

- The trust results of the NHS staff survey 2015 were 3.76 which was slightly below the average of 3.79 for similar trusts in England for staff engagement. This was also slightly lower than last year's survey results of 3.77.
- Staff told us that although there was opportunities in relation to training, development and being link nurses in areas of interest to them, these were difficult to access due to staffing constraints. Staff told us that there was concern around the future plans for the emergency department and how that might affect their work.

Innovation, improvement and sustainability

- Doctors on both sites were involved in projects to aid closer working alignment, admission avoidance and improved clinical pathways. These included referring patients directly to primary care encouraging dual site working to improve communication for staff between the two departments.
- The department had a presence on the high intensity user group, a multi-disciplinary working group across partners to ensure appropriate support for high users of ED services. This enabled the trust department to better serve frequent attenders and refer them to more appropriate care pathways.
- The introduction of an emergency department Intervention Team. This team delivered rapid senior decision making at the front door of the department. Investigations were completed and initial assessments were carried out by a nurse.
- The trust had supported a business case for 4 new consultants to enhance senior medical cover seven days a week and a business case to provide additional nursing which included enhancing the Emergency Nurse Practitioner streaming service up until 2am.
- Middle grade and A&E doctors were able to undertake training in a new simulation suite.
- During our inspection we found that patients were being admitted to the Clinical Decision unit for longer than the 24-48 hours outlined in the trust policy. When senior staff were made aware of this, efforts were made to admit these patients to more appropriate ward environments; however staff within the department told us that this was an on-going problem.
- Following feedback at the inspection in relation to a number of patients on the clinical decision units in the accident and emergency departments who had an extended length of stay on the units whilst waiting for a general inpatient bed and staffing levels on CDU. The trust had reviewed the use and developed a standard

operating procedure for the use of the units which identified the three categories of patients cared for on CDU these included patients on the CDU pathway, patients awaiting cross site transfer and patients awaiting a speciality bed.

- An escalation process had been developed and implemented for those patients not on the CDU pathway which identified key trigger points after admission for example eight hours post admission if the patient was still on CDU this would be escalated to the on-call director.
- The trust has implemented a core staffing team on the unit at CRH which included a band 6 who would provide clinical leadership.

Medical care (including older people's care)

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

Information about the service

The Calderdale and Huddersfield NHS Foundation Trust ("the trust") provided care to the residents of Kirklees and Calderdale in West Yorkshire. The trust had two main hospital sites, Calderdale Royal Hospital ("CRH") and Huddersfield Royal Infirmary ("HRI"). The trust secured foundation status in 2006.

The medical division incorporating the acute medical directorate, the integrated medical specialities directorate and the emergency department directorate provided in the region of 400 in-patient beds and reported in excess of 42,000 admissions from September 2014 – August 2015 across the range of services offered, namely respiratory, cardiology, stroke medicine, endocrinology, general medicine, gastroenterology, hepatology, haematology, oncology and older people's medicine.

CRH opened its doors to patients in April 2001. With just over half the directorate beds across its specialist medical in-patient wards, CRH situated in the suburbs of Halifax accounted for 24,200 of these admissions. The CRH offered broadly the same in-patient care services as HRI, namely, general and specialist medical services in respiratory medicine, cardiology, stroke care, rehabilitation, oncology and older person's medicine. The location provided ambulatory care services, a medical day case unit and a chemotherapy day unit.

The division strategy aligned with the trust vision and five year strategy "together we will deliver outstanding compassionate care to the communities we serve." By putting the patient first, the service aimed to transform and improve patient care, to keep its locations safe, to develop a workforce for the future and to ensure financial stability.

During our inspection, we spent time at CRH visiting wards, the medical assessment unit, ambulatory care, the chemotherapy day unit and the endoscopy suite. We spoke with 51 members of staff (including managers, doctors, nurses, therapists, pharmacists and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information) and completed some 20 reviews. Our team met with 19 patients and relatives, observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times and care being delivered at various time of the day and night.

Medical care (including older people's care)

Summary of findings

We rated medical care (including older people's care) as good overall because:

- Staff understood their responsibilities to raise concerns and report incidents. Senior staff managed staffing shortfalls proactively.
- Staff delivered evidence based care and overall patient outcomes recorded in local and national audit were good. There was evidence of collaborative and effective multi-disciplinary team working.
- Staff cared for their patients with a real understanding on the importance of involving patients and their family members in care delivery. Patients had individual care plans and felt safe. Staff considered physical, emotional and social aspects of wellbeing. Patients were positive about the care received and would recommend the service as a place to receive care.
- The division was responding to the internal and external demands placed upon it. The division reported very good 18-week national indicator results. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.
- Managers led the division well with consistency across both sites. There was an open and honest culture. Governance arrangements were set up to effectively identify, manage and plan service improvements, efficiencies and to implement actions to mitigate risks affecting upon service provision.
- The division had a real strength in their ward teams with everyone focussed to deliver patient care.

However:

- We found the divisional management of patient safety incidents to require improvement, in particular, around incident grading and investigation. The division were consistently below national target for harm free care.
- Medicines management needed to improve at ward level to ensure refrigerated medications remain stable and those past their expiry date are disposed of in a timely manner and in accordance with local policy.
- The completion of risk assessment documentation required improvement and the division needed to ensure all staff completed mandatory training in accordance with trust policy.
- There were noted delays in transferring patient care into non-hospital settings compounded by limited integration with Local authority services in the Calderdale area. The division had bed occupancy pressures leading to a number of patients moving after 10pm at night. The division had reported mixed sex breaches.
- While staff were passionate about working in the division, a number felt as though there could be better communication from senior management and more attention to their well-being.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- There was confusion surrounding incident grading and levels of harm. Incident investigation was slow and there was a backlog of incidents. There was a significant number of pressure ulcers reported as serious incidents and the division recorded an increasing number of falls. A number of Duty of Candour letters were actioned outside the trust's required timescale. Learning from incidents was variable across the division.
- Registered nurse fill rates for day shifts were low.
- The division was consistently below target for harm free care evidenced by safety thermometer data and reinforced by the number of serious incidents (SIs) reported across the division related to category 3 and 4 pressure ulcers (PUs).
- Medicines management required improvement at ward level, in particular, surrounding the storage and monitoring of medications requiring refrigeration.
- The quality of record keeping was variable and a number of reviewed notes identified risk assessments and medical clerking to be partially complete.
- Mandatory training levels across the division were low particularly in safeguarding. Staff were not always given protected time to complete necessary mandatory e-learning modules during working hours.

However,

- Staff confidently reported incidents and had an awareness of the Duty of Candour regulations. There were no never events in the division.
- The division recorded safety thermometer data and displayed results on wards. The division set up collaborative working groups to look at safety thermometer data, in particular around falls incidence.
- We observed good infection prevention and control practices underpinned by reasonable local audit compliance results.
- Overall, patients had individual care plans and relevant risk assessments attached.
- Staff had an awareness of safeguarding procedures and were conversant with the correct procedure to follow if they had concerns.
- There was good use of the National Early Warning Score (NEWS) to identify a deteriorating patient and for care escalation. This was further supported by use of 'Nervecentre' technology where senior nursing staff and clinicians could remotely view patient observations.
- The division used an acuity tool to monitor patient need and staffing levels.
- Senior staff managed staffing shortfalls well by utilising existing staff, moving from better-staffed areas and accessing bank and agency workers.

Incidents

- The division reported incidents through the trust electronic reporting system.
- The trust categorised incidents according to severity of harm in accordance with their Incident Reporting, Management and Investigation Policy (Incorporating the Serious Incident Process) ratified in December 2015.
- Such reported incidents were graded as green (no harm/near miss), yellow (low/minimal harm), orange (moderate/short term harm) and red (severe/ permanent long term harm or death).
- Patient safety team reviewed submitted incidents and grading of harm. The division acknowledged slow progression in the investigations of red and orange graded incidents and responded to this backlog by setting up an incident improvement group and holding weekly orange validation meetings. All orange and red validated incidents were also reviewed by a divisional panel and the patient safety and quality board (PSQB).
- Between October 2014 to November 2015, the division overall reported 4,297 incidents, of which 1,709 (40%) originated from CRH wards. 44 (3%) were red, 31 (2%) orange, 584 (34%) yellow and 1,050 (62%) green.

Medical care (including older people's care)

- The most common incident type within the red category related to grade 3 and 4 pressure ulcers (PUs) and in the orange category related to falls with fractures and clostridium difficile infections ("C. difficile").
- We reviewed six incident investigation reports/root cause analysis (RCA) documents. We found the investigation reports to contain relevant history, detail surrounding the scope and level of investigation, timeline, findings and areas of good practice/concern. Actions were identified and plans were on-going at the time of our inspection.
- In accordance with the Serious Incident Framework 2015, the medical division reported 120 serious incidents (SIs) which met the reporting criteria set by NHS England during August 2014 and July 2015. Of these, 113 (94%) were pressure ulcers meeting the serious incident criteria. The numbers reported broadly correlated with those recorded on the trust electronic reporting system.
- Staff confidently reported incidents however were less so in grading the incident. Staff provided examples of incidents that they would report. This included any incidences of falls, pressure ulcers, near misses and medication errors.
- There were no never events in the service between August 2014 and July 2015.
- Staff we spoke with explained they received feedback on incident outcomes by e-mail and at safety huddles.
- Staff reported all PUs irrespective of grade or classification. All category three and four PUs were graded 'red'. The tissue viability nurses (TVNs) responded to the incidents within 24 hours.
- Staff we spoke to knew of the Duty of Candour requirements and of the trust policy. Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- We were able to review a set of records that detailed the cross-divisional working involved in a duty of candour incident. We observed the response to be prompt, proportionate, an appropriate apology given and an investigation had commenced.
- The PSQB Governance Report in February 2016 confirmed 100% of SIs within the division complied with the Duty of Candour requirements however; a review of orange incidents between October and December 2015 identified five incidents where the Duty of Candour letter was issued outside the trust's 10-day timescale.
- The division specialisms shared learning from incidents and when things went wrong. This reflective learning mainly took place during handovers and at safety huddles. Some wards informed us they were becoming more reliant upon e-mail to cascade information. Heads of Units, Ward Managers and Matrons also discussed incidents at their regular meetings and safety huddles. The division contributed to the trust monthly patient safety newsletter, which detailed key learning themes and patient safety topics.
- Each specialism within the directorate held regular mortality and morbidity (M&M) meetings. Staff discussed individual cases identifying any issues or actions taken. Feedback from these meetings was cascaded to ward staff and relevant others during safety huddles and via direct contact with those concerned.

Safety thermometer

- From April 2015 to December 2015, the division was consistently below target of 95% for harm free care. The division averaged 89% between October and December 2015, with a year to date average of 91%
- Between September 2014 and September 2015, the division reported 52 pressure ulcers, 60 falls and 38 CUTIs (urine infections in patients with a catheter) in the service. There were no clear trends in the data over this period to show sustained worsening or improvement in this performance.
- From November 2015 to January 2016, staff reported 299 PUs across the division. 258 were non-trust acquired and 41 trust acquired.
- Staff reported 25 category 2 PUs, six category 3 PUs and one category 4 PU from the CRH medical wards.
- The division reported PU risk assessment within six hours of admission compliance to be 100% from August – December 2015 and 97% in January 2016. Of 20 records reviewed on the medical wards at CRH, staff completed 16 pressure ulcer risk assessments within six hours of admission equating to 80% compliance. Two of the charts identified the patient to be at high-risk of developing PUs however no SSKIN bundle (identifies recognised factors and interventions to reduce pressure ulcers – surface, skin inspection, keep moving, incontinence/moisture and nutrition) had been

completed. There were two other charts where the SSKIN bundle was only been partly completed and a number of four hourly reviews were not documented. Overall divisional compliance with SSKIN bundle completion ranged from 85% - 96% from August 2015 to January 2016.

Cleanliness, infection control and hygiene

- The trust had a healthcare associated infection (HCAI) Prevention and Control Strategy underpinned by national guidelines and IPC policies to manage and monitor infection essential for patient and staff safety.
- All wards we visited were visibly clean and tidy.
- Therapy rooms that we visited had cleaning rotas and all the equipment was visibly clean. All sluices we visited were visibly clean and tidy. We observed clinical waste been disposed of appropriately. Commodes had green stickers placed on them to indicate the time and date they had been cleaned. Staff told us the correct procedure for cleaning the commodes.
- The commode cleanliness audit completed at CRH showed consistent findings from September to December 2015 averaging 87% compliance.
- Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. difficile).
- In December 2015, year to date figures showed the division had reported two cases of MRSA bacteraemia (trust total of three against a threshold of zero) and 14 of the trust 17 C. difficile cases (against threshold of 18). The division identified four of the C. difficile cases were avoidable.
- The division reported 99.8% hand hygiene compliance and 99% MRSA screening compliance.
- The wards we visited displayed posters at the entrance asking visitors not to visit the ward if they had been unwell. This was in order to reduce the spread of infection.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. Staff used PPE appropriately.
- We observed patients requiring isolation nursing cared for in side rooms. Staff displayed appropriate signage advising staff and visitors not to enter without appropriate protective clothing. We observed staff using appropriate protection when entering the room and disposing of the same appropriately when they left.
- Hand sanitizing gel was available on the entrance to all the wards we visited. The wards displayed clear instructions and signage to encourage visitors to wash their hands on entering the ward. We observed some visitors attending wards without sanitizing their hands.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "Bare Below the Elbow" protocol. The division was part of the trust annual hand wash roadshow 2015. The purpose of the audit was to reinforce good infection control practice, to remind of the importance of hand washing and to reinforce hospital policy. 391 staff from CRH took part and compliance overall was 81%, remaining the same as 2014. The division followed up the annual audit with monthly ward checks. In 2015, all medical wards at CRH achieved 100% compliance with the exception of ward 7B/C who failed to meet the target in four months, ward 5C failed in two months and wards 2A/B and 2C/D (including medical assessment unit) failed in one month.
- Staff used clinical waste and sharps disposal appropriately on the wards we visited.
- The trust provided us with sight of results from their annual Aseptic Non-Touch Technique (ANTT) Audit Report published in 2015. The medical division wards were included. The auditors observed staff practising aseptic technique and measured ANTT compliance of various invasive procedures. The audit showed sustained level of ANTT compliance but no improvement to the previous 12 months with an overall rating of 78%. Auditors found junior medical staff to be the most non-compliant in procedures observed with cannulation, IV drug administration and venepuncture highlighted. The audit recommended a review of the ANTT strategy and mandatory training sessions for all junior medical staff.
- During April to October 2015, the Infection Prevention Quality Improvement auditors completed checks on a number of medical wards. Members of infection control, cleaning services, estates, senior nursing and service performance comprised the audit team. Auditors assessed the wards against key infection prevention criteria such as environmental cleanliness, use of PPE, waste management and isolation procedures. Auditors benchmarked compliance against a target of 90% and rated wards according to risk, green achieved standard (over 90%), amber (between 80-90%) and red (below 80%). No wards fell into the red category. CCU and ward

5A/D were rated green. All remaining wards were rated 'amber' with scores ranging from 78% to 90%. Auditors found a variance in key audit indicators across the wards however there were no common themes arising.
- The trust completed a side room isolation audit in September 2015. Auditors considered 54 side rooms in use on the medical wards at CRH. Staff used side rooms appropriately, all wards used correct isolation signage and 77% complied with door closure procedure.
- IPC training was mandatory within the trust and staff accessed IPC staff for advice and guidance when required. 77% of staff in the medical division had completed this training so far this year.
- Staff carried out equipment cleaning on site in the endoscopy suite and disinfection facilities were good.

Environment and equipment

- The hospital opened in 2001 and facilities were modern. Wards made optimal use of space to deliver patient care.
- Patient led assessments of the care environment (PLACE) see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. Auditors inspected the division in April 2015. Overall, the PLACE inspectors found ward areas to be clean, staff compliant with BBE procedure and an improvement in food quality from 2014.
- Cleaning and housekeeping staff informed us that the matrons had very high standards and were always doing 'spot-checks'.
- Senior nurses completed weekly 'back to the floor' walkabouts, which afforded the opportunity to look at ward equipment and fittings, identify ward issues or staff concerns. Staff stated these visits had brought about a number of quick fixes and identified themed issues on medical wards such as stock management and storage issues.
- We checked the resuscitation trollies on all the wards we visited and these contained correct stock. To assist staff, the trust produced a visual checklist of the content. Staff checked the electrical equipment daily (defibrillator and portable suction/oxygen) and after use. Staff completed weekly content checks and fuller monthly check of all stock including emergency drug expiry dates. We saw each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly.
- Staff told us the medical devices department coordinated the monitoring of equipment and calibration checks where necessary. All equipment we checked had safety-testing stickers in date.
- Endoscopy equipment was up-to-date and in good condition.
- Staff provided patients at risk of developing pressure sores with appropriate pressure relieving support surfaces such as mattresses and cushions.
- For those patients who were admitted into hospital with pressure sores or developed skin damaged whilst in hospital, access to higher specification mattresses were available through TVN or equipment stores.
- The TVN team purchased additional pressure relieving equipment to support patient comfort and skin integrity such as the 'Repose Wedge' (air filled wedged used as a pillow, for foot support or to aid positioning) and the team were trialling new air mattresses.

Medicines

- The management of medicines required improvement.
- Four out of five wards where in-depth medicines reviews were completed did not have a safe system to monitor the storage of medicines requiring refrigeration. Staff did not seek advice from pharmacy when the recorded temperatures were outside of the indicated safe range.
- We checked the storage of medications on the wards we visited. We found that medications overall were stored securely in appropriately locked cupboards and trollies. On ward 5 A/D, we observed the medicines fridge lock to be broken. Staff immediately had this repaired whilst we were present on the ward.
- We checked the storage of controlled drugs. Staff stored and locked away controlled drugs appropriately and recorded dispensing in a controlled drugs book. On one of the wards visited we identified that a controlled drug date expired but this had continued to be administered on a further five occasions over three days before a replacement supply was obtained. We also observed an anaphylaxis shock pack expired in May 2015. Staff immediately replaced this.
- Staff wore a disposable 'do not disturb' tabard identifying themselves as completing the medication round to ensure patients received their medications in a timely and safe manner,.
- We saw that people received their medicines as prescribed and that reviews of their medicines were taking place. People were able to look after their own

medicines and these were stored in a patient's own medication (POD) locker. We found record keeping for patient's managing their own medications to be variable. Additionally, on checking one POD we found a previous patient's medication still present.
- Staff maintained clear records for the electronic prescribing of chemotherapy. The chemotherapy unit had separate fridges for chemotherapy and non-chemotherapy medicines.
- Staff coordinated and managed discharge medications well. We found some delays in obtaining the take home medications when patients were discharged via the discharge lounge however there was a process to track progress.
- We reviewed 22 prescription charts. Medical and nursing staff completed the charts legibly with the names of the prescribed medication clearly written along with accompanying start and end dates where appropriate. We observed six charts where staff omitted medication however; staff had not specified the reason for the omission. All prescription charts had patient allergies recorded. Overall, staff reviewed antibiotic prescribing in accordance with guidelines.
- In October 2015, auditors recorded the number of missed medication doses for each ward. This ranged from 0% on MAU to 14% on ward 5C. The medical division overall reported 34 medication errors in total (year to February 2016) against 77 reported by the trust overall.

Records

- Wards stored patient records in secure portable cabinets located outside bays at staff base areas.
- We reviewed 20 sets of medical records. Overall, the records were up-to-date however, it was not always clear, due to illegible written entries, who the name/grade of the clinician/nurse/other healthcare professional was that made the note. Senior medical staff documented daily reviews along with a clear diagnosis and treatment plan. Staff recorded discussions following MDT meetings detailing on-going treatment, input from therapies, discharge plans and dialogue with family. This was particularly well noted on ward 5 A/D, complex care unit.
- We found nursing records overall to be up-to-date with evidence of regular care review. We found appropriate risk assessments within care plans. All nursing notes included a core care plan identifying care needs however these were not always individualised to identify specific patient care needs and full completion of risk assessments was variable.
- Nine sets of records (45% of those reviewed) were deficient to varying extents. Our review highlighted one particular theme, namely partially completed documentation. Medical clerking and in particular, falls risk assessments were completed erratically. This correlated with divisional audit results in January 2016, which highlighted 86% of patients 'at-risk' of falls had care plans completed and 74% had the falls prevention bundle present within the records.
- The division were completing a retrospective audit of the medical clerking proforma with a view to improve record keeping.
- Staff caring for patients on the respiratory unit used speciality specific care bundles for patients with chronic obstructive respiratory disease (COPD) and non-invasive ventilation (NIV) in accordance with best practice and British Thoracic Society (BTS) guidelines.

Safeguarding

- The trust had a Head of safeguarding supported by a specialist team with responsibility for children.
- All staff we spoke with knew how to raise safeguarding concerns through the correct channels.
- At the time of our inspection, data provided by the trust showed that staff in the medical division had achieved 67.1% compliance overall with safeguarding adults/children mandatory training. Staff completing safeguard level 2 and 3 training recorded between 45% and 74%, and 31% and 46% for nursing and medical staff respectively. The service was potentially not updating staff on current safeguarding themes.

Mandatory training

- Mandatory training modules included a range of topics, such as moving and handling, infection prevention and control, safeguarding, and dementia awareness.
- The division provided us with sight of mandatory training figures across CRH medical wards. Figures varied considerably from ward to ward and on topic to topic. Based on February 2016 figures, ward 2A/B recorded PREVENT (covering topics around vulnerable adults at risk of radicalisation, terrorism and criminal activity) training compliance as 10% with fire safety awareness at 90%.

- Overall, division compliance was low ranging from an average of 42% compliance on PREVENT training (compared to 55% across trust) to with moving and handling and IPC training at around 80% (compared to around 85% across trust).
- Ward managers also showed us mandatory training figures for their respective wards, which showed a degree of variance from divisional figures. Generally, ward based capture of mandatory training was higher than reported.
- Ward managers kept an internal ward level list of key mandatory training dates.
- Staff that we spoke with understood they were up to date with mandatory training requirements in the current year. Staff accessed some mandatory training modules via the trust electronic learning system. This allowed staff to monitor training due dates when they logged onto the system.
- Staff explained they completed the majority of their mandatory training around daily work commitments and that they did not always receive protected time to complete training.

Assessing and responding to patient risk

- The division recorded falls prevalence on the risk register. Staff reported falls prevalence in accordance with the National Audit of Inpatient Falls 2015. This showed that the number of falls per 1000 patient occupied bed days (OBDs) was higher than national average (8.42 against 6.63) and regionally the trust rated 10 out of 13 trusts. The trust reported falls with moderate or severe harm to be 0.09 per 1000 OBDs, lower than the national average of 0.19 and regionally rated 3 out of 13 trusts.
- We noted there was a steady increase in falls per 1000 OBDs from 4.99 in 2012/13 however falls with harm remained relatively static from 0.10 in 2012/13.
- In January 2016, the falls collaborative group completed a thematic review on performance and learning from experiences. The medicine collaborative identified wards with higher falls incidence, namely wards 6D and 7AD. The falls group prioritised additional resource to these areas by way of increased equipment investment, falls beds, falls mats and footwear assessments.
- Locally, the collaborative tasked ward managers to ensure compliance with falls bundle, e-learning, the development of falls prevention leaflets and monitoring the effectiveness of the safety huddles.
- The falls collaborative were currently reviewing the falls prevention strategy and had secured funds to appoint a falls prevention specialist. The falls collaborative had extended the reach of experts to progress the group, which now includes a consultant physician, clinical educators and therapy services.
- The division were involved in the trust objective to reduce falls resulting in patient harm by 10% in the coming year.
- In January 2016, the pressure sore collaborative group completed a thematic review on performance and learning from experience in response to the increasing incidence of trust acquired PUs. The review concluded with a thorough and detailed action plan, which was in the process of being implemented at the time of our inspection. This included a training survey, the development of PU competencies, a targeted project to tackle ward areas with higher incidence and consideration for the development of a new PU screening and risk assessment tool (PURPOSE T).
- The TVN team also completed a comprehensive educational project with nursing homes in the Calderdale area with the aim to reduce the incidence of community acquired PUs leading to hospitalisation.
- The TVN team reviewed 98% of patients referred to them within 24 hours and 100% of patients were seen within 48 hours.
- All the staff we spoke with knew how to identify and respond if a patient was deteriorating. Staff told us they used the National Early Warning Score (NEWS) along with professional judgement as a trigger to escalate concerns. Additionally, the trust used 'Nervecentre', a handheld electronic based software package to record patient observations. The software would alert staff and clinicians if a patient's observations were outside specified parameters allowing for prompt review.
- Staff accessed the 'Nervecentre' from any location on the trust-site and out of hours therefore could see changes in patient condition if not immediately by the bedside.
- To assist the on-call team at the weekend, consultant led directorate ward rounds were completed on MAU on Friday afternoon. This meeting identified vulnerable patients and those of particular concern for monitoring and closer senior review during the weekend.

- Staff we spoke with knew how to escalate concerns out of hours. The division planned to implement a senior clinician led hospital at night service to support medical cover out of hours.
- The CRH provided level two (those requiring more intense monitoring) and level three (those requiring advanced respiratory monitoring/organ support) care on site.

Nursing staffing

- The service had used the 'Safer Nursing Care Tool' (SNCT) to measure patient dependency and determine the number of staff required to care for those patients. Senior nursing staff informed us they used their own internal professional judgment along with safe nursing indicators to reinforce SNCT findings and determine staffing numbers/skill mix required for the medical wards.
- The management team had identified nurse staffing as an issue within the medical directorate and this appeared on the services risk register. All wards visited confirmed they had vacancies.
- Staff displayed planned and actual staffing numbers on whiteboards at the entrance of the ward.
- The medical division had an overall nurse vacancy rate of 11.4% and there were widespread issues with staff shortages. Staff told us most areas tried to cover gaps with their own staff, by requesting assistance from other wards and the Matron or requested staff from the nurse bank.
- Medical division nurse management broadly followed NICE guidance and National Quality Board expectations to monitor, manage and react to ward staffing levels. All ward managers had an awareness of 'red flag' indicators to trigger escalation steps.
- The trust provided us with sight of data detailing qualified nurse and unqualified staffing vacancies across the medical division, equating to approximately 87.9 and 35.2 whole time equivalents (WTE) respectively. Vacancies across medical wards at CRH were relatively evenly spread with the greatest number of qualified vacancies being on complex care and acute stroke wards.
- Nurse staffing was further compromised by turnover rate of 84 WTE and staff sickness averaging 5.8% respectively.
- Nursing fill rate trends from December 2015 to February 2016 varied from ward to ward however consistently showed all medical wards at CRH falling short for planned daytime registered nurses with average figures in the region of 80-90%. Ward 5A/D was significantly lower averaging 70% with figures remaining static between December to February. The division average had remained consistent at around 84% overall.
- The majority of wards had significantly higher daytime unregistered nursing fill rates in excess of planned figures, in one case in excess of 200%, averaging 108.3% across the division overall in February 2016, increasing by 4% from December 2015 figures.
- Nursing fill rate trends for the night shift was considerably better with most wards meeting or exceeding planned figures for registered nurses and all wards in excess of 100% for unregistered staff at CRH. The division average for night registered and unregistered staff was 96.1% and 132.6% respectively in February 2016, increasing from 94.1% and 120.6% in December 2015.
- The trust provided us with data on the use of bank and agency nursing staff. Most wards at CRH reported the use of bank and agency staff to be in excess of 5%. Additionally, the division reported that a number of requested bank and agency shifts went unfilled.
- The division was involved in the trust incentive scheme whereby any existing staff members covering unfilled shifts were given a financial bonus and enhanced hourly rates.
- Despite nurse staffing shortfalls, we obtained consistent evidence in all wards to confirm that there was a process in place for managing staffing levels and should there be a need to escalate due to a change in patient need. All staff confirmed patients were safe and not at risk.
- British Thoracic Society Guidelines confirm patients receiving non-invasive ventilation (NIV) require 1:2 staffing in the first 24 hours. Ward 5C confirmed an average number of patients requiring NIV to be up to six at any given time. There were no patients with NIV present on the ward at the time of our inspection. Historic ward rotas showed good ratios and the ward manager confirmed compliance.
- We were able to view staff rotas from a number of wards, which confirmed actual numbers of staff on duty for given shifts. We were able to view historic rotas showing where additional staff had been requested to compliment shortfalls where need demanded.

- The service was actively recruiting nursing staff and had filled a number of vacancies with nursing staff from outside the UK.
- The nursing handover at shift change was a two staged process and very thorough. Firstly, there was an office-based discussion of each individual patient using the 'Nervecentre' technology, which contained all relevant patient history and current care needs including safety risks. There followed a specific team bedside handover with the patient and their relatives.
- Staff moved patients to specialist wards following initial assessment on MAU. Staff handed over relevant patient information to the receiving ward prior to the transfer.

Medical staffing

- The medical staffing skill mix showed the trust had a higher proportion of consultants and a lower proportion of registrar grades than the national average. Consultant staff made up 37% (national average 34%), middle career doctors (with at least 3 years in a chosen specialty) were 6%, registrars were 35% (national average 39%) and junior doctors were 23%.
- On-call medical staffing rotas varied across the division. There were three rotas covering unplanned services (general medicine, cardiology and stroke) with consultant cover available 24/7. Consultants were on-site until 8pm and often later as required thereafter on-call. Overall, division consultants were covering the rota from 1:5 to 1:11 (for medical admissions unit) to 1:22 (weekend support for all medical wards).
- In planned services (dermatology, rheumatology, neurology, consultants were present until 5pm and often later if the need arose. Leeds provided neurology out of hours (OOH) cover. Oncology and haematology had consultant presence during the weekend. Another trust provided telephone advice for neurology OOHs cover.
- There was 24/7 registrar cover for all directorates within the medical division. Junior doctors (foundation year 1/2, core trainees and staff grade) covered MAU and the wards respectively.
- The trust performed within expectations for all questions on the 2015 General Medical Council (GMC) National Training Survey.
- The clinical directors confirmed some recent senior clinician departures had a bearing on current specialist rota planning and frequency of on-call duties. During the winter months, the division opened extra beds and staffed accordingly. Managers ensured extra consultants were available out-of-hours and at weekends.
- Across the division, the trust reported a 4.6% vacancy rate for medical posts, a 2.3% turnover rate and a 1.1% sickness rate.
- The trust provided us with data on the use of medical locum staff in 2015. There was an increased use of locum staff during winter months and on opening additional contingency beds. Average monthly usage varied from 1.0% to 10.4%.
- Medical handovers at shift changes was comprehensive with detailed and relevant information shared. Medical handovers ran succinctly and timely prior to post-take ward rounds. Although invited to attend, senior nurses did so intermittently due to pressures and workload on their respective wards.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Some staff we spoke with were not clear on their specific role in the event of a major incident but were aware on how to access the major incident policy for guidance via the trust intranet.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.
- The trust was using this data to drive down PU incidence and was targeting a 10% reduction for hospital-acquired category 2-4 PUs in the coming year.
- Between October and December 2015, the medical division reported 422 falls (75% of the overall total reported by all divisions within the trust in the same period). Of those reported, only three (0.7%) were identified as falls with harm.
- Venous-thromboembolism (VTE) Risk Assessment Audit results produced by the division from August 2015 – January 2016 showed increasing compliance from 95% to 97%. On the medical wards at CRH, compliance varied each month. Every ward recorded compliance of

less than 90% on at least one occasion. Ward 6B/C failed to achieve compliance in excess of 83% in every month of the period audited and coronary care (CCU) ranged from 59% to 92% compliance.

- Of 20 records reviewed, we noted staff completed 19 VTE risk assessments within the first 24 hours of admission. This would accord with compliance of 95% in line with trust improving audit results. We also observed in all patients who required VTE treatment, staff prescribed the relevant prophylaxis.
- The division reported variable compliance with the use of the falls prevention bundle and the completion of the care plan for those patients assessed to be at risk of falling. In August 2015, the division recorded compliance at 47% improving to 74% in January 2016. Care plan completion for the same period went from 88% to 86% respectively. Of 20 records reviewed, 16 patients had a multifactorial falls risk assessment on admission (equating to 80%) and included in their care plan where appropriate. Falls prevention bundle compliance was mixed at CRH, in particular, wards 2A/B, 2C/D and 6B/C showed variance from 50% to 100% in the monthly audits across the period.
- The trust had developed a collaborative strategy for the prevention of slips, trips and falls. The medicine falls collaborative was currently reviewing the falls prevention bundle following first national inpatient falls recommendations. The group were undertaking a falls mapping exercise to further analyse high incidence areas and implement measures to aid prevention.
- The division supported the trust's agenda to ensure effective prevention and control of healthcare associated infections (HCAI) including CUTI's. In the 2015 urinary catheter audit, the infection prevention and control team (IPC) reviewed 64 patients in the division who had indwelling catheters. IPC measured 15 standards against national guidelines and best practice. IPC noted 100% in four standards (storage, closed sterile system and correct procedure for obtaining specimens). The audit highlighted poor compliance around the documentation of insertion details, on-going need and daily review of catheter care. The IPC recommended adherence to trust urinary catheter policy, the use of the catheter care plan and daily review.
- We found current safety thermometer information displayed clearly and consistently in an accessible and readable format on large whiteboards situated at the entrance of all wards.

Are medical care services effective?

Good

We rated effective as good because:

- The service was actively involved in local, national and international audit activity and followed recognised guidance which provided a strong evidence base for care and treatment.
- There were good patient outcomes from the heart failure, diabetes, myocardial infarction and lung cancer audits.
- Patients were comfortable on the wards and food standards were good.
- Staff had access to a number of internal and external learning opportunities and ward based learning opportunities were good.
- We found very good multi-disciplinary working (MDT) working across the division. Medical and nursing handovers were good. The service had strong senior physician and nursing staff presence out-of-hours and at weekends. The division developed a very effective seven-day ambulatory care service and were progressing the hospital at night function.
- Staff had an awareness of consent and capacity issues relating to Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- Patient outcomes from the stroke audit were poor and below trust target in terms of scanning and time to thrombolysis. Staff from the division had attended another trust to observe different practice and were developing a new door to needle process.
- Appraisal rates across the division were unreliable with divisional data differing from ward level records. Overall, appraisal rates were low.
- Staff highlighted differences in MDT working where patients required community input from colleagues at Calderdale community services which they indicated was due to a lack of long term placement and transitional beds.

- Despite many wards developing their own specialism specific competencies there was a variable robustness to the assessment of staff competence.

Evidence-based care and treatment

- Staff referred to a number National Institute for Health and Care Excellence (NICE) Guidelines/Quality Standards, Royal College, Society and best practice guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site reflected up-to-date clinical guidelines.
- We reviewed a number of clinical guidelines on the intranet and all were current, identified author/owner and had review dates.
- The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The directorate compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and on-going evidence-based reviews.
- In accordance with NICE Quality Standards, the division was involved in data collection activity for numerous national audits such as heart failure, diabetes, acute coronary syndromes, falls and fragility fracture audit programme (including hip fractures) and gastrointestinal bleeding.
- The division had developed a number of evidence based condition specific care pathways to standardise and improve patient care and service flow across the division. In ambulatory care, there were pathways for low risk pulmonary embolism, anaemia, headaches, low risk upper gastrointestinal (GI) haemorrhage and high INR treatment.
- The division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. For example, staff in diabetes medicine reviewed current systems around staff education and care for younger persons with type 1 and type 2 diabetes. In respiratory and cardiology, action plans were in place to engage with patients to develop services further across the full care pathway. There were also action plans for stroke care and falls prevention.
- Senior staff recorded and monitored a number of local quality measures such as IPC and patient meals against recognised standards and best practice guidelines.

Pain relief

- Patients received pain relief as prescribed and where appropriate on an as required basis.
- On the coronary care unit (CCU), patients described having their pain managed "efficiently and promptly".
- Patients confirmed that staff recognised when they were uncomfortable and were proactive in enquiring if pain relief was required.
- Staff provided pain relief in a timely and efficient manner when required.
- The CQC National Survey of In-Patients 2015 recorded a score of 7.9 out of 10 under the care and treatment category, which was similar to other trusts. Specifically, the trust scored 8.5 out of 10 for pain management, which was similar to other trusts.

Nutrition and hydration

- Of 20 records reviewed, we observed one patient did not have a malnutrition universal screening tool (MUST) risk assessment (equating to 95% compliance). Staff implemented care plans for those patients who required support and assistance with eating and drinking.
- Staff told us that they could access support from the speech and language therapy service (SALT).
- In August 2015, the division was involved in the trust wide MUST screening audit. This multifactorial audit addressed a number of variables involved in nutritional assessment such as BMI measurements, unplanned weight loss, the use of fluid balance/food charts and care-plans. Overall, the auditors found 98% of patients had a MUST risk assessment and care plan. Auditors found relevant documentation was not always completed in full and in accordance with trust documentation standards. The auditors presented the findings at the ward sister's meeting in October 2015. Auditors noted improved documentation compliance across all medical wards in November and December 2015.

Patient outcomes

- The stroke service at CRH performed poorly in the Sentinel Stroke National Audit Programme (SSNAP) with a level D (where A is the best and E is the worst) rating during July to September 2015. This had improved however from earlier 2015 results.

- From October – December 2015, the division achieved 80% compliance with stroke patients who spent 90% of their stay on a stroke unit.
- The division achieved 67% compliance against scanning within an hour of arrival against a target of 90%.
- 50% of stroke patients were thrombolysed within an hour slightly lower than the trust target of 55%.
- Members of the stroke team visited a stroke unit of a neighbouring trust who scored an 'A' rating in the SSNAP audit aiming to learn how to minimise time delays in the management of stroke patients, in particular those needing thrombolysis. Following this, the division has developed a new door to needle (DTN) process in conjunction with the local ambulance service, accident and emergency (A&E) and radiology.
- To improve patient outcomes for stroke patients, the division had coordinated a pre-call alert with the local ambulance service to inform stroke clinicians in advance of a patient was being brought into the hospital. This allowed the stoke clinician to be present when the patient arrived into A&E to progress the care pathway through prompt imaging and treatment.
- CRH performed well in the 2013/14 Heart Failure Audit. It scored better than or similar to the England average in eight of the 11 areas considered.
- CRH performed better than the England average in the Myocardial Ischaemia National Audit Project 2013-14 (MINAP) for patients seen by a cardiologist and those referred for angiogram. The division admitted only 42.5% of patients to a cardiac unit compared with a national average of 55.6%. CRH audit results improved compared to 2012-13 findings.
- CRH made significant improvements in seven indicators within the National Diabetes Audit 2015 compared with 2013 findings however had worsened in four. 72.5% of patients reported their satisfaction with the service compared to a national average of 84.3%. Audit shortfalls related to staff knowledge and the diabetes team had responded to this with the appointment of a diabetes nurse specialist.
- The respiratory speciality published their National British Thoracic Society (BTS) Emergency Oxygen Audit findings in January 2016. Four wards at CRH were involved. Of those patients receiving oxygen therapy, 41% had a target saturation range identified. 97.9% of patients were maintained within 2% of their target compared with national average of over 80%. 20% of patients found to be using oxygen had no prescription or bedside order.
- The division was involved in the Society for Acute Medicine Benchmarking Audit (SAMBA) 2015. This audit focussed on two areas, namely patient opinion and acute medical services available. Findings had not been published at the time of our inspection.
- The National Lung Cancer Audit (2015) showed better than national average results for multi-disciplinary team discussion (95%, national average 93%) and patients seen by a nurse specialist (84%, national average 63%).
- The CRH Endoscopy Unit had Joint Advisory Group (JAG) Accreditation recognising competence in delivery of endoscopy services against independently recognised standards.

Competent staff

- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- The division had an acute coronary syndrome nurse specialist working in the cardiology unit at CRH. The cardiology unit had developed ward based competencies in electrocardiogram (ECG) interpretation, advanced life support skills and nurse prescribing.
- Junior medical staff confirmed they had regular meetings with their educational supervisor to discuss training needs
- Staff confirmed to us learning and development opportunities came up regularly through informal and formal discussions and at appraisals. Senior staff chose members of the team to represent the division at external events.
- At the CRH focus group, matrons told us the division supported learning and innovations. Matrons told us they were actively encouraged to "go see" other areas to learn and share best practice.
- At the junior doctor focus group, doctors informed us of good local mandatory training and access to clinical skills teaching. Additionally, the doctors stated they had protected time to attend the West Yorkshire clinical skills training sessions.
- Staff identified learning and training needs during annual appraisal and 1:1 reviews. Appraisal rates in the division partway through the year, as at February 2016

were variable between wards and across different staff groups. Overall, the division averaged 59% for staff groups across the division. Staff indicated to us they were up-to-date with their appraisals. Managers completed appraisals in the staff's birth month.
- Medical and nursing staff acknowledged mentoring and clinical supervision on the wards was very good.
- Many specialist areas had developed local ward based competencies for nursing staff. Ward 5C developed ECG, NIV and medical device training competencies at ward level in accordance with best practice guidelines. We were advised however staff were 'signed off' as competent in NIV care after a half day training session and competency was not measured against a given number of supervised observations. Staff on the chemotherapy day unit had a competency framework attached to assessment and sign-off to ensure they had the necessary skills and knowledge to administer chemotherapy.
- The trust TVN's were visible in the division and provided comprehensive training packages to staff. TVNs advertised training dates on the intranet, on bulletin boards and via the pressure ulcer newsletter circulated to wards. The TVN's had set up a link nurse champion group and ran various courses such as VAC training, mattress awareness, leg ulcer management, categorisation and wound management. The TVN team also ran an annual event – STOP Pressure Ulcer Day every November.
- At the time of our inspection, 77% of staff in the division had undergone equality and diversity training to help ensure that they delivered tailored care.
- Many areas were actively involved in specialist regional networks where staff shared learning experiences, best practice and current developments.
- Ward staff completing induction checklists with agency staff and ensured they were familiar with ward protocols before delivering any patient care.

Multidisciplinary working

- We observed multidisciplinary working (MDT) throughout our visit at CRH.
- MDT involvement in the assessment, planning and delivery of patient care was apparent on all wards and we observed interactions between various different teams and services. Records reviewed showed evidence of this input from the MDT.
- MDT working in all wards was very good and involved a wide reaching cohort of healthcare professionals.
- We observed good MDT attendance at safety huddles on a number of wards.
- The MDT meeting on MAU and ward 5A/D was very well attended by nursing/medical staff, therapists, pharmacists and medical social workers. Staff discussed each individual patient, their current medical condition, where internal referrals were required, any concerns and discharge plans. The MDT had an in-depth knowledge of each individual patient, his or her family and everyone contributed.
- There were clear internal referral pathways to therapy and psychiatric services. Additionally, staff confirmed external referral to community services in Kirklees generally flowed well and community staff would often attend MDT meetings. Staff advised the process with Calderdale community services was less effective due to fewer long-term placement beds being available.
- The stroke service had strong working relationships with the local ambulance service.

Seven-day services

- The division supported the trusts commitment to 24/7 working. This was not fully integrated into the division due to current staffing pressures and resource restraints.
- The division provided a specialist thrombolysis nurse across a 24 hour, 7 day service on the acute stroke unit (ward 6D).
- Staff in ambulatory care provided seven-day week between the hours of 8am and 8pm.
- There was consultant presence out-of-hours (OOH) up to 10pm in general medicine however frequently beyond these hours.
- Daily consultant ward rounds occurred seven days a week with additional review of any patients of particular concern, as required.
- The division was progressing a hospital at night service seven days a week to assist in out of hours and weekend medical cover. The service would be led by senior clinicians who could provide additional support in clinical areas where need arose.
- Diagnostic testing and reporting was available at all times. A clinician of registrar grade or above could only request certain scanning investigations OOH that some junior doctors found delayed care progression.
- Endoscopy facilities were available OOH and the trust had a 'bleeding rota' that was covered by surgeons,

gastroenterologists and nurse endoscopists. In the majority of cases, staff transferred patients requiring urgent endoscopy procedures to HRI theatre suite for these procedures to be completed.
- The trust confirmed that both physiotherapy & occupational therapy is provided 7 days per week to all wards. Occupational therapy and speech and language therapy was available Monday to Friday.

Access to information

- Staff we spoke with raised no concerns about being able to access patient information in a timely manner.
- Medical staff informed us they received investigation results in a timely manner.
- Staff informed us discharge-planning considerations commenced on admission with input from the discharge coordinators.
- Staff informed GPs of discharge in writing by way of a discharge summary, which tended to follow the patient on the day of discharge. The division were moving to full electronic patient records and this would provide more efficient communications with stakeholders.
- Staff identified what community services or on-going care needs would be required for the patient on discharge. Staff involved the patient, his or her family and the service providers in discharge planning.
- If GPs have any queries or concerns regarding on-going patient care needs on discharge they would call into the service where they would be able to speak to a relevant member of staff. Staff informed us that this would not always be the consultant and was subject to the query raised.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the Mental Capacity Act.
- Staff knowledge of the Mental Capacity Act and DoLS was variable however; all knew how to escalate concerns. Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent.
- Staff accessed the Safeguard Team if concerned about a patient. We observed the referral process and the promptness of the response.
- We found variable completion of MCA/DoLS documentation and some patients with transient symptoms suggestive of cognitive impairment did not have capacity assessments. Staff immediately took steps to review these patients.
- The division had access to trust specialist nurses who had particular expertise in dealing with vulnerable groups such as learning disabilities and those living with dementia.
- We observed nutrition and hydration recorded on fluid/food charts, which summarised periodic intake during the course of the day. Overall, the completion and accuracy of these charts was good.
- The medical division engaged with trust monitoring of nutritional standards against various national stakeholder benchmarks such as the nutritional alliance, the diabetic association, Public Health England and Department of Environment, Food and Rural Affairs (DEFRA).
- In April 2015, Healthwatch Kirklees completed a very detailed audit on patient experience of hospital food at the trust. The auditors obtained feedback from 51 in-patients at CRH, a number of which were on medical wards. 65% of patients rated the quality of food as good or very good. 93% of patients confirmed their special dietary needs were met. 86% of in-patients confirmed their meal times were uninterrupted. 96% of patients reported they had access to drinks at all times and 88% confirmed they were able to wash their hands before and after eating. Patients commented they would have liked the option of a cooked breakfast and many would have liked the meal times further apart.
- In December 2015, the patient survey received 40 comments regarding catering services. 34 of the 40 (85%) were positive with themes highlighting the food to be warm, tasty, well-presented and a good choice. The trust received six negative comments, two of which related to portion size and spicing used in some soups.
- Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.
- Staff used visual 'road-signs' alert symbols at the bed head to identify those patients who required assistance with eating and drinking.

Medical care (including older people's care)

- We received positive comments from patients regarding food quality and menu choice. There were various menu options for individual dietary requirement such as halal.
- We observed ward managers, staff nurses, health care assistants and nutritional assistants feeding patients. Where encouragement was required this was given in a supportive way and at a relaxed pace. Staff updated care plans when a patient refused to eat.
- Staff provided 'snack platters' in between meals with choices from sweet and savoury offerings.

Are medical care services caring?

Good

We rated caring as good because:

- There was a real desire from all staff to deliver compassionate care.
- Staff considered physical, emotional and social elements of wellbeing equally. Patients and family members felt included when discussing care decisions and treatment plans.
- Patients consistently provided positive feedback with examples where staff had taken extra care to ensure patients and their families were truly involved in the care.
- There was a reasonable response rate in the NHS Friends and Family Test, nearly all patients at CRH would recommend the service. The division performed well the CQC In-Patient Survey and Cancer Patient Experience Survey.
- All patients had individual care plans relevant to their particular care needs.

Compassionate care

- The CRH response rate to the NHS Friends and Family Test (FFT) was lower than national average (35% compared with 39.7% for July 2014 – June 2015).
- Between August 2014 and July 2015, all medical wards at CRH scored consistently over 90% recommendation on FFT. Staff published these findings on the ward.
- In the National Cancer Patient Experience Survey 2014, the trust were in the top 20% in 19 of the questions asked, performing particularly well in informing patients about necessary investigations, the quality of nursing care and information provided on discharge. The trust was in the lower 20% in three questions. Of the remaining questions, the trust compared with the majority of similar trusts.
- The trust performed the same as other trusts for all 12 questions on the CQC Inpatient Survey, with no responses being worse than the England average.

Understanding and involvement of patients and those close to them

- The trust performed the same as other trusts on the CQC Inpatient Survey question 'were you involved as much as you wanted to be in decisions about your care and treatment'.
- All patients had a care plan detailing current identified needs of the patient. There was evidence of communications with family members.
- Patients and relatives informed us they felt involved in care options, decision making and planned treatment. We observed staff sharing joint discussions with patients and the relatives. Staff allowed a relative on ward 2 C/D to continue caring for her husband, as she was at home, whilst he was in hospital. She felt fully involved in care decisions surrounding a care package put in place to support them both.
- On the CRH Macmillan Unit, patients and relatives stated they were fully aware of the reasons for treatment, the side effects and the aims of the medication cycles.
- On cardiology wards, family members told us how they were involved in planning for care on discharge. In particular, they appreciated the opportunity to get involved in supporting lifestyle changes to aid in rehabilitation.
- A patient on ward 6D informed us that the therapists involved in his care had put together a joint exercise package in which his wife could also engage to support her health needs.
- Staff informed us patients could manage their own medications if deemed safe to do so.

Emotional support

- Staff explained to us, when caring for a patient they take into account all aspects of their particular needs from physical deficit to emotional and social elements that may affect their holistic well-being.

Medical care (including older people's care)

- Staff empathised with patients who were frightened and concerned about their health and being hospitalised. We observed genuine warm and caring interactions.
- On ward 2 C/D, staff met a patient request to have his family be present for support at the MDT ward round when told the findings of his investigations. He added, the doctors explained findings in a way that he could understand and gave him time to come to terms with the prognosis.
- Patients and relatives on the CRH Macmillan Unit felt fully supported and cared for on the unit "from the cleaner to the consultant". One relative described receiving devastating news about her father's prognosis. Staff supported her in coming to terms with the prognosis and offered counselling support.
- We observed staff spending time and offering reassurance to patients who were distressed because of their health deficit. On ward 7B/C, we observed a member of staff encourage and support a frustrated patient who insisted on feeding himself but had difficulty in doing so.
- We observed a member of staff on ward 5A/D engaging with and supporting an agitated patient with a personal task. The member of staff involved the patient with a safe low risk activity thereby removing the anxiety trigger.
- We observed staff at all levels recognising patients who required emotional support. We observed cleaning and housekeeping staff take time to spend with patients who wanted to talk.
- Staff informed us patients received emotional support from a variety of sources and the chaplaincy service was available at all times for patients and carers.
- Patients informed us staff tried their best to make the hospital environment as normal as possible and we observed a number of patients had personal belongings with them.
- Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.
- Staff recommended the trust to be a place to receive care and treatment in line with NHS staff survey findings.
- We observed nursing, medical, therapy and non-clinical staff interacting with patients in a genuine caring manner. This included addressing patients by name, actively listening, recognising each individual, and coming to the patient's level when they were in beds and chairs.
- Of the 19 patients and relatives we spoke to, the consensus was care received was good.
- Patients and relatives on ward 2 C/D commented care was "excellent".
- A patient on ward 7B/C stated that during his time on the ward he had got to know the whole team caring for him personally. He praised the therapists for their patience and the nurses for "all they do".
- Patients described feeling safe and that they could always get a member of staff when needed. We observed patients using their buzzers and staff responded to these quickly.
- Patients explained to us that staff maintained their privacy and dignity and always informed them of any care delivery or procedure in advance.
- At the listening events, we heard from a number of former patients who spent time at CRH and all comments received were positive.
- The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside these hours to assist in individual circumstances.
- Staff enjoyed telling us of positive feedback received from patients and family members and most wards we visited displayed 'thank you' cards.

Are medical care services responsive?

Good

We rated responsive as good because:

- Overall, we found facilities and premises appropriate to meet patient needs.
- The division planned and adapted services, in conjunction with stakeholder input, to meet the needs of the local people.
- The division had excellent results against 18-week standards across all specialisms.
- The number of patients boarded out to non-medical specialism wards was relatively low.

Medical care (including older people's care)

- The division proactively responded to issues identified in discharge planning by employing a team of discharge coordinators. The delayed transfer of care integrated meeting was energetic and proactive.
- Ambulatory care services had developed to implement care pathways for specific medical conditions under strict criteria thus avoiding the need for hospitalisation and inpatient treatment.
- The division provided reasonable adjustments for vulnerable patient groups such as those living with dementia and those with additional needs due to learning disabilities.
- Staff knew the trust complaint policy and we observed relevant information for patients and relatives on the wards.

However,

- The division recorded considerably longer stays in stroke medicine compared to national average. Readmission rates in non-elective cardiology was higher than national average .
- There were a relatively high number of patient moves after 10pm and there had been three mixed sex breaches in the division in 2015.
- There remained high numbers of patients where transfer of care was delayed and this was particularly apparent at CRH. Staff indicated this was due to a lack of community facility beds.
- The division had a backlog of complaints awaiting response however had identified and addressed this by prioritising additional management resource into dealing with outstanding matters, reducing the backlog overall.

Service planning and delivery to meet the needs of local people

- Management staff attended meetings with local Clinical Commissioning Groups (CCG's) in order to feed into the local health network and identify service improvements to meet the needs of local people.
- The division had been particularly proactive in forging strong working relationships with community colleagues particularly in respiratory medicine and discharge planning across Kirklees. The division was also working with community colleagues in Calderdale to plan and deliver transitional efficiencies into non-hospital based care.
- Management staff knew of issues regarding delays in the repatriation of patients back to their local authority. Staff told us managers worked closely with local agencies, highlighting concerns to commissioners where planning and delivery of services was hindered.
- In planning services, the directorates appointed a number of specialist nurses in gastroenterology and diabetes services. The directorates also appointed clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care.
- In stroke services, the division provided specialist transient ischaemic attack (TIA) clinics.
- The medical oncology and chemotherapy service provided a 24 hour helpline for patients and their family should they need advice or support OOH.
- The stroke service accessed a telemedicine facility to allow face-to-face discussions with on-call team, specialist clinicians locally and further afield.

Access and flow

- The medicine division at CRH had approximately 24,200 admissions to its service between September 2014 and August 2015. Admissions were broken down into emergency (48%) elective (3%) and day case (49%). The majority of admissions to CRH were in general medicine and medical oncology.
- Between October 2014 and September 2015, the division were consistently better than England average and national operational standard in beginning treatment within 18 weeks. The division exceeded the standard every month and treated over 99% of patients, across all the specialisms, cardiology, general medicine, neurology, gastroenterology, thoracic medicine and rheumatology within 18 weeks.
- The average length of stay at CRH for elective admissions was lower than national average and similar to national average for non-elective admissions. At speciality level, CRH had a considerably higher length of stay for non-elective stroke medicine admissions (21.3 compared to 11.3 days).
- Overall, the relative risk of readmission at CRH was lower than national average for elective admissions however slightly higher for non-elective. The division reported higher than average readmission rates at CRH for elective clinical haematology admissions (116 against a standard of 100) and non-elective cardiology (119 against the standard of 100).

Medical care (including older people's care)

- The Internal Medicine Activity Dashboard in December 2015 confirmed ward occupancy levels consistently in excess of 90% across the division. The division highlighted specific pressures in general medicine and older person's medical wards and an increasing average length of stay across all the division in the last quarter of 2015.
- The division had 47 extra capacity beds open at the time of our inspection with a dedicated consultant allocated to care for these patients.
- During the inspection, the service had a number of medical outliers. Around 32 medical patients were being cared for on non-medical wards ("Boarders") across the two sites, 17 of which were at CRH. The division provided a specific consultant to care for all medical outliers.
- Nursing staff we spoke with on the wards where patients were out-lying told us that they observed medical staff attending the ward every day to check on patients.
- Live bed occupancy rates, admissions by ward/ consultant/site, outliers, bed vacancies and patient length of stay were monitored on an electronic 'knowledge portal' which was accessed by senior staff to assist in access and flow issues.
- The trust held a patient-flow teleconference call every two hours during the day to address access and flow issues. Divisional senior nursing staff, business managers and discharge coordinators attended to record bed occupancy and availability, discharges and pending admissions. Here staff identified actual and potential bottlenecks to patient flow for that day and prioritised actions to remove obstacles for patient admissions and discharges.
- The patient flow bundle followed a pathway of senior clinician review, all patients to have a planned discharge date, flow of patient at the safest and earliest opportunity, early time discharge and review weekly (SAFER).
- The patient flow team had started to monitor and analyse discharge lounge use in order to get a greater understanding on how this could further improve patient flow or to see if the lounge could be better utilised as a transitional ward.
- The trust held a weekly formal delayed transfer of care (DTOC) meeting. Representatives from discharge coordination, ward managers, patient flow, medical social work, community matrons, primary care coordinators and therapy services attended. The DTOC team tracked 'medically fit for discharge' patients, who had particularly complex discharge needs or who were vulnerable and coordinated an integrated MDT approach to discharge planning. The DTOC team were monitoring 135 patients, 80 were at CRH, almost double that of HRI.
- The DTOC team reviewed a cohort of their tracked patients to progress discharge planning away from hospital-based care.
- The discharge team informed us the progression of the DTOC meeting at CRH was not working as well as the same gathering at HRI. Staff suggested this was due to less well-established relationships, different social care thresholds and nursing home bed closures affecting Calderdale local authority services.
- Data from the trust relating to delayed transfer of care from April 2013 to August 2015 provided 25% of delayed transfers of care were due to the patient awaiting a care package into their own home. A further 24% of delayed transfers were due to a delay in the completion of an assessment and almost 17% due to waiting further NHS non-acute care. We observed some delays in transferring care due to intermittent and inconsistent input from family members leading to slower care progression.
- The division had employed 20 discharge co-ordinators to assist with patient discharge planning. The co-ordinators were ward based and dealt with their own cohort of patients who required assistance. The discharge co-ordinator matron was evolving the service whereby each discharge co-ordinator would have a non-ward specific caseload of patients whom the co-ordinator would follow throughout the care pathway and during transition into community care.
- Some discharge coordinators had specialist qualifications or particular expertise in dealing with vulnerable patient groups such as those living with dementia or patients receiving palliative care. The discharge coordinator matron allocated her staff to wards where their specific skill set was of greatest benefit.
- The directorate had developed a 7-day ambulatory care model. In February 2016, over 350 patients benefitted from streamed care pathways without admission at CRH. The service provided treatment for syncope, atrial fibrillation, low risk upper gastrointestinal bleeding, anaphylactic reaction, low risk chest pain and cellulitis. These pathways provided criteria to help staff identify

patients whom could be safely cared for in ambulatory care setting without hospitalisation. Additionally, the ambulatory care team liaised with the outpatient antimicrobial therapy team (OPAT) to provide intravenous antibiotics in the community for those patients on urinary tract infection or cellulitis care pathways. The team further planned to review the frailty care pathway and integrating with the discharge team to support care transition into the community.

- The respiratory team had set up a 'hot' clinic for direct GP referral where a senior respiratory physician saw patients at an earlier stage. Staff provided prompt treatment and avoided many unnecessary admissions.
- Between December 2014 and November 2015, CRH medical wards reported an average of 40% of patients did not have to move ward during their admission, 41% on one occasion, 13% on two occasions, 4% on three occasions and 2% on four or more occasions.
- From June to November 2015, there were a number of patients moved wards after 10pm. The total numbers were similar each month and in November totalled 219 at CRH with 156 (71%) recorded against the division. The patient flow team advised there were multifactorial influences for these moves such as patient changing need, late admissions from general practitioners, turnaround times for bed/room cleaning, protected meal times and A&E requests.
- There had been three mixed sex breached in the division in 2015.

Meeting people's individual needs

- The division involvement in national dementia audits had shaped the formation of the trust-wide dementia strategy by the Vulnerable Adult Strategic Group. We viewed a holistic and comprehensive plan, which aimed to ensure quality care delivery met the needs of the patient and their carer. The strategy included leadership and governance, assessment and diagnosis, working in partnership, staff competence, the right care, end of life care and environmental factors.
- Staff attached an electronic flag onto the patient administration system (PAS - electronic patient record) to identify those patients living with dementia and who may require additional support during a period of hospitalisation.
- All patients aged 65 and over received a cognitive assessment on admission as part of the medical admissions proforma. The nursing assessment tool prompted the use of the 'butterfly scheme' as part of the dementia/delirium care plan, the memory care plan and the rapid risk assessment tool. The butterfly scheme is a visual identifier to alert staff of particular care needs an individual living with dementia may have. This was used in conjunction with a bed-side magnetic symbol and a bed-side care summary identifying detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which are helpful in supporting during difficult periods. We observed this being used effectively on ward 5A/D, complex care unit.
- The division identified patients living with dementia to the matron responsible for dementia care on admission and the appropriate care pathway followed.
- We visited recently refurbished wards which had been designed 'dementia friendly' with appropriate signage to aid communication and perception, with triggers for reminiscence such as music, photographs and decorations to encourage positive interactions and to reduce environmental conflict.
- The division recently secured funding for the appointment of six engagement support workers to support those patients in hospital living with dementia.
- At the time of our inspection, 72% (CRH wards range 54% to 93%) of staff across the division had undergone training to help in treating people with dementia.
- Between October and December 2015, the division complied with dementia indicators (find, assess, investigate, refer, clinical leadership and support for carers) for CQUIN (Commissioning for Quality and Innovation – an achievement of local quality improvement goals) requirements.
- The trust used a VIP (vulnerable inpatient) alert on PAS to flag persons admitted into hospital with particular care needs because of a learning disability (LD). Local GP registers also had an alert added to ensure consistency from primary to secondary care.
- The trust had a specialist LD matron in post since 2008 who coordinated care for those with more complex needs. All VIP alerts went directly to them and all reasonable measures were considered to assist the patient through their care pathway whilst hospitalised and to support a smooth transition back into the community.
- Staff provided a 'passport' to patients with LD, which was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which are helpful in supporting during

difficult periods. The LD nurse specialist identified, in conjunction with carers and ward staff, what reasonable adjustments were required to support the patient whilst in hospital. This could be pre-visits to suites for procedures to support desensitisation, an offering of a side-room for privacy and to reduce anxiety, flexible visiting, carers staying with the patient overnight and other individual preferences unique to that individual.

- Staff informed us they had ease of access/referral into psychiatric services for those patients requiring this care, in particular when needing MCA/DoLS guidance.
- Staff informed us that where patients attended with visual or auditory deficits they discussed what specific assistance the patient required on an individual basis. There was currently no electronic alert for people with hearing or sight problems. Staff inputted free text into PAS as an alert.
- Staff informed us they have good links with ophthalmology and ENT specialists who they access when they require input with a patient. They tell us they respond quickly. Additionally, staff told us they also liaised with community visual impairment teams when the patient was fit for discharge.
- We saw a number of information leaflets produced in an 'easy to read' format. The trust offered all patient information in a variety of languages, in large print/ braille and other formats.
- All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward and general useful signposting on where to get further information such as PALS, complaints and support groups.
- Staff explained that translation services were available by telephone or by attendance in person. Staff also accessed British Sign Language (BSL) services.
- The trust had chaplains representing major faiths within their communities such as Christian, Muslim and Sikh. Staff accommodated faith preferences in the faith centre or at the bedside. The chaplain services were involved in developing trust policy to support key faith beliefs and cultural needs. The chaplaincy service audited its services in 2015 and over 80% of patients and staff rated the service 'very valuable' or 'valuable'.
- Staff we spoke with explained that they could easily access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs and chairs.

Learning from complaints and concerns

- The number of written complaints to the trust had remained relatively consistent each year from 2010. 617 were recorded in 2014/15. The division of medicine generated the greatest number of complaints within the trust accounting for over a third of all submitted. From October to December 2015, the division received 71 complaints.
- The three main categories of complaint related to clinical treatment, communications and admissions discharge and transfers. By February 2016, the division had reduced the number of on-going and outstanding complaints awaiting response to 59.
- The wards we visited displayed leaflets and posters outlining the complaints procedure.
- We saw that the trust had a complaint policy and staff were aware of it.
- Staff discussed feedback from complaints and lessons learnt at ward meetings and at safety huddles.
- The division listened to patient and carer feedback surrounding a perceived lack of therapists on the acute stroke unit and secured funding for an increase in therapy services to support rehabilitation and reduce length of stay.

Are medical care services well-led?

Good

We found well-led to be good because:

- The division had a clear strategy and vision with patients at the heart.
- Governance arrangements enabled the effective identification of risks and the service monitored these against agreed action plans. There was evidence that controls were in place to mitigate such risks.
- There was recognition of the importance of the 'team', at all levels, when it came to delivering patient care. Staff informed us of an open-door policy. Senior medical staff and nursing staff were visible and accessible. Local ward managers and matrons were approachable and supportive.

- Staff felt part of the service and able to contribute to local initiatives. Senior staff member support for such projects was apparent. There was evidence of public and staff engagement.
- The service had strong local networks with peers and academic bodies. The division was involved in treatment research and local improvement projects.

However,

- Staff felt senior management did not always listen to their views and they needed to improve communications with the frontline.

Vision and strategy for this service

- The trust vision, strategic goals and core values highlighted its desire to deliver outstanding compassionate care to the communities served.
- The medicine divisional strategy aligned with the aims of the organisation. The divisional management team clearly stated their vision for the service in the coming years. This included a review of the whole care pathway, a reconfiguration of acute care services and a drive toward seven day working with patient safety, quality outputs and efficient services at the heart.
- The division ambitions, service priorities and principles of working in the coming five years were detailed in their annual plan.
- The management team recognised the importance of quality clinical governance, encouraging an open culture, and listening to patients, stakeholders and staff to develop services further.
- The divisional and directorate management teams told us they were actively involved in the shaping of the trust agenda. The management team actively sought staff opinion on the strategy of the service and for future plans.
- In the NHS Staff Survey 2015, 70% staff stated they were able to contribute towards improvements at work, compared to 69% nationally.

Governance, risk management and quality measurement

- The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician driven through multi-specialism input and presentation at the medical strategy group.
- In conjunction with the directorate strategy, we were provided with sight of a very detailed and comprehensive risk register which recorded concerns, rated according to risk/priority, along with control measures and action plan progress.
- The management team stated their three main concerns were surrounding staffing levels, finances and patient flow issues. These were noted on the risk register and we were told of progress made by the division in addressing these shortfalls.
- The management team advised us of recruitment drives and financial incentives made available to staff to assist in staffing shortfalls. In relation to finances, we heard of improvement projects to support cost-efficiencies.
- There was a consistency, and alignment in what the directorate was concerned about and what appeared within the register. The senior management were open and honest about this and their plans to address perceived shortfalls in areas of concern.
- The service had governance systems and processes in place ensuring continual monitoring of performance, quality and risk. This included divisional board meetings, patient safety quality board (PSQB) meetings, directorate board groups with clinical leads, directorate finance performance meetings and turnaround meetings (looking at activity, finance, complaints, incidents and improvement projects). We viewed activity summaries and internal monthly dashboards about financial, HR and operational performance, and monthly team meetings. The minutes we reviewed showed staff discussed relevant matters, considered risk and quality issues, including the provision of training.
- We were informed by the management team how governance and risk issues were cascaded to frontline staff by way of ward-based meetings, safety huddles and listening groups.
- There was internal clinical audit activity in the medicine division. This drove the vision, strategy and quality improvement measures.
- The service used quality measurement outcomes from such activity to identify areas for improvements in future initiatives. Specifically, the management team confirmed plans to develop future nursing leaders, reduce falls and review incident reporting via an improvement group looking at risk ratings and root cause analysis.

Leadership of service

Medical care (including older people's care)

- The divisional managers provided leadership across all medical services on both sites.
- The medicine division had a clear management structure defining lines of responsibility and accountability.
- The divisional and clinical directors had an open-door policy and invited regular contact with their unit heads.
- Staff considered their respective ward managers to be part of the team.
- A number of staff we spoke with told us their leaders were visible and approachable. Ward staff interacted with matrons and managers as peers.
- Staff commented they felt as though their views were not always listened to and communications from senior management could be better. This coincided with the findings in the NHS Staff Survey 2015 where only 26% of staff reported communications between senior management and staff to be good (compared with 32% nationally).

Culture within the service

- Staff at all levels spoke enthusiastically about their work, describing the pride and enjoyment they felt working for the trust.
- At the staff listening events in October 2015 and at focus groups, a variety of staff described a 'team' culture where everyone has a valued and respected opinion. Staff acknowledged the division always put the patient first.
- All staff we spoke with told us that their immediate line managers were professional, supportive and helpful.
- Senior nursing staff supported newly qualified nurses with many being supernumerary for a period of preceptorship. They added their mentors and ward managers were approachable and always willing to share from their experiences to aid in their development.
- Senior nurses provided junior members of staff with the opportunity to complete 'a day in the life' of a more senior colleague whilst under supervision. This allowed junior staff to experience the role of wider team members.
- The division recognised good practice with celebratory and service improvement.
- Senior medical colleagues and consultants supported junior medical staff and were available at all times to address any concerns or queries.
- Junior doctors attended senior clinician meetings to gain a greater understanding into the workings and culture of the division.
- Senior staff supported colleagues who had been off work for a period or had flexible working needs found the e-rostering system unhelpful in allocating shifts to meet these needs. This was mirrored in the NHS Staff Survey 2015 where the trust overall ranked in the worst 20% for supporting flexible working arrangements.
- Staff agreed there was a culture of openness and honesty throughout the division underpinned by the trust 'Raising Concerns' policy. Staff were also able to discuss concerns with the Freedom to Speak Up Guardian.
- Overall, morale was good on the wards we visited. Staff commented on the strength of ward comradery however felt stressed at work from time to time. Staff felt as though senior management could do more for staff wellbeing.

Public engagement

- The division was party to the trust 'You said, we did' project which provided a forum to patients to voice comments about trust services.
- On the request of feedback from patients and their families, the stroke service developed a community based support and networking group.
- The trust published a monthly 'open and honest' care report on its website containing information relevant to the division. This included details such as patient complaints, safety thermometer data, and infection control statistics.
- The division had commenced a real time patient monitoring programme (RTPM) to evaluate patient experience of the service. At the time of the inspection, staff had not fully implemented this at CRH.
- The division had good links with Macmillan and Age UK support groups for the benefit of patients.

Staff engagement

- The medicine division and the sub-directorates provided staff with information via newsletters, intranet updates and e-mail on trust developments, clinical issues, patient themes and staff recognition.
- The division was party to the trust 'You said, we did' project which provided a forum to staff to voice comments about trust services.

Medical care (including older people's care)

- Trust management recognised divisional wards and staff with STAR awards.
- During October 2015, divisional managers invited staff to attend trust-wide listening groups. These events provided an arena for all staff grades to feedback on what they were proud of, what it was like to work for the trust, any concerns about care delivery, any 'fixes' that were required and what they felt senior management needed to do.
- Staff had developed good links with colleagues at Macmillan and Age UK.

Innovation, improvement and sustainability

- The trust aimed to build on care partnerships and research opportunities to develop innovations and pioneering services to improve patient health, care and treatment.
- The medical division had long established relationships with university medical and nursing schools. Many directorate specialisms were actively involved in regional specialist networks.
- The division actively encouraged and supported a junior doctor in his personal project to develop bespoke teaching packages for final year students learning within the division. The junior doctor went on to win a clinical development excellence award and a grant for further medical education.
- The respiratory department were involved in new treatment trials such as TIME3, PILOT and DIAPHRAGM. The department were involved in national and European projects looking at interstitial lung disease, bronchiectasis register and theophylline treatment studies.
- The dementia team have been working in partnership with academics and clinicians at University of Bradford to develop holistic strategies to improve care and quality of life for patients living with dementia.
- The older person's medicine team were involved in a MDT project with community specialist colleagues (including therapists, nurses, pharmacists and psychologists) to reduce numbers of avoidable admissions into hospital for vulnerable patient groups. The 'QUEST' project involved the use of telehealth technology to remotely monitor vital signed where required and has seen deteriorating patients receive earlier interventions in their home environment.
- The division has employed a discharge coordinator matron and a team of 20 discharge coordinators to improve patient flow in care pathways and to support transition home or into community care. The team has integrated with community services at HRI and in Kirklees developing an on-site integrated discharge suite for all healthcare professionals involved in discharge planning and the provision of community care. The suite has hot desks for community staff providing a working base and direct access to hospital colleagues.
- The divisional clinical neurophysiology team had been recognised nationally, gaining accreditation from UKAS (United Kingdom Accreditation Service).
- A directorate consultant was the chair of the UK Resuscitation Council and had represented the European Resuscitation Council in the development of international guidelines.
- The Nursing Times awardee the IPC team an award in 2015 for their partnership work with healthcare providers in Romania.
- The stroke team, in conjunction with patients and their families, had set up a community support network for patients who had suffered a stroke.
- The division has rolled out the implementation of 'safety huddles'. These real-time MDT meetings prioritised patient safety issues. The huddles promoted awareness of key themes such as falls and highlighted particular individual patient needs concerns surrounding safety risks. The forum shared lesson learnt from incident feedback.
- The division used 'Nervecentre' technology to monitor real-time patient data such as observations, NEWS scores, clinical noting and assessments. Clinicians and managers monitored acuity and patient flow remotely using 'Nervecentre'.
- On a day-to-day basis, the division was involved in a number of trust quality improvement initiatives and had a number of local care improvement projects to promote sustainability in service provision.

Surgery

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

Information about the service

Calderdale Royal Hospital provided emergency surgery and orthopaedic trauma services, as well as elective ophthalmic, urology, orthopaedics and general surgery.

During this inspection we visited surgical Ward 8A, Ward 8B, Ward 8D, the Pre Assessment Unit, the Admissions and Procedures Unit. We visited all theatres on site and observed care given and surgical procedures undertaken.

We spoke with 18 patients and relatives and 20 members of staff. We observed care and treatment and looked at 23 care records.

Summary of findings

We rated surgical services as good because:

- The trust had good systems and processes in place to protect patients and maintain safety. Staff understood the process for reporting and investigating incidents and there were good reporting and feedback processes at Calderdale Royal Hospital. Each ward recorded and displayed individual incidences of insignificant, minor and moderate falls, catheterized urinary tract infections (C.UTI's) and pressure ulcers. Staffing levels and skill mix had been planned and implemented at Calderdale Royal Hospital.
- All patients reported their pain management needs were met in a timely manner. Care of patients' nutrition and hydration were being met as part of the surgical care pathway. We observed care that was coordinated and discharge and transfer planning took account of patient's individual needs. We observed patients being cared for with dignity, compassion and respect in all the surgical wards and departments we inspected.
- Feedback from patients through the NHS Friends and Family Test consistently showed patients would recommend the hospital to friends and family.
- The 'Five Steps to Safer Surgery' and completion of the World Health Organisation (WHO) checklist was

Surgery

consistently good at the hospital. Mandatory training was well attended and meeting overall training targets was in progress with action plans in place to meet year-end targets.

- Surgical wards were modern in design with good provision of single room accommodation. The wards and departments were spacious, visibly clean and well organised. We saw evidence of regular audit with regard to infection control and cleanliness.
- Patient care was personalised in line with patient preferences, individual and cultural needs and ensured flexibility, choice and continuity of care. Clear strategies were in place and implemented to improve the care of patients. For example, the appointment of link nurses, associate cancer physicians and engagement support workers.
- The trust met the NHS operational target of 90% of patients waiting less than 18 weeks for treatment and rated second in the Yorkshire and Humber Region. The Trust was continuing to work on waiting times to improve services for patients.
- Senior managers had a clear vision and strategy for the division and identified actions for addressing issues, the strategy clearly identified objectives for improving patient care and safety. There was good staff morale and staff felt supported at ward level. There was a culture that supported innovative practice and improvement and the trust had embedded a number of ways of working and improvements in practice that were improving quality of care and experience for patients.

However:

- There was no rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant. This had not been resolved at the time of our inspection and staff identified this as a risk to the safety of patients.
- Daily temperatures for the storage of medications were not all within the correct limits on all wards and were recorded outside the margins for the safe storage of medicines. No action had been taken to check whether records were accurate or whether there was a fault with equipment.
- Trust data showed only 45% of complaints were closed within target in the surgical division.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- The trust had good systems and processes in place to protect patients and maintain safety. Staff understood the process for reporting and investigating incidents and there were good reporting and feedback processes at Calderdale Royal Hospital.
- Each ward recorded and displayed individual incidences of insignificant, minor and moderate falls, C.UTIs and pressure ulcers. The National Early Warning System (NEWS) was used throughout the division to monitor and record patient observations. Observation and escalation processes were in place for all patients and used the Glasgow Coma Scale (GCS).
- There was no formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant. This had not been resolved at the time of our inspection and staff identified this as a risk to the safety of patients.
- Surgical wards were modern in design with good provision of single room accommodation. The wards and departments were spacious, visibly clean and well organised. We saw evidence of regular audit with regard to infection control and cleanliness.
- Staffing levels and skill mix had been planned and implemented ensuring actual staffing levels met planned staffing levels through the use of patient acuity tools. We observed multidisciplinary (MDT) handovers and good communication between staff and completion of patient documentation was good.
- We observed the 'Five Steps to Safer Surgery' and completion of the World Health Organisation (WHO) checklist was consistently good at the hospital.
- Mandatory training was well attended and meeting overall training targets was in progress with action plans in place to meet year-end targets. The trust prioritised safeguarding and work was on-going to ensure all staff were aware of their responsibilities in safeguarding vulnerable adults and children.

However:

- There was no rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant. This had not been resolved at the time of our inspection and staff identified this as a risk to the safety of patients.
- Daily temperatures for the storage of medications were not all within the correct limits on all wards and were recorded outside the margins for the safe storage of medicines. However, no action had been taken to check whether records were accurate or whether there was a fault with equipment.

Incidents

- The trust reported 21 Serious Incidents Requiring Investigation (SIRI) and reported 85% (18) of these as pressure ulcers, 10% (2) due to diagnostic incident delays and one (10%) due to treatment delays. No never events were reported.
- Staff at Calderdale Royal Hospital understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff were fully supported and attended regular meetings where feedback and learning was encouraged.
- Staff reported incidents through the electronic system and learning was shared through meetings, communication books, one-to-one and team briefings.
- We saw evidence of this approach displayed in staff and patient areas and saw minutes of clinical governance meetings, including monthly ward meetings.
- Ward sisters had an overview of every incident, complaint and concern and operated an effective system of response and feedback to patients and staff. Staff understood their responsibilities in reporting and learning from events.
- The trust held monthly mortality and morbidity case review meetings.
- Staff had attended training in 'Duty of Candour' and shared recent experience of practice in carrying this out and shared learning.

Safety thermometer

- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information.

- This tool was used to measure, monitor and analyse patient 'harm free' care, was displayed in ward entrances and was easy to understand; staff had knowledge of the displayed information and ward performance.
- Information for the past year was displayed for monthly incidence of hospital acquired pressure ulcers, patient falls, urine infections associated with catheter insertion and the prevention of blood clots in those patients assessed as being at risk.
- Within surgery, there were eight pressure ulcers, eight falls and two catheterized urinary tract infections (C.UTI's) reported between September 2014 and September 2015. Each ward recorded and displayed their individual incidences of insignificant, minor and moderate falls, C.UTIs and pressure ulcers.
- The Integrated Performance Report (November 2015) showed 94% received harm free care and 95% of patients had a VTE assessment.
- The division had introduced 'repose wedges' in support of mattresses for patients with complex needs to reduce the incidence of pressure ulcers.

Cleanliness, infection control and hygiene

- Infection control policies were available as paper copies, with review dates, and on the trust internet. Monthly reports are generated and reported for clostridium difficile infection (C difficile), and Methicillin resistant Staphylococcus Aureus. (MRSA).
- The surgical division reported no incidences of MRSA and three cases of C. difficile since April 2015.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistently good and we observed signage for isolation of patients in single rooms that was clear.
- An annual Hand Wash road show (HWRS) was carried out across the trust during September 2015 by the Infection Prevention and Control (IPC) team. All wards and departments across both hospital sites were visited to highlight good hand hygiene technique and frequently missed areas when performing hand hygiene.
- Wards and surgical areas had daily, weekly and monthly cleaning schedule for domestic staff, housekeepers and nursing staff.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas. The surgical division reported 99% compliance with hand hygiene procedures.
- We observed staff washing their hands and all patients we spoke with told us that this was done without exception. Hand gel was available at the point of care and staff used personal protective equipment (PPE) compliant with policy.
- The trust audit of Carbapenemase Producing Enterobacteriaceae (CPE) of whether specific questions were being asked when a patient was admitted showed 97% compliance. This identified whether a patient had been an inpatient in a hospital abroad or been dialysed abroad or in a UK hospital known to have had problems with the spread of CPE in the last twelve months.
- The hospital monthly commode cleanliness audit showed 86% compliance with trust standards (November 2015).
- We observed clean equipment throughout surgical areas and staff completed cleaning records, domestic cleaning schedules and identified clean equipment.
- Wards had appropriately equipped treatment rooms for aseptic technique and dressing changes. Nurse assessment of aseptic technique competence took place annually.
- Clinical and domestic waste disposal and signage was good and staff were observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.

Environment and equipment

- Ward staff had attended medical device equipment training and ward managers addressed this as a priority.
- We inspected resuscitation trolleys and suction equipment on wards and found all appropriately tested, clean, stocked and checked as determined by policy.
- All equipment including equipment in theatres was recorded on maintenance schedules which identified installation date and 'last seen' date and a planned preventive maintenance policy and schedule for medical devices was in place.

Medicines

- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- Medication rounds were conducted with good practice principles and wards had dedicated support from pharmacy.
- The storage of medication in refrigerated units was monitored and daily temperature checks recorded.
- However, daily temperatures were not all within the correct limits on all wards and were recorded outside the margins for the safe storage of medicines. No action had been taken to check whether records were accurate or whether there was a fault with equipment.
- All medication was prescribed and administered in line with the trust policy and procedures. Pharmacists liaised with the ward team regularly. We found allergies clearly documented. We checked five records at random and found all correctly completed.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics and liaised with pharmacy prior to prescribing for MRSA and C. difficile.
- Staff were required to attend mandatory updates on storage and recording of controlled drugs. Newly qualified staff were required to attend training and complete the safe medication training before being able to administer. Ward managers ensured training was in place to achieve trust targets.

Records

- We looked at 23 sets of patient, medical and nursing records on the wards and theatres at Calderdale Royal Hospital. We saw they were complete, legible and organised consistently.
- The alert forms provided prompts and the opportunity for staff to record allergies, involvement in medical trials, infection alerts and other associated risks to patients on admission to hospital.
- Patient notes were stored in lockable trolleys and patient care charts were kept at the bedside for ease of access to staff. We did not observe a breach in confidentiality during inspection.
- Daily entries of care and treatment plans were clearly documented. Care plans and charts we reviewed had completed patient assessment, observation charts and evaluations and records examined included a pain score and allergies documented.
- We reviewed handover sheets used by ward staff and found documentation was effective in communication and decision making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in patient's notes. The trust had a 'Policy for Consent to Examination or Treatment' in place and we saw that this was adhered to at all times.

Safeguarding

- The trust had a clear safeguarding strategy and held regular safeguarding board meetings. Minutes and action plans were clear and these meetings are well attended by senior staff from across the trust. This meeting provided a forum for staff to discuss safeguarding concerns and share learning across the trust.
- Staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust and were aware of who to contact, where to seek advice and what initial actions to takes.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.
- The trust safeguarding committee discussed learning from serious case reviews and monitored the training dashboard that showed attendance and compliance of staff at safeguarding training.
- Training plans and schedules were displayed in ward offices. The training strategy was reviewed to update the key elements. The document included a flow chart, which showed training requirements for staff.
- Staff we spoke with had attended training and an on-going programme of sessions was available for staff to attend. At the time of inspection 64% of staff had attended mandatory safeguarding training.

Mandatory training

- The trust had introduced a new mandatory training approach (The Core Skills Training Framework or CSTF) in June 2015. Staff were becoming more familiar with the approach and this was reflected positively in compliance figures.
- In November 2015, 91% of staff had commenced completion of the programme of mandatory training.

Mandatory training was available through the intranet portal and gave access to the Electronic Staff Record (ESR) to complete mandatory training elements and support materials.

- Within the division compliance rates for staff at mandatory training (Integrated Board Report – October 2015) was highest for information governance (63%) and manual handling (56%) and worst for conflict resolution (8%).
- The surgical division had an action plan in place to achieve compliance with mandatory training targets and attendance at mandatory training programmes for all staff was monitored locally.
- Senior staff we spoke with in surgery at Calderdale Royal Hospital had an organised and consistent approach to delivering the mandatory training programme.
- Staff accessed mandatory training in a number of ways, such as online modules and e-Learning, workbooks and trainer delivered sessions. Staff said they were supported with professional development through education.
- Staff said they had a good induction and preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.
- We spoke with 20 staff and they told us they were up to date with mandatory training, the access to the training system online was good and they felt supported to attend training and mandatory update sessions.

Assessing and responding to patient risk

- The strategy and processes for recognition and treatment of the deteriorating patient in surgery were embedded. Staff gave examples where escalating a sick patient and transferring them had worked well.
- We saw thorough completion of observation and monitoring charts at the bedside including the national early warning score (NEWS) observation chart. We reviewed handover sheets used by ward staff and the escalation documentation was effective in communication and decision making for those patients at risk of deterioration.
- The National Early Warning System (NEWS) was used to monitor and record patient observations. Observation and escalation processes were in place for all patients and used the Glasgow Coma Scale (GCS). This allowed staff on the ward to record observations, with trigger levels to generate alerts, which identified acutely unwell patients.
- Audit of NEWS charts (December 2015) showed 100% documented in full for each set of observations and 100% for actions taken based on escalation plans within the division.
- Trust data showed 99% compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saved lives') between April and November 2015. We observed the WHO checklist used appropriately in theatres at Calderdale Royal Hospital.
- WHO compliance reports were generated electronic theatre system and showed all patients on both sites for the previous day and all parts of the checklist. Operations managers gave feedback to individual theatres on any deficiencies as a means of training and education. The reports are presented to the Patient Safety Quality Board and the Trust Board.
- All patients, on admission, received an assessment of venous thromboembolism (VTE) and bleeding risk using the clinical risk assessment criteria described in the national tool. We saw patients were re-assessed within 24 hours of admission.
- Patient safety was monitored through the completion of moving and handling assessments; falls risk assessments, completion of 'Braden' scores, NEWS and malnutrition (MUST) assessments and by following infection, prevention and control measures.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patients' nutritional needs. Pain scores and diaries for patients were available.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example one to one nurse patient ratio, close observation, safety rails on beds, falls stockings, stickers to identify risk on display boards and nurse call system in reach.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- Ward managers, matrons and managers in surgical wards and areas were available and visible and involved in supporting staff and addressing issues.
- Risk assessments, handover processes and safety briefs were observed and we saw all staff worked and

communicated well as a team. We observed 'risk approach' handover sheets used by ward staff and escalation plans were effective in decision making for patients at risk of deteriorating.
- Advanced nurse practitioner (ANP) cover was available at all times and ANP's felt supported by their medical and nursing colleagues and the wider team. Good communication and teamwork existed.
- However, there was no formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant. This had not been resolved at the time of our inspection and staff identified this as a risk to the safety of patients.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- The trust had formal nurse staffing review processes in place and the surgical division had a staffing establishment based upon agreed methodology and professional judgment triangulated through benchmarking, relevant national guidance and acuity information.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours by senior nurses with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances. On all wards inspected, actual staffing levels were in line with those planned. Variations were appropriately made to meet surgical activity and patient acuity and nurse staffing levels were managed day to day through regular senior nurse team meetings to meet demands in ward activity.
- Staff were happy with the arrangements and felt individual nurses and teams were enthusiastic and motivated about working at the Hospital. Staff told us they felt valued, appreciated and listened to by colleagues and senior staff. Staff described the teamwork as one of the best things about working for the trust.
- Nurse sickness rates were 5.3% compared to overall sickness rates within the surgical division of 4.6%. Nurse turnover rates were 0.93% compared to an overall turnover rate of 0.41% with the surgical division.
- The average 'fill rate' was 90% for nursing staff and 100% for health care assistants.
- The trust had an established staff 'bank', which provided cover for short notice requests.

Surgical staffing

- Medical staffing skill mix across the hospital was similar to the England average at 45% consultant (national average 41%), 20% Middle career (national average 11%), 25% Registrar group (national average 37%) and 10% junior doctors (national average 12%).
- Medical sickness rates were 1% compared to overall sickness rates within the surgical division of 4.6%.
- Out of hours cover from senior medical staff was provided at Calderdale Royal Hospital. This included access to all day consultant review for patient care when required.
- Consultants and junior doctors were available for handovers, ward rounds and MDTs. Staff had good relationships with senior surgical doctors and consultants.
- Consultant led surgical handovers took place daily at the hospital in private areas to maintain confidentiality and systems and policies were in place for escalation of a deteriorating patient.
- The development of Advanced Nurse Practitioners for continuous cover of surgical wards at the hospital was embedded and working well.

Major incident awareness and training

- The trust had major incident and business continuity plans in place that included protocols that included deferring elective activity to prioritise unscheduled emergency procedures. Major incident plans were reviewed and updated annually.
- Non-urgent surgery is delayed (if not already underway) until a review is undertaken to assess nature, size and type of incident and immediate staff available to manage the admissions. Processes are in place for monitoring compliance with the policy.
- Potential risks were taken into account when planning services and consideration given at daily safety huddles

regarding seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Action plans were discussed and implemented as necessary.
- The impact on safety when carrying out changes to the service and staff, was assessed and monitored through robust, embedded assessments, staff engagement and on-going service monitoring.

Are surgery services effective?

Good

We rated effective as good because:

- All patients reported their pain management needs had been met in a timely manner and they were regularly asked about their pain levels, particularly immediately after surgery. Care of patients' nutrition and hydration were being met as part of the surgical care pathway.
- Consent to treatment was in line with the trust policy and Department of Health guidelines. Policies and procedures were in place and used in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- We observed care that was coordinated and discharge and transfer planning took account of patient's individual needs. Patients were discharged at an appropriate time and when all necessary care arrangements are in place, handover processes were good between hospital sites.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients and ensured patients were escorted through the care pathways and ensured each patient received continuing care, including preoperative assessments, perioperative admission and postoperative discharge and follow up.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery division took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- Audit outcomes were used to develop surgical practice. For example audits had been undertaken in 'Prostate cancer: 'protocol for active surveillance' (NICE Clinical Guidance 175), 'advanced breast cancer; (CG 81), 'management of hip fracture on adult (CG 1240 and 'neuropathic pain' (CG173).
- An example given was the 'Audit of Patient Blood Management (PBM) in adults undergoing elective, scheduled surgery' which provided a baseline of practice prior to full implementation of the national PBM recommendations. This highlighted good practice as well as variability in practice and enabled the hospital to prioritise implementation of PBM initiatives.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported their pain management needs had been met in a timely manner.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients.
- Each ward had identified a pain link nurse and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.

Nutrition and hydration

- Protected patient mealtimes were complied with and showed practice was in line with trust nutrition policy, protected mealtimes policy, and clinical management of complex feeding problems in adults with cognitive impairment guidance.
- Patients reported their meals to be good, with a hot breakfast, choice and staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients before and after surgical procedures.
- Records observed showed that patients were advised of their time of preoperative fasting and this was specific to their individual care plan and treatment.

- Patients were screened using the Malnutrition Universal Screening Tool (MUST) and where necessary patients at risk of malnutrition were referred to the dietician.
- We reviewed 23 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the dietetic department.
- Staff reported that dieticians were accessible and visited wards daily and met with bariatric patients before and after procedure.
- Information and lessons learnt information was shared at the clinical leaders, clinical managers and nutrition link nurses forums, nutrition steering group, and with catering managers.
- Meal charts were completed comprehensively and reviewed.

Patient outcomes

- The trust had lower than the standardised relative readmission rates (July 2015) England average (100) for elective surgical patients for general surgery (79) and urology (79); the standardised relative readmission rate for ophthalmology (77) was higher than the England average at 104.
- Calderdale Royal Hospital had lower than the standardised relative readmission rates (July 2015) England average (100) for elective surgical patients for general surgery (63) and trauma and orthopaedics (91); the standardised relative readmission rate for ophthalmology (109) was higher than the England average.
- Non-elective procedures were much higher than the England average (100) for general surgery (170).
- The trust had good performance in the National Bowel Cancer Audit in 2015. Case ascertainment rate (111%, national average 94%), data completeness (92%, national average 80%) and the adjusted two-year mortality rate (27%, national average 22%) were all better than national averages.
- The trust recorded worse than the national average figures for patients seen by a clinical nurse specialist (80%, national average 93%), laparoscopic surgery attempted (33%, national average 57%) and the length of stay above five days (77%, national average 69%).
- The surgical site infection (SSI) rate for knee replacement was 0.8% (April - June 2015), slightly lower than the national average of 0.9%.
- The trust performed well in the National Emergency Laparotomy Audit (2015). This showed 76% of patients had risk documented before surgery (national average 57%), the proportion of patients who had a CT scan performed and reported by a consultant radiologist before emergency laparotomy was 69% (national average 68%) and the proportion of cases reviewed by a consultant surgeon within 12 hours of emergency admission to hospital was 535 (national average 47%).
- Theatre utilisation at the hospital varied between 73% and 98%. Utilisation rates were higher in October 2015 compared to September and December 2015.

Competent staff

- Annual staff appraisals were in place and 36% of staff within the surgical division had undertaken appraisal by the end of October 2015 and plans were in place to ensure compliance with trust targets.
- Staff told us that the appraisal process was helpful and allowed them to discuss developmental and learning objectives agreed between staff and managers. Generic training needs were addressed through the trust and local induction as well as ongoing mandatory training sessions and updates.
- There were also informal one to one meetings for staff should they request these. Monthly governance and staff meetings were taking place.
- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- Staff were advised of the Nursing and Midwifery Council revalidation process through the trust intranet. New nursing staff had completed the trust induction programme and completed learning logs with a designated supervisor or mentor.
- Staff felt supported with their training and in maintaining competence. We found staff were encouraged to undertake additional learning when time allowed.
- Ward managers were clear during discussion that new members of staff were mentored and supported until they gained the necessary skills, knowledge and experience to do their job when they started their employment.

- Experienced members of staff were gradually encouraged to take on additional role and responsibilities once it had deemed appropriate.

Multidisciplinary working

- Daily consultant led ward rounds, including weekends, involved the multidisciplinary team.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately. Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietician, diabetes nurse, or speech and language team when needed.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays and weekends and dedicated pharmacy provision for each ward was planned.
- Staff explained discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- Staff worked closely with the patient, their family, allied professionals and the local authority when planning discharge of complex patients to ensure relevant care was in place and that discharge timings were appropriate.
- We observed staff, including those in different teams and services, becomes involved in assessing, planning and delivering people's care and treatment.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.

Seven-day services

- The trust provided seven-day services for all emergency attendances and admissions. A comprehensive transfer plan was in place for deteriorating patients to access emergency care within the trust seven days a week.
- Consultants were available at all hours on call and attended daily ward rounds over seven days to review new admissions and provide emergency patient care.
- There was access to a full range of diagnostic services across seven days to deliver high quality and efficient care to patients.
- The rota enabled significant improvements on the national laparotomy audit results e.g. reduction in time to theatre with an average of 2.8 hours to surgery, time to see a consultant (5.3 hours) and length of stay reduced to 14 days(previously 17 days).
- Significant improvement to consultant presence in theatre had been achieved. Consultant presence in theatre had improved and was above 80% between September 2014 and December 2015, with the exception of 2 months. It was 100% for eight of these months. Consultant surgeons were in theatre 91% of the time and consultant anaesthetist in theatre 76% of the time.
- Further outcome improvements had been a reduction in ICU admissions as patients were treated quicker and deteriorated less before their operation and a reduction in post-operative 30 day death from 12% (national average 15%) to 6.4% (national average 11%). The mortality ratio (SMR) had reduced from 0.78 to 0.51.

Access to information

- Risk assessments were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and planning started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff. Staff told us systems were in place to ensure effective communication of information when transferring a patient.
- All staff had access to policies, procedures and NICE guidelines on the trust intranet site. Staff we spoke to stated they were competent using the intranet to obtain information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies in place to inform and guide practice around the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Information

and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.

- Staff we spoke with were confident in identifying issues about mental capacity and knew how to escalate concerns in accordance with trust guidance.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and DoLS were referred to the trusts safeguarding team. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Consent, MCA and DoLS training was delivered as part of staff induction and annual mandatory training. The development of nurse practitioners had enabled patients to be consented in a timely manner and MCA and DoLS assessments were included in risk assessments.
- We looked at 23 records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.

Are surgery services caring?

Good

We rated caring as good because:

- The services in Calderdale Royal Hospital received positive feedback scores and comments from the different approaches used by the trust to capture the patient experience.
- We observed patients being cared for with dignity, compassion and respect in all the surgical wards and departments we inspected. Patients we spoke with knew the name of their nurse and other members of the healthcare team. We saw patients spoken to in a professional and prompt manner. All patients said staff were caring, friendly and professional.
- Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.

Compassionate care

- We observed staff treating patients with kindness and respect. Staff took time to introduce themselves to patients and give explanations for the treatment and care provided.
- We spoke to 18 patients and they told us that staff were kind and caring, with patients stating that staff were "…very good, very caring, brilliant" and "…nurses are fantastic and they do a fantastic job!". All patients said they had been kept informed of their care, treatment and discharge.
- The NHS Friends and Family Test (FFT) in July 2015 showed between 92% and 100% of patients would recommend Calderdale Royal Hospital to friends and family if they needed similar care and treatment. Response rates were as high as 74% (ward 8A).
- We spoke to 20 staff and it was clear that the demonstration of a caring approach was a high priority. Staff spoke to patients as individuals and demonstrated knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.
- Patients told us staff responded promptly to the call bell system and that they asked about pain control. Pain relief was given as required.
- Staff understood and respected people's personal, cultural, social and religious needs, and considered these when delivering care and planning discharge. We observed staff take time to interact with patients and relatives in a respectful and considerate manner.
- Staff showed empathy and were supportive to people in their care. People's privacy and dignity was respected when assisting with physical or intimate care.
- We saw staff give emotional support to patients who needed reassurance in a calm, friendly and patient manner.
- Staff promoted independence and encouraged those in bed to take part in personal care, to mobilise within their limits and positively encourage those patients who were having difficulty.

Understanding and involvement of patients and those close to them

- Patients said staff took time to explain procedures, risks and possible outcomes of surgery and after care. Complex information was repeated more than once by different staff so that they understood their care, treatment and condition.

- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan and felt involved in their care. Regular ward rounds gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients and relatives felt involved in their care, due to regular ward rounds with consultants. Staff provided an opportunity to ask questions, and explained patients surgery and treatment.
- Patients were given information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan. The division planned to develop information in the most easily understood formats, e.g. DVD.
- Senior nursing staff were visible on the day of inspection and staff reported the Ward Manager and Matron were available for patients and their relatives. It was made clear to patients and visitors to the ward who was on duty as this was displayed at the ward entrance.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs.
- Care plans highlighted the assessment of patients emotional, spiritual and mental health needs. These care plans were complete in case notes observed on wards and surgical areas.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially. When they had concerns about a patient's emotional well-being, they referred to the psychology team and patients were offered professional therapy and support.
- Staff spoke with patients to ensure they knew the 'what, why, how' regarding their procedure and aftercare. Nursing staff felt this enabled patients to ask additional questions and address their fears.

Are surgery services responsive?

Good

We rated responsive as good because:

- Patient care was personalised in line with patient preferences, individual and cultural needs and ensured flexibility, choice and continuity of care.
- Clear strategies were in place and implemented to improve the care of patients. For example, the appointment of link nurses and advanced care practitioners and improvements made in the care of patients with a dementia through the availability of engagement support workers for one-to-one support, seven days a week.
- The trust met the NHS operational target of 90% of patients waiting less than 18 weeks for treatment and was rated second in the region. The Trust was continuing to work on waiting times to improve services for patients.
- Escalation procedures during busy times included bed meetings and cross-site working to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.

However:

- Within the division 134 complaints had been received since April 2015 and the trust Integrated Performance Report (November 2015) showed 88% of complaints were acknowledged with three working days. Trust data showed only 45% of complaints were closed within target in the surgical division.

Service planning and delivery to meet the needs of local people

- Commissioners, third party providers and stakeholders were involved in planning services. Consultation was undertaken with commissioners regarding each directorate plans.
- Commissioners were also involved in annual reviews of the service and discussion had been held with national commissioning groups. The trust was actively worked with stakeholders to provide an appropriate level of service, based on demand, complexity and commissioning requirements.
- Advanced care practitioners (ACP) had been appointed for surgical wards at the hospital. Three ACPs worked within the orthopaedic department and helped the service cope with a reducing number of junior doctors and one assisted in theatre. The ACPs took part in the surgical rota on evenings and weekends.

- The ACPs were viewed as essential to the running of the Orthopaedic Directorate and to wider surgical specialties. The division was planning to expand the model to other specialties, including General Surgery.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.
- We saw a range of food choice, meals and snacks, safe storage and an additional supply of crockery and cutlery that met the needs of patients with dementia and staff had a good understanding of the nutritional needs of bariatric patients in their care.
- Wards, surgical areas and departments were bright and well organised. Staff and patients spoke positively about the facilities and environment at Calderdale Royal Hospital. Additional storeroom capacity had been identified and planned by converting some office rooms into storage areas.
- The standard of fixtures and fittings in ward kitchens was high and improved the service to patients. We saw a range of food choice, meals and snacks, safe storage and supplies of crockery and cutlery for patients with specific needs.
- A system was in place to identify patients who required nutritional support to the catering staff. Details of dietary needs for individual patients were clearly identified on displays in the kitchen.
- A 'Head and Neck MacMillan Project' had been developed, aimed at delivering care for patients tailored to their needs and giving them support to self-manage their condition and become less reliant on the healthcare system.
- Collaboration with neighbouring trusts and MacMillan Cancer Support resulted in the redesign of the ways in which patients are supported through their cancer journey, from diagnosis, to treatment and ongoing care. This enabled patients to feel empowered, independent and to have quality of life.
- The new ways of working have led to a number of improvements, e.g. reduced post treatment support and time patients require enteral feeding.
- A new role, cancer care coordinator had been implemented, which has freed up nursing time to focus on patient's individual needs and optimising rehabilitation.

Access and flow

- The trust had 42,273 surgical spells between September 2014 and August 2015; 18,600 were at Calderdale Royal Hospital and 77% of these were day cases, 20% elective and 3% emergency.
- A pre-assessment appointment was made with the patient before their surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. A satellite pre-assessment service (Todmorden) was available giving patients a choice of where to attend.
- Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- At the end of September 2015, the trust was meeting (91%) the NHS operational target of 90% of patients waiting less than 18 weeks for treatment.
- National indicators were met within general surgery (91%), trauma and orthopaedics (91%), urology (93%), oral surgery (94%), plastic surgery (92%) and ophthalmology (91%). This target was not met within ENT (89%).
- A review of national indicators showed the trust second in the Yorkshire and Humber Region for 18 week national indicator. The Trust is continuing to work on waiting times to improve services for patients.
- The trust used an enhanced recovery programme to assist in patients recovering from orthopaedic surgery and included the mobilisation of patients on day zero after hip and knee replacement surgery. The MDT worked closely to support recovery and patients were routinely discharged with reduced length of stay.
- The trust average lengths of stay for elective patients (2.7 days) were below England averages (3.3 days) and slightly above for non-elective patients (5.4 days, England average 5.2 days).
- The average length of stay for elective patients at this hospital was below the England average for ENT (1.2 days, England average 1.5 days) and general surgery (1.9 days, England average 3.5 days) and higher for trauma and orthopaedics (3.7 days, England average 3.4 days).
- Average length of stay for non-elective patients was below the England average for trauma and orthopaedics (3.0 days, England average 8.7) and higher for ENT (2.7 days, England average 2.4 days) and ophthalmology (3.9 days, England average 2.1 days).
- The hospital had an escalation and surge policy and procedure to deal with busy times. Capacity bed

meetings and cross site working was working well to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.
- Across the Trust, there have been no cancelled operations, which were not rebooked within 28 days.
- The proportion of elective operations that were cancelled was similar to the England average, at around 1% in April to June 2015.
- A 'theatre productivity and theatre action week' had been held where staff from focussed on how to improve the productivity and operational flow of theatres. The outcome was a jointly shared action plan as well as an increase in moral across the service. As a result, a weekly meeting and engagement group had been set up to help identify pilots that would enable lists to start on time and communicate to teams within theatres.
- Staff in the pre-op assessment unit had redesigned the service to reduce patient backlogs. Following patient feedback, a one-stop appointment had been developed, optimising the time at which the pre-operative assessment is carried out during the patient pathway.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request. Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services. This ensured flexibility, choice and continuity of care.
- The surgical division worked closely with learning disability nurse specialists and applied the personal patient passport and health record supporting patients with learning needs.
- A dementia strategy was in place which identified the trust's aims and objectives in the care of people who have a dementia and their families and carers. This applied to all adults accessing hospital and community services provided by the trust.
- Engagement support workers had been appointed to provide engagement, socialisation and companionship, cognitive and physical support for patients with dementia and/or delirium.
- The team supported patients during the day with either group or one-to-one activities and promoted sleep at night. Through providing suitable engaging activities during the day, less 1:1 care was required during the day and night. This also helped other patients experience by reducing sleep disruption on the wards.
- Facilities and premises were appropriate for the access and availability to disabled people who accessed and used services.
- Information leaflets were available on each ward covering various conditions and surgical procedures to enable patients and family members to find further information. Nursing staff and specialist nurses were available to ask questions about care and treatment at any time.
- Wards had access to interpreters both in person and on the telephone, Requests for interpreter services were also identified at the pre-assessment meeting.
- We saw that the care and rehabilitation of patients following surgery was particularly effective through the provision of on-going physiotherapy and occupational therapy services.
- Information leaflets on each ward included complaints guidance from the Patient Advice and Complaints Service, nutrition guidance, stop smoking support, friends and family test data, infection prevention and control guidance, hand hygiene data, and the Forget-me-not booklet.
- Patients were provided with leaflet information regarding their surgery and condition on discharge, which they were encouraged to take home.
- During the inspection at Calderdale Royal Hospital and across the trust, we saw consistent examples of patient's individual needs and preferences being central to the planning of services and care.
- A system of pre-assessment for patients was well established and in addition it was planned for patients to be able to watch DVD information about their procedure provided before surgery.

- Senior nursing staff were visible on the day of inspection and they reported that the ward manager and matron were available for patients and their relatives to speak to on a daily basis. It was made clear to patients and visitors to the wards who was on duty as this was displayed at the ward entrance.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required and the trust had policies in place covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'.
- We observed effective access and facilities for wheelchair users and disabled bathrooms and toilet access. Signage, lifts and corridors at Calderdale Royal Hospital had tactile numbers and floor announcements for people with visual impairment.
- There was a system in place for open and individual visiting for relatives and friends of patients. Staff said single room accommodation allowed for a greater degree of privacy and facilitated open visiting.

Learning from complaints and concerns

- The trust had integrated the Patient Advice and Liaison Service and the Complaints Service to form the 'Patient Advice and Complaints Service' to increase effectiveness in listening and responding to patient feedback and improving the patient experience.
- Within the division 134 complaints had been received since April 2015 and the trust Integrated Performance Report (November 2015) showed 88% of complaints were acknowledged with three working days.
- However, trust data showed only 45% of complaints were closed within target in the surgical division.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Complaints Service and the mechanisms for making a formal complaint.
- We saw leaflets available throughout the hospital informing patients and relatives about this process. All wards had 'Complaints Procedure' booklets for patients and relatives which provided information and were available in a number of formats to ensure they were accessible to all, including easy-read, large font and the top five foreign languages.
- Complaints were handled in line with trust policy that provided guidance on the complaint process, including the nominated investigative lead and timescales for responses.
- Complaints and concerns were discussed at staff meetings where training needs and learning was identified as appropriate.
- Patients and relatives making an informal complaint were able to speak to individual members of staff or the ward manager and staff were able to explain this process.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Complaints Service and the mechanisms for making a formal complaint.
- If patients or their relatives needed help or assistance with making a complaint, the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.
- We saw leaflets available throughout the hospital informing patients and relatives about this process.

Are surgery services well-led?

Good

We rated well-led as good because:

- Senior managers had a clear vision and strategy for the division and identified actions for addressing issues, the strategy clearly identified objectives for improving patient care and safety. Communication was good throughout the division. Systems for clinical governance were clear and robust throughout surgery and led to the identification and resolution of risks.
- Service leads and managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and staff felt supported at ward level. Feedback from patients through the NHS Friends and Family Test consistently showed patients would recommend the hospital to friends and family.
- There was a culture that supported innovative practice and improvement and the trust had embedded a number of ways of working and improvements in practice that were improving quality of care and experience for patients.

Vision and strategy for this service

- We met with senior managers who had a clear vision and strategy for the surgical division and identified actions for addressing issues. The strategy clearly identified the vision, behaviours and goals for the division.
- Specific objectives had been set for transforming and improving patient care, maintaining safety, developing a workforce for the future and financial sustainability, e.g. review the pre-op assessment process, ensure all staff within the division complete mandatory training and appraisal.
- The vision and strategy had been communicated throughout the division and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust and divisional vision and strategy were displayed in wards and staff were able to articulate to us the trust's values and objectives across the surgical division.
- We were told the trust had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection.

Governance, risk management and quality measurement

- Monthly divisional board, joint clinical governance, directorate and patient safety and quality meetings were held each month. We reviewed minutes from the 'Head and Neck', 'Urology', 'Orthopaedic' and 'Surgical' divisional management teams (August 2015 – October 2015) and also the 'Bradford and Airedale, Calderdale and Huddersfield Vascular Network'.
- We saw the agendas and minutes for these meetings included evidence of audit activity, learning from complaints and clinical risk management issues, peer review data, and patient and public involvement.
- Agendas included a rolling agenda focussed on governance, personnel, clinical and cost effectiveness, access and choice, safety, patient focus, risks and updates on action plans.
- The trust held monthly mortality and morbidity case review meetings by a number of reviewers who are randomly allocated mortality reviews out with their own area or speciality and a standard mortality tool is used.
- Additionally, each of the surgical specialties as well as urology and vascular reviewed deaths on a monthly basis at clinical governance meetings - this included general surgery, orthopaedics, ENT and critical care.
- The division's risk register was updated following these meetings and when needed. Risks were assigned to specific staff responsible for the monitoring of actions and the revision of the risk assessment as required.
- The register included risk ratings, action plans, and information on timescales in which issues were to be resolved. Reports identified risks throughout the directorate, actions taken to address risks and changes in performance. These monitored (amongst other indicators) MRSA and C.difficile rates, national indicators, pressure ulcer prevalence, complaints, never events, incidents and mortality ratios.
- We saw action plans were monitored and implemented across the division and the risk register was updated with any progress or new risks. We saw that the division had recognised the risk in managing patients with a gastrointestinal bleed and placed this on the register.

Leadership of service

- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level.
- Clinical management meetings were held weekly and involved service leads and speciality managers. During inspection of Calderdale Royal Hospital, this approach was observed and reported to us by all levels of staff.
- Monthly surgical speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff at Calderdale Royal Hospital spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings, which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- At ward and theatre levels, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- All staff we spoke with felt that they received appropriate support from management to allow them to perform their roles effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Ward managers were given dedicated management time. This allowed them to focus on management and administrative issues. Management staff told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading their services.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority.

Public engagement

- The trust engaged the public in assessing the hospital environment. This helped the trust to gain an understanding of how patients and service users felt about the care provided.
- Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.
- The NHS Friends and Family Test (FFT) in July 2015 showed between 92% and 100% of patients would recommend Calderdale Royal Hospital to friends and family if they needed similar care and treatment. Response rates were as high as 74% (ward 8A).
- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and the Patient Advice and Complaints Service were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.

Staff engagement

- In the FFT staff survey, 79% of staff within surgery said they would recommend the trust to friends and family as a place to receive treatment and 55% of surgical staff said they would recommend the trust to friends and family as a place to work.
- Data collected by the Health and Social Care Information Centre (HSCIC) showed that the sickness absence rates for the trust have been very similar to the England average during 2014 and 2015.
- Results from the 2015 NHS Staff Survey identified the key findings for which Calderdale and Huddersfield NHS Foundation Trust compared most favourably with other acute trusts in England in areas such as staff appraised in last 12 months.
- The survey also identified the key findings for which Calderdale and Huddersfield NHS Foundation Trust compared least favourably with other acute trusts in England such as staff satisfied with the opportunities for flexible working patterns, and recognition and value of staff by managers and the organisation.

Innovation, improvement and sustainability

- During the inspection, it was clear there was a culture that supported innovative practice and improvement.
- The trust had embedded a number of innovative ways of working and improvements in practice that were improving quality of care and experience for patients. The following examples were noted at Calderdale Royal Hospital during our inspection:
  - The introduction of a seven day acute rota for general surgery;
  - Improvements on the national laparotomy audit results e.g. reduction in time to theatre, time to see a consultant and length of stay;
  - Improvement to consultant presence in theatre;
  - The appointment of engagement support workers;
  - Collaboration with neighbouring trusts and MacMillan Cancer Support to redesign cancer patient support from diagnosis to treatment and on-going care;
  - The appointment of advanced care practitioners for surgical wards at the hospital;
  - The development of a one-stop appointment for pre-operative assessment;
  - The introduction of ‘repose wedges’ for patients with complex needs to reduce the incidence of pressure ulcers.

Critical care

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

Information about the service

The Calderdale and Huddersfield NHS Foundation Trust provides critical care services in the Huddersfield Royal Infirmary (HRI) and the Calderdale Royal Hospital (CRH). The critical care unit sits in the trusts surgical and anaesthetic division.

The trust has two critical care units with a total of 13 adult beds and receives approximately 700 admissions a year.

Across the two critical care units there are ten 'intensive care' (ITU) beds, for complex level 3 patients, who require advanced respiratory support or at least support for two organ systems; and five 'high dependency' (HDU) beds, for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative care or single organ support and this includes care for those 'stepping down' from level 3.

At Calderdale Royal Hospital, ITU can flexibly admit three level 3 and two level 2 patients, four bed spaces are single rooms. The service provides intensive and high dependency care for patients who have had elective or emergency surgery It also provides care for emergency admissions and those that need respiratory support.

There is a nurse-led, critical care outreach service (CCOR) available seven days a week from 07.30hrs to 20.00hrs. The team share their skills and expertise to ensure that acutely ill ward-based patients receive appropriate care.

During inspection our team spoke with eight members of staff. We spoke with one patient and three relatives. We observed care, reviewed policy and documentation and checked equipment in all units. We were able to review a range of performance data to inform the inspection.

Critical care

Summary of findings

Overall we rated critical care as requires improvement .We rated the effective, responsive and well-led domains as requires improvement and safe and caring as good.

- There was an inconsistent understanding of incident grading and reporting of incidents in critical care, there were processes to share learning from incidents however not all staff we spoke with were aware of this. Patient harm incidents were low and results for recent falls and pressure ulcers were displayed on a 'how are we doing' noticeboard.
- We reviewed a range of paper copies of clinical guidelines and policies that were out of date during the inspection, we raised this at the time of inspection and they were removed. Access to online policy and critical care network guidance was good.
- Physiotherapy staff were unable to achieve the discharge prescription as part of rehabilitation after critical illness, as per NICE CG83 guidance. Physiotherapy resources limited the opportunity to deliver the required forty five minutes of daily critical care rehabilitation, and this was more challenging at weekends. Dietitian support was not available at weekends and this was identified in the local risk register. There was a standard ITU feeding protocol for new admissions so that nurses could commence nutritional support.
- Staff appraisals rates were low at a recorded 21% in November 2015 against the 100% target required by April 2016. The critical care matron and clinical educator reported improvement at 50% appraisal rates for nursing staff at the time of inspection and an action plan in place to achieve the target.
- Patients were occasionally transferred out of the Huddersfield unit to the Calderdale unit for non-clinical reasons. CRH had 19% of all discharges as out of hours, between 10.00pm and 07.00 am. Approximately half of all discharges to ward areas were delayed more than four hours, once a decision to discharge had been made.
- Patients had follow up from the CCOR team after discharge to the wards to support their recovery however there was no formal follow up clinics for patients who were recovering from critical illness and admission in line with GPICS (2015).
- The unit submitted data to the intensive care national audit and research centre (ICNARC) case mix programme, and it was able to benchmark its performance against comparable units. Patient outcomes were generally good however; 41% of all patient discharges were delayed more than four hours after the decision to discharge. At CRH 19% of discharges were at night. This was not in line with national recommendations.
- Thirty nine percent of nursing staff held a post registration award in critical care nursing and intensive care however national guidance recommends a minimum of 50%. There were plans for four staff to attend the course in 2016. In line with recent recruitment there was a higher ratio of inexperienced nursing staff and an additional clinical educator had been appointed to provide support. Senior staff recognised that they needed to retain its current establishment of experienced nursing staff.
- The vision and strategy for the critical care service was not shared or clear across the team. The senior team we spoke with from critical care and the surgical and anaesthetic directorate told us of the trust five year proposals for a single site unit in 2021 in order to improve achievement against GPICS (2015), however interim strategy or vision was limited to address some of the current issues in the unit.
- Around half of the nursing staff we spoke with told us that although there was a good nursing structure and senior staff in post were experienced however not all staff were supportive or approachable. More recently the clinical matron and senior team had begun to put strategies in place to improve working experiences and welfare for nursing staff.
- Staff we spoke with told us that they enjoyed working in critical care as a speciality as it was rewarding and challenging. However nursing and medical staff across sites, expressed concerns over cultural issues that had been historic. Morale was low in eight out of 11 nursing staff we spoke with across both sites about these issues.

However,

- Nurse and medical staffing was good at the time of inspection however we found areas of non-compliance with intensive care standards for all

Critical care

staff groups. There had been historical concerns with the recruitment and retention of nursing staff dating back to 2014-15, however recruitment to nursing staff vacancies had been successful in 2015-16.

- The unit was visible clean, had good facilities and equipment for care of the critically ill patient. Infection control practices were good amongst staff and there was a low incidence of infection, better than national averages (ICNARC).
- Care of patient's nutritional need was good. The dietician was an integral part of the team to ensure good standards of patient assessment and support. There was evidence of good multidisciplinary working. Medicines management and record keeping was also good in critical care.
- The critical care outreach team and central vascular access device service was well established to support critical care, wards and patients.
- We observed caring staff. Patients and relatives we spoke with were positive about their experiences in critical care. We saw individual care plans and good documentation around risk assessment, and patients and family needs were also documented well. There was a low number of patient complaints in critical care.
- We observed good teamwork amongst staff and over half of nursing staff were experienced in critical care, however some junior nursing staff we spoke with were frustrated with limited cascade and communication of information, a lack of investment in professional development of experienced staff and staffing issues which had caused a negative impact on staff morale, particularly in 2015.The senior critical care team had also identified these issues, they held staff 'listening events' and had developed an action plan which they were making progress against at the time of inspection.
- There was a governance structure in place under the surgical and anaesthetic division. We saw evidence in the management and divisional team meeting minutes that incidents and complaints were monitored and reviewed.

Are critical care services safe?

Good

We rated safe as good because:

- The clinical environment at CRH was visibly clean and well equipped. We observed healthcare professionals with good infection prevention control practice and audit activity in the division directed monthly improvement in compliance against targets. The CVAD team was established and worked to reduce infection rates in all patients with Central Vascular Access Devices in place across the hospital. Staff had attended a medical device competency training programme for all items of critical care equipment.
- The critical care outreach team (CCOR) was established across seven days and supported the recognition of the acutely ill or deteriorating patient. The 'Nerve Centre' technology in use by the CCOR team and the ward staff across the trust was a consistent and innovative approach for recording patient physiological observations and triggering patient review and assessment by medical or CCOR staff.
- Medicines management was good and incidents were reported as low in number, with a total of nine 'no harm' drug errors or incidents across both sites.
- We observed good handovers amongst the critical care team, the senior team told us that there were plans to implement a 'safety brief' approach in the future to provide further improvement in sharing safety messages.
- At the time of inspection there were sufficient numbers of nursing staff however many staff had been newly recruited and required senior support and training to ensure safe delivery of care. Additional clinical educator support had been appointed to support new staff.
- Medical staffing did not achieve all of the requirements of the Guidelines for the Provision of Intensive Care Services GPICS (2015) although rotas had been adjusted to provide improved continuity of patient care. Consultants were all experienced in critical care however not all were trained as Faculty of Intensive Medicine (FICM). The trust reported that some of the consultants trained as intensivists overseas so were not eligible to be FCIM compliant.

However:

- There was an inconsistent understanding by staff of the incident reporting system. The new grading thresholds that had been introduced in 2014 had not been fully embedded as were not clearly understood by all staff we spoke with. Incidents reported as no harm included examples of 'near misses' that were not investigated or discussed in team meetings.
- There were processes to share learning from incidents and information was included in unit and divisional meetings with senior staff and through the critical care newsletter. However not all staff we spoke with were aware of this and staff reported this as a concern during the inspection. Junior nursing staff in particular told us that the lack of unit meetings for nursing staff reduced opportunity to share learning.
- Across the service the whole consultant team did not cover regular daytime critical care sessions, which was not in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- The unit did not have a 24/7 supernumerary nurse coordinator, this is recommended by the Guidelines for the Provision of Intensive Care Services (GPICS) (2015) and this was noted to be on the local risk register. A band 7 nurse was available Monday to Friday until 5pm.The critical care outreach team (CCOR) was established across seven days and supported the recognition of the acutely ill or deteriorating patient. The 'Nerve Centre' technology in use by the CCOR team and the ward staff across the trust was a consistent and innovative approach for recording patient physiological observations and triggering patient review and assessment by medical or CCOR staff.
- Medicines management was good and incidents were reported as low in number, with a total of nine 'no harm' drug errors or incidents.
- We observed good handovers amongst the critical care team, the senior team told us that there were plans to implement a 'safety brief' approach in the future, the detail of the planning and a timescale were not agreed at the time of inspection.

Incidents

- Critical care staff reported incidents in the electronic system and we were told that staff could complete a paper copy if they did not have access or time to complete the electronic version. The trust had a policy for reporting of incidents, investigation and management and this was reviewed in December 2015. The electronic system had been implemented in 2014.
- Critical care at the CRH had reported no never events and two serious incidents in 2015. These incidents were reported in the Strategic Executive Information System (STEIS). The critical care matron reviewed both incidents with our team. We reviewed two action plans, root cause analysis (RCA), investigations and letters of apology to patients as per duty of candour regulations. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. The division had achieved 100% compliance with sending all patients who required duty of candour letters within a ten day time period.
- Senior staff described a good process of investigation and sharing learning; however junior nursing staff we spoke with told us that action plans were not consistently shared. Staff were given feedback by email after completing an electronic incident form but reported that this was not always detailed or helpful in guiding improvement in practice.
- There were processes to share learning from incidents and information was included in unit and divisional meetings with senior staff and through the critical care newsletter. However not all staff we spoke with were aware of this and staff reported this as a concern during the inspection. Junior nursing staff in particular told us that the lack of unit meetings for nursing staff reduced opportunity to share learning.
- There was a reported backlog of 'open' red and orange incidents across the division that required senior manager's review.
- Staff told us that they accessed an e-learning training module for duty of candour however some of the staff we spoke with had varying levels of understanding of the requirements. We found the trust had a clear policy for the duty of candour requirements. A central trust team also had responsibility for monitoring incidents that would trigger the duty of candour to ensure the trust were compliant with the requirements.
- Medical and nursing staff discussed an example of shared learning as a consequence of incidents in the unit; improvement in patient airway safety and the introduction of an individual airway care plan, visible in

the patient bed space. This had been implemented across both sites and we saw this at the CRH site when junior nurses were reviewing the information whilst arranging a patient's discharge from the unit.

- We reviewed 196 incidents between October 2014 and November 2015 across both hospital sites. 147 incidents with a green grading, 3 with an orange, 36 with yellow grading and 5 as red. Incidents that were graded as green were 'no harm' incidents whereas the other colours were used to grade incidents 'with harm.' Staff we spoke with in critical care did not get consistent feedback on themes from incident reports and could not clearly explain what incident they would report as orange or yellow. There was good understanding of reporting of red incidents, and we saw prompts in the system to guide staff.
- We reviewed the 147 'green' incidents that had been reported of which 73 related to this site. The system did not detail if these no harm incidents had been investigated further. Green incidents we reviewed included;
  - medicines administration errors,
  - admission of patients to recovery in theatre,
  - early discharge to ward areas from critical care,
  - staff shortages and lack of bed capacity.
- Nineteen pressure ulcers were reported in 2014/2015 as red or yellow incidents. It was reported in a sisters meeting that it was not clear if staff were knowledgeable about grading of pressure ulcers. Work was planned for staff training in critical care as there had been evidence of incorrect grading in the reporting system. Fifteen grade two pressure ulcers or moisture lesions reported as yellow incidents required further investigation and management to reduce future incidence.
- Staff shortages were reported in the incident reporting system by nurses on duty. Of 196 incidents in October 2014 to November 2015, 67 were related to staffing and capacity issues across both sites. A peak of reporting in November 2014 was noted with 23 no harm incidents, however in view of consistently poor staffing levels in 2015, the reporting numbers were nil or low for each following month.
- Mortality and morbidity review took place monthly at the clinical governance meetings in the surgical and anaesthetic division. The review was consultant led and included general surgery, orthopaedics, and critical care. A mortality review tool was used. Senior staff reported that 100% of deaths were reviewed and we did not see evidence of sharing learning from the forum with staff. The forum was multi professional but there was limited attendance by nursing or allied health professionals.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm-free care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CAUTI), and blood clots or venous thromboembolism (VTE).
- Critical care had plans to implement a more detailed approach to display of the safety thermometer information as this was currently displayed as a 'how are we doing noticeboard' in the unit. We observed the display of two measures of harm, including pressure ulcers and falls for the previous two months. We saw evidence of, and staff we spoke with told us that there was a paper data collection system which was transferred into the intranet system by nursing staff. The critical care matron told us of plans to improve display of information across the units.
- The reported incidence of avoidable harms was nil for CAUTI and VTE in 2015.
- There had been two 'no harm' patient falls incidents in ITU in 2014/15. One patient was reported as 'lowering themselves to the floor.' The other was described as 'fall from bed – no harm'. As neither patient had sustained injury the incident was graded as 'green – no harm.' Incidence of patient falls was low in critical care.

Cleanliness, infection control and hygiene

- There was good access to the intranet system for staff. The infection control policy was up to date on the intranet however we did see paper copies of policies and guidance that were out of date and located in the CRH unit. The team were reviewing files at the time of our inspection and any out of date infection prevention and control documents had an immediate plan for removal or update.
- There had been one reported incidence in 2014/15 for unit acquired Methicillin-Resistant Staphylococcus Aureus (MRSA). There was a 100% compliance with the MRSA screening programme. We noted that the infection control dashboard reported 641 days since last unit acquired MRSA; however the reporting system described one incident in August 2015. It was not clear if

the reported August incident was an error. The senior team in surgery and anaesthetics had challenged the validity of the infection control data in a number of areas and this was documented in the Patient Safety and Quality Board (PSQB) meeting November 2015.

- There had been one incidence of Clostridium Difficile (C.Difficile) in 2014/15 as described in the incident reporting system. The infection control November 2015 dashboard accurately reported 302 days since last incidence.
- The most recently available 2014/15 intensive care national audit and research centre (ICNARC) data showed that the unit was performing better than similar units for unit acquired MRSA, C.Diff and unit acquired blood infections.
- Critical care had an infection control link nurse. Staff we spoke with told us that the link nurse system and unit staffing did not always allow attendance to relevant infection control meetings or training, which would support a cascade of information or learning from the trust infection control team. The trust provided information which showed for the meetings in September 2015 and December 2015 there had been representation from the Huddersfield ITU.
- We found all areas inspected to be visibly clean and uncluttered in CRH ITU. The unit had four single rooms and negative pressure isolation facilities in line with national guidance. The unit was modern and spacious and had been purpose built as a 16 bed critical care unit, but had never been fully utilised. Areas that were decommissioned were screened off and used for storage. The design of the unit allowed for half the environment to be non-clinical without any disruption to patient care. There was a cleaning schedule and running water programme for areas not in use.
- The monthly matron environmental audit scored 86%-94% in the six months prior to inspection. These audits included ten areas of infection prevention and control. Hand hygiene, clinical practices, isolation of patients and cleanliness of equipment scored consistently well and above 95%. Areas identified as 'amber' in the reports were kitchen cleanliness, general environment and storage in the clean utility area, although we found all to be visibly clean at the CRH site.
- We observed staff cleaning bed areas. There was a system in place and staff were aware of their cleaning duties and responsibilities.
- Domestic staff we spoke with in both units told us of;
  - The correct storage and use of cleaning chemical.
  - We observed domestic staff changing bedside curtains.
  - Cleaning schedules were available for review.
  - There was evidence of water flushing schedules and domestic staff we spoke with had a good understanding of the risks associated with a build-up of waterborne bacteria.
- Staff adhered to uniform policy and we observed good compliance with 'bare below the elbows' policy. We observed staff in critical care taking opportunity for hand hygiene and use of personal protective equipment (PPE) when delivering patient care. Infection control signage was clear and there was good provision of two isolation cubicles.
- The Central Venous Devices Service (CVAD) was established in 2007 to reduce the incidence of device healthcare associated infection through the application of best practice across the Trust. There was a process of referral of patients across all clinical areas and clinical care, treatment and additional support and advice was given by staff. There had been stable numbers of central venous catheter (CVC) days across both sites at a rate of 1.43 per 1000 days was in line with the published national and international averages of 1.4/1000 CVC days (ICNARC).
- All staff attended training for infection control as part of mandatory training. The surgical and anaesthetic business unit reported overall staff attendance. Data included critical care staff across both hospital sites; we did not have access to separate attendance figures for critical care staff. The critical care matron reported to our team that 90% overall attendance with mandatory training had been achieved. Nursing staff had 67% attendance across both sites, medical staff had 42% and allied health professionals achieved an 80% attendance this was below the trust 100% compliance target for training.

Environment and equipment

- The critical care unit at CRH had been purpose built as a sixteen bed facility although was currently utilised for five critical care beds. The environment overall in critical care at CRH was good with modern facilities, natural light and appropriate space and storage.

- There was good provision of equipment to provide level 3 and level 2 care to patients. There was good provision of single rooms. The environment met the standards of the Department of Health HBN 04-02, 2013.
- The trust and critical care matron led environmental audit had been planned for 2015 and cancelled twice due to staffing issues. There were no recent results for environmental audit specific to critical care units.
- We checked sixteen items of equipment, including emergency trolleys and transfer equipment; we found all equipment to be clean and well maintained. There were good arrangements for maintenance of equipment in the trust.
- We observed completed bedside safety checklists for equipment cleaning and two mattresses were found to be clean. Mattress audits were performed and discussed with staff, who were knowledgeable about the process and audit.
- Staff checked resuscitation equipment and trolleys and they were stocked, clean and checked as per policy. The blood gas monitoring equipment in the critical care units were clean and well maintained.
- Single use stock items were stored across a number of store rooms. We found all items to be in date and stock was well organised. The storage arrangements were good in the unit. The unit had an identified member of staff to manage stores.
- Hand washing facilities in ITU were good with appropriate provision of sinks. The single rooms offered privacy for patients and the ability to isolate any patients with infection. The main bay was spacious and well equipped in each bedside with a central nurse's station and good visibility.

Medicines

- The critical care pharmacists provided medicines management with daily review of prescribing, attendance of daily ward rounds, drug reconciliation, guidance on fluid balance management and liaison with other centres when required.
- The pharmacist attended the critical care governance meeting and feedback was given to staff from the Medicines and Healthcare Products Regulatory Agency (MHRA) safety alert updates and highlights of were cost savings could be made.
- Pharmacists completed monthly audits. The results were shared with the medical staff and senior nursing team fed back to individuals involved and discussed at handover. However this information was not consistently shared with junior nursing staff in critical care. Audit results showed good compliance with trust policies around the use of;
  - antibiotics, an important factor in reducing incidence of C.Difficile and MRSA,
  - storage and security,
  - controlled drug management and,
  - fridge temperatures
- We reviewed good compliance with storage and record keeping for controlled drugs and drug fridge temperatures were recorded accurately.
- Medicines are prescribed using a paper system, we observed two medicine prescription charts in ITU, and no errors were noted. There was clear display of patient allergies in care records and on identification bracelets. There was a low number of nine 'no harm' drug errors or incidents were reported in 2014/15.
- The unit was not compliant with the guidelines for the provision of intensive care services (GPICS) which state that there should be at least 0.1 WTE 8a specialist clinical pharmacists for each single Level 3 bed and for every two Level 2 beds.

Records

- We observed two care records, and two care charts. A paper system was in use. Most entries in the records were accurate, complete and in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015) and professional GMC and NMC standards, with the exception of ;
  - Admission summaries were clearly documented but did not include time of decision to admit to critical care, and if the admission met the GPICS (2015) guidance of being within four hours of the decision being made. The consultant had reviewed the patient on admission.
- Notes were stored securely at the bedside, in line with trust policy. There had been no incidence of confidentiality breach.
- Consultants and junior doctors completed bedside notes as part of their critical care daily assessment. The multi-disciplinary team, pharmacist and dietetic staff recorded care in the main record. Physiotherapists had separate notes and staff we spoke with said they could easily access and locate the patient information they needed.

- Information governance training was provided as part of the mandatory programme. ITU had a compliance target for attendance of 100%. At the time of inspection nursing staff had 77% attendance, with medical staff 52%, and allied health professionals had 83%. This was lower than the unit's target.

Safeguarding

- The trust safeguarding policy was available to staff. Safeguarding awareness information was observed in critical care offices and on display.
- Staff we spoke with told us that they had attended safeguarding training and they understood the processes in place to escalate any concerns for vulnerable adults and children, however the trust training target had not been achieved at the time of inspection.
- At the time of inspection the surgical and anaesthetic directorate had not achieved the 100% compliance target for safeguarding adults and children level 1. Seventy two percent of nurses had attended level 1 and 59% had attended level 2. Level 3 had the poorest attendance with only 5% attendance against the 100% target of those nursing staff identified as requiring this training. Medical staff attendance was better, but also did not achieve the trust 100% target

Mandatory training

- Calderdale and Huddersfield Hospitals NHS Foundation Trust had a mandatory training policy and compliance targets of 100%. The surgical and anaesthetic division collated the overall attendance figures for staff across all departments at 90% and the critical care unit compliance was included in the overall results.
- During the inspection senior staff told us that critical care had an action plan in place to achieve attendance and reported that staff had achieved 90% across all areas of mandatory training. We did not see written information to support this at the time of inspection. Senior staff recognised releasing staff to attend or complete e-learning was a challenge. We were told that recent improvements in staffing levels in critical care would allow for improved attendance in 2016. The new approach to mandatory training was described as positive.
- Ten mandatory courses were available for all staff to access. They included a range of topics, such as moving and handling, infection prevention and control, safeguarding, and dementia awareness.
- Staff we spoke with in critical care were mostly positive about the mandatory training they received, some sessions were easily accessed via the intranet and others delivered face to face. Staff we spoke with reported that it had been difficult to get protected time for e-learning due to staffing pressures.

Assessing and responding to patient risk

- There was an established seven day service for the critical care outreach team who were available from 7:30 to 20:00 hrs. The team were well regarded by colleagues we spoke with across the Trust. Outside of these hours the hospital at night team provided cover. At night time, there was a face-to face handover between outreach team and the Hospital at Night team, and in the morning, there was a written handover document available for the outreach staff when they arrived on shift. However we spoke to a registrar and CCOR staff who told us that handover was written on paper and left in the office for the next shift on duty.
- The trust used a recognised national early warning score (NEWS) which is calculated as part of physiological observations, The NEWS can indicate when a patient's condition may be deteriorating and 'trigger' that they may require a higher level of care. Compliance with NEWS was said to be very good since the implementation of the 'Nerve Centre' system, with 100% recording of scores in recent audit in the surgery and anaesthetic division.
- The electronic observation and alert system is well known by staff in wards. Outreach staff received referrals and updates of patients whose observations trigger cause for concern through the 'Nerve Centre' system. Staff record observations electronically and have hand held devices as part of the system. This facilitated the outreach team's quick response to the deteriorating patient and those patients who required follow up and review after discharge from critical care.
- The critical care outreach team followed up 90% of all patients discharged to wards from both units between April and September 2015.
- The critical care unit had adopted a magnetic visual display system for displaying individual patient risk at the bedside, for example falls risk, nutritional

assessment, communication and infection risk. The system was popular with staff and used effectively. During the inspection we noted that it was in use across wards in the hospital.

- We reviewed two care records to evaluate the assessment of clinical risks to patients in critical care. A range of risk assessments were recorded accurately, pressure areas and on-going care plans, urinary catheter bundles, MRSA screening, nutritional MUST scores, moving and handling and pain assessment. There was good evidence of review of indwelling peripheral, central and arterial lines. We found all assessments and reviews to be complete on the day of inspection.
- VTE risk assessment was complete in two care records we reviewed. According to trust audit, 95.2% VTE risk assessment were completed year to date by November 2015.
- Clinical risks were discussed routinely in handovers and the template used prompted daily evaluation of risks and plans for treatment.

Nursing staffing

- At the time of inspection critical care was well staffed. Actual levels of staffing were good against planned levels and adhered to the staffing guidelines for the provision of intensive care services, 2015. The trust had an electronic rostering system and was able to analyse safe staffing levels. In February 2016 there had been nil red alert staff shortages and one episode of amber alert shortages that had not impacted on patient care.
- At the time of inspection a low number of vacancies, (three) for registered nurses were not filled and recruitment was on-going.
- Nursing staff rotated across both critical care sites within the trust and the critical care unit was managed as one service. Staff rotas observed in both units had fairly consistent staffing levels recorded for the previous three months.
- At the time of inspection minimal agency staff were used to cover staff shortage and monthly data was collected. Agency, trust or unit bank staff that were used to cover shifts in critical care were well known to the team and unit staff mainly worked additional shifts to cover gaps in the rota at the time of inspection. Critical care staff were familiar with any temporary staff working in the unit and good arrangements for orientation were in place. There had been 'block bookings' of agency staff during times of staff pressures to provide safe staffing levels.
- In 2014/15 actual unit staffing levels had been significantly and consistently lower than planned levels with a low of 44.35 WTE against the planned 59.46 WTE of registered nurses. This translated into a 35% vacancy rate and poor retention of staff as escalated in the Patient Safety and Quality Board (PSQB) meeting by senior staff.
- The units did not have a 24/7 supernumerary nurse coordinator, this is recommended by the Guidelines for the Provision of Intensive Care Services (GPICS) (2015) and this was noted to be on the local risk register. A band 7 nurse was available Monday to Friday until 5pm. Staff told us that the supernumerary coordinator would work in the numbers during busy times and when the unit was short staffed. The nurse coordinator role should coordinate critical care activity, facilitate effective patient flow and support the team. We did review that good band 6 and 7 senior cover in the nursing team and clinical nurse educators were in post.
- Nursing staff we spoke with told us that 40% of staff had not been in post more than 12 months. There had been 11 new nursing staff appointments at the end of 2015 to fill the vacancies left by experienced staff. Staff we spoke with felt that more work was required to retain experienced staff. Senior staff recognised the issues and an action plan had been developed to support the team. This was being implemented at the time of inspection and included additional clinical educator support.
- The nursing staff we spoke with told us that the duty matron would move critical care nurses to cover shortfalls in other wards across the trust. Four nurses we spoke with told us that decisions did not always take into account patient dependency and that the matrons but instead made assessments and decisions by telephone. Senior staff we spoke with recognised that the use of critical care nurses to fill gaps in ward rotas was not an effective use of resources and could contribute to ITU staff turnover. However the trust acknowledged that there was a need to support safe staffing across the Trust and this meant that staff were on occasions moved.
- Sickness and absence rates in the critical care unit were 5.7% higher than the trust average of 3.5%. This

information was captured through the e-rostering system. It was reported in the unit sisters meeting in October 2015 that the critical care unit had sickness rates that were treble that of the trust average. At the time of inspection senior staff we spoke with told us that there had been some improvement in sickness figures.
- Nursing staff handover was consistent and we observed a communication folder that supported the handover process. Nurses also attended the consultant led handovers. The senior team had plans to implement a safety brief/huddle strategy across the units as a way of further improving handovers as a critical care team.

Medical staffing

- The current model for medical staffing at CRH was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- There were nine intensive care consultants; all had significant experience of intensive care. However, two consultants who cover the on call service at both sites were not Faculty of Intensive Care Medicine (FICM) compliant. The trust reported that the two consultants had trained as intensivists overseas so were not eligible to be FCIM compliant.
- Across the service the whole consultant team did not cover regular daytime critical care sessions, which was not in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- . It was reported in the risk register that risks were mitigated in the event of a consultant, middle grade or trainee being in theatre when ITU required urgent cover, and they could call the on call HRI consultant or a colleague not on duty.
- Care was led by a consultant in intensive care medicine. The decision to admit a patient to intensive care was made by a FICM consultant in most cases and patients were reviewed within 12 hours of admission to critical care. Additional pressure was on the consultant team at the CRH site as they covered obstetrics and theatres as part of on call duties.
- One week prior to the inspection visit a new consultant rota had commenced. A consultant covered out of hours calls off site. Consultant staff we spoke with told us that they were called less than half of night shifts by the two middle grades on site. Monday to Thursday would be covered by one consultant with Friday to Sunday being covered over a 24 hour period by rotation of the team. The changes had been implemented to improve continuity in patient care as the previous rota was one shift at a time.
- Consultant to patient ratio was compliant with the 1:8 Guidelines for the Provision of Intensive Care Services (GPICS) (2015) Resident medical cover and out of hours ratios also met compliance standards. Junior medical staff told us that consultant cover and support was excellent.
- Out of hours and on call cover at CRH could include referrals to critical care from the emergency department, obstetrics, theatre emergencies and any NEWS triggers from wards. Medical handover for sick or patients at risk of deteriorating across the hospital was part of the overall evening handover with medical and hospital at night staff.
- There was minimal use of locum or agency critical care medical staff or anaesthetists in 2014/2015. Anaesthetic locum use for last quarter was 1.6% from an average 2% previously.

Major incident awareness and training

- Major incident policies and protocols were in place and readily available on the trust intranet.
- We did not see evidence to demonstrate that the major incident plan had been tested with critical care services.

Are critical care services effective?

Requires improvement

We rated effective as requires improvement because:

- We reviewed a range of paper copies of clinical guidelines and policies that were out of date during the inspection, we raised this at the time of inspection and they were removed. Access to online policy and critical care network guidance was good.
- Physiotherapy staff were unable to achieve the discharge prescription as part of rehabilitation after critical illness, as per NICE CG83 guidance. Physiotherapy resources limited the opportunity to deliver the required forty five minutes of daily critical care rehabilitation, and this was more challenging at weekends.

- Dietician support was not available at weekends and this was identified in the local risk register. There was a standard ITU feeding protocol for new admissions so that nurses could commence nutritional support.
- Pharmacist staffing did not comply with GPICS (2015)
- Staff appraisals rates were low at a recorded 21% in November 2015 against the 100% target required by April 2016. The critical care matron and clinical educator reported improvement at 50% appraisal rates for nursing staff at the time of inspection and an action plan in place to achieve the target
- Thirty nine percent of nursing staff had achieved a post registration award in critical care nursing. GPICS (2015) advocate that 50% of staff should hold this qualification. The senior team had identified four nursing staff to attend the course locally in 2016. They had identified this as an on-going priority. The lack of provision of this course at a local university had impacted on attendance rates.

However:

- New staff had a supernumerary period of critical care training to support their competence, there were good numbers of senior staff and dedicated staff in educational posts across critical care. We saw staff working well together to deliver person centred care and treatment. Staff had attended a medical device competency training programme for all items of critical care equipment and a tracheostomy training programme delivered by CCOR.
- The unit collected and submitted data for the intensive care national audit and research centre (ICNARC) for validation, it was therefore able to benchmark its performance against other similar units. The ICNARC case mix programme data showed that patient outcomes and mortality were generally within expected national range.
- Pain management was planned as part of patient care and the pain team was accessible to critical care staff. Multidisciplinary working was good with involvement in Monday to Friday daily ward rounds from pharmacy, physiotherapy, specialist nurses and microbiology. Dietician support was good through the week and all critical care patients had a nutritional assessment on admission. The unit had guidelines to support patient nutrition and hydration.
- The critical care outreach team provided a service that included follow up of all patients discharged to hospital wards and this supported the patient's recovery and rehabilitation from a critical care admission.
- Staff we spoke with understood the consent process in critical care, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).Staff training figures for MCA and DoLS were not available in the mandatory collection of information at the time of inspection.

Evidence-based care and treatment

- The unit used a combination of national guidelines to determine the treatment they provided. These included guidance from the National Institute of Health and Care Excellence (NICE), Intensive Care Society and the Faculty of Intensive Care Medicine.
- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes for patients were benchmarked against similar units nationally. The case mix programme demonstrated information on occupancy, admission and discharge times, organ support, outreach activity, infection, patient age and medical complexity.
- Staff was able to access a range of critical care policies and guidelines via the internet and trust intranet. These were validated by the WYCCODN and had review dates. Of 18 online policies 16 were in review date and two had been due for review in February 2016.
- We did review paper copy policies and guidelines that were out of date, and had no review dates, at the bedside and in resource areas. Folders had quick reference guides to over 30 areas of clinical practice and these were being reviewed or destroyed during the inspection visit. Staff had good access to online policies and guidelines that were up to date.
- Staff we spoke with were aware of issues critical care patients can experience with delirium. A new approach had been recently implemented and audit was consultant led; staff also had access to a nurse led training package in the unit and we observed a delirium checklist in practice. This had not been fully implemented at the time of inspection; however we did see two good examples of completion of documentation.

- All patients across critical care had admission assessment and discharge prescription as part of rehabilitation after critical illness, as per NICE CG83 guidance. Physiotherapy resources limited the opportunity to deliver the required forty five minutes of daily critical care rehabilitation. Thirty minutes was achieved for each patient.

Pain relief

- We reviewed two care records and two charts and noted that pain assessment was recorded. We observed that pain scores were charted appropriately.
- Staff we spoke with told us that the pain team were very involved in patient care in the unit and easy to access for advice. Patients recovering from surgery in critical care had patient controlled analgesia (PCA) and epidural pain management, the specialist pain team supported staff training in critical care.
- We spoke with patients and their relatives who told us that staff managed their pain well and asked them if they were comfortable.
- We did not see any evidence of pain audit activity or results in critical care.

Nutrition and hydration

- Patients admitted to critical care had a malnutrition universal screening tool (MUST) assessment. Patients who are malnourished, at risk of malnutrition or obese can be identified using this tool. There was a standard ITU feeding protocol for new admissions so that nurses could commence nutritional support.
- A dietitian was dedicated to the unit in a 0.25 WTE role, Monday to Friday and had expertise in critical care in order to support patients effectively. Patients were commenced on feeding regimes as soon as possible. We observed patients receiving total parenteral nutrition (TPN) and Nasogastric (NG) feeding.
- We saw good fluid management and hourly documentation of fluid balance on two patient charts.
- Patient information to help patients and relatives understand nutrition in critical care was available in the visitors room. This included advice around nasogastric and intravenous feeding and helpful contact details.
- The nutrition nurse and dietitian worked together with complex cases, particularly TPN, although there was no formal MDT for TPN decision, support and advice from the biochemist, pharmacist and gastrointestinal consultant was available.
- Patients and staff we spoke with told us that there was good provision of meal choices by the catering department and prepared by housekeeping staff within ITU. Snack boxes with sandwiches and fruit and drinks were available 24/7 for patients.

Patient outcomes

- Intensive care national audit and research centre (ICNARC) supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP) Critical care units can benchmark their practice and services against 90% of other units.
- The results from ICNARC in 2014/15 showed that mortality was within expected ranges when compared to other units nationally.
- Critical care contributed to national mandatory audit, including the national cardiac arrest audit and other audit outside of the mandatory requirement, i.e. delirium audit – use of confusion assessment method in intensive care unit (CAM-ICU) and DoLS audit, ventilator associated pneumonia, perioperative hypothermia, glycaemic control in critical care, and procalcitonin usage in critical care. We did not see results of audits, including pain, skin or sepsis during inspection.
- There was audit underway to establish the impact of CCOR and there was a general sense that readmissions were avoided and escalation of patients to critical care by CCOR was timely.

Competent staff

- Staff we spoke with told us that they received trust and local induction. One hundred percent of critical care staff had attended induction. Nursing staff worked across site in both critical care units.
- Twenty one percent of nursing staff had received an appraisal by November 2015. Although senior staff reported to us that this figure was 50% at the time of inspection. One hundred percent compliance was required by April 2016 and achieving this target had been identified as a priority by the critical care senior nursing staff. Medical staff had received appraisal on target and trainees were supported with good training opportunities.
- Junior medical staff we spoke with told us that overall they were pleased with the educational opportunities, both informal teaching on ward rounds, supervision and

formal education. There was an active academic and audit programme for medical staff. Three medical staff we spoke with told us that they felt their training was supported.

- The critical care service had 1.5 WTE critical care nurse educators in post. Both staff delivered supervision and training and a variety of education programmes. Staff we spoke with told us that the new part time educator had been very supportive of the new staff since January 2016 and had worked alongside them on clinical shifts to teach against the critical care steps competency programme. The clinical educators in critical care were responsible for arranging and documenting staff attendance. This role was in place to support all nurses with structured programmes of education essential to competence in critical care. Staff we spoke with had mixed experiences of training and development in the department.
- We observed a record of medical device training specific to specialist critical care devices and there was good management and attendance of training for each device with a system of competency sign off.
- We spoke with the nurse lead for outreach. They teach and manage a variety of study days for critical care and ward staff and reported that they had a healthcare student in attendance on most shifts.
- Revalidation for nursing staff was being supported across the trust. Awareness sessions and information on the intranet was available for nursing staff.
- Critical care had a local induction and preceptorship programme for new staff nurses. Staff received four to eight weeks supernumerary whilst they achieved critical care competencies essential for safe practice. The national critical care steps competency programme had been recently introduced for new nursing staff.
- In September 2015 it was reported that over half of the nursing staff in critical care had less than 18 months nursing or critical care experience. The senior team had recognised that this skill mix requires senior staff to provide more support and supervision until staff have been assessed to be fully trained in critical care competencies in order to deliver safe patient care.
- Thirty nine percent of nursing staff had achieved a post registration award in critical care nursing. GPICS (2015) advocate that 50% of staff should hold this qualification and low compliance was identified as part of the critical care risk register. Four nursing staff had been booked into the newly established course at a local University for 2016. The lack of provision of a locally accessible course had impacted on attendance rates.
- A senior nurse told us that the unit staff were only trained in basic life support, and not intermediate or advanced life support. We spoke with staff who felt there was a lack of education and training support for those staff who were not new starters. No barriers to accessing training existed but a lack of overall organisation of training for all critical care staff was evident from our staff interviews.
- The unit did not have nursing clinical supervision; there was no formal arrangement for this support of nursing staff.

Multidisciplinary working

- We observed the multidisciplinary team working and communicating well with each other during this inspection. They attended team meetings and handovers.
- We reviewed two sets of care records. Patients were assessed and rehabilitation assessment was complete in all patients admitted Monday to Friday, however with less compliance at weekends as a consequence of limited physiotherapy cover. The same team covers patients from admission to ITU to discharge, offering a good level of continuity and support.
- The physiotherapy team had good opportunity to work with ventilated patients who required weaning and rehabilitation over a long term admission and after discharge. The team had good access to occupational therapists and orthotics.
- The unit was not compliant with the guidelines for the provision of intensive care services (GPICS) (2015) which state that there should be at least 0.1 WTE 8a specialist clinical pharmacists for each single Level 3 bed and for every two Level 2 beds. This ratio meant that for 14 beds occupied, with ten at level 3 the units would not achieve the staffing ratio standard by 0.2 WTE, in addition the dedicated pharmacist was a lower grade than recommended at 0.8 WTE band 7, and also covered theatres and clinical trials with support from a Band 8a, who was one day a week. Staff we spoke with told us provision of cover was good across site Monday to Friday with an on call system at weekends.

- Dietitian support was not available at the weekend and this was identified in the risk report for the unit. The dietitian performed a daily patient ward round and attended the morning multidisciplinary handover when available. They made detailed notes in the care record.

Seven-day services

- Consultant Intensivists and anaesthetists are available 24/7 on site and through an on call system to support the junior team when required. There was a robust and supportive system in place.
- Daily (including weekends) consultant patient ward rounds and review was documented. In two notes we checked, two were complete.
- Physiotherapist, pharmacy and dietetic staff had dedicated hours in critical care and on call services for out of hours emergencies. Physiotherapy did not comply with GPICS (2015) guidance on staffing levels to provide rehabilitation for critical care patients at weekends. Dietetics was not available at weekends.
- There is 24/7 access to diagnostic services across the hospital site.

Access to information

- Staff had good handover processes in critical care, which included paper templates to guide communication. During the inspection we observed the team communicating well to support the sharing of patient information, delivery of effective care and reduction of risk.
- Information was easy to access in paper versions of care plans, observation charts, risk assessments, care charting and case notes. Test results could be accessed electronically.
- The electronic Nerve Centre system for recording and reviewing observations would be rolled out to critical care as part of the trust programme. CCOR were trained in the system and could access patient information easily.
- In conversations with staff we were told that they gathered information with patients and their relatives to support assessment and inform care and treatment.
- On discharge from critical care the staff prepared a detailed discharge summary for every patient to support handover to the ward team, in line with NICE CG50.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of the issues around consent, capacity and deprivation of liberty safeguards (DoLS) for patients in critical care. Staff had access to relevant policy on the trust intranet.
- We did not have opportunity to observe any clinical examples of DoLS assessment in practice at the CRH site.
- Consultant and medical staff used an assessment of capacity using a five point Mental Capacity Assessment after the patient had been off sedation for 48-72 hours. A DoLS referral was made at that point, followed by a consultant-led best interest discussion.
- We were told by staff we spoke with the safeguarding team worked well with ITU staff and staff knew how to seek advice and support.
- Staff we spoke with told us that they had accessed training on the intranet e-learning system and they did appear knowledgeable.

Are critical care services caring?

Good

We rated caring as good because:

- During the inspection we saw patients, their relatives and friends being treated with dignity and respect. We observed the team to be caring whilst delivering care and treatment. Relatives and patients we spoke with were positive about the staff.
- The feedback from patients was very positive and critical care were adopting a new approach to surveying patient experience.
- We observed staff being compassionate with relatives at the bedside and during stressful situations in the unit. They supported families emotionally and planned individualised care that included the patient in decisions.

Compassionate care

- Without exception our team observed staff being caring and compassionate with patients and relatives during the inspection. We observed episodes of care that were kind and patients were treated with respect.
- The unit had designed a critical care version of 'family and friends' questionnaire, with three questions; what has gone well for you? What could we have done better? And number of staff gone the extra mile? This had been

rolled out from August 2015. Results were not in any detail and 13 responses were recorded over four months. The themes were as follows; there was nothing the service or team could have done better, no action for improvement was suggested and 26 positive comments were made out of a possible 26 opportunities.

- We did see numerous messages of thanks from families and patients on display in the unit.
- We observed staff taking time to talk to high dependency patients.
- Privacy and dignity was maintained in the unit, the use of curtains around the bed spaces was very effective. There were good facilities for private conversations to take place in the unit.
- We noted one example of staff being commended for caring practice and this had been cascaded through the team meetings.
- During our inspection we received positive feedback about staff.

Understanding and involvement of patients and those close to them

- Staff we spoke with told us that the unit had a flexible policy to support patients with open visiting and overnight stay
- During observation of handovers we listened to staff discuss individual needs of patients. This included good examples of assessment of capacity.
- We observed staff speaking to patients in a way they could understand about their care. This also applied to the approach of staff communication with sedated patients.
- We spoke with two relatives and one patient who praised the team and told us that they felt informed about their stay in the unit and reported that staff had been caring and supportive.

Emotional support.

- We observed the trust chaplain in the critical care unit on each day of our inspection. Staff and relatives we spoke with said that the service was supportive and appropriate.
- Nursing and medical staff were observed organising meetings with relatives to ensure regular communication and support was available.
- There were no examples of formal access to psychological support at the time of inspection. We spoke with a senior nurse who told us that this service did exist previously and staff were hoping to reinstate this emotional support at discharge clinics in the future.

Are critical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The critical care unit required some improvements to be able to ensure timely access to services to meet the needs of patients. Delays in discharges and admissions led to patients being transferred to CRH for non-clinical reasons. There was capacity at CRH and occupancy was lower than the HRI site and solutions did not include the use of the beds across sites.
- Patients were occasionally transferred out of the Huddersfield unit to the Calderdale unit for non-clinical reasons. CRH had 19% of all discharges as out of hours, between 10.00pm and 07.00 am. Approximately half of all discharges to ward areas were delayed more than four hours, once a decision to discharge had been made.
- Patients had follow up from the CCOR team after discharge to the wards to support their recovery however there was no formal follow up clinics for patients who were recovering from critical illness and admission in line with GPICS (2015). Bed occupancy in the CRH unit had 67% occupancy. The team had identified a need for planning for future services that took into account their current understanding of lack of capacity and aspirations for a single site unit were evident in trust proposals.

However:

- The policy for managing complaints was good and understood by all staff we spoke with. Complaints in critical care were low and two formal complaints had good evidence of investigation and response by the senior team. Improvements in sharing lessons from concerns or complaints with junior staff had been identified by senior staff for action.

Critical care

- Critical care worked to meet people's individual needs. Relatives and friends of patients were able to stay overnight as facilities were very good. The unit had a dedicated quiet room and relatives we spoke with told us visitors facilities were excellent.
- Patients had follow up from the CCOR team after discharge to the wards to support their recovery. Readmissions to ITU were low as a consequence of this support.

Service planning and delivery to meet the needs of local people

- Critical care leads worked across the trust to plan service delivery. There was evidence of collaborative working within the WYCCODN and good practice and learning was shared across the region. For the purposes of governance and planning of services the critical care unit sat in the trusts surgical and anaesthetic division.
- The critical care team attended the trust bed management meetings to be able to monitor the flow and activity of patients across the hospital, to support planning for utilisation of critical care beds.
- We did not see evidence of formal follow up clinics for patients who were recovering from critical illness and admission in line with GPICS (2105)

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Meeting people's individual needs

- Care plans demonstrated that individual patient needs were assessed and considered before delivering care. The trust had interpreter services and an awareness of their local population in order to address the needs as patients and visitors to the hospital.
- Patients had follow up from the CCOR team after discharge to the wards to support their recovery. Readmissions to ITU were low as a consequence of this support.
- The trust had a specialist matron for learning disability who was well known to staff. Staff we spoke with told us that there was good access to resources and education to support patients with specific needs at the trust. They would be alerted through a vulnerable patient flagging system at admission, and staff spoke of patients having passports or diaries to support meeting their individual needs.
- Relatives and friends of patients were able to stay overnight as facilities were very good. The unit had a dedicated quiet room and relatives we spoke with told us visitors facilities were excellent.
- There was good access to specialist bariatric equipment for patients and bathroom facilities had been adapted to meet the needs of the patient.
- We noted a range of leaflets and information to support relatives of patients in the visitors area. There was a quiet room separate to the main visitors area for relatives who required privacy.

Access and flow

- The unit had a recently developed admission and discharge policy that had a published date of February 2016. Lead consultants and the critical care matron had authored it. It included an appendices to support procedures for using theatre recovery and transfers to CRH for critical care patients when beds were not available.
- The Intensive Care society identifies 80% as an average occupancy for critical care to accommodate the frequently changing needs of emergency and elective services. The average occupancy remains high overall at 85% at midnight recording for January to March 2016 across both sites. The Royal College of Anaesthetics recommends that bed occupancy should be below 70%. The CRH site had lower occupancy (at times 60%) than the HRI site by a 30% margin across the three months as reported in the critical care dashboard.
- Consultants we spoke with told us that bed capacity was a concern, with increasing frequency of overflow of patients to the theatre recovery at the HRI site, with 'oversight' from consultants. Any medical critical care patients would be transferred to the CRH site to enable prioritisation of surgical patient admissions to critical care beds.
- The overall number of admissions in 2014/15 was 703, slightly less than the previous year. The main activity was for level 2 or high dependency patients with an average of 145 bed days being utilised against a planned 124 a month. Some small numbers of level 1 patients, 5 to 15 bed days a month over a six month period in 2015, were being cared for in the unit rather than a ward area. Lower figures of level 3 or intensive care patients received care in the units than there was

the planned capacity and staffing for. Figures for the first six months of 2015 showed a monthly planned capacity of 279 level 3 bed days against an actual average of 207 level 3 bed days.

- According to GPICS (2015) standards discharges should occur within four hours of the decision being made by a consultant. This is frequently not achieved. Over half of all patients are delayed between four and 24 hours after the decision to discharge has been made. 290 of 560 discharges were delayed in 2014/15.
- There was issue with delayed discharges across both critical care units. Sixty three percent of patients discharged to wards were delayed greater than four hours after the decision had been made to discharge. Out of hours discharges between 10pm and 7am were particularly high at CRH site at 19% of all discharges.
- There were occasions when patient's surgical procedures were cancelled due to lack of critical care availability. In the first six months of 2015 there had been 12 on the day surgical cancellations which the team had highlighted as an amber risk.
- Critical Care Outreach services, if effective can have a positive impact on readmission rates into critical care. Readmission within 48 hours of discharge in CRH ITU were 0.6% of the 560 discharged patients, a low number of early readmissions in 2014/15, better that the 1% national average.

Learning from complaints and concerns

- Complaints policy and process was followed by staff and staff we spoke with were aware of the processes.
- The monitoring arrangements for complaints at the trust were good and complaints had remained consistent for each year of reporting since 2010. Complaints were monitored in the divisional governance meetings.134 were received in 2014/15 by the division, however only half had been closed within the target timeframe. In the most recent minutes of the integrated divisional this had been set out as a priority.
- The critical care matron discussed two formal complaints which were investigated and shared, although junior staff we spoke with did not feel that the lessons from complaints were shared with the whole team. We noted that methods of communication with the junior nursing team had been recently reviewed and a communication book and unit meeting had been introduced to support an improvement.
- We observed notices and leaflet information outlining the complaints process and access to the patient advice and liaison service (PALS), which had integrated with the complaints service and were now known as 'patient advice and complaints service' (PACS).

Are critical care services well-led?

Requires improvement

We rated well-led as requires improvement because;

- Around half of the nursing staff we spoke with told us that although there was a good nursing structure and senior staff in post were experienced however not all staff were supportive or approachable. More recently the clinical matron and senior team had begun to put strategies in place to improve working experiences and welfare for nursing staff.
- Staff we spoke with told us that they enjoyed working in critical care as a speciality as it was rewarding and challenging. However nursing and medical staff across sites, expressed concerns over cultural issues that had been historic. Morale was low in eight out of 11 nursing staff we spoke with across both sites about these issues.
- Five nursing staff we spoke with felt that although they were listened to by senior staff; however no action was taken when suggestions were made for improving patient care or practice.
- There was a governance structure in place and a local risk register. The governance of critical care sat in the surgical and anaesthetic directorate. Consultant staff we spoke with had good relationships with the team and nursing colleagues; however it was reported that there was poor involvement by nursing staff at all levels in local governance meetings. The senior team reported to us that communication had been a big challenge especially in regard to the cascade of information to junior nursing staff.

However:

- There was good practice but a lack of innovative approaches to critical care practice. Nursing staff development opportunities at the time of inspection were reported by some nurses as poor, however we did speak with staff who were attending masters programmes and plans were in place for staff to attend critical care training in 2016.

- Unit meetings for nursing staff had been recently introduced, however further work was required to ensure the unit staff meetings, including sisters meetings, were in line with trust vision and standards for governance and sharing of learning and information.
- The vision and strategy for the critical care service was not shared or clear across the team. The senior team we spoke with from critical care and the surgical and anaesthetic directorate told us of the trust five year proposals for a single site unit in 2021 in order to improve achievement against GPICS (2015), however interim strategy or vision was limited to address some of the current issues in the unit.

Vision and strategy for this service

- Senior staff we spoke with were focused on the timescales of the five year vision and strategy recently proposed by the trust. This included a single site critical care unit but this development would be complete by 2021. The team had produced a detailed action plan against GPICS (2015) standards, however the majority of standard measures that required improvement and were categorised as amber or red rating under medical staffing and had an action as 'awaiting a major reconfiguration of services to allow single site ITU'. Mitigation of GPICS (2015) and other relevant risks needed to incorporate clear action plans for the interim period, before a single site solution, specifically for delays in discharging patients, admission to theatre recovery and working across full site capacity.
- Staff we spoke with had shared some of the risks and concerns with us and we did not see evidence in meeting minutes that these issues were being discussed in the integrated surgical and anaesthetic governance meetings or critical care strategic meetings.
- We were told by the senior team that there had been a consultant led audit to assess the current demand for level 2 and 3 beds across the trust and this informed the strategy for future critical care provision. Senior staff we spoke with did not tell us of any other strategies to inform future provision and had not outlined the impact, for example, that more timely unit discharges to wards would make to bed availability in critical care.
- Nurse recruitment had been made a priority strategy in October 2015 after vacancy concerns were escalated through the governance structures. The unit was fully staffed at the time of inspection. The implementation of all strategies to retain experienced nursing staff were not established at the time of inspection but had been identified as a priority.
- There was inconsistent assessment of compliance with GPICS (2015) over both sites by the service. This was demonstrated in risk assessments and risk registers submitted to the inspection team. For example pharmacy staffing was not risk rated.
- Staff we spoke with were aware of the trust vision and had good experiences of the Chief Executives communications and approach with staff.

Governance, risk management and quality measurement

- Governance arrangements in critical care were not clear to all staff. Critical care was represented at board and trust level and information was shared across the service. The arrangements for governance and performance management in the critical care unit as part of the surgical and anaesthetic division did not appear to operate effectively, as many critical care issues were not reviewed in detail on review of minutes from 2015/16.
- There was a risk register and issues on the register were not always dealt with in a timely way. During our inspection it was clear that solutions to longstanding issues had been implemented in the week or two before, for example consultant continuity of patient care and changes to rota's, communication books for nursing staff and review of paper policies and guidelines.
- We saw agendas, and meeting minutes of unit and divisional meetings which included information on safety, performance, finance, staffing and the risk register in senior meetings.
- Critical care had consistently submitted data to ICNARC since 2009. There was a dedicated nurse employed to manage the ICNARC data collection at each site. We did not see how this information was shared with the team or used for improvement. There was also some inconsistency in ICNARC reporting timescales at each site which could be aligned to support data analysis.
- A performance and quality dashboard had become a recent feature to provide information to staff about patient harm incidence and performance. We noted three examples of the critical care dashboard in the data submission; however we did not see this in practice during inspection.

Critical care

- There was conflicting information provided by the service. For example within critical care information regarding staffing in post indicated that 44.35 wte staff were in post in November 2014. Subsequently the trust provided information which identified there was 58 wte staff in post for the same month. It was not clear which presented an accurate picture.
- Four medical staff we spoke with told us of limited engagement with nursing staff in a number of areas, protocol development, attendance at shared meetings, i.e. mortality and morbidity and governance meetings, and they shared concerns around recent nurse staffing levels, and critical care admissions to theatre recovery.
- The unit had experienced a peer review by the West Yorkshire Critical Care Operational Delivery Network (WYCCODN) in November 2015. The review gave the unit evidence against the range of intensive care standards. Areas of compliance and non-compliance were RAG rated with a description to guide the critical care units. The report outlined that medical staffing was not fully compliant with GPICS (2015) and standards for the Faculty of Intensive Care Medicine (FICM). The report recommended that solutions must be found rather than waiting for a proposed single site unit. Strategy to retain nursing staff was recommended as a priority. Patient flow issues, particularly related to delayed discharges were also reported as a concern.

Leadership of service

- We observed good teamwork however accounts of staff satisfaction were mixed in the nursing staff we spoke with. We spoke with 34 staff in total and the majority told us that they enjoyed working in critical care. Nursing staff in the majority told us that but they did not feel consistently supported by all senior staff. There was no performance of staff satisfaction surveys specific to critical care at the time of inspection. Listening events had been performed in 2015 to support staff after a period of low staffing and low morale had been reported.
- A communication file for nurses had been introduced and made available in the staff room one week before the inspection. This was a measure implemented to address limited cascade of performance, risk management or issues from the senior meetings attended by senior nurses to the junior team.
- The unit had experienced unprecedented staff turnover in 2014/15, with a 37% vacancy rate in November 2015. This had prompted staff 'listening events' facilitated by the associate director of nursing,(who was no longer in post) for staff to discuss concerns; these included;
  - low priority of education and training for experienced staff,
  - staff being redeployed to wards,
  - intimidating and unsupportive behaviours of senior staff,
  - a range of problems with e-rostering,
  - retention of experienced staff,
  - stress associated to the site coordinator role taken by ITU staff.
- Staff we spoke with told us of proposals to improve morale after the listening events however during inspection staff told us they still had many of the same concerns.
- We saw a summary and action points to support recruitment of new staff and retain current experienced staff. At the time of inspection there had not been enough time to evaluate the effectiveness of actions identified to address many of the issues at the time of inspection. Many actions had only recently been implemented or were on-going. There was a commitment from the matron and senior team for improvement.
- There was lack of investment or priority in continuous professional development, which included limited leadership development for experienced staff.
- Medical staff we spoke with described a supportive consultant network and good sharing of information. The multidisciplinary team also had positive experiences.

Culture within the service

- Staff we spoke with told us that they enjoyed working in critical care as a speciality as it was rewarding and challenging. However nursing and medical staff across sites, expressed concerns over cultural issues that had been historic.
- Morale was low in eight out of 11 nursing staff we spoke with across both sites about these issues. This was not found to be the case for the therapy teams and medical staff.

- We were not assured that there was an open and transparent culture. There had been evidence of negative behaviours in the nursing team and this had an effect on staff in 2015. Work was on-going to improve the culture in the unit.
- Nursing staff we spoke with told us that they did share concerns or comments they had about patient care, colleagues or the service overall, however they felt that action taken by senior nursing staff wasn't always clear or consistent

Public engagement

- There were no examples of public engagement other than that of the friends and family test and an adapted survey of patient experience that was freely available for visitors to complete and leave in the department in an anonymous drop box.
- Staff we spoke with and observed were patient focused and were seen to be friendly and approachable in their interactions with patients and their relatives.
- A good range of leaflets and information was available in the visitors room.
- The critical care Matron was visible and available for patients and their relatives on both units.
- On speaking with staff we were not made aware of any suggestions from patients that had led to improvements in the service.

Staff engagement

- The 2015 trust staff satisfaction survey compared Calderdale and Huddersfield NHS Foundation Trust favourably against other trusts, especially in areas around reporting errors and incidents. The trust had worse results for flexible working, work related stress and management interest in staff wellbeing. Specific responses from critical care could not be extracted however these themes were noted to be relevant to unit responses during inspection.
- It was recognised that nursing staff engagement was poor in the unit, with a plan for improvement being partially developed. Nurse vacancies had been filled at the time of inspection and sickness rates were beginning to improve.
- Communication with nursing staff was noted to be an area for concern by senior staff and was felt to be a priority, there was an action plan in place at the time of inspection and some measures had been put in place to improve the sharing of information at the time of inspection; however this work should be evaluated.

Innovation, improvement and sustainability

- The Nerve Centre system was due to be rolled out across the trust and was found to be effective in the recording of observations, NEWS and triggering assessment and decisions from senior staff about patient care and treatment. We felt that this improvement work was innovative and would be of benefit to critical care. CCOR were part of the early implementation of the system and had supported ward staff in understanding and training.
- We observed a magnetic bedside risk display system that was simple and effective. It was a consistent approach to alerting staff to patient individual needs and risks.
- There was good engagement and attendance from the critical care team with network clinical groups, including a clinical advisory board, senior nurses forum, outreach forum, clinical educators group. Nursing staff led and contributed to data collection for ICNARC and West Yorkshire Critical Care Network (WYCCODN) global measures.
- The Central Venous Devices Service (CVAD) was established in 2007 to reduce the incidence of device healthcare associated infection through the application of best practice across the Trust. There was a process of referral of patients across all clinical areas and clinical care, treatment and additional support and advice was given by staff. There had been stable numbers of central venous catheter (CVC) days across both sites at a rate of 1.43 per 1000 days was in line with the published national and international averages of 1.4/1000 CVC days (ICNARC).

Maternity and gynaecology

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

Information about the service

Calderdale and Huddersfield NHS Foundation Trust provided a full range of maternity services for women and families within two hospital sites and community settings. Services at Calderdale Royal Hospital ranged from consultant led and specialist care for women with increased risks, to midwifery led care for low risk expectant mothers. There was twenty four hour access to a maternity assessment centre.

Community midwifery teams provided antenatal and postnatal care in women's homes, clinics, children's centres and GP locations.

A women's health unit incorporating a pregnancy advisory and termination service and a gynaecology assessment unit, provided a range of treatments for gynaecological problems.

The service at Calderdale Hospital delivered 4,947babies between April 2014 and March 2015. 751 of these were midwifery led births and 4,196 were obstetrician led.

We visited the antenatal clinic, labour ward, induction of labour suite, obstetric theatres, pregnancy advisory service, early pregnancy assessment unit, maternity assessment centre, antenatal and postnatal ward, gynaecology assessment unit and gynaecology in-patient ward.

We spoke with 19 women and 27 staff, including midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at 13 care records. We also reviewed the trust's performance data.

Summary of findings

Overall we rated maternity and gynaecology services as requires improvement.

- Mandatory training figures were variable and figures were generally lower for medical staff and safeguarding training. Training was not provided on the mental capacity act and deprivation of liberty safeguards which left a gap in knowledge for staff.
- We were concerned over the numbers of women experiencing third and fourth degree perineal tears and postpartum haemorrhage following delivery. This had been flagged on the maternity dashboard as being higher than the regional average.
- Staffing on the gynaecology ward was often below the planned level.
- We received negative feedback from some of the women we spoke with, which reflected comments seen in some of the serious incidents and complaints data.
- We were concerned that the risk associated with the opening of a second emergency obstetric theatre and subsequent theatre delays were not a focus within the service.

However:

- We saw the careful planning and support systems had been put in place when implementing the electronic patient record.
- Handovers between staff were detailed and informative.

Maternity and gynaecology

- Clinical areas were clean and tidy with sufficient equipment to meet the needs of patients.
- Care bundles and action plans had successfully reduced the number of stillbirths.
- The preceptorship package for newly qualified nurses and midwives was comprehensive and ongoing development of staff was supported through the 'clarity' project.
- Staff spoke in a positive way about local leadership and visibility of the senior management.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Two of the serious incidents related to a failure to follow guidance on assessment of fetal growth and there had been two never events both of which related to retained swabs.
- We had concerns about the process of opening a second obstetric theatre out of hours and the potential impact this had for women requiring an emergency caesarean section. We found evidence of delays in women requiring category one caesarean sections getting to theatre within the recommended time scale of 30 minutes.
- We saw gaps in the checking of stock balances of controlled drugs and missing second signatures in the administration of controlled drugs.
- Mandatory training figures were variable but notably lower for medical staff, between 43.3% and 69.9%. Training figures for safeguarding were a particular concern; they were between 15.9% and 56.6%.
- We were not assured that all staff was knowledgeable in relation to female genital mutilation (FGM). This meant staff may not recognise or report cases of this.
- Actual staffing levels on the gynaecology ward were often below the planned.

However:

- Electronic patient records (EPR) had been implemented with plans in place to support staff.
- Ward areas were clean and tidy and we observed good practice in relation to infection prevention.
- The appropriate equipment was available to meet the care needs of women using the service and resuscitation equipment was checked daily.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were embedded in maternity and gynaecology. Incidents were reported on the trust

electronic reporting system (Datix). We spoke with staff of various grades who were aware of how to use the system and could describe the process for reporting an incident.

- Incident reporting was encouraged, and this was reflected in the results of the 2015 National NHS Staff Survey. This showed the percentage of staff reporting potentially harmful errors, near misses or incidents was 95%; this was higher (better) than the national average of 90%.
- Between October 2014 and November 2015 there were 1,322 incidents reported in maternity and gynaecology services. 67% of these were rated as green (no harm). The remainder were all rated as incidents which caused 'harm' but separated into yellow, orange and red. 0.4% of the incidents were rated as red.
- However it was noted on the departmental risk register that midwives were not completing incident forms for electronic patient records (EPR) incidents. From the incident data received there were only two which related to EPR. In response to this an email had been sent to all staff and the EPR midwife had been asked to encourage incident reporting in this area.
- Analysis of the incidents identified the themes were: staffing, postpartum haemorrhage (PPH), third and fourth degree tears and shoulder dystocia. (Shoulder dystocia is when the baby's head has been born but one the shoulders becomes 'stuck' behind the mother's pubic bone). Feedback from staff supported this, although only two members of staff were able to articulate any learning or examples of changes in practice relating to these areas. However we were told that PRactical Obstetric Multi-Professional Training (PROMPT) included training on perineal repairs as a response to the number of incidents.
- There were a number of ways incidents were shared. We observed one of the twice daily safety huddles on the labour ward where two incidents of post-partum haemorrhage (PPH) from the previous day were discussed. Other methods of sharing information about incidents were emails, team meetings, monthly newsletters or face to face feedback from managers.
- The maternity patient safety group (MPSG) met monthly and we reviewed meeting minutes which listed individual incidents and any outstanding actions. The patient safety quality board (PSQB) minutes discussed incidents in more detail and we saw they were well attended.
- Minutes were also reviewed from the maternity and gynaecology forum and directorate meetings. These meeting were attended by departmental managers and clinical leads. Incidents were not discussed at these meetings and where they were a brief general statement had been recorded. For example, staff had to 'be careful when grading whether an incident was red or orange'.
- Most incidents were reported on the day they occurred or the following day. We did find small numbers of incidents where it had taken between seven and 14 days for the incident to be reported. The PSQB governance report to the quality committee from February 2016 also made note of two incidents, one relating to the early pregnancy assessment unit (EPAU) from November 2015 and one in gynaecology from May 2015. Neither investigation was completed; therefore there was a potential risk of reoccurrence.
- Between July 2015 and December 2015 three serious incidents were reported within the service, each of these was a maternity/obstetric incident. We reviewed the investigation reports which identified areas of good practice and areas of concern, contributory factors and recommendations. A root cause and lessons learnt were also identified with an action plan; this was in line with the serious incident framework guidelines 2015. However when we asked staff about recent incidents, none of the 12 maternity staff referred to any of the serious incidents. This was a concern as two of the incidents related to fetal growth and identified guidelines were not adhered to. We were therefore not assured that there had been shared learning for all maternity staff.
- Several recommendations and actions were identified following the serious incidents. Some related to the processes in clinical situations, for example, ruptured membranes at term and guidance if fetal distress was identified. They each included feedback to those staff involved and presentation of the incident (anonymised) at a multi-disciplinary team meeting.
- There had been two never events reported in 2016 within maternity services. 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.

- Both never events related to retained swabs and occurred within a few weeks of each other. The full investigation had not been completed at the time of inspection but we were provided with information on immediate actions taken, for example revising the standard operating procedure (SOP) for accountable items.
- Staff we spoke with were aware of the never events and spoke about changes in practice in relation to swab counts.
- The RCOG guidelines recommended two obstetric operating theatres for a hospital with a birth rate of over 4000. There was a second theatre within the main operating department, but out of hours the team which staffed it were not on site and had to travel from home. This was not on the departmental risk register and staff we spoke with at all levels did not identify it as a risk.
- On review of the incident data from October 2014 to November 2015 we found some incidents relating to delays in opening the second obstetric theatre. Further information provided by the trust showed in the last 12 months there had been six delays in category one caesarean sections, with times ranging from 37 to 88 minutes. The analysis from the trust found three of the category one caesarean sections had been incorrectly classified. A category one caesarean section should occur within 30 minutes as it is a situation where an immediate life threat to a woman or baby has been identified.
- There were also four delays identified in category two caesarean sections. Further investigation and analysis by the trust following our inspection identified that only four of the cases were true delays.
- We reviewed perinatal mortality and morbidity meeting minutes which included discussions and learning points.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of the duty of candour and spoke about being open and honest. Staff were able to provide the inspection team of examples where duty of candour was applied and it was evidenced in the serious incident investigations we reviewed.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer measures the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- We saw that safety thermometer data was displayed in clinical areas. For example on ward 4C, it showed the last avoidable fall was in September 2015.
- The maternity safety thermometer was used and collected data on **perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby** and **psychological safety**. Data showed that between February 2015 and January 2016 the percentage of woman experiencing 'harm free care' was above average.

Cleanliness, infection control and hygiene

- The clinical areas we inspected were clean. Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels were located at the entrances and throughout clinical areas.
- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all wards we visited and 'bare below the elbows' guidance was adhered to. The women we spoke with all said staff washed their hands and used hand gel when attending to them and their babies.
- Laminated cleaning guidelines were located in the rooms in the birth centre and 'I am clean labels' were used to indicate equipment had been cleaned following use. We also saw flow charts for the disposal of waste, indicating which container or bin to use.
- Single rooms were available in all areas if a patient needed to be isolated. On the gynaecology ward appropriate signage and precautions were being used for a patient requiring isolation.

- We reviewed the infection control performance dashboard from October 2015. There were no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within obstetrics and gynaecology.
- The trust target was 95% for screening of women for MRSA who were undergoing elective surgical procedures, the infection control performance dashboard showed this target was being achieved.
- Training data showed that 90.8% of nursing and midwifery staff had completed infection prevention training.
- In the 2015 CQC Maternity Survey, the trust scored 8.7 out of 10 for the cleanliness of rooms and wards. They scored 8.6 for the cleanliness of toilets and bathroom facilities. Both results were similar scores to the England average.

Environment and equipment

- Access to the labour ward, maternity assessment unit and maternity wards was via a video intercom system. This complied with Health Building Note 09-02 – Maternity care facilities (2013).
- The wards were a combination of bays and single rooms. The induction of labour suite had five rooms, with 11 rooms on the labour ward. A bereavement suite was also available.
- There was a dedicated ward and theatre for women who underwent elective caesarean sections.
- The obstetric theatre could be easily accessed from labour ward. If a second theatre was required this was on the floor above in the main theatres.
- There was adequate equipment on the wards to ensure safe care, such as cardiotocography (CTG) and resuscitation equipment. CTG is a technical means of continually recording the fetal heartbeat and the uterine contractions during labour. Staff confirmed they had enough equipment to meet patients' needs; this included a variety of equipment for women to use in labour. Specialist equipment for women with a high body mass index (BMI) was available when required.
- A birthing pool was available on the labour ward and two on the birth centre. An evacuation simulation had taken place the day prior to our visit and laminated guidelines on the evacuation procedure were in the room.
- All delivery rooms had piped ENTONOX® (gas and oxygen) and the delivery suit had a fetal blood analyser.
- Resuscitation trolleys were easily located on the main corridors in each of the areas we visited. Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). We inspected resuscitation equipment in the clinical areas and were assured that daily checks had been undertaken.
- We inspected equipment for evidence of safety testing. This is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at all types of equipment and all had evidence of in date PAT.

Medicines

- We checked the storage and administration records of controlled drugs in all clinical areas. There were significant gaps in daily checks on the gynaecology assessment unit (GAU) and the gynaecology ward (4C). For example in January 2016, controlled drug checks had not been recorded on 22 days on GAU and nine days on 4C. On labour ward there was absence of a second signature check for controlled drugs on two entries. We were therefore not assured that trust policies and guidance in relation to management of controlled drugs were being followed.
- Daily controlled drug stock balance checks in other clinical areas were completed; with the minor exception of two days missed between January and March 2016 on the birth centre.
- We saw evidence of daily recording of fridge temperatures in the clinical areas we visited.
- On the labour ward there was a separate fridge which contained drugs required in an emergency. A decision had been made by the trust to reinstate the use of this fridge in February 2016. The inspection team found the fridge was unlocked with the key in the lock; we were told this was due to it containing emergency drugs which required quick access. The fridge was within a room, accessed by a key code lock and there was restricted access to the room.
- We saw posters in clinical areas highlighting the importance of 'critical medicines' and the process for obtaining these to prevent doses being missed.
- The trust commissioned the West Yorkshire Audit Consortium to provide assurance on medicines management. We saw the audit summary from the audit the Consortium had carried out in 2015 with the

community midwifery teams. Recommendations made following the audit included, updating patient group directions (PGDs). These are documents which allow specific medications to be given by certain people without needing a doctor.
- We reviewed data relating to 'mock inspections' of different wards and areas, this included looking at various aspects of medicines management. Issues identified were raised with the ward manager or appropriate person to action immediately. For example, on the antenatal assessment unit the solution for glucose tolerance testing was on the worktop. It was removed and placed in a locked cupboard as per trust guidelines.

Records

- The maternity service had implemented the K2 electronic patient records (EPR) in June 2015. Some antenatal notes were carried by women throughout pregnancy in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3, although much of the information was recorded electronically.
- EPR were on the divisional risk register with regards to records not being fully completed due to staff's unfamiliarity with the system. A comprehensive training plan and support system for staff was implemented to aid the transition from paper to EPR. This included a whole time equivalent (WTE) midwife to support the system and named EPR 'champions' in each area.
- We also reviewed the EPR work plan which detailed individual aspects of the record, twenty in total, and timescales for achieving them, for example implementation of an audit cycle for EPR.
- We met with the EPR midwives and reviewed eight sets of EPR as well as observing the records being assessed and updated in 'real time' whilst in clinical areas.
- The records we reviewed were complete and contained a pathway of care. An antenatal care checklist was produced for community midwives and risk assessments were completed at booking and repeated at every antenatal visit.
- The 'fresh eyes' approach was used for review of CTGs, and we saw evidence of this in the EPR.
- Staff spoke positively about EPR as they were now more familiar with the system. We were told if they identified any issues, they would inform the EPR midwife and they were quickly resolved. For example some of the mobile units were not saving data; this was escalated to the EPR midwife and within 24 hours the issue was resolved.
- Records were audited using the Clinical Records Audit Standards (CRAS); this had been in place since 2012 and had been updated to enable the review of EPR. The CRAS was a comprehensive review of records. It had 19 standards including, questions around fetal monitoring and the completion of admission documents. We were told five CRAS audits were completed each week, but that the current auditing was insufficient to produce a report. This meant any trends or gaps in records could not be easily identified.
- We reviewed CRAS audit data relating to gynaecology that reviewed seven aspects of the nursing documentation, for example date of nursing assessment recorded. The audit data showed in a 12 month period records had been fully completed 100% of the time. The exception to this was September 2015 when 67% of care plans had been completed in full.
- We reviewed five sets of paper records and found them to be completed appropriately and each contained completed risk assessments on topics such as: Malnutrition Universal Screening Tool (MUST); skin integrity and falls.

Safeguarding

- There was a named midwife for safeguarding and an up-to-date safeguarding policy. All staff we spoke with could describe what the process was if they had concerns and how to contact the safeguarding teams for different areas. The staff also described good working relations with community midwives over safeguarding concerns.
- We were provided with an example of a very complex case which had required careful consideration of safeguarding, and required a multi-agency approach to manage the situation.
- We were told about a yellow safeguarding padlock on the hospital intranet which was a quick access resource for information and guidance on safeguarding.
- Safeguarding was documented within the EPR and an icon would appear at the top of the woman's record if any concerns had been added. Any safeguarding concerns could be added to the record at any stage by both community and hospital midwives.

- We were provided with two sets of safeguarding training figures by the trust and the trust target for training was 100%. This presented a confusing picture as nursing and midwifery staff within maternity and obstetrics had an overall safeguarding training compliance figure of 82.5%. However, more specific data showed safeguarding adults level two training was at 32% and level three 15.9%. Safeguarding children level two was 48.8% and level three was 56.6%. These figures were supported by some of the staff we spoke with who said they could not all access safeguarding training as due to staffing levels training was cancelled.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). Not all staff was clear about the process for this and comments were made such as it wasn't very common. However other staff could give examples and talked about the new guidance in relation to FGM.
- There was a section of the EPR which related to FGM. We reviewed the trusts clinical guideline which was very comprehensive and included flow charts and clear guidance on care during pregnancy. The guidance stated mandatory FGM training and updates were to be rolled out for all staff. This data was not included within the mandatory training data provided.
- Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. The trust stated this data was collected by the information team from a variety of sources.

Mandatory training

- Mandatory training comprised of ten elements including moving and handling, fire and dementia awareness. We were provided with different targets for mandatory training, one of 75% and another of 100%. Training percentages for nursing and midwifery staff in maternity and obstetrics were between 66.8% and 92.1%. The lowest percentage of 66.8% was for PREVENT training (PREVENT is part of the government's counter terrorism strategy).
- Percentages for medical staff within obstetrics and gynaecology were lower. They were between 43.3% and 69.9%.
- There was additional training for midwives such as PROMPT training. This was led by the consultant midwife and is evidenced based practice training for obstetric emergencies. Training percentages for this in 2015 were; 91% for midwives, 81% for consultants, 82% for junior doctors and 84% for health care support workers.
- We were told mandatory training was not centrally managed which meant that it was difficult for managers to see what mandatory training attendance figures were. Basic life support training compliance was not included in the mandatory training data provided.
- Mandatory training was identified on the departmental risk register and in November 2015 it was updated stating the division was on target to fully deliver mandatory training by March 2016.

Assessing and responding to patient risk

- Staff on the gynaecology ward used the national early warning system (NEWS) for assessing the condition of patients. The five sets of notes we reviewed showed observations were recorded and scores calculated correctly. Staff were clear about the process of escalation if someone was unwell. The gynaecology ward and gynaecology assessment unit had some medical patients at the time of inspection. We were told getting medical review if a medical patient became unwell was not an issue. There was also access to a critical care outreach service, which meant ward staff were supported if a patient deteriorated.
- A maternity early warning scoring assessment tool (MEOWS) was used within maternity services. This assessment tool enabled early identification of women who required additional medical support or closer monitoring.
- An audit of 12 sets of maternity records in January 2016 showed that 25% of the observations and scores had not been completed twice a day postnatally. This meant that potentially staff were not aware of those women who could have been unwell or had abnormal observations.
- We reviewed an action plan in relation to this which included ongoing review and audit using the CRAS tool and individual feedback to those identified as not having recorded women's observations.
- There was on site access to Neonatal Intensive Care beds.
- Risk assessment at antenatal booking was done for all women using trust guidance to determine whether individuals were high or low risk.

- The trust had an Antenatal Screening Specialist Midwife and we were told there were failsafe's across all screening programmes. A failsafe is a back-up mechanism, in addition to usual care. This ensures if something goes wrong in the screening pathway, processes are in place to identify what is going wrong and what action follows to ensure a safe outcome.
- The EPR included sections on mental health, substance misuse and domestic violence assessments. There were also specialist midwives in each of these areas.

The EPR section for postnatal checks did not include a tool to assess for postnatal depression.

- We observed the triage system in the maternity assessment centre (MAC) as well as looking at the SOP on clinical decision making and the admissions process. There were four pathways used for women contacting or attending the MAC and suggested attendance criteria.
- The triage process in the MAC was listed on the departmental risk register and an improvement plan had been put in place. We were told the unit was always looking at how to improve. As part of this, care pathways and how they could be improved to give more guidance and confidence to midwives, was being looked at.
- The World Health Organisation (WHO) devised a safer surgery checklist which included five steps to be completed when anyone had an operation. This was adapted to include obstetric procedures in 2010. The EPR clearly detailed each of these steps and audit data provided by the trust showed compliance was 98-99% for October, November and December 2015.

Midwifery staffing

- The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG), recommend a ratio of 1:28. This being one midwife to 28 births. Information from the trust dashboard in February 2016 showed the midwife to birth ratio to be 1:30.
- The service used Birth Rate Plus (a midwifery workforce planning tool) every six months to ascertain the appropriate staffing levels for the women in their care. This was done in conjunction with professional judgement and discussions with the consultant on call and/or the supervisor of midwives (SoM).
- Birth rate plus suggested an average midwife to birth ration of 1:29.5 with a range of 1:20 to 1:32 meaning the trust was within the suggested range.
- As a result of these tools being used the workforce model had changed. For example, in October 2015 the number of midwives on the labour ward and MAC was increased from ten to twelve.
- Review of incident data from October 2014 to November 2015 revealed 10% of the incidents related to staffing issues. For example, insufficient staffing levels for the demands on the unit or delays in treatment for mothers. This was supported by the staff we spoke with whom all mentioned staffing as one of their concerns.
- The trust provided the inspection team with further information in relation to the above incidents stating the numbers were in response to Red Flag maternity staffing guidance. This guidance was published by NICE in February 2015 and explains what signs indicate there may not be enough midwives available. For example, if there was a delay of two hours or more between a woman coming in for induction of labour and the process being started. Each of the incidents were categorised as 'green' meaning no harm was experienced.
- Midwifery staffing was on the departmental risk register. This was because it was identified 100% fill rates may not be achievable due to staff sickness and maternity leave. Data from April to December 2015 highlighted that the ante/postnatal ward consistently had below 80% fill rates, meaning the required number of staff was not achieved.
- We reviewed an action plan in relation to this, which included management staff being released to work clinically and specialist midwives working one clinical shift per week. One impact of this was managers reported they found it more difficult to attend meetings and complete their administrative duties. To achieve safe staffing levels across the maternity and obstetric department, staff were moved between areas; we were told this could happen on a daily basis. There was an escalation policy in place and escalation of midwifery staffing concerns was via the shift co-ordinators who would address the situation at a local level.
- We were assured that 99.8% of women had 1:1 care during labour, (Data from February 2016) which had improved from February 2015 when it had been 89.5%.

- The gynaecology ward was also highlighted as an area which for the same time period identified fill rates below 80%. A workforce review had taken place for this area in November 2015 and additional posts recruited to.
- We reviewed a month of staffing rotas for the gynaecology ward (4C). The rota was red, amber, green (RAG) rated for each day and night for fill rates for qualified and unqualified staff. Six of the 29 days were rated as green. This meant 79% of the day shifts for the month did not have the required number of qualified nurses.
- This was supported by planned and actual staffing numbers seen during our inspection. On the late shift, it was noted the ward was short of one qualified nurse on the two occasions we visited. Ward 4C had also planned to have one health care support worker on a night shift; this was achieved on one night during February 2016.
- At the time of inspection the GAU had four beds in use for medical patients. This had an impact on staffing for ward 4C and GAU as it had to be staffed overnight (when it would normally be closed). This was being managed by moving staff from 4C and the use of bank and agency staff.
- We observed handover on ward 4C, the labour ward and the ante/postnatal ward. The handovers were concise and provided detailed information about the patient's clinical condition. Due to a number of medical patients on ward 4C, the handover included information relating to the patients home circumstances and discharge planning.
- On labour ward they had a 'commander role' which was a band seven midwife. They co-ordinated and supported the other midwives, for example when providing 'fresh eyes' to review CTGs. Another band seven midwife's role was to oversee births classed as high risk.

Medical staffing

- The medical staffing was in line with the England average and there was 24 hour availability of an anaesthetist.
- Consultant cover on the labour ward was 98 hours per week and was provided by 12 consultants working a one in 18 week rota. The 'hot week' consultant was resident from 8am until 6pm and the on call consultant was resident from 6pm until 11pm.
- Obstetrics on call cover was provided 24/7 in two shifts with a 30 minute overlap to allow a handover to take place.
- First on call cover for gynaecology was provided from 9am to 5pm Monday to Friday.
- Second on call cover for gynaecology and obstetrics was provided 24/7. There were two trainees allocated to the 8.30am to 9pm shift, one for gynaecology and one for obstetrics.
- The trainee on call from 8.30pm to 9am covered obstetrics and gynaecology. When we asked if this was adequate cover, the service leads felt it was as the on call consultant was available on site until 11pm. The doctors we spoke with had no concerns if they were on call as support was always available if needed.
- There was no designated medical cover for the MAC. When a doctor was required staff would contact the on call doctor for obstetrics or gynaecology.
- At the time of our inspection there were six medical patients on ward 4C and four medical patients on the gynaecology assessment unit (GAU). Staff reported no issues in these patients being reviewed by the medical team or obtaining medical assistance to the ward if they were concerned about a patient's clinical condition.
- We observed the medical handover which was led by the consultant and was detailed and advised on prioritisation of work. It also included a safety briefing.

Major incident awareness and training

- The trust had a major incident plan which outlined the roles and responsibilities of staff in each area.
- Business continuity plans were in place for maternity and gynaecology services which included risks specific to each clinical area. There was an escalation plan in place to manage shortage of midwifery staff and potential closure of the delivery suite. This would also be used in the event of adverse weather conditions.
- Although PROMPT training was in place. We found no evidence of ward based 'skills and drills' taking place for midwives and medical staff. These are scenarios based on obstetric and neonatal emergencies.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- The percentage of women experiencing post-partum haemorrhage and third and fourth degree tears following assisted birth had increased. They were above the regional average.
- We were not assured that staff understood the legislation in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards; the trust did not provide training for this.
- Staff involved in the care of children could not explain Gillick competence.
- We received some negative comments from women in relation to assisting them or their babies with their nutritional needs.
- Laminated copies of clinical guidance on the labour ward had no review date, version or author. Some patient information leaflets were not current or past their review date.

However:

- Guidelines were evidence based and were easy to access.
- The implementation of the SaBiNE care bundle had reduced the number of stillbirths.
- Audit of third and fourth degree tears following normal birth had prompted an action plan which had reduced the incidence of this to below the regional average.
- The trust had exceeded the targets relevant to maternity in the National Neonatal Audit Programme (NNAP).
- The preceptorship programme and training for new nurses and midwives was very comprehensive and the 'clarity' staff development projects had had a positive impact.

Evidence-based care and treatment

- The care and treatment provided was based on guidance from the National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG) and evidence based practice. Policies and guidance could be accessed on the trust intranet which was easy to navigate. We reviewed a number of policies on line, including the management of PPH and pre-eclampsia, which were in date with version control and an author clearly identified.
- However we found that eight protocols and guidelines displayed on the labour ward were out of date. For example, contained in a file on the emergency trolley was a laminated copy of the major haemorrhage transfusion policy which had a review date of March 2013. We saw copies of the sepsis care bundle and sliding scale insulin regime, neither of these had a date, author or version number on them. Therefore despite the up to date information online we could not be assured this was the information that was being used in practice.
- Audits of NICE guidance and quality standards were in place as part of the trust's audit programme. The PSQB governance report to the quality committee from February 2016 provided a summary of the trusts status with regards to the services compliance with guidelines. For example there were four guidelines with which they were partially compliant but no further action was needed, and they had identified they were partially compliant with NICE CG190 recommendations for intra-partum care but were working towards full compliance.
- We found from our observations and reviewing of records that care was provided in line with RCOG guidelines including Safer Childbirth: minimum standards for the organisation and delivery of care in labour.
- NICE Quality Standard 22 related to the antenatal care of all pregnant women up to 42 weeks of pregnancy. From our observations, reviewing of records and discussions with staff, we could see the care delivered was in line with this standard.
- NICE Quality Standard 32 related to the care of women who either need or had chosen to have a caesarean section. There was a dedicated ward and theatre for those women who chose an elective caesarean section. The women we spoke with who had needed an emergency caesarean section confirmed this decision had been made following discussion with a consultant obstetrician.

- NICE Quality Standard 37 related to postnatal care and we saw evidence of this standard been met, for example the women we spoke with felt supported with breastfeeding and knew where they could seek additional support on discharge.
- We found staff in the GAU adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary forms (HSA1 and HSA4).
- The service had implemented the NHS funded Saving Babies in North England (SaBiNE) care bundle for still birth prevention.

Pain relief

- There were several methods of pain relief available to women in labour and information on these was provided during pregnancy.
- A birthing pool was available on the labour ward and two on the birth centre.
- Entonox gas was available in each of the birthing rooms and opiates were also available. A 24 hour epidural service was also provided.
- Assessment of pain was seen in the EPR we reviewed and on the gynaecology wards pain scoring was recorded on the NEWS charts.

Nutrition and hydration

- Meals were provided in the in-patient areas by a menu ordering system. Meals were available for different dietary requirements. On Ward 9 (ante/postnatal ward) meals were provided from a meal trolley and could then be taken by women to their own room if that was preferred.
- We were given two examples from the 19 women we spoke with of help not being offered on ward 9. These related to someone being unable to walk to get a hot meal and make up formula for their baby.
- On ward 4C we saw patients being assisted with meals as required.
- We received positive feedback from women in relation to support for breastfeeding and there were three lactation consultants.
- Data from October 2015 to December 2015 showed the unit had a breastfeeding initiation rate of 78% post-delivery with 46% still breastfeeding at discharge from maternity care (6-8 weeks post-delivery).
- The UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships. The maternity unit received the baby friendly initiative accreditation for the fourth time following reassessment in May 2015.

Patient outcomes

- The trust reported a total of 5,330 deliveries in 2014/2015; of these 63.7% were normal vaginal deliveries which was better than the England average of 60.2%. Additionally 9.4% were elective caesarean section deliveries compared to an England average of 11%. The rate of emergency caesarean section was the same as the England average 15.2% (Source: HES 2014/15).
- 2,492 babies had been delivered at Calderdale hospital between September 2015 and February 2016.
- Between April 2014 and March 2015 there were 512 unexpected admissions to the neonatal intensive care unit. 210 of which were full term babies.
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2014 showed the trust met the standard for recording babies' temperature within the first hour of birth when born at less than 28 weeks and six days old. The trust exceeded the target of 85% for giving antenatal steroids for all mothers who deliver babies between 24 and 34 weeks and six days, this was an improvement from the last audit.
- Data provided by the trust showed the stillbirth rate had reduced from 30 in 2013/2014 to 25 in 2014/2015. This put the overall stillbirth rate per 1000 births at 3.59% which was below the threshold of 4.7%. This reduction was felt to be as a direct response to the implementation of the SaBiNE care bundle.
- The Yorkshire and Humber maternity dashboard RAG rated third and fourth degree tears in normal and assisted births, and PPH was rated red. Third and fourth degree tears following a normal birth were 3.6%, which was higher than the regional average of 2.8%. Third and fourth degree tears following an assisted birth was 6.9% compared to a regional average of 4.2%.
- However in 2015, the RCOG identified the overall incidence of obstetric and sphincter injuries (OASIS) was 2.9%, and for the same time period the trust had an overall rate of 2.65%. This showed that overall the trust was below the national average.
- PPH rates at the trust were 3.5% compared to a regional average of 2.2%. This was supported by the analysis on

clinical incidents which showed 12% of incidents reported between October 2014 and November 2015 related to PPH and 7% related to third or fourth degree tears.

- The trust had been auditing all cases of PPH greater than 1500mls since April 2015. We reviewed an audit which was carried out during April to October 2015 which identified 190 women who had a PPH of greater than 1500mls. The audit looked at their previous medical history, any antenatal problems and method of delivery as well as the reason for the PPH. An action plan was written and completed in response to the audit findings, and audit of cases was ongoing. Examples of actions included updating the PPH guideline to include risk factors and introducing Syntocinon 50/50 for instrumental births and lower segment caesarean sections (LSCS). Syntocinon is a drug which contains a naturally occurring hormone which causes the uterus to contract to stop bleeding after delivery.
- Despite this, information provided by the trust show in 2015/2016 the incidences of PPH greater than 1500mls had increased by 1.2% compared to 2014/2015. A revised action plan was implemented following a PPH summit in March 2016 with a trajectory set to reduce PPH by 1% by the end of quarter two in 2016/2017.
- A retrospective audit of 35 cases of third and fourth degree tears took place during September, October and November 2015. Looking at all aspects relating to the birth such as mode of delivery and baby's weight. Eight recommendations were made including presenting the OASIS recommendations to staff as part of PROMPT training and ongoing audit.
- Further data provided by the trust for quarter three 2015/2016 showed a reduction in the number of third and fourth degree tears with a normal birth to 2.1%, however the number of third and fourth degree tears associated with an assisted birth had risen to 10%. As a response to this the trust was planning to undertake an external review as well as reviewing incidents daily and weekly monitoring at governance meetings.
- From speaking with staff we saw there were clear pathways for when an abnormality or concern was detected on a scan. For example, if an abnormality was detected a referral was made to the screening midwife.
- The early pregnancy assessment unit collected data on each woman who attended and what the outcome was. There was also a database for termination of pregnancy. The trust had no active maternity outlier alerts.

Competent staff

- The trust had a preceptorship programme for newly registered staff. There was also a midwifery preceptorship document which outlined specific competencies and essential training for midwives. For example, operating theatre essential skills and antenatal and new-born screening. Midwives were also trained in cannulation and venepuncture. We were also told about an 'in house' management of high dependency women course which had been developed for midwives.
- We spoke with midwives who were working through their preceptorship programme and they felt supported; they also told us they had been supernumerary for two weeks in each area.
- There was a community preceptorship package. Newly qualified midwives had minimal on-call commitments and back up phone support from senior colleagues.
- The trust had undertaken the national initiative 'Sign up to safety'; it focussed on reducing the number of babies admitted to neonatal intensive care (NICU). Reducing the number of term babies with an APGAR score (this was a way of quickly summarising the health of a new-born) of less than seven at one minute, and to have no intrapartum stillbirths of healthy term babies between January 2015 and March 2016.
- This was achieved through additional training in the areas of CTG and intermittent auscultation; however the targets for training staff had not been met. As part of this initiative funding had been secured for the post of a clinical educator.
- Staff on the gynaecology assessment unit also received specific training for their area. We were told they had core staff as it was recognised that it was a specialist area which required staff to have particular skills.
- A project called 'clarity' had been developed which aimed to broaden learning for band seven midwives. It provided specific roles for staff such as managing complaints. The 'commander role' was also developed whose responsibility it was to undertake duties such as bed management and patient flow, but also as an

source of knowledge or advice for midwives on duty. This project had been well received amongst the staff we spoke with and 'clarity 2' had been developed to focus on band five and six midwives.

- The inspection team were told by various staff that the turnover of midwives had resulted in a lack of experienced midwives. We were provided with examples of where this had resulted in a delay in care for women. Whilst the trust acknowledged this feedback from staff, they felt it was a perception rather than a reality. They provided data showing 74% of the maternity workforce had been qualified for over three years, and the number of band five midwives was comparable to other trusts in the region.
- At the time of our inspection, information provided by the trust showed between 87% and 100% of staff within maternity and gynaecology had undergone an appraisal in the last 12 months. This was supported by many of the staff we spoke with who confirmed their appraisal had taken place. Professional revalidation was discussed as part of this and staff felt informed and aware of their responsibilities.
- All midwives must have a supervisor of midwives (SoM). This is a statutory role which provides guidance and support for practicing midwives. The national recommendation is a ratio of 1:15. This ratio was not being achieved at the time of inspection and was 1:18. Plans had been put in place and it was expected that the recommended ratio would be achieved by May 2016.
- In the interim period the trust had worked with the Local Supervising Authority (LSA) to develop a substantive SoM role. They worked two days a week and took a larger caseload to mitigate the impact of a higher ratio.

Multidisciplinary working

- There was good multi-disciplinary (MDT) working evident in clinical areas. There were close links with community staff on the maternity unit and gynaecology ward with regards to safeguarding concerns or complex cases.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals. Staff on the GAU also referred women to sexual health services as appropriate.
- We observed ward rounds with nursing/midwifery and medical staff with good communication. We saw good communication between the ward and NICU and this was supported with positive comments from mothers.
- Most staff said they felt happy escalating concerns to doctors.
- Staff had access to a critical care outreach team if they were concerned that a patient was deteriorating.

Seven-day services

- Medical staff were available on the maternity unit and gynaecology ward 24 hours a day. Out of regular working hours there was always a consultant available on call.
- Access to dedicated obstetric theatres and anaesthetic and theatre staff were available seven days a week. There was also access to critical care facilities at the trust.
- The maternity assessment centre was open 24 hours a day. The early pregnancy assessment unit had seven appointments available seven days a week and included the availability of a sonographer. Additional scanning was available Monday to Friday in the main department.
- The termination of pregnancy clinic offered a service three afternoons a week with seven appointments available.
- The gynaecology assessment unit was open from 7am until 7pm. At the time of inspection due to having four medical patients it was open 24 hours a day but admissions were not taken overnight.
- An emergency gynaecology clinic operated five days a week.

Access to information

- Information leaflets were available in ward areas on a variety of subjects such as contraception, perineal tears and post-natal care. We did find some which were past their review date for example 'information for women who have had a third or fourth degree tear'; we saw two versions of this one had a review date of February 2015, another a review date of October 2011.
- Information relating to a woman's discharge was sent electronically to GPs and health visitors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Maternity and gynaecology

- Some women we spoke with felt involved in their care and that they had been provided with sufficient information to make informed choices.
- Midwives and nursing staff were able to articulate how they would ensure consent was obtained either verbally or written prior to a procedure. Within the EPR we did not see specific prompts around consent although it was recorded in the free text.
- Staff could not articulate what was meant by Gillick competence despite giving examples of children accessing services.
- The most up to date audit relating to consent took place in 2014. The information was a retrospective review of 30 sets of records, 15 from maternity and 15 from gynaecology. The audit reviewed various aspects of consent documentation and consent forms were present and risks and benefits detailed in 100% of all records reviewed.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. Staff told us under no circumstances would they proceed with a termination of pregnancy if the appropriate documentation had not been completed.
- Staff had some understanding of legislation such as Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, however there was no specific training for this.

Are maternity and gynaecology services caring?

Requires improvement

We rated caring as requires improvement.

- Although positive comments were received and the overall friends and family test data responses were good, we were concerned about the number and content of the negative comments we received during the inspection.
- These included comments from women who felt they had not been involved in decision making about their care and feeling unsupported. A period of time had passed since the birth for some of the women we spoke with and they still felt affected by the experience.

Compassionate care

- Results from the NHS friends and family test were mixed. The percentage of friends and family that would recommend antenatal care was better than the England average for most months in the period October 2014 to November 2015. With the exception of February, July and September 2015 the recommendation percentages for the Post Natal ward were worse than the England average.
- The recommendation percentages for Birth and Post-natal Community Provisions were mostly worse than the England average.
- Data for December 2015, January and February 2016 showed the overall percentage who would recommend maternity was higher (better) compared to a national average.
- The trust performed about the same as other trusts in 13 of the 16 questions in the CQC Survey of Woman's Experience of Maternity 2015. Performance was better than other trusts for two questions in the area of labour and birth and one question in the area of staff during labour and birth.
- We spoke with 19 women and received mixed feedback about their experience of the service. Nine women gave negative feedback and some comments were extremely negative. Some women told us they felt unsupported and their dignity was not maintained. We were given an example of a situation where a midwife's personal opinion over a woman's choice of delivery was strongly voiced.
- One woman reported feeling distressed after her experience. Another felt she and her partner were not involved in decision making. Several women also spoke of a lack of emotional support.
- However the other 11 women gave positive feedback with comments (four of these were from the gynaecology ward). Specific to maternity comments such as 'amazing care, well looked after' and 'the care was second to none' were made.
- Counselling services were provided pre and post termination and everyone under the age of 16 was seen by a counsellor.
- Single rooms were provided for medical management of pregnancy or miscarriage.

Understanding and involvement of patients and those close to them

- The women we spoke with on the gynaecology ward felt informed regarding their care and had been involved in decision making.
- Some of the women we spoke to on the maternity wards did not feel they had been involved in decision making, or did not feel able to express their preferences. For example, one woman would have liked to have had a water birth but their options were not discussed on the labour ward and she did not feel able to voice them.
- Prior to our inspection we received feedback from two women who stated they did not feel listened too.
- One woman felt anxious about her birth as she had medical conditions which made her high risk. She did not feel confident all her needs were being taken into account.
- Feedback relating to antenatal care from two women was that they felt anxious and again unsupported.
- It was noted in the patient safety and quality board (PSQB) governance report minutes that the consultant midwife had given a presentation to midwifery staff on the importance of compassionate care. The presentation included understanding the feelings of women following delivery and reviewing a difficult case where the woman involved did not feel listened to.
- The local supervising authority (LSA) report from 2015 RAG rated the maternity services for examples of SOM advocacy for women. They looked at areas such as care planning and supporting women's choices including place of birth, as limited examples were presented during the audit, an amber rating was given.
- Two of the serious incident reports made reference to the fact the mothers were not offered a choice of management of labour and their decision over place of birth was not respected.
- We reviewed complaints data and found examples of complaints made due to treatment during and after birth and maternal requests during birth not acted on.
- Feedback from the 'meet the midwife' forum in December made note of comments such as 'drugs given and not explained' and the process of induction not being clearly communicated to provide reassurance. These were not complaints and the trust used these comments to help improve services.
- There were good examples of understanding patients and their family's needs. Positive comments were given by women whose babies were on NICU with regards to being kept informed of what was happening and the communication between the two areas.
- There were many positive comments made by the nine women who attended the 'meet the midwife' event including the explanations given by community midwives and the involvement of partners.
- Partners were able to stay in some areas and we were told about flexible visiting to allow relatives who lived a long distance away to visit. On ward 9 we saw a photography display of the midwives with their children. It had the caption 'many of our midwives are mums too' to show they had experience of childbirth themselves.
- The LSA report 2015 identified some positive comments in relation to involvement in decision making such as, partner fully supported and involved. However one comment was made that they had to be persistent about what they wanted.

Emotional support

- There was a midwife who had a specialist interest in bereavement and there were policies and guidelines in place to support mothers and their family in the event of a stillbirth or neonatal death. There were rooms for mothers and their partners to stay separate to the delivery suite if they had experienced bereavement. The chaplaincy service could also provide support in these situations.
- Specialist midwives were also available for support in areas such as teenage pregnancy and domestic violence.
- Counselling services were available on site for women attending the pregnancy advisory clinics.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- There was evidence of involvement of service users in the planning of services
- The maternity assessment centre (MAC) could be accessed 24 hours a day and provided a range of services and support for women during and after pregnancy.
- The dedicated induction of labour suite meant this service could be managed more flexibly.

- There was a dedicated ward and theatre for women choosing to have an elective caesarean section providing continuity of care.

However:

- A number of delays had been identified for women requiring suturing after delivery.
- It had been identified that having medical patients on the gynaecology ward was potentially affecting the ability to provide elective gynaecology and breast surgery for women.

Service planning and delivery to meet the needs of local people

- Women had the option to either deliver at home, in the midwifery led units at Huddersfield Royal Infirmary and Calderdale Royal Hospital or on the labour ward.
- There was a dedicated ward (1D) for those women who had undergone an elective caesarean section. Pre assessment also took place on this ward by the midwives which provided continuity of care.
- Maternity and gynaecology services worked with local commissioners of services, the local authority, other providers, GP and patient groups to co-ordinate care pathways. The maternity services liaison committee (MSLC) had an active role in maternity services and meeting minutes from February 2016 showed a good representation from service users.
- The PSQB governance report to the quality committee from February 2016 stated the service was compliant with NICE CG 62 which relates to antenatal care being accessible to all and midwife and GP led models of care for women with uncomplicated pregnancies.
- Meet the midwife events had been organised by the trust to help build closer working relationships with the community to improve services. Six events had been planned each looking at a different aspect of maternity care**.** The event in December 2015 was attended by nine women and focused on induction of labour.

Access and flow

- From February 2015 to February 2016 the service had achieved 91.4% of antenatal booking appointments at gestation less than 13 weeks; this was higher (better) than the regional average and the England average for the same time period.
- The schedule for antenatal appointments was in line with NICE Clinical Guideline 62.
- We were provided with examples of actions taken as a result of targets not being met. For example, in January 2016 antenatal booking performance did not meet its target of 90% of women being booked by the 13th week of pregnancy. We were told this was flagged in the second week of January 2016. A case by case analysis was done by week three looking at the reasons for not meeting the target. They discovered it was due to women changing their mind about a termination of pregnancy, so the trust could then provide a reason for the target not being achieved.
- The midwives were available, on call, 24 hours a day for home births as needed. Community midwives were on call for home births and provided cover on the birth unit if it was busy.
- The unit had closed three times from 2014 up to the time of inspection, once in July 2014 and twice in October 2014.
- Bed occupancy rates for quarter two in 2015/2016 were below the England average.
- The maternity assessment centre (MAC) could be accessed 24 hours a day and was midwife led. Women could be referred by their GP, midwife or self-refer for a variety of problems such as reduced foetal movements or abdominal pain in pregnancy. There was no designated medical cover for this unit.
- We were provided with information about a woman who was in the MAC for a significant amount of time (5 hours) awaiting a decision. We observed an escalation policy at the desk to implement if women were waiting more than three hours. This included actions such as liaising with the 'commander' on the labour suite when the unit became busy and an escalation process for getting a doctor to the unit.
- The trust had set a local target of four hours for length of stay (LOS) and data relating to this from December 2015 to March 2016 showed this was achieved 92-95% of the time. Where the LOS had been greater than four hours the main reason (which accounted for 26 of the cases) was waiting for a bed on the antenatal ward or delivery suite.
- Failure to triage women in a timely way in the MAC was on the department's risk register with an improvement plan in place and a target of March 2016. This identified actions such as refining the SOP and identifying any

barriers. We requested further data from the trust which showed an improving picture between January 2016 and March 2016 with the number of women being triaged within 30 minutes rising from 82% to 94%.

- Induction of labour took placed in a designated area with five rooms. The booking system had changed from a paper based system to an electronic system. This allowed better planning and inductions could only be booked by designated staff which had reduced over booking and subsequent delays.
- We reviewed information relating to relating to post-delivery suturing in theatre. An audit into PPH from April 2015 to January 2016 by the trust found 35 women experienced delays waiting for theatre, with one woman waiting5 hours and 9 minutes. A further audit of third and fourth degree tears conducted from September to October 2015 showed 63% (22/35) of women waited over one hour to be sutured. The range was one hour 13 minutes to five hours and 57 minutes. The trust guideline for perineal trauma recommends suturing should be within the hour. The reason for delay was only identified in the case which waited five hours and 57 minutes. This was due to delayed inspection of the perineum and transfer to Calderdale.
- It was identified on the departmental risk register that there was a potential failure to provide scheduled treatment for women requiring elective gynaecology or breast surgery due to insufficient beds. This was because there were outlying medical patients on the gynaecology ward. We spoke with staff about this who said it was a challenge. For example, on the day we visited they had five elective patients due to come in and no empty beds at the start of the shift. Staff said they usually managed to accommodate all the planned admissions.
- Staff in the gynaecology assessment unit (GAU) said that having medical patients on the unit was having an impact. For example, they would usually take admissions directly from accident and emergency if they had presented with hyperemesis (persistent vomiting during pregnancy leading to dehydration). On occasions they could not do this; however we found no evidence of patient harm as a result.
- The GAU was located next to the gynaecology ward which helped with flow through the department if women required admission.
- Further data provided by the trust showed the number of cancelled operations due to having no beds was very small. For example, between September 2015 and February 2016 there were only four procedures cancelled due to a ward bed not being available.

Meeting people's individual needs

- There were a range of specialist midwives to support women throughout their pregnancy such as perinatal mental health and substance misuse. There was also access to other medical specialities.
- Pathways had been developed to improve the management of hyperemesis, to allow women to stay at home overnight by hydrating them with intravenous fluids during the day.
- We were provided with some examples of those with complex needs and how they managed the care for these women. For example on the GAU, they had a complex case which had input from various staff from the MDT. They ensured there were no other patients on the unit on the day of admission and plans had been put in place to support a variety of outcomes such as having theatre on standby.
- Staff on the gynaecology ward could describe adjustments they would make in caring for those patients living with dementia, such as ensuring patients were in an area on the ward which could easily be observed and involvement of family. Dementia awareness training was mandatory with compliance rates for nursing and midwifery staff at 80.5%.
- If a high dependency room was needed on the labour ward to monitor a woman more closely, equipment would be obtained from intensive care or theatre.
- Bariatric equipment was available on site and we saw a SOP related to caring for women who had a body mass index of over 35.
- There were rooms which allowed wheelchair access.
- Translation services could be accessed and staff were aware of how to do this.

Learning from complaints and concerns

- There was a trust complaints policy and procedure which staff were aware of. Staff said they would always try and resolve complaints at ward level.
- We reviewed complaints data from December 2014 to November 2015. We identified 42 complaints related to

the maternity and gynaecology services at Calderdale Royal Hospital. The majority of complaints related to care and treatment. 12 complaints related to the birth centre at Calderdale.

- The majority of complaints were investigated and closed within one to two months. The division had a complaints dashboard which was reviewed by the PSQB.
- Not all staff were aware of recent complaints or could give examples of any learning. We reviewed minutes of the maternity forum and the gynaecology forum. Complaints were discussed at the gynaecology forum but not the maternity forum.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well led as requires improvement because:

- We were concerned that risks to the service were not always clearly identified and shared amongst all staff.
- Directorate meetings were variable in their structure and content meaning information was not shared consistently.
- Consequently learning from incidents and serious incidents was not embedded with all staff.

However:

- Clinical leads felt they had been able to contribute to the service strategy.
- We saw good local leadership and visibility of senior management in clinical areas.

Vision and strategy for this service

- We reviewed the maternity strategy document; we were told this was to be reviewed later in the year to align with the trust's overall strategy. Staff we spoke with such as matrons and clinical leads felt they had been able to input into the development of the strategy.
- It was stated that the strategy was ambitious with a number of areas identified for improvement and development. These included workforce development, a focus on women and their families using the service and improvement in clinical outcomes.
- Each area had identified how improvements could be made and what needed to be put in place to achieve it. For example, using the skills of the maternity support workers to enable them to play a more active role in support with breastfeeding. This could enable earlier discharges and improve patient flow as this support could be provided in the women's home.
- Staff within maternity and gynaecology were aware of the overall trust vision and values and the importance of being patient focused.

Governance, risk management and quality measurement

- We reviewed the maternity dashboard which was RAG rated and provided information on a number of indicators. The data for this service was compared to the Yorkshire and England average to enable monitoring of performance and outcomes.
- The service was rated red for third and fourth degree tears following normal and assisted births, also for PPH and low birth weight at term. At the time of inspection further assurance was requested from the trust in relation to shoulder dystocia, learning from serious incidents and the availability of a second obstetric theatre.
- During our inspection we were concerned that staff we spoke with did not highlight these issues as a risk. We were therefore not assured that the systems in place for sharing information, monitoring and identifying risks were effective.
- As a response to our request for assurance, we were provided with audits and action plans. The audit data supported the concerns identified. For example, data showed there had been situations where the recommended timescales were not met for category one caesarean sections. This was related to the availability of a second obstetric theatre. Whilst it is accepted there is no benchmark for comparison, it was felt the potential risks around the opening of a second theatre should have been a focus. Following our inspection the trust set up a working group with maternity and theatres to ensure the standards for emergency caesarean sections were met. They had also reviewed their governance arrangements regarding access to theatres and asked for this information to be included in the Yorkshire and Humber dashboard.
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Maternity and gynaecology

- A review by the Royal College of obstetricians and gynaecologists was requested by the trust following our inspection. The specific areas identified above were in the draft terms of reference.
- In relation to serious incidents, the framework states under the seven principles that "Those involved in the investigation process must not be involved in the direct care of those patients affected nor should they work directly with those involved in the delivery of that care." This was not the case for the three investigation reports we reviewed.
- We were told about further work planned as a result of the second never event relating to a retained swab. This included a thematic review and consideration of human factors.
- The family and specialist services risk registers identified 15 risks. All had a review date between January 2016 and March 2016. Most senior staff (ward managers/ matrons) were aware of the risk register and its contents.
- The opening a second emergency obstetric theatre was not on the risk register. Minutes from the maternity forum in September 2015 highlighted ongoing issues within theatres. Theatre staff were not happy with overnight cover and at this time the trust was looking into issues around opening a second theatre.
- Following this a project called 'work together, get results' was undertaken to understand the concerns of the theatre staff. Communication was found to be a key factor and ensuring a clear message was shared with all staff if a category one caesarean section was required. It was not clear if the data relating to this was collated before or after this learning had taken place.
- The service had completed a gap analysis following the publication of the Kirkup report in 2015 and produced an action plan. The report, action plan and updates were discussed at meetings inside and outside of the trust. We reviewed the action plan which indicated changes had been implemented. For example, developing training plans linked to the needs of staff.
- We reviewed directorate meeting minutes, which were very brief. The monthly maternity and gynaecology forum minutes followed different agendas and complaints and incidents were not discussed at the maternity forum.

Leadership of service

- The maternity and gynaecology directorates formed part of the families and specialist services division. The service was led by a divisional director and the team was still relatively new having been together for nine months.
- Nursing and midwifery staff we spoke with at ward level felt well supported and spoke of the visibility of the head of midwifery, director of nursing and the chief executive.
- Discussions with the senior management team demonstrated a team which was patient focused and committed to improving services.
- We saw good leadership at ward level with staff saying managers were supportive and approachable.

Culture within the service

- The changes in management structure and the turnover of staff meant there was a mix of feelings amongst staff. This was reflected in the NHS staff survey results. The percentage of staff recommending the organisation as a place to work had fallen from 57% in 2014 to 54% in 2015; both were below the national average of 61%. However the percentage of staff who were happy with the standard of care provided had risen from 65% in 2014 to 67% in 2015.
- The percentage of staff experiencing work related stress was 42% this was higher than the national average of 36% (NHS staff survey results).
- Staff did tell us about changes in policy which had had a positive impact on them, for example returning to work following long term sickness. Staff felt more supported and no longer had to use annual leave to facilitate a phased return to work.
- We observed good teamwork between disciplines and staff and most were happy and enjoyed working at the trust. We were told managers worked clinically and staff felt this meant they understood the pressure of the role.
- Staff felt they were encouraged to be open and honest with patients and examples of such situations were provided.
- Senior management told us 'Undermining Behaviours Toolkit ' had been launched to enable the service to pick up on low level concerns, such as staff feeling undermined by colleagues. They felt this had had a positive impact and from this staff were more willing to share any concerns they may have.

Public engagement

- There had been a relaunch of the maternity services liaison committee (MSLC) which had good representation from service users.
- Friends and family test data was collected and the feedback had been used to help improve services for example induction of labour. Response rates were noted to be particularly good for gynaecology and a text message service was used to seek feedback from women accessing the GAU.
- Meet the midwife sessions had been arranged to look at various aspects of pregnancy and birth, to seek the views of those using the services.

Staff engagement

- There was no service specific data from the 2015 NHS staff survey in relation to staff engagement. However the overall score remained slightly below the national average.
- Within maternity the 'clarity' projects had made staff feel valued and involved in service development.

Innovation, improvement and sustainability

- The maternity electronic patient record had been implemented for hospital and community midwives.
- The service had implemented Saving Babies Lives in the North of England scheme (SABiNE) and had been shortlisted for National Patient Safety Award for stillbirth reduction.
- Funding had been secured for the from the NHSLA 'Sign Up to Safety' scheme for an intrapartum clinical educator post. The scheme provided additional training on fetal heart monitoring.
- 'Meet the Midwife' had been developed to seek further information from mothers about their pregnancy and birth experience.

Services for children and young people

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

Information about the service

Calderdale Royal Hospital is part of Calderdale and Huddersfield NHS Foundation Trust. The paediatric services at Calderdale Royal Hospital were part of the Families and Specialist Services Directorate. The service provided a 24 hour, seven days a week paediatric assessment unit with four beds and a 25 bedded paediatric ward (ward 3) providing medical and surgical care. There was a neonatal unit (NNU) with 24 cots, three for Intensive Therapy (ITU), three for high dependency (HDU) and 18 for special care (SCBU). There was a paediatric outpatients' department and a child development service. There was also a home care team who cared for children with long term complex needs at home. This team also provided support to children when they were admitted to hospital.

There were 7,062 paediatric admissions across both Calderdale and Huddersfield NHS Foundation Trust Hospitals between September 2014 and August 2015, of which 93% were emergency admissions. 6425 of those admissions were to Calderdale Royal Hospital.

During our visit we visited all clinical areas where children and young people were either admitted or attended. These included the paediatric assessment unit and paediatric outpatients' department. We spoke with four doctors, five senior nurses, nine nurses, two support workers, the children's safeguarding team and we met with the senior management team. We also spoke with nine families and two teenagers during our inspection. We observed care and treatment and examined 11 medical/nursing records from across the service. We also reviewed quality and performance information.

Summary of findings

Overall we rated the service as requires improvement because:

- Safeguarding training levels were far lower than the trust requirement of 100% compliance. Training in other areas, such as infection control, were also below the trust target.
- There were examples of lack of oversight by leaders and the ability of staff to recognise safety issues, for example, resuscitation trolleys behind locked doors.
- Investigations into incidents, prior to inspection, using root cause analysis were not always comprehensive and were poorly documented.
- Action plans to mitigate risks and issues in the service did not demonstrate timely action and response.
- Audit data showed that patient outcomes were worse than the England average.
- The neonatal unit were not undertaking universal precautions to reduce infection control risks.
- There were no facilities to support the needs of older children and adolescents.
- Some parents said communication about their child's care could be improved.

However:

- The service had a system for reporting incidents. Incidents were reportedly in a timely manner. Staff provided examples of lessons learnt from incidents; however, staff did not always get direct feedback

Services for children and young people

when they had reported an incident. There was an electronic system in use which alerted staff to deteriorating patients and the need to monitor patients closely. This system was introduced following learning from a serious incident.

- The trust was a pilot site for the Child Protection – Information Sharing (CP-IS) project, an NHS England sponsored programme. The aim of this project was to provide timely information regarding safeguarding concerns across health care providers.
- The service had processes in place to implement NICE guidelines and other best practice guidelines. The service also participated in national audits. The service implemented local audits such as infection control audits.
- There was evidence of multidisciplinary working across all the children's services.
- Throughout our inspection we saw patients and relatives treated with dignity, respect and compassion. We heard staff using language that was appropriate to patients' age and level of understanding. All the patients and families we spoke with were happy with the care and support provided by the staff.

Are services for children and young people safe?

Requires improvement

Overall we rated children's services as requires improvement for safe because:

- Safeguarding training across professionals was not meeting the trust target of 100%. Level three safeguarding training for medical staff was only 38%. Medical staff were involved in child protection medical assessments.
- There was no evidence that staff received and recorded safeguarding supervision in line with the policy.
- Infection and prevention control training for both nursing and medical staff was below the trust target. Staff in the neonatal unit were not always undertaking universal precautions to reduce infection control risks.
- Overall mandatory training levels were low according to data provided.

However:

- There was a culture of incident reporting and learning from incidents. There was an electronic system in use which alerted staff to deteriorating patients and the need to monitor patients closely. This system came into place following learning from a serious incident.
- The trust was a pilot site for the Child Protection – Information Sharing (CP-IS) project, an NHS England sponsored programme. The system provided early warning to staff for children with safeguarding concerns.
- We found all clinical areas visibly clean and the equipment was fit for purpose and well maintained.

Incidents

- There had been two serious incident investigations at the trust in children's services, which involved both hospital sites between October 2014 and September 2015. One child death and one confidential information leak/information governance breach. These incidents were not further classified as never events.
- There had been no never events reported in the service between October 2014 and September 2015. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative

measures are implemented. 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 categorized as a never event.

- Incidents were reported through an electronic incident reporting system. Between October 2014 and September 2015 there were 536 reported incidents on the National Reporting and Learning System (NRLS) across the families and specialist services directorate.
- Two hundred and forty-five incidents were reported on ward 3. Eighty-five per cent of reported incidents were classified as no harm. The main themes of the reporting were: inadequate staffing levels (23%), relating to medicines (15%) and relating to patients behavioural issues (13%). Three of the reported incidents were classified as severe harm. Two were investigated as serious incidents and one was a safeguarding investigation.
- One hundred and forty-seven incidents were reported on the neonatal unit. Eighty-five percent of reported incidents were classified as no harm. The main themes of the reporting was: inadequate staffing levels (31%); there had been 45 reported incidents and 19 of these recorded the unit had been closed for admissions (42%). Medicines management accounted for 14% of incidents reported.
- Six incidents had been reported by the child development unit and were related to environmental and operational issues. One incident classified as harm was an accidental patient fall.
- Staff were aware of how to report an incident. Staff reported to have received feedback from incident reporting through the team meetings and emails. We were provided with an example where systems and practice had changed following two reported incidents of wrong redistribution of expressed breast milk. Bottles of expressed breast milk were stored in labelled bottles on labelled trays and were now checked by two members of staff prior to redistribution to the patient. The unit was also implementing barcoding system to further ensure that expressed breast milk was redistributed correctly.
- Following an incident there had also been the development of a pathway to check for sepsis in children.
- Duty of Candour was introduced as a statutory requirement for NHS trusts in November 2014. Staff told us they understood the need to be open and honest with families when things went wrong.

Cleanliness, infection control and hygiene

- All of the areas visited were visibly clean and uncluttered including communal areas, toilets and bathrooms. Bins were clean and not overfull and there were adequate bins for both clinical and general waste. All sharps bins were below the marked levels.
- Clinic rooms were clean, with storage areas adequately stocked and well organised and the sluice areas were observed to be clean and tidy.
- According to the trust infection control dashboard for October 2015, ward 3 had no reported cases of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and no reported cases of Clostridium Difficile (C. Diff.).
- Wall mounted alcohol gel was available at all entrances and exits to the departments, personal protection equipment (PPE) and alcohol gel was available at all sink areas. We observed staff to be compliant with bare below the elbow (BBE) policy. We saw staff using the hand gel when entering the ward and also undertaking hand hygiene before attending to patients.
- Ward 3 undertook an infection control audit in November 2015 and received an overall score of 78%, receiving an amber rating. There was an action plan following the audit to drive improvement.
- The neonatal unit undertook an infection control audit in July 2015 and received an overall score of 91%, receiving a green rating. The infection prevention control team provided a dashboard to highlight areas of concern and good practice.
- In the neonatal unit staff did not always use universal precautions for infection prevention and control. This meant they did not always use disposable aprons and gloves when delivering care to patients. They wore a cloth apron that was kept with the patient's cot and changed on a daily basis. We were told at the time of inspection this practise had been assessed by the infection prevention control team and reported as safe practice. However, national infection control standards support the use of universal precautions to minimise the risk of infection.

- The trust recorded training rates in infection control as a cross site figure for the families and specialist services directorate. Eighty-three per cent of nursing staff and 50% of medical staff had undertaken training in infection control against a trust target of 100%.
- In the 2014 CQC Children and Young People's Survey, the trust scored 8.7 out of 10 (about the same as the England average) in the question of whether the hospital room or ward the child was seen in was considered to be clean.

Environment and equipment

- Resuscitation trolleys were observed in all areas attended by children and young people. However, on ward 3, the trolley was kept behind a locked door. This was against the UK resuscitation council 2015 guidelines that 'all clinical service providers must ensure that their staff had immediate access to appropriate resuscitation equipment and drugs'. We informed senior staff at the time of inspection and they took immediate action to rectify this.
- Checks to the resuscitation trolley on ward 3 and in the child development unit was done and recorded on a weekly basis.
- The resuscitation trolley on the NNU was checked and recorded daily and was seen to be fit for purpose.
- Ward 3 and the NNU were locked to prevent unauthorised access. There was also CCTV insitu outside the NNU. Parents and visitors gained access via a buzzer.
- There was a lack of storage areas for equipment on the NNU, which resulted in equipment and resources being stored on the corridors.
- The children's assessment area had only beds; there were no cots for young children. We were told that cots could be provided following assessment. However, a parent told us that they had to sit in the waiting area with their baby, who had a temperature, in their arms for six hours due to lack of cots on the unit.
- The children's outpatient department had a reception area which also acted as a waiting room. There was space for pushchairs or wheelchairs. There was a table and chairs with toys appropriate for toddlers and young children. However, there were limited facilities to meet the needs of older children or teenagers.
- Theatre suite had dedicated lists for children and had a separate waiting area and a recovery area which was segregated by curtains. This area was also used to stabilise deteriorating patients, who maybe waiting for the Embrace paediatric transport service.
- All the equipment observed was safety tested; ventilators were maintained by the medical physics department and had in date service stickers. Staff reported to understand how to report faulty equipment. . Staff reported to understand how to report faulty equipment. Staff were provided with medical device training.
- In the 2014 CQC Children and Young People's Survey, parents and carers of children under 16 years of age were asked to say whether the ward where their child stayed had appropriate equipment or adaptations for their child. This trust scored 9.4 out of 10, which is about the same as other trusts.

Medicines

- Medicines were stored safely on the wards with no excess stock or expired medicines.
- The temperature of the medicine's fridges was recorded once per day and was within range with minimum and maximum temperatures recorded.
- Controlled drugs were handled, stored and recorded correctly.
- We looked at eight prescription charts across the children's ward and the NNU. They all included the patient's weight. Administration of medication was appropriately signed and documented.

Records

- We examined eleven records across the services and found the notes to be well maintained.
- All records seen were legible, dated and signed, and included relevant risk assessments and care planning.
- No medical or nursing notes were observed unattended.
- Record audits undertaken between April 2015 and December 2105 showed 100% compliance in two out of the nine months. PAWS scores and baseline blood pressure recording were the most frequently non-compliant areas of recording in records. In May 2015, these indicators scored 0%, however by July 2015 the scores had increased to 75%.

Safeguarding

Services for children and young people

- The trust lead for safeguarding children was the director of nursing. The safeguarding children's team consisted of a head of safeguarding, a named nurse, a named midwife, a paediatric liaison nurse, two designated doctors for safeguarding, and two designated doctors for looked after children and a named safeguarding doctor for the trust.
- There was an up to date trust policy for safeguarding children. The policy outlined the trust training strategy for safeguarding.
- Data supplied to us for training rates in safeguarding was a cross site figure within the families and specialist directorate. The trust target for safeguarding children was 100%. However, data provided at the time of inspection showed Level 1 training to be at 58% for medical staff, 78% for allied health professionals and 82% for nursing staff.
- Level 2 training for allied health professionals was at 65%, 62% for medical staff and 28% for nursing staff.
- Level 3 training (for staff with direct responsibilities for involvement in reporting and contributing to the assessment of safeguarding concerns) for allied health professionals was at 50%, 75% for nursing staff and 38% for medical staff.
- Paediatric consultants provided support for local authority children's services to undertake medical examinations (with the exception of sexual abuse) for child protection purposes. These examinations were carried out at Huddersfield Royal Infirmary. The trust had concerns that not all consultants would have 'sufficient skills to perform such medicals' and this was on the trust risk register. However, the named doctor for safeguarding told us they were confident consultants had the appropriate knowledge and skills, due to peer review and competency testing provided by the lead consultant for safeguarding children.
- There was no evidence that staff received and recorded safeguarding supervision in line with the policy. The safeguarding team told us there were issues in recording staff safeguarding supervision and would like to develop this.
- The trust is a pilot site for the Child Protection – Information Sharing (CP-IS) project, an NHS England sponsored programme. This is an electronic system which allows the sharing of information across health care providers when children were subject to safeguarding concerns.
- There was a risk assessment for staff to implement when concerned of a child's risk of Female Genital Mutilation (FGM) or Child Sexual Exploitation (CSE). Staff reported to understand the impact on patients of FGM and CSE and to recognise when referral needed to be made.
- The trust had reviewed its Savile Action Plan in November 2015 and developed a policy for non-patient visitors. There was also a media and VIP policy.
- Safeguarding records were kept within nursing/medical notes in a locked trolley.

Mandatory training

- The trust supplied training rates data as a cross site figure for the children's services as of 3rd January 2016. The trust target for all mandatory training was 100%.
- There were ten elements to mandatory training and the training rates were variable. None of the modules had received 100% compliance. Compliance ranged from 57% (conflict resolution) to 83% (equality and diversity).
- However, staff told us they received mandatory training and appraisal. We saw evidence from team records that staff had completed, or were booked to undertake mandatory training. This suggested a disconnect between the trust overview of training figures and training at ward level.

Assessing and responding to patient risk

- The children's ward used the Paediatric Advanced Warning System (PAWS) to monitor and assess a patient's condition. The score would alert staff of the need to monitor a patient condition by showing signs of deterioration since last recording by an increase in score. This promoted early detection and intervention.
- If a patient became unstable or deteriorated and required transfer to a specialist hospital the trust had a contract with Embrace, a paediatric medical transfer service. Guidance on how to access Embrace was seen on the wards and was also available to staff on the intranet. The Embrace service provided support in advisory capacity over the telephone when patients deteriorated and would also come to the hospital to help stabilise a patient as necessary.
- Embrace located a bed in a specialist paediatric service if necessary and would transfer the patient. Sometimes

this required a nurse from the ward to travel with the patient. On two occasions when this had been required the children's ward had delayed admissions due to staff shortages.
- We saw risk assessments in use: Glamorgan scale (pressure ulcers), STAMP (nutritional assessment), skin integrity assessment, Wong-Baker faces pain assessment tool.

Nursing staffing

- According to the British Association of Perinatal Medicine (2010), neonatal services should provide a staff to patient ratio of the following:

Intensive care cots – 1 registered nurse : 1 patient

High dependency cots – 1 registered nurse : 2 patients

Special care cots – 1 registered nurse : 4 patients

- According to the Royal College of Nursing (2013) on children's wards the staff to patient ratio should be:

Patients under two years of age: 1 registered nurse : 3 patients

Patients over two years of age: 1 registered nurse : 4 patients

- The Royal College of Nursing (RCN) recommended these levels of staff for day and night shifts.
- We were provided with neonatal staffing data between December 2015 and February 2016. The data was based on British Association of Perinatal Medicine (BAPM) guidelines. The rota showed that staffing levels were meeting or exceeding the BAPM guidelines over 85% of the time. Shortfalls in staffing occurred more often during nightshifts.
- The neonatal unit had a staffing vacancy rate of 0.94 whole time equivalent (WTE) for registered nurses.
- On ward 3 senior staff used a daily nurse staffing calculator, which was updated on a four hourly basis. The tool identified levels of staff required depending on the acuity of the patients. Data from this demonstrated that ward 3, between December 2015 and February 2016, maintained staffing levels above 85% for the majority of shifts. Night shifts were most likely to fall below a fill rate of 85%. Staffing levels were most likely compromised when the ward was running at capacity i.e. all 25 beds were filled and the children's assessment unit was in use, according to the staffing rotas provided.
- There was an escalation procedure for staffing and activity levels. We saw evidence of reporting staff shortages.
- Senior staff would use staff from ward 18 at Huddersfield Royal Infirmary to fill the gaps in staffing. During inspection, we saw an example where a nurse working on ward 18 was sent to ward 3 during her shift at midnight. Senior staff told us they would always try to let staff know of changes prior to the start of a shift. All staff worked cross site so standards of care were not compromised.
- The children's outpatient department had two WTE paediatric nurses supported by one health care assistant to run a capacity of three clinics in the morning and afternoon each day. This met the standard minimum of one qualified member of staff in outpatient departments as recommended by the Royal College of Nursing (2013). Staff from the department also supported staff shortages across the service.
- Agency staff undertook an induction worksheet prior to starting shift.
- Senior staff reported an on-going recruitment drive to fulfil the four WTE nursing vacancies across paediatric services.
- Staff absence was at 4.1% which included long term sickness and maternity leave. The trust's target was 4%.
- We observed a handover. Handover was done using an SBAR format (situation, background, assessment, recommendation). Handovers were undertaken twice per day. General information and sensitive information was shared in the nursing office. Staff then had a face to face handover at the patient's bed with the staff member responsible for caring for the patient.

Medical staffing

- The service had 14 consultant paediatricians, with one WTE vacancy. There were also 2.4 WTE vacancies for middle grade doctors. The gaps in medical staffing were mitigated by a cohort of advanced paediatric and neonatal nurse practitioners.
- Consultants provided cover between 9am and 5pm for ward 3 and the neonatal unit seven days per week. Consultants provided an on-call service between 5pm and 9am. Out of hours there were three registrars until 21.00hours, 2 until 23.00hours, then one registrar 21.00hours until 08.30am.

Services for children and young people

- We observed a medical handover. A consultant was present. Patients who had not been seen by a consultant were reviewed first to ensure they were reviewed by a consultant within 24 hours of admission.

Major incident awareness and training

- There was a major incident plan in place. Children's services were included in the strategy. Senior staff had received training.

Are services for children and young people effective?

Requires improvement

Overall we rated children's services as requires improvement for effective because:

- Audit data showed patient outcomes were worse than the England average for diabetes, indicating that fewer individuals had well controlled diabetes.
- The trust had a higher multiple admission rates than the England average for children aged 1-17 years for asthma and epilepsy.
- The trust had a higher readmission after non-elective general surgery and paediatric admissions for 1 – 17 year olds than the England average.
- Local auditing showed a need to improve care planning but no action plan for improvement was seen.

However:

- The service had processes in place to implement NICE guidelines and other best practice guidelines. Care pathways were in use.
- There was involvement in national and local audits. The neonatal unit achieved higher than the England average in nine out of ten standards reported to the National Neonatal Audit Programme.
- There was evidence of multidisciplinary working across all the children's service.

Evidence-based care and treatment

- Staff had access to Embrace procedures and Neonatal Network Guidelines on the trust intranet. Paediatric policies were accessible on the intranet. The policies we saw included NICE guidelines for example, nasogastric feeding, wheeze management and meningitis guidelines. The information was accessible to staff and there were also links to the NICE guidelines.
- Staff used care pathways for patients with abdominal pain, asthma, epilepsy, diabetes and head injury. These were in date and reflected national guidelines.
- Staff in the child development unit used the schedule for growing skills and DSM V criteria.
- There was a children's services standard operating procedure policy. This covered expectations of service provision across all areas of children's services. All staff were aware of the policy.

Pain relief

- Patients' pain was monitored within the Paediatric Advanced Warning Score (PAWS) and by clinical assessment from the nursing staff.
- Staff used the Wong-Baker faces pain assessment tool, which is specific to assessing pain in children.
- Patients we spoke with reported their pain was monitored and they had received appropriate pain relief.

Nutrition and hydration

- Families and patients we spoke with had no concerns regarding the quality and availability of meals and drinks. Drinks and snacks were available on the wards.
- Kitchen staff ordered food for parents so they didn't have to leave the ward. Breastfeeding mothers were provided with all meals.
- Fluid balance records were completed accurately for those patients who required monitoring.
- Breast feeding was encouraged on NNU and breast pumps were available. There was a facility for the storage of breastmilk. The bottles were clearly labelled and stored on a labelled tray and it was reported that two nurses would check the labelling to ensure correct redistribution to patients.

Patient outcomes

- The paediatric service had undertaken audits on compliance with NICE Quality standards. Data provided was trust wide.

Services for children and young people

- For patients with diabetes, the trust performed worse than the England average for the percentage of patients with an HbA1c <58 mmol/mol. The trust also had a higher mean HbA1c indicating that fewer individuals had well controlled diabetes.
- NICE define excellent diabetes control as HbA1c levels less than 58 mmol/mol as this indicates good glycaemic levels. The higher the HbA1c levels the greater the risk of complications.
- The trust had a higher readmission rate after non-elective general surgery and paediatric admissions for 1 – 17 year olds than the England average.
- The trust had a higher multiple admission rates than the England average for children aged 1-17 years old for asthma and epilepsy.
- The trust had a slightly lower multiple admission rates than the England average for children aged 1-17 years old.
- The NNU participated in the National Neonatal Audit Programme (NNAP) 2014. There were ten standards audited. The unit achieved the national standard in five areas. In the remaining five standards the unit achieved above the England average, with exception to the proportion of eligible babies receiving any of their mother's milk at final discharge. The unit achieved 50% against the England average of 60% for this standard.
- The unit provided an action plan to address the outcomes of the NNAP data and was aiming to have breast pumps available to all mothers by March 2016.
- The neonatal unit reported to a national perinatal IT reporting system (BadgerNet). The child development unit also reported to this system for pre term children's developmental assessments at one and two years of age.
- Matrons completed a monthly nursing audit. The audit outcomes were based around care, for example, evidence of reviewing and evaluating care plans. The audit from January 2016 showed ward 3 met six out of the eleven outcomes and partially met three outcomes. Two outcomes were not met which related to individualising and reviewing care plans. We did not see an action plan for improvement.

Competent staff

- The service did not provide simulation training for staff to improve competencies. A lead paediatric consultant was responsible for clinical education, and there were plans for training.
- Seventy-one percent of staff on the neonatal unit were qualified in speciality (QIS) meeting Government recommendation of 70%.
- The service had an appraisal system for staff and 88% of staff had completed appraisals.
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.

Multidisciplinary working

- The paediatric service benefitted from a Play Team, which consisted of four play leaders. The team worked with children cross-site in areas to promote their safety and emotional wellbeing.
- The wards had access to physiotherapists and dieticians to meet the needs of patients.
- We were told that if a patient was admitted who was at risk of causing actual or potential harm to themselves they would be seen by CAMHS within 24 hours, or when medically fit.
- There was a process for informing GPs, health visitors and school nurses of discharges. We saw examples of the handover documents in patient records.
- We saw the transition to adult services pathway for 14-19 year olds, which was a multiagency model.

Seven-day services

- Consultants provided 24 hour on call service for seven days and staff reported they were available for ward rounds at the weekend.
- There was 24 hour support from the pharmacy service and a seven day service from diagnostics.
- There was on call service from therapeutic teams.
- The play and family support team operated seven days a week between 8am and 6pm.

Access to information

- Ward 3 used joint medical and nursing records. These were accessible on the ward to speciality staff involved, for example surgical teams.
- Patients who attended the ward through the emergency department would be flagged on the electronic system if there were safeguarding concerns to inform staff.
- There was a process for informing GPs, health visitors and school nurses of discharges.
- Electronic records were available for patients attending day surgery and outpatients.

Consent

- Staff we spoke with told us they were aware of how to apply Gillick competency and Fraser guidelines to assess the decision making competency of children and young people. They told us they would obtain consent from parents when a child was below the age of 16 years. Staff said it would be unusual for a young person under 16 to attend the services without a parent. This process was seen in the trust's consent policy.
- We saw good examples of consent documents for patients who had had surgical interventions.

Are services for children and young people caring?

Good

Overall we rated children's services as being good for caring because:

- Throughout our inspection we saw patients and relatives treated with dignity, respect and compassion. We heard staff using language that was appropriate to patients' age and level of understanding.
- All the patients and families we spoke with were happy with the care and support provided by the staff. Parents felt confident when leaving their child on the wards that their child would be safe and well cared for.

Compassionate care

- During the inspection we observed staff to treat children and families with dignity and respect. We heard staff using language that was appropriate to patients' age and level of understanding.
- During our inspection we spoke with nine families to gain an understanding of their experiences of care. They said they with were happy with the care and support provided by the staff. They felt confident when leaving their child on the wards that their child would be safe and well cared for.
- Families had access to the wards day and night and there were facilities for them to stay overnight. Families were encouraged to help care for their child.
- We spoke to a family who attended the children's ward frequently. They told us staff were always kind and very caring, even when the ward was busy.
- Friends and Family test results for paediatrics were cross-site. The response rate was low and the trust responded to this by introducing a child-friendly format. Marvel the monkey gave children the opportunity to draw their feelings about the service and child-friendly boxes had been introduced. In December 2015, 98% would recommend the service according to cross site data provided.
- The results of the National Children's Inpatient and Day Case Survey 2014 published in June 2015 showed that parents and children and young people rated their overall experience at 8 or more out of 10 which was the same as most other trusts.

Understanding and involvement of patients and those close to them

- We observed staff explaining to families the care their child was receiving and the purpose of the equipment helping them to do this. This was done in a compassionate way allowing the families to ask questions to understand what was happening.
- Families we spoke with felt involved and well informed about the care of their child.
- We observed a range of information leaflets across the service to help inform families about care and support services available to them.
- We spoke with older children. They told us they felt involved in their care. The staff introduced themselves to them and they were friendly. However they felt that the ward environment did not meet their needs, for example age appropriate books, DVDs and the decor.
- We observed a child and their parents going to theatre, the play therapist was present and provided support to make the experience less distressing. The theatre staff were welcoming and engaged the child at a level appropriate for their age.

Services for children and young people

Emotional support

- Staff from the play and family therapy team worked across the children's services to offer support, such as distraction therapy, to engage children and reduce distress during treatments. The staff would also accompany children and families to theatres.
- We observed a member of nursing staff respond in a sensitive way to a parent who received bad news.
- Bereavement support was available to families and the service had close links to the local hospice.
- Staff who had cared for a seriously ill patient were debriefed following the care episode and could also access counselling if necessary.

Are services for children and young people responsive?

Good

Overall we rated children's service as good for responsive because:

- There were innovations in place to promote care closer to home for children.
- There was a pathway to promote a safe transition to adult services for children.
- The child development unit supported children waiting multi-disciplinary assessment.

However:

- There were limited facilities to meet the needs of older children and adolescents.

Service planning and delivery to meet the needs of local people

- The outpatient service was working in partnership with GPs, medical and nursing staff to offer outpatient services within a community setting, at family friendly times across Calderdale and Huddersfield. This had been recognised as innovative practice by the Royal College of Paediatrics.
- The children's ward had a business plan to develop its service to include oncology treatment to enable children to receive care closer to home.
- The children's services worked together to promote early discharge and reduce readmissions.
- The service had a business strategy that reflected 'right care, right time, right place' Royal College of Paediatric and Child Health 2015 guidelines.

Access and flow

- Children were referred to the paediatric assessment area via their GPs or A&E, and following triage were either admitted or returned home. Waiting times within the paediatric assessment area were recorded on a white board to enable staff to monitor that children received timely medical care.
- All children requiring admission, who were less than four months of age, across Greater Huddersfield, were admitted to ward 3.
- Bed occupancy on ward 3 was measured daily at midday. Between December 2015 and February 2016 occupancy fluctuated between 88.8% and 63.1% with an average occupancy rate of 75%.
- Bed occupancy on the children's assessment unit was measured daily at midday. Between December 2015 and February 2016 occupancy fluctuated between 50.6% and 56.1% with an average occupancy rate of 52%.
- The children's ward had daily contact with the children's community nursing team to promote early discharge and reduce readmissions.
- Children with complex needs were seen by staff at the child development unit. The staff provided a home assessment immediately following referral, and no waiting list was required.
- Children requiring autistic spectrum disorder assessments were waiting 16 months for a multi-disciplinary assessment. The service mitigated this by providing interim support services at the child development unit, for example speech and language therapy, support playgroups, and portage service (a home-visiting educational service for pre-school children with additional support needs).
- At the time of inspection 45 children were awaiting assessment, and the service had the capacity to assess four children per week.

Meeting people's individual needs

- The paediatric ward had separate male and female bays for patients. There was a room specifically for use by young people with mental health issues. There was a lack of facilities to meet the needs of adolescent patients.

Services for children and young people

- Providing appropriate care for CAMHS patients was on the risk register and had led the service to provide a mental health admission guidance pathway. The pathway provided guidance on risk assessments to be undertaken to identify the level of observation required, and escalation procedures. Some staff had undertaken training related to CAMHS around managing aggressive behaviour, and caring for patients who self-harm. We were told that if a patient was admitted who was at risk of actual or potential harm they would be seen by CAMHS within 24 hours, or when medically fit.
- The service provided a home care team. This team provided support and care for children with complex needs in their own home. They also came into the hospital to provide support for these children. This promoted continuity of care and meet the individual needs of those patients.
- There was a range of equipment available to use for patients with physical disability, for example tracking hoists to help with mobility.
- We observed staff involving patients and relatives when delivering care and worked in a way which was family centred.
- The paediatric ward had a quiet room for children with complex needs, which included sensory equipment.
- Staff told us they used a translation service to meet the needs of families from different cultural and ethnic backgrounds if English was not their first language. We did not see any information leaflets in different languages.
- There was a pathway for young people to promote a safe transition to adult services called Ready, Steady, Go – Hello. Transition to adult services was supported by a matron. There were transition clinics, for example, diabetes and epilepsy.

Learning from complaints and concerns

- Friends and family questionnaires were observed on the children's wards. They were all in a child friendly format.
- We saw an example of responding to feedback. 'You said - we did' was a response to the family and friends test.
- Nine complaints were made about the service provided on ward 3 and two on the neonatal unit. Complaints were closed in a timely way, with the 25 day target, and only one complaint remained on-going. The main theme of complaints was about treatment and care. Complaints were discussed at team meetings.

Are services for children and young people well-led?

Requires improvement

Overall we rated children's service as requires improvement for well-led because:

- The risk register was reviewed and control measures in place, however responses were not timely to implement strategies which would address the risks.
- Governance meetings provided action plans following incidents. However no timescales were applied to the action plans. Therefore there was no assurance controls and mitigations were applied in a timely way.
- Investigations of incidents, prior to inspection, using root cause analysis were not always comprehensive and were poorly documented.
- There was lack of management oversight of clinical areas to support staff in identifying and reporting safety issues.
- There were no action plans to implement strategies to improve patient outcomes.
- Safeguarding training levels were not being met.

However:

- Staff were aware of the trust vision of compassionate care.
- Staff were encouraged to develop leadership skills and felt supported by management.
- We saw evidence of the service being active in seeking feedback from patients and relatives.

Vision and strategy for this service

- The director of nursing acted as the board level Executive Director for Children's Services, as required by the National Service Framework for Children. However, there was no non-executive led for children, as recommended.
- We met with the senior management team for children's services. The team worked cross site managing the services provided to children.
- The strategy for the service was to develop a one site service for children. Staff were working across sites and they reflected this strategy as a way to improve services for children. Strategic aims were to improve partnership

working with external agencies to improve safety of care. Senior staff told us the strategy was benchmarked against 'Time to move on' a report by the Royal College of Paediatrics and Child Health, 2014.
- Staff could tell us about the vision of 'compassionate care' of the trust. Staff also referred to the 'go see' strategy supporting staff to go into external areas of practice to drive improvements in their own.

Governance, risk management and quality measurement

- There were 12 risks on the register as at March 2016 for children's services across both sites. The risk register had open risks from July 2013 (neonatal staffing). Risks were reviewed and controls were demonstrated. Actions to address the gaps in controls were evident. However, the dates the risks were identified suggest a delay in implementation of strategies to fully address them.
- During inspection, we highlighted to senior staff the risk of resuscitation trolleys behind locked doors. Senior staff were responsive to the issues and made the necessary changes to promote safety. However, this demonstrated a lack of oversight from senior staff of safety issues at ward level and the ability of frontline staff to identify issues.
- We were provided with examples of root cause analysis investigation of incidents. These were not comprehensive; there was not a clear chronology of events and identification of the cause leading to incidents.
- Monthly paediatric forum meetings were well structured to include the reporting of complaints, incidents, audits and risks. Issues were highlighted and actions allocated to members of the forum. However, there were no timescales for actions to be completed.
- We didn't see any action plans to improve patient outcomes in response to national audit data.
- Safeguarding level three training was below the trust target. Meeting minutes provided for the children's directorate did not acknowledge this in the safeguarding standing agenda item.
- A quarterly report from the families and speciality directorate was provided to the quality committee.
- Ward 3 had a staff notice board. Information included staff council meeting minutes, paediatric forum minutes and directorate meeting minutes. There was a section informing staff of research projects. There was also a safeguarding board, sharing information about learning from incidents. Information included training opportunities for CSE and FGM and CAMHS and MCA/ DoLs online training.

Leadership of service

- Nursing staff we spoke with said they were supported at ward level and had confidence in the ward leaders.
- Nursing staff were encouraged to 'act up'. That meant staff could take the opportunity to work as the nurse in charge on some shifts to develop their skills. This could contribute to workforce planning, by having the appropriate management skills when vacancies occurred
- The service had a staff council held every six weeks, with representatives from all staff groups. This was a way to encourage staff to feed issues and concerns into the monthly paediatric forum meetings. It was implemented due to lack of staff engagement at meetings and staff told us it was well attended.
- Community children's nursing team received a 'virtual noticeboard' through email twice per month, informing them of relevant issues, for example learning from complaints and incidents.
- Students told us they were given good learning opportunities felt supported by staff. They had good access to mentors.

Culture within the service

- Staff talked positively about the service they provided; they enjoyed working at the trust. Some members of staff had worked there for many years. They felt part of the team and felt staff worked well together and supported each other. Morale appeared good.
- Staff told us they felt supported by their colleagues and management. They said they were happy to raise concerns and report incidents.

Public and staff engagement

- We saw evidence that the service was active in seeking feedback from patients and relatives in a format appropriate to the service. We saw evidence of positive feedback which was displayed for staff and patients to see.
- Patients and families had been involved in procuring suitable cutlery for paediatric patients and reclining chairs.

- Parents have been consulted to improve the wards towards a home from home environment.

Innovation, improvement and sustainability

- Children's outpatients' staff were providing a service in the community. This was part of the local vanguard work.
- Ward 3 was in the process of developing a service to provide oncology care, to allow children to have care closer to home.
- The trust was a pilot site for the Child Protection – Information Sharing (CP-IS) project, an NHS England sponsored programme. This is an electronic system which allows the sharing of information across health care providers when children are subject to safeguarding concerns.

End of life care

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

Information about the service

End of life care (EOLC) was delivered by nursing and medical staff throughout Calderdale Royal Hospital and Huddersfield Royal Infirmary. There were no dedicated beds within the hospital for specialist palliative care. In-patient specialist palliative care was provided for Calderdale residents in Overgate Hospice, a 12-bedded specialist unit in Elland and for Kirklees residents at Kirkwood Hospice in Dalton which was a 16-bedded specialist unit. The hospice was funded through charity and donations.

End of Life care encompasses all care given to patients who are approaching the end of their life and following death.

The Specialist Palliative Care Team (SPCT) sat within the Integrated Medical Speciality Division. They were part of a multidisciplinary team approach to end of life care and covered both Calderdale Royal Hospital and Huddersfield Royal Infirmary. The team provided help and advice for difficult symptoms in advanced disease and emotional/ psychological support for patients and families. They also provide information about diagnosis and treatment. The SPCT delivered a Monday to Friday 9am-5pm service, with advice available out of hours and at weekends from the local hospice and on-call consultant. The team were based at Huddersfield Royal Infirmary and included 1.5 WTE (whole time equivalent) SPC consultants covering both hospitals and the hospices. This comprised of four consultants. There were 4 WTE clinical nurse specialists who provided cover to both Calderdale and Huddersfield hospitals.

The four consultants in Palliative Medicine (one of which was a lead for the service) provided cross site cover between both hospitals and the hospices. Within these posts there was a band 5 development post. There is also a band 4 post to co-ordinate training. In addition there was a team secretary.

There were 1049 recorded deaths recorded for the trust between April 2014 and March 2015. This was the latest data available at the time of inspection.

We spoke with the lead consultant, who told us there were plans to re-design the end of life care teams. There was a current vacancy for the End of Life scoping facilitator and a band 4 care co-ordinator, Currently, two of the four consultants had responsibility for the hospital acute on-call cover, with the additional consultants providing cover to the hospice. These arrangements will be reviewed as part of the re-design of the care teams.

We visited medicine and respiratory wards, the medical admissions unit, critical care and the accident and emergency department, where end of life care could be provided. We also visited the chapel, the hospital mortuary and viewing room. We observed care being delivered by both SPCT nurses and ward staff.

We spoke with four patients and relatives. We spoke to 20 staff including the clinical nurse specialists and palliative care consultants in the SPCT. In addition we spoke with ward nurses, ward doctors, healthcare assistants, allied health professionals, bereavement office staff, porters and the end of life training facilitator. We looked at the records of six patients receiving end of life care and 10 DNACPR (do not attempt cardiopulmonary resuscitation) forms.

End of life care

Summary of findings

We rated end of life care services as good overall because:

- Patients were provided with an end of life care service that was safe and caring.
- The mortuary was clean and well maintained.
- Staff delivering end of life care understood their responsibilities with regard to reporting incidents and ensured information and lessons learnt were shared proactively with other colleagues within the hospital.
- We saw clear, well documented and individualised care of the dying documents and appropriately completed DNACPR forms.
- The referral process was clear and responsive and staff ensured that patient's wishes were central to the care planning process.
- Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care.

However:

- The end of Life Strategy / Vision was in draft form. It did not contain business objectives for the team and lacked robust definition of what the vision and outcomes would be for the team in the future.
- There was a limited approach to obtaining the views of people who used the service and other stakeholders. There was no mechanism to ensure feedback was captured and actioned in a timely way.

Are end of life care services safe?

Good

We rated safe as good because :

- There were systems for reporting actual and near-miss incidents across the hospital. We saw examples of lessons learnt following audit feedback.
- There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.
- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.
- Staff were supported to attend mandatory training and in most areas of training, compliance was 100%.
- There were adult safeguarding procedures in place supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- There was sufficient equipment available including syringe drivers and plans were in place to arrange a central store to locate them across the hospital easily.
- Medications were stored correctly and syringe drivers were used in accordance with National Patient Safety Agency (NPSA) Rapid Response Alert.

Incidents

- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents and they knew how to report them. They also told us that they received direct feedback relating to the incidents.
- We saw the SPCT carry out morning 'safety huddles' to ensure patient safety issues were shared and mitigated.
- We saw 33 incidents recorded relating to end of life care during November 2015- April 2016, of which 19 were graded as green meaning no harm and the remaining rated as yellow meaning minimal harm.
- The SPCT told us they were involved in the review of incidents trust-wide where end of life care and / or treatment had been identified.

Duty of Candour

End of life care

- Duty of Candour is a legal duty on NHS trusts to inform and apologise to patients if there had been mistakes in their care which led to moderate or significant harm.
- Staff spoke with some understanding about their duty of candour, they understood their responsibly to be open and transparent. They gave us an example of when they had used duty of candour. For example recognising delays in communication with family members.

Cleanliness, infection control and hygiene

- The trust had a policy for the prevention and control of infection and hand hygiene. This was available for staff on the trust intranet system.
- We visited the wards and found there were infection control and prevention. Systems were in place to keep patients safe with appropriate signage around the wards. For example, appropriate handwashing signage and the use of antibacterial hand gel upon entering and leaving the wards.
- We visited the mortuary at Calderdale Royal Hospital and saw that it was clean and well maintained and that hand washing facilities were available. Cleaning records were easily accessible and up to date. We saw appropriate hand washing facilities were available.
- We saw records of handwashing audits and these showed the mortuary had 100% compliance over the last three months.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and hand hygiene facilities.
- Mortuary protocols were reviewed and we saw that relevant infection control risks were managed with clear reporting procedures in place. We spoke with staff who reported they were confident in their role and using the reporting protocol.
- We saw that 100% of staff within the mortuary had completed infection control training.
- We saw that the trust had developed a 'care of the deceased' policy. This was reviewed in January 2016 and contained comprehensive guidance relating to infection prevention in all aspects of the care of the deceased policy.

Environment and equipment

- Staff we spoke with told us they had no problems accessing equipment for patients at the end of life in the hospital.
- Syringe drivers were available and although there was no central point of storage, plans were in place to ensure all syringes drivers were logged when in use and were tracked so that they could be obtained quickly and efficiently. This was the responsibility of the band 4 member of staff who was part of the end of life care team.
- The trust followed the guidelines within the NPSA Rapid Response Report: Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010, which advised that ambulatory syringe drivers should change over to devices with specific safety features. Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged via the fast track route.
- We visited the mortuary at Calderdale Royal Hospital. We saw the mortuary was well equipped and that the capacity was adequate.
- Equipment was in place to support the transportation of bariatric patients.
- The temperature of the mortuary fridges was recorded on a daily basis and we saw that they were appropriately recorded and within the correct temperature range.
- The mortuary staff told us that they had not experienced any difficulties involving capacity but they could access the mortuary at the Huddersfield Royal Infirmary if they experienced problems.

Medicines

- Patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of pain and other symptoms.
- The trust provided guidance regarding anticipatory medicines. We saw this within the Individualised Care of the Dying Document (ICODD). These had also recently been made available on the trust intranet. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should they need it.
- Anticipatory end of life care medication was appropriately prescribed. The SPCT had an active role in writing the guidance and training staff in the use of anticipatory medication.
- We saw that the SPCT worked closely with ward staff to provide daily advice and support.

End of life care

- We looked at the records of three patient's Medication Administration Records (MAR) and we saw that they were completed clearly, including administration of medicines prescribed 'as required'.
- The band 7 Team Leader is studying to become a clinical advanced practitioner and is due to start her non-medical prescribing course in September 2016.

Records

- There was a trust wide electronic record system (SystmOne) in place that enabled sharing of patient information within the team and with other health care professionals.
- The trust had developed the ICODD, which recorded the care, treatment and wishes of the patient leading up to and at the point of death. We saw these documents were in place and audits completed regularly by the SPCT to ensure that the quality of information was high.
- We viewed 10 DNACPR forms when visiting the wards and found that on all occasions these were completed correctly with discussions with the patient and relatives recorded where appropriate. In only one document we saw that patient discussion had not been recorded in full. Forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant.
- Information governance training was part of the annual mandatory requirement for all staff. We saw that all staff within the end of life care team achieved 100% compliance.

Safeguarding

- We spoke with staff about safeguarding. Staff were knowledgeable about the trusts safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- We saw that the trust had developed and achieved a key milestone for establishing policies around the reporting of safeguarding and lone working.
- Specialist palliative care staff mandatory training completion for safeguarding adult's level one was 100%. All staff within the end of life care team achieved 100% compliance.
- The only training which was below this was 'PREVENT' training. PREVENT training is a government anti-terrorism initiative to recognise signs of radicalisation. The end of life care team achieved 66.67% in this area.

Mandatory training

- Mandatory training was provided for all staff and was undertaken by all staff providing end of life care.
- We were supplied with data from the provider which showed that the all staff within the end of life care team was achieving 100% compliance in all areas of training. 100% compliance was achieved in infection control, equality and diversity, health, safety and welfare, information governance, moving and handling and conflict.
- The end of life care team also achieved 100% within dementia training.
- The SPCT provided education and training to staff on a formal and informal basis.

Assessing and responding to patient risk

- Ward staff provided care to patients requiring palliative and end of life care.
- When a patient was deemed to be reaching the end of their life, the palliative care team was contacted through the referral process. Ward staff completed the ICODD.
- Ward staff told us the SPCT team were a visible presence on the wards. Any changes to patient's conditions generally instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes.
- Matrons within the hospital held 'safety huddles' each day to discuss specific patient issues. The SPCT were involved in these meetings to ensure all staff were aware of patients requiring end of life care, fast track discharge or had complicated needs.
- Within the ICODD it was a requirement to assess nutrition, spiritual needs, hydration, pain management, comfort, pastoral care and patient's wishes throughout. This enabled a way of better recording the narrative of the patient's journey and to manage any risk.

Nursing staffing

- We found staffing levels were sufficient to ensure that patients received safe care and treatment at the end of their lives.

End of life care

- Nursing staff on the ward told us they would have liked to spend more time with patients following death to support relatives and families, however they could contact the SPCT who would provide support.
- Specialist palliative care was provided from 9am to 5pm five days a week. Outside of these hours and at weekends, general in-patient staff could access specialist support from a consultant on call rota or the two local hospices.
- End of life care was provided by ward staff all the time, with specialist support from SPCT.
- The SPCT consisted of 4 WTE clinical nurse specialists. This post would be involved in the training and development of staff.
- There was a vacancy for a scoping facilitator for end of life. We were told that this post would be utilised to develop the services moving forward and ensure the strategy objectives were achieved.
- There was also funding for band 2 posts to support the band 4 end of life care training lead with administration. The clinical nurse specialist team and consultants had an education element to their role, which included "in-reach support" attending consultant meetings and ward rounds in the following disciplines: oncology, haematology, gastroenterology and respiratory medicine.
- Link nurses had been identified for some wards with an emphasis on medical wards. The link nurse role was to attend end of life meetings and attend training events in relation to end of life care and cascade back to the ward team. Although the process did not seem consistent as there were not link nurses on every ward. Attendance for those who did attend was inconsistent due to difficulties leaving the ward.
- We spoke with the lead clinician who told us there was a business case in place to provide a seven day direct service from the SPCT.

Medical staffing

- There were four palliative care consultants for the trust. Two of which were aligned to the hospitals and two to the hospice services. Each provide cross site cover when needed. This was in line with the best practice guidance for the number of patient's deaths.
- Medical staff we spoke to told us that the SPCT were available for specialist advice as needed.
- The palliative care consultants did not provide full on-call cover. They were available 5pm to 9am weekdays and 9am to 9am weekends and bank holidays, for telephone advice. Ward staff told us that they would contact the usual on-call consultant when required.
- There was also SPCT consultant input into the heart failure and respiratory multi-disciplinary team meetings.

Major incident awareness and training

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need.

Are end of life care services effective?

Good

We rated effective as good because;

- The service participated in relevant local and national audits, including clinical audits. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by end of life care staff. It was used to improve care and treatment and people's outcomes.
- Care and treatment was delivered in line with national guidance and best practice outcomes.
- We saw the use of nursing assessment tools within the ICODD, which included the assessment of pain, nutrition and hydration. Additional prompts were in place in the Caring for the Dying Patient document, which included patient choice, comfort and individual's ability to tolerate food and drink.
- The SPCT consisted of a team of doctors and nurses who were skilled and knowledgeable. They were experienced in providing support and training to other staff. For example symptom control, opioid prescribing, DNACPR, palliative care emergencies and legal and ethical training.
- The trust had a Commissioning for Quality and Innovation (CQuin) target to deliver end of life care to staff working within cardiology and complex care services. The CQuin was achieved on respiratory wards which saw 90% of staff received end of life training.

End of life care

- Ward staff worked together with the specialist palliative and end of life care teams to understand and meet the range and complexity of patient's needs. They demonstrated joint working in assessing, planning and delivering end of life care to patients.
- Staff providing end of life care were qualified and had the skills to carry out their roles effectively and in line with best practice.

However:

- Results from the National Care of the Dying Audit 2015 showed that the trust was below the England average in all five of the clinical indicators and achieved four of the eight organisational indicators.

Evidence-based care and treatment

- The trust participated in the requirement, development and roll out of the Individualised Care of the dying document (ICODD). This was launched in November 2014. The document was created using elements which worked well from the Liverpool Care Pathway and incorporated existing nursing documentation. Patient representatives were approached during the creation of the document and a multi-professional group developed the document.
- The document contained guidance on appropriate medication for controlling common symptoms at the end of life and daily recording of patients and family's needs. The document included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Strategy and the National Institute of Health and Care Excellence (NICE).
- The SPCT delivered study days based on 'One chance to get it Right' as part of the mandatory training programme for nursing staff. There were also designated educational sessions for medical staff. This approach was developed by the Leadership Alliance for the Care Of the Dying Patient (LACDP 2014) and focused on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be.

Pain relief

- We saw pain assessments in place as part of the ICODD. We looked at the records of six patients and saw that patients were assessed and reviewed regularly.
- Staff told us they could contact the specialist palliative care team for advice about appropriate pain relief if required.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.

Nutrition and hydration

- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that, following MUST, appropriate nutrition and hydration monitoring tools had been used by staff. These included monitoring charts for food and drink as part of the ICODD. Specialist dietician support was available on all wards and we saw records of their involvement.
- Nursing staff told us that patient choice and comfort were included in the prompts and we saw this within the ICODD.
- We saw within the results of the 2015 National Care Of the Dying audit that within the patient files that were audited, 61% of the cases were found to have documented evidence that the patients ability to eat and drink had been assessed in the last 24hrs of life. In two thirds of cases the patient's ability to drink had been assessed.
- Staff told us that those patients identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed.
- A patient told us that food 'could be better' but 'I am always given assistance when I need it'. Another patient told us 'It suits me. I have no complaints'
- Staff told us that snacks were available for patients throughout the day and night.

Patient outcomes

- The trust participated in the National Care Of the Dying (NCDAH) audit 2015. The results were published in April 2016. The results were shown by the use of clinical indicators. These were a way to measure how effectively a hospital achieves key objectives or targets. Both organisational and clinical quality indicators were measured.

End of life care

- The trust was below the England average in all five of the clinical indicators and achieved four of the eight organisational indicators.
- The clinical indicators looked at documentation showing the patient would probably die in the coming hours or days. We saw that the trust were below in the following areas:
- The decision regarding end of life had been discussed with a nominated person important to the patient.
- The patient was given an opportunity to have concerns listened to.
- The needs of the patient important to them were asked.
- A holistic assessment of the patient's needs was documented in the last 24 hours of life.
- Within the organisational indicators, those not met were:
- Between 01/04/14 and 31/03/15 formal in house training did not include / cover specifically communication skills training for care in the last hours or days of life for allied health professional staff. A work stream was developed in response to this which showed planned training dates for nurses to cover communication skills and breaking bad news.
- Face to face access to specialist palliative care for at least 9am to 5p.m Monday to Sunday was not available. Outside of these hours consultant on-call telephone advice was available.
- We saw evidence of audits of DNACPR forms being carried out and saw decisions were being recorded with actions in place to address the issues raised. These were recorded within the minutes of the end of life care team minutes.
- We viewed an audit of the ICODD document that had been undertaken by the clinical lead and saw that ongoing improvement work was being carried out in the areas identified through the NCDAH audit. We saw from the results in September 2015 that the percentage of patients who died whilst being cared for on the ICODD was 45.3%. It was agreed by the trust, that a target of 75% compliance should be set.
- Patients with a learning disability were encouraged to bring in their 'VIP passport'. This is a guide to assist staff communicate with patients, which is specific to their needs.

Competent staff

- There was 1.5 WTE (whole time equivalent) SPCT consultants (consisting of 4 consultants) covering both hospitals and the hospices. There were 4 WTE clinical nurse specialists providing cover to both Calderdale and Huddersfield hospitals. The community team were separate.
- Staff told us they had received an annual appraisal. Compliance figures varied within the team with the mortuary staff achieving 100% compliance and the remaining end of life staff achieving 67% compliance.
- SPCT staff told us they had opportunities to shadow community colleagues and they told us they found this very beneficial.
- The specialist palliative care team delivered training to staff as part of their mandatory training. This was based on the values within the 'one chance to get it right' document.
- Previous audit information in 2015 showed that standards of mouth care during end of life were falling. A policy was put in place and cascaded to staff on all relevant wards. We did not see any evidence of audits following the implementation of this policy.
- Prior to the roll out of the ICODD, all relevant wards received a comprehensive training programme regarding the use of the documentation.
- The trust had a CQuin target to deliver end of life care to staff working within cardiology and complex care services. The CQuin was achieved on respiratory wards which saw 90% of staff trained.
- The trust had a policy in place regarding consent to care and treatment which was in line with Department of Health guidelines.
- The SPCT participated in roll out of study days 'One chance to get it right'. This document sets out the approach to caring for dying people that health and care organisations and staff caring for dying people in England should adopt in future. Although not every ward had received this training at the time of our inspection, we saw an action plan to roll this out in all areas.
- A nurse told us 'the training is very good. We are supported to attend study days at the hospice'.
- The SPCT spoke with pride around the importance of working with their colleagues in the community. This involved delivery of training to staff from external organisations, including those working in local nursing homes.

End of life care

- A junior doctor told us 'we invite the SPCT once a week to the acute medical training. They update us with any new developments'.
- The doctors and nurses in the SPCT were skilled and knowledgeable. They were experienced in providing support and training to other staff. For example symptom control, opioid prescribing, DNACPR, palliative care emergencies and legal and ethical training.
- There were two resuscitation officers covering both hospital sites. They completed resuscitation audits each week across the wards. Data was being collated following these audits at the time of our inspection.
- Training was rolled out earlier this year to staff on each ward to perform 'last offices'. Last offices are the preparation of the dead for burial.
- We were told that training days were planned for advanced communication skills. We were told that training days were planned for advanced communication skills. We saw that this recently commenced the previous week with both qualified and non-qualified staff attending.
- A regional training DVD on DNACPR decisions was produced last year and was available on the intranet for all staff.
- Funding had been received from Health Education for Yorkshire & Humber for training. The trust had commissioned Kirkwood Hospice to deliver a series of free one day courses for doctors and registered nurses working in the Trust. This course was designed to improve knowledge, skills and confidence when communicating with palliative care patients. It will focus on the five priorities of care which are recognise, communicate, involve, support, plan and do. We could not see commencement dates for these sessions.

Multidisciplinary working

- The palliative care team had established positive working relationships with community services, including GPs, district nurses and the community palliative care team at the local Overgate and Kirkwood Hospices.
- The specialist palliative care team worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from the bereavement office staff.
- The specialist palliative care nurses planned and attended weekly palliative care multidisciplinary meetings where new referrals to the service were discussed.
- The palliative care team told us they benefited from good working relationships with staff at the hospital and in the community. For example, there were opportunities to attend ward meetings on occasion.
- We observed a Multi-disciplinary team (MDT) meeting and saw discussions around patient care and how staff across the teams could meet the patient's needs.

Seven-day services

- Plans were in place to provide a seven day service with an integrated service Trust wide. A business case had been submitted but was subject to financial resources and trust approval.
- All staff told us without exception they felt it would benefit patient care if there was a seven day specialist palliative care service.

Access to information

- We saw records of plans of care within the ICODD. We spoke with staff who confirmed risk assessments were available. We confirmed this by checking patient records where we saw evidence of appropriate risk assessments in place.
- We saw guidance documentation by the SPCT that could be accessed by ward staff. Staff told us that they found the system easy to follow.
- Information regarding the fast track discharge and referral process to the SPCT was available on the intranet.
- There were plans to develop a DNACPR leaflet for patients and end of life data had just recently been introduced onto the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place regarding consent, which was in line with Department of Health guidelines.
- We saw literature offering patients an advocate when required and mental capacity guidance.
- Staff within the end of life care team achieved 100% compliance within safeguarding training.
- Staff we spoke with all had confidence of their understanding of the mental capacity act and deprivation of liberty safeguards.

End of life care

- A nurse told us that mental capacity assessments were audited as part of the DNACPR audit process.
- We saw nursing staff seek consent from patients prior to assisting with personal care. This was carried out in a dignified and caring manner.
- The Resuscitation Council UK (2015) states healthcare organisations "Should ensure effective communication with and explanation of decisions about CPR to the patient's family, friends, other carers or other representatives, or clear documentation of reasons why that was impossible or inappropriate".
- We saw evidence of the end of life care team addressing DNACPR document completion and improvements made following consultation with ward staff and clinicians. We saw regular audits for DNACPR to ensure compliance.
- We saw examples of lessons learnt as a result of this. For example the introduction of the DNACPR bundles and case file stickers. The stickers identified clearly to staff that a DNACPR was in place.
- The trust initiated an 'Effective Quality Improvement Project' for DNACPR. The Trust target was 90% of DNACPR decisions that have been discussed with the relative or where the patient was unable (i.e. dementia, unconscious). This was to allow some leeway when decisions needed to be taken in critical situations and there was no opportunity to communicate with the patient or carer. The target was not achieved in July (88.4%), August (83.3%) or September 2015 (82.8%), but was achieved in October (92.75%).
- We viewed 10 DNACPR forms. We saw clear and appropriately completed DNACPR forms and examples of patients who did not have the capacity to be involved in discussions about the situation. We saw evidence of assessments being completed with their lack of capacity clearly recorded. We saw that the decision had been discussed with the patient's relatives and that the decision had been clearly recorded.

Are end of life care services caring?

Good

We rated caring as good because:

- All feedback we received from patients regarding their end of life care was positive.
- Patients were involved in their care and we observed care that was attentive and sensitive to the needs of patients. Staff treated patients with dignity and respect.
- Patients felt involved in their care and patient's social needs were understood.
- Patients' feedback or views on their experiences were regularly collated through the bereavement surveys and the end of life care team was aware of the feedback.
- We saw patient's privacy and dignity was respected at all times.
- Patients and their relatives had good emotional support from the bereavement office and ward staff.

Compassionate care

- During our inspection we visited the mortuary and spoke with the mortuary staff. On discussion staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.
- We observed staff interacting with families arriving to view the deceased with compassion and we saw staff had a patient and kind approach.
- During our inspection we also visited the bereavement office and the chaplaincy staff. They also demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect.
- Ward staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support they required. They showed a good understanding and demonstrated compassion and respect.
- We saw the porters transporting patients with dignity and respect.
- Patients and relatives were offered support with emotional and psychological pain through the SPCT, the chaplaincy service and ward staff. We saw this support was documented within care records.
- The chaplain told us a memorial service is held each year in remembrance for those who have died at the hospital.
- Comfort packs were issued to families wishing to stay with relatives in hospital. The bags contained essentials, such as bed socks, tissues, a dental kit and a notebook and pen to ease time spent at a bedside if a relative needed to stay overnight.

Understanding and involvement of patients and those close to them

End of life care

- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- We saw that where patients had been assessed as not having capacity to make decisions, care options had been discussed with their next of kin.
- There was evidence of patients and/or their relatives being involved in the development of their care plans.
- In addition there were boxes for text which asked if there was anything more that could have done and if they had any suggestions about how care could be improved. CFDP document contains a section where it can be documented that the Family Voice has been offered.
- We saw advance wishes were discussed with patients and their relatives and recorded within the care planning documents.
- We saw that the ICODD included prompts to assist with patients and their relative's involvement. For example ensuring communication has been shared with families in the event of deterioration in breathing.
- Families were encouraged to participate in care and provide feedback through surveys. The patient experience group (PEG) carried out a survey of bereaved relatives in October 2015. Feedback showed that relatives had confidence and trust in doctors and nurses caring for their loved ones at end of life. Although over half of patients experienced pain, restlessness and noisy breathing in the last days of life, it was felt that staff worked hard to relieve these symptoms. However, in 20% of cases, relatives were not alerted to the fact that death was likely soon (we cannot know if these related to sudden deaths or to anticipated ones). We saw an action plan produced by the trust which included a review of the mortality process to improve the likelihood of missed opportunities.
- We saw information available as a leaflet offering advice for relatives on the care of the dying patient. The leaflet included information regarding the ICODD, side rooms, visiting arrangements and general hospital information.

Emotional support

- During our inspection we visited patients who were in receipt of end of life care. Patients spoke positively about the way they were being supported. One patient told us 'they can't do enough for me'.
- As part of the National Care of the Dying Audit the trust sent a questionnaire to relatives of patients who died within the trust in May 2015. The response rate was 35%. They were asked a variety of questions relating to general care received from doctors and nurses. Generally relatives had confidence and trust in the doctors and nurses caring for their relatives at the end of life. Emotional / spiritual support was rated as good or excellent in 90% of the responses and patients were seen to be treated with respect 90% of the time.
- We saw that privacy and dignity was maintained and opportunities were taken to further inform the patient and their family of the situation. We observed that patients and relatives were central to this process and this was in the form of a discussion rather than informing the patient.
- Patients were routinely offered a side room for dignity and comfort and to prevent distress to other patients.
- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their visitors. This included the chaplaincy and bereavement office staff.
- A nurse told us that counselling was available through occupational health should they require it.
- Staff in all ward areas told us they had sufficient staffing levels which enabled them to provide end of life care which included emotional support.

Are end of life care services responsive?

Good

We rated responsive as good because;

- Ward and SPCT staff responded to patients' individual needs in a timely and co-ordinated manner.
- Patients were offered side rooms when available and there was a piece of work commissioned to look at access and availability of side rooms in end of life care.
- Fast track discharges were managed efficiently. Patients received support and advice out of hours.
- The trust had initiated an 'Effective Quality Improvement Project' for DNACPR.
- The ICODD was fully embedded within the acute wards and encouraged and promoted patient choice and decision making.
- We saw that the trust was supporting the increasing numbers of non-cancer referrals.

End of life care

- We saw evidence of learning following complaints and feedback provided to the staff following issues and concerns.

However;

- The SPCT did not offer patients direct seven day service but there was a business case in place to improve this.

Service planning and delivery to meet the needs of local people

- The SPCT were available Monday to Friday from 9am to 5pm and delivered advice outside of these hours and at weekends through the local hospice and consultant on-call.
- The lead clinician told us that the model delivered was to see patients within one working day of referral. We saw that referrals could be made on the electronic system or through telephone contact. A nurse told us that visits to the patient by the SPCT following referral are 'very quick and often the same day'. However we were unable to find any audits completed by the trust that measured the timeliness of referrals.
- The trust had commissioned Kirkwood Hospice to deliver a series of free one day courses for doctors and registered nurses working in the Trust.
- The Chaplaincy team funded one of the Muslim chaplains to undertake a project looking into why the uptake of end of life care services was so low in the South Asian community. This work was undertaken in conjunction with the end of life care team, Community engagement teams and Overgate Hospice. End of life training is planned for the local Iman.
- The Chaplaincy team funded one of the Muslim chaplains to undertake a project looking into why the uptake of end of life care services was so low in the South Asian community. This work was undertaken in conjunction with the end of life care team, Community engagement teams and Overgate Hospice. An information sharing morning on end of life care is being planned for the South Asian Community.
- The ICODD had been rolled out within the ward areas to facilitate coordinated care that gives the patient choice. Emphasis had been placed on ensuring care was carried out in the patient's preferred place. For example the trust delivered a Fast Track Discharge for Dying Patients. Patients requiring a fast track discharge were supported to return home within 48hrs.
- The trust were advertising for a scoping facilitator within the end of life care team. The post will scope local service providers of end of life care to develop an end of life care strategy and an educational strategy.

Meeting people's individual needs

- The multidisciplinary team documented their information in the patient's notes which ensured the social and health care professional involved were aware of the care and treatment patients were receiving.
- Nursing staff told us that they could access specialist nurses relating to dementia and learning disabilities to ensure best care and practice.
- Staff we spoke with had a good understanding of safeguarding issues and of the mental capacity act (2005) and how this impacted on caring for patients who did not have capacity to make their own decisions.
- Wards offered a 'relaxed' visiting policy for relatives to visit patients who were at their end of life. Family members wishing to stay with their relatives were encouraged to do so.
- The chaplain told us that a steering group had been set up to look at the cultural issues amongst the south Asian communities. One of the Muslim chaplains sat on this steering group.
- Mortuary visiting times were fixed but mortuary staff told us they would be flexible to allow for bodies to be removed due to cultural needs.
- Comfort packs and refreshments were provided to relatives and friends wishing to stay with patients.
- Interpreters were available within the trust and we saw information relating to these services. Staff told us they had not experienced any problems accessing an interpreter.
- We saw a leaflet 'The care of the dying patient' available for relatives and visitors which included information regarding facilities within the hospital and what to expect during the patient's journey.
- The mortuary at Calderdale Royal Hospital offered set viewing times for relatives and family to view the deceased. However mortuary staff told us that they try to be as flexible as possible with this and try to accommodate where possible.

Access and flow

End of life care

- The SPCT delivered a Monday to Friday 9am to 5pm service, with advice available out of hours and weekends from the local hospice and on-call consultant.
- Nursing staff told us that they had not experienced any problems accessing advice or support out of hours.
- Ward staff told us they knew how to access the SPCT. A nurse told us they found the service 'helpful and friendly'.
- Two nurses told us that they felt 'frustrated' and they had experienced 'delays' in decisions regarding end of life by senior doctors. The nurses felt these delays were 'detrimental' to the patients.
- The SPCT told us that referrals were actioned within one working day and we saw many were actioned within this time frame.
- The trust did not collate information regarding preferred place of death but we did see that it was recorded within the ICODD.
- We saw that advice given was recorded in the ICODD and included patient treatment and outcome guidance.
- There were set times in which the mortuary released bodies, however mortuary staff were flexible where possible and local funeral directors understood this.
- Nursing staff told us there were no direct hospital delays to discharging patients who required end of life care at home. However, there were difficulties arranging social services homecare packages due to lack of resources in the community, which resulted in delay for some patients. We did not see any audit activity which captured this information.
- The percentage of referrals to the SPCT had shown a gradual increase across the year with referrals for non-malignant disease at 35% at October 2015.
- A piece of work had recently been commissioned to look at patient flow in relation to availability of side rooms within the hospital. We saw as a result of this work that a colour coded priority system was introduced for staff. Patients requiring end of life care were identified as red, which was high priority.

Learning from complaints and concerns

- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- The SPCT would provide specialist input in relation to reviewing complaints to ensure learning is occurring and cascaded. Staff told us they received verbal information from their line manager regarding complaints.
- We saw that there were three complaints relating to end of life care within the last 12 months. These related to concerns around clinical care that was delivered involving several different departments across the trust. We did not see any action plans in relation to these.

Are end of life care services well-led?

Good

We rated well-led as good because;

- Staff knew who the lead staff were for end of life services and felt they could approach them openly at any point.
- The SPCT was led by a palliative care consultant and line managed by a band 7 clinical nurse specialist. We spoke to ward staff that were aware who the lead person was for the end of life service. There was a general feeling of 'openness and honesty' and staff told us they would ask senior staff for advice if they needed it.
- Patient safety and quality were addressed at a senior management level within the divisional risk management group meetings.
- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying Audit for Hospitals in 2015. The trust had recently completed a survey of 120 bereaved relatives and carers.
- Staff told us that they were informed verbally of any areas of improvement during monthly ward meetings.

However;

- The End of Life Strategy / Vision was in draft form at the time of our inspection. It did not contain business objectives for the team and lacked robust definition of what the vision and outcomes would be for the team in the future. Staff in the SPCT did not appear to have been consulted with the development of the draft strategy.

End of life care

- Governance meetings were held regularly for the end of life care team. However they did not review quality outcomes each month and did not contain clear actions following discussions around poor quality outcomes.
- There was a limited approach to obtaining the views of people who use the service and other stakeholders. There was no mechanism to ensure feedback was captured and actioned in a timely way.

Vision and strategy for this service

- The trust had produced a draft vision / strategy. The draft did not set out its objectives or vision for the future or include the business case to move towards seven day service provision. We saw an action plan produced in response to the results of the National Care of the dying audit 2015. It included development of a business case to support workforce development within SPCT for the provision of seven day face to face working. The deadline for this was the 31st October, 2016.
- We spoke with both junior and senior nursing and medical staff from across several directorates. The majority of which had not been included in any discussions about the End of Life Care strategy. Staff we spoke to were unclear about the vision and priorities for the future.
- SPCT staff we spoke to were also unclear about the vision and priorities for the future.
- We saw minutes of end of life care governance meetings, which discussed that a strategy was to be developed but did not include timescales, development criteria and was not included on the action log.

Governance, risk management and quality measurement

- The end of life care team met each to month to discuss issues such as ICODD, CQUINN data and training. An action plan was developed following each meeting, however this did not cover each item discussed which required improvement.
- Risk management was not discussed in the minutes of any meetings that we saw. For example complaints and incidents did not appear to be discussed in any detail.
- Staff told us that they were informed verbally of any areas of improvement, for example DNACPR audit results, during monthly ward meetings.
- The trust told us there were no risks in end of life care and therefore no risks on the register for the service. The end of life management team did not identify any risks.
- We did not see evidence of written risk management information shared with staff. A nurse told us 'we are told when something has gone wrong, and we work to put things right'. We could not see any evidence in relation to end of life.
- The SPCT participated in matron 'safety huddles' to share patient risks, treatment and ICODD plans.
- Patient safety and quality were addressed at a senior management level within the divisional risk management group meetings. We saw examples of divisional investigation reports.

Leadership of service

- The director of nursing was the executive lead for end of life care at trust board level.
- There was a lay member on the trust board with a responsibility / role for end of life.
- The SPCT was led by a palliative care consultant and line managed by a band 7 clinical nurse specialist.
- We spoke to ward staff that were aware who the lead person was for the end of life service but were unclear as to specific responsibilities. For example, there was uncertainty as to who completed appraisals for the SPCT and who collated incident data which involved the end of life care teams.
- There was a general feeling of 'openness and honesty' and staff told us they would ask senior staff for advice if they needed it.
- A nurse told us 'the chief executive has made a huge difference. He knows everyone's name and takes the time to listen to us'.
- A consultant told us 'there is a lack of ambition' when discussing the leadership of the service.

Culture within the service

- Staff at ward level told us end of life care delivery was part of their daily role. They spoke positively of the involvement of the SPCT and their involvement was essential. Staff on wards and departments spoke passionately about the end of life care they provided.
- Staff shared their views about the service openly and constructively. They were caring and passionate about the hospital and about the care they provided to patients.
- All staff we spoke with could provide examples of how the patient's needs was at the centre of the end of life care being delivered and offered.

End of life care

Public engagement

- There was information displayed throughout the public areas regarding the Patient Advice and Liaison Service (PALS).
- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying Audit for Hospitals in 2015.
- The trust had recently completed a survey of 120 bereaved relatives and carers. Feedback showed that relatives had confidence and trust in doctors and nurses caring for their loved ones at end of life. Although over half of patients experienced pain, restlessness and noisy breathing in the last days of life, it was felt that staff worked hard to relieve these symptoms. However, in 20% of cases, relatives were not alerted to the fact that death was likely soon (we cannot know if these related to sudden deaths or to anticipated ones). We saw an action plan produced by the trust which included a review of the mortality process to improve the likelihood of missed opportunities.
- The palliative care consultants had presented information to groups with the trusts geographical area. These have included training sessions and awareness meetings to GPs and local care homes.

Staff engagement

- We observed the SPCT team meeting. All service staff, except community, attended this. We saw the meeting gave the opportunity for all members of staff to raise items on the agenda. Additionally, every member of staff felt confident to raise issues that were relevant to their role or they could add value to the discussion.
- Staff in the SPCT told us they attended ward level meetings on a regular basis.
- The trust received a 40% response in the NHS staff survey, against a national average response of 42% within the staff survey results of 2015. We saw that within the survey staff appraisal rates within the trust were higher at 88% against a national average of 84%.
- We saw effective communication both written and verbal between the SPCT and ward nurses in relation to patient care.
- Staff were invited to attend 'trust update' events. These were sessions held regularly across the year which were open to all staff and encouraged teams from across the directorates to share good practice, lessons learnt, and specific patient journeys.
- The trust produced a monthly newsletter which was available to all staff.

Innovation, improvement and sustainability

- We spoke with staff at ward level who told us they had attended end of life care training and ICODD support.
- A business case was in place to support seven day SPCT working.
- The end of life care training co-ordinator had recently won the 'unsung hero award' which was an internal award for recognition of training and improvements made. For example the introduction of the central syringe driver store.

Outpatients and diagnostic imaging

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

Information about the service

Calderdale Royal Hospital (CRH) is one of the two main hospital sites of Calderdale NHS Foundation Trust and is located in Halifax, approximately five miles from the other main site, Huddersfield Royal Infirmary (HRI).

The trust has off site OP clinics at Todmorden Health Centre, Brighouse Health Centre, King Cross Surgery and Lister Lane Surgery both in Halifax. We did not visit these locations as part of this inspection.

From July 2014 to June 2015 there were 410,148 outpatient attendances for first and follow up appointments at the trust overall. Between January 2014 and June 2015 (18 months), there were 290,289 attendances at CRH and 26,471 at off-site OP clinics. The specialties with the highest number of OP attendances were trauma and orthopaedics and ophthalmology.

Data submitted by the trust showed there were 160,000 radiology referrals to all modalities from surgery and 120,000 from medicine at the trust in 2014-2015. General practitioners (GPs) also made direct referrals to radiology.

There were blood sciences pathology laboratories on site, which provided a 24-hour, seven-day service and a phlebotomy service. The trust's microbiology and histopathology departments, including a mortuary, were located at the CRH site.

The outpatients, radiology and pathology directorates were part of families and specialist services (FSS) division. Ophthalmology and maxillofacial were part of the surgery and anaesthetics division and dermatology and cardiology were part of the medical division.

In March 2016, outpatients and radiology employed 190 nurses and healthcare assistants and 100 radiographers across all trust sites. In December 2015, there were 34 physiotherapy staff in post and 8.5 vacancies.

During our inspection we visited the following OP areas:-

- general medical
- ear, nose and throat (ENT)
- audiology
- ophthalmology
- general surgical
- trauma and orthopaedics
- occupational therapy

We also visited radiology, phlebotomy and the pathology laboratories.

The hospital provided radiology services for outpatient, inpatient and emergency referrals. Calderdale hospital had three X-ray rooms used for general radiography examinations, one room for cardiac interventional work, three ultrasound rooms in the main department, an accident and emergency x-ray room, a computed tomography (CT) and magnetic resonance imaging (MRI) room. There was also an area dedicated to breast examinations.

During the inspection, we spoke with six members of staff in radiology and 44 members of staff in OP, phlebotomy

Outpatients and diagnostic imaging

and pathology, including managers, nurses, radiographers, medical staff and administration staff. We also spoke with 27 patients and six visitors/relatives. We reviewed a mixture of paper and electronic patient records in OP and electronic patient records in radiology. We looked at a range of other records such as policies, procedures and audits. We also reviewed the systems and management of the departments including quality and performance information.

Summary of findings

We rated the service as good overall. We rated the responsive domain as requires improvement and the safe, caring and well-led domains as good. The effective domain was inspected but not rated. This was because we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic imaging.

Patients, visitors and staff were kept safe as systems were in place to monitor risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with the staff to improve services. There was a robust process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed.

The environment we inspected was visibly clean and staff followed robust infection control procedures. Records were stored electronically for X-ray images and OPD had a mixture of electronic and paper records. Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.

Outpatients and radiology nurse staffing levels were appropriate with a low number of vacancies. Radiographer vacancies were higher; a recruitment plan was in place and fifteen staff had been recruited, due to start in the summer of 2016. There were also recruitment issues with ultra-sonographers and breast radiologists. There was an ongoing recruitment and retention plan in place.

There was evidence of service planning to meet patient need such as the agreement for purchase of a third MRI scanner. Diagnostic imaging waits were within targets for the national waiting times.

Staff had good access to evidence based protocols and pathways. The OP and radiology departments were very busy during the inspection but patients received good communication and support during their time there. Staff followed consent procedures and had a good understanding of the Mental Capacity Act (2005).

Outpatients and diagnostic imaging

We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients living with a learning disability or dementia. Staff clearly demonstrated that they put the patient first.

The diagnostic imaging department had a local development plan in place to improve services and the environment. The plan gave a comprehensive review of the demand and capacity on the department to deliver a sustainable and high quality clinical service, taking account of seven-day working plans.

Governance processes were embedded across diagnostics and the pathology and radiology teams felt supported in the new directorate structure however governance processes in OP were less well developed.

However:

People were not always able to access OP services when they needed to. There were issues with appointment backlogs, waiting lists and appointment bookings. Patients experienced long waiting times within the departments, appointment delays and cancellations. Outpatient clinics were often overbooked and we found issues with capacity and demand in all OP clinics. Actions taken to address these issues had not always been effective.

Staff we spoke with were aware of the complaints policy and told us most complaints and concerns were resolved locally. A high proportion of the total complaints received by the outpatients department (22%) related to appointment problems.

We did not see any evidence to show current trends and themes from incidents and complaints were monitored.

Are outpatient and diagnostic imaging services safe?

Good

We rated the safety of this service to be good because staff planned and delivered care and treatment in a way that ensured people's health and safety, which protected them from harm and abuse. We found:

- Staff knew how to report incidents and there was evidence of learning from incidents. Staff informed patients about incidents and departments followed the duty of candour requirements.
- All of the areas visited were visibly clean and there were effective systems and processes in place to reduce the risk and spread of infection. Cleaning and routine checks on equipment were in place and complete. We saw staff adhering to infection control procedures to prevent the unnecessary spread of infections.
- The environment used by OP and diagnostic imaging was well appointed, maintained and fit for purpose. Equipment was well maintained and tested in accordance with manufacturers guidelines.
- People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.
- Patient records were stored securely and completed accurately and appropriately.
- Staff had a good understanding of safeguarding procedures and what procedure they needed to follow in order to raise a concern.
- The diagnostic imaging department had robust policies and procedures in place based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations were to protect patients, staff and the public. The department had good support networks in place for expert advice from their Radiation Protection Advisory service.
- There were sufficient staff to manage the diagnostic imaging service but high vacancies meant the service was under strain to manage the workload. The trust was relying on current staff undertaking additional paid shifts to cover the service.

However;

Outpatients and diagnostic imaging

- There was no evidence to show that current trends and themes from incidents were monitored.
- Staff were well supported for training but mandatory training levels were not meeting the trust target of 100%.
- Referring clinicians using the radiology service did not always take action on urgent results. This meant there was a potential risk to patient safety.
- There were a number of vacancies for physiotherapists, radiologists and histopathologists at the trust. Staff told us there was a national shortage of staff for these specialist roles and managers were actively recruiting to fill the vacant positions. Locum staff, permanent staff acting up and advanced practitioners were being used to maintain safe services for patients.

Incidents

Outpatients

- Staff knew how to report incidents and there was evidence of learning from incidents.
- Data submitted by the trust showed 200 incidents had been reported in the FSS division in the 12 months to November 2015. Forty-three of which were classed as 'incidents with harm.'
- No 'never events' had been recorded by outpatient and diagnostic imaging services. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented. Trusts are required to monitor the occurrence of never events within the services they commission and publicly report them on an annual basis.
- Staff we spoke with told us they knew how to report incidents on Datix, the trust's electronic reporting system. Staff told us they received feedback about incidents.
- We saw evidence of lessons learnt from incidents, including those classed as 'no harm' and /or near misses. However, we did not see any evidence to show that current trends and themes from incidents were monitored.
- Senior nursing staff told us all staff were all aware of their obligations under duty of candour and of the need to be open and honest. We confirmed staff informed patients about any incidents with harm and departments followed the duty of candour requirements.

Diagnostic Imaging

- Staff we spoke to demonstrated a good understanding of the incident management process, which was accessed via the hospital intranet, and were aware of their responsibilities. They were confident in using the electronic system. During our inspection, we saw minutes of meetings where incidents had been discussed and changes made in practice as a result. Staff told us they were emailed with any updates required if they were unable to attend the departmental meetings.
- There had been no Care Quality Commission (CQC) reportable radiation incidents in the past year. The hospital, however, had the correct processes in place to report any radiation incidents to the (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) if required.
- The majority of incidents reported were of low or no harm.
- Senior managers told us they encouraged a culture of open incident reporting and staff confirmed this. Staff told us they received the feedback and lessons learnt via staff question and answer meetings and on-line learning on their own shared drive. We saw evidence of meetings being held to encourage staff to ask questions and they told us they felt confident to do so. All staff we spoke with in the diagnostic imaging department understood their responsibilities to raise concerns and to record safety incidents, including near–misses.
- We looked at the minutes for the Family and Support Services Directorate Radiology Board meeting covering September, October and November 2015. Reports on incidents were broken down by level of severity and trends were discussed. The requirements for duty of candour were also addressed. One staff member gave a good example of what Duty of Candour meant and what their roles and responsibilities were in line with the regulation.

Cleanliness, infection control and hygiene

Outpatients

- All of the areas visited were visibly clean and there were effective systems and processes in place to reduce the risk and spread of infection. People were cared for in a clean, hygienic environment.
- Link infection prevention control (LIPC) practitioners carried out handwashing audits once a week and

performance in infection control audits was good in all areas. For example, in CRH phlebotomy the cleanliness scores in hand hygiene was 99% against a trust target of 95%.

- We observed appropriate signage and handwashing instructions in all areas; for example, there were 'five stages to handwashing' notices above wash hand basins.
- Personal protective equipment (PPE), such as hand wipes and hand gel dispensers, was readily available and we observed staff using PPE correctly.
- Waste was correctly segregated and waste bins and sharps containers were readily available.
- Data submitted following the inspection showed 95.5% of OP and records services staff had attended mandatory training in infection control against a trust target of 100%.
- However, we observed felt notice boards on display in OP areas were not covered with glass. Notices on the felt boards were laminated.
- The healthcare assistants cleaned toys in the children's waiting areas at the end of each day. We observed green 'I am clean' stickers on equipment and toys.

Diagnostic Imaging

- All clinical rooms and waiting areas in diagnostic imaging were visibly clean and tidy. We saw records of daily and monthly cleaning in place. These were completed correctly.
- There were plenty of hand sanitizer points to encourage good hygiene practice. We observed staff using good infection control practices.
- We saw that all staff were 'bare below the elbows' in clinical areas which enabled thorough hand washing and to prevent the spread of infection between staff and patients.
- All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is department of health best practice guidance.
- All soft furnishings were wipeable. The Patient-Led Assessment of the Care Environment (PLACE) audit done in April 2015 commented that some aspects of seating in x-ray showed evidence of excessive wear although were not damaged. Overall, the report concluded that Calderdale Hospital was "A modern building (for the most part) with very high standards of cleanliness with a good standard of maintenance with a rolling programme of upkeep and repair."
- Personal protective equipment (PPE) such as gloves and aprons were readily available for staff in all clinical areas to ensure their safety when performing diagnostic imaging procedures.
- Mandatory training records showed that 76% of the diagnostic imaging team across the trust had attended infection prevention and control training in the year to date.
- Infection control practices were monitored by the infection prevention and control lead and action plans were produced across divisions, displaying their performance and what areas needed to be improved. Policies and procedures were available for staff to view.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins.
- There were clear notices around the hospital detailing hand hygiene and infection control measures for patients and visitors.
- The staff in the diagnostics imaging department understood their responsibilities in relation to infection control and hygiene. They told us the procedures for infectious patients who were booked at the end of the day lists and deep cleaning arranged at the end of the examination.

Environment and equipment

Outpatients

- The trust provided care in an environment that was suitably designed and adequately maintained. Patients we spoke with were happy with the environment.
- All equipment had safety testing and was up to date. Staff told us, and we observed that there were adequate supplies of appropriate equipment available for the clinics.
- In April 2015, patient-led assessment of the care environment (PLACE) audits had been carried out. The inspection at CRH showed all areas were well maintained and cleaned to a good standard. Actions were required regarding appropriate seating in dermatology and cardiology and improved signage, especially in the Macmillan Unit. Review of the January 2016 PLACE action plan showed a review of the CRH site was planned for 2016.

- We found resuscitation trolleys were easily accessible. Staff checked stocks daily, defibrillators once a week and sealed units once a month. Staff signed to confirm checks had been completed. In ENT and ophthalmology, we saw the paediatric resuscitation trolley was in ENT and the adult resuscitation trolley in ophthalmology.
- When we asked staff whether their equipment was fit for purpose, they told us the patient administration system (PAS) 'sometimes 'went down' and the computer systems were often slow.

Diagnostic Imaging

- The department's risk register included the need to upgrade the PACS Reporting Workstations at Calderdale as they were past the five-year 'end of life' stage, being 9 years old. We noted that on-site PACS engineers repaired the machines using spare parts from other obsolete machines. Managers told us this risk was included in the capital replacement plan for 2016/17.
- There was resuscitation equipment available in the diagnostics department. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis and a full check undertaken on a monthly basis. We were told by staff that any items due to expire were replaced.
- During the inspection, we looked at four pieces of equipment and the safety testing of equipment was in date.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation. There was a large range of protective equipment available.
- In diagnostic imaging rooms, IR(ME)R local rules were displayed and up to date.

Medicines

Outpatients

- People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.
- We found staff handled controlled drugs appropriately and prescriptions were stored securely. Staff in ENT OP told us cocaine for administration to patients attending the voice clinic was only stored on the day the clinic was running. In ophthalmology, we checked the controlled drugs records for the medication used for day case surgery and found these were all completed correctly.
- We found good compliance in the use of prescription pads in the OPD clinic areas. For example, prescriptions could be tracked for each doctor and traced to the relevant patient. Each doctor's prescription pad was individually controlled.
- Staff checked medicine fridges daily and we confirmed maximum and minimum range and temperature were recorded regularly. We checked medicines expiry dates; which were all in date.

Diagnostic Imaging

- Medicines were stored safely. The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. We did not observe any medications left out in unsecured areas.
- There was a robust process in place for double-checking of controlled drugs, which were stored in locked cabinets.
- Patient Group Directions (PGD) were available for all staff to refer to. PGDs are written procedures for the supply and administration of medicines authorised by the Trust in advance, such that it does not need a prescription written by the prescriber. A competency framework for the use of PGDs was in place for staff to complete.
- There was a Standard Operating Procedure in place for the management of drugs and contrast media. This met the standards for the Imaging Services Accreditation Scheme (ISAS), which had been awarded to the department.

Records

Outpatients

- People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.
- Trust data submitted prior to the inspection showed that 0.05% of patients were seen in outpatients without their full medical record being available; this was low. Missing clinical information can result in delays or disruptions to patient care and a potential risk of harm.

- The trust used an electronic document management system. Records for planned OP attendances were digitised (converted to digital format for use on a computer) and available three to six days prior to attendance to support clinic preparation. The health records team ensured records were available. The trust had a case note tracking system for paper records, which included free text comments. Staff could also view dictated letters and results via the system.
- In OP, healthcare assistants prepared the notes in advance of the clinics. Patient notes were in 'minipacks'. The trust was moving to electronic notes in place of paper records. The general manager told us staff were receiving training on using the electronic patient record (EPR).

Diagnostic Imaging

- The diagnostic imaging department had a central electronic patient records system to record comprehensive details of each patient's imaging history.
- Staff in the diagnostic imaging department were able to show us how the radiation doses were recorded on the system for each procedure.
- Images were available to view of the Picture Archiving and Communications Systems (PACS). This system was available and used across the hospital.
- Image transfers to other hospitals were managed electronically using the Image Exchange Portal. (IEP)

Safeguarding

Outpatients

- People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.
- Staff we spoke with were able to describe what actions they would take in the event of a safeguarding concern and knew when to escalate their concerns to their managers.
- We reviewed safeguarding training records in departments and found these were all up to date. Data submitted following the inspection showed 89.9% of OP and records staff had completed their mandatory safeguarding training, against a trust target of 100%. However, the data provided did not indicate whether this safeguarding training was for adults or children.
- Senior nursing staff in ophthalmology and orthopaedic OP confirmed their mandatory training in safeguarding was to level one or level two.
- Several clinics, including ophthalmology and ENT, saw children in adult clinics. We found none of the nursing staff working in OP clinics were trained to safeguarding level 3. Nurses working with children who could potentially contribute to assessing, planning intervening and evaluating the needs of child where there are safeguarding/ child protection concerns should be trained to safeguarding children level 3.
- The OP matron assured us all band six and seven nursing staff would be trained in safeguarding level 3 in the week following the main inspection. However, on our unannounced visit three weeks later staff had not completed this training. The matron told us this was because they had not been able to book staff onto the appropriate training courses yet.
- We observed 'safeguarding advice and referrals notices on display in OP clinic areas, including phlebotomy. These included safeguarding contact names and numbers.

Diagnostic Imaging

- We saw policies were in place and in date for both safeguarding children and adults.
- The staff we spoke with demonstrated they understood safeguarding processes and how to raise a concern and the process they should follow, but had not had to raise any recent concerns.
- All staff within the diagnostic imaging department were trained either to level one or level two safeguarding for both adults and children depending on their role. Attendance at the mandatory training course for adult safeguarding was recorded by the Trust as 74% across diagnostic imaging services in the year to date.

Mandatory training

Outpatients

- During the inspection visit, staff told us Calderdale and Huddersfield Hospitals NHS Foundation Trust had a mandatory training compliance target of 85%. However, trust policies stated the target was 100%.
- Records submitted by the trust pre-inspection, dated October 2015, showed low compliance rates for mandatory training. Mandatory training records viewed

during the inspection appeared to show compliance had improved since October 2015 and staff were all up to date with their training. Staff we spoke with told us they were up to date with their training.

- We found OP departments were keeping local records of mandatory training; staff explained this was because they felt the trust system was not reliable and/or up to date. Pathology managers told us there was a delay in updating the trust systems with mandatory training data. Managers we spoke with were aware that this was an issue.
- Data submitted post-inspection showed overall mandatory training compliance rates of 91.4% in divisional support, 89.9% in OP and records services and 89.6% in pathology. However, during the inspection we were shown data which indicated mandatory training compliance in pathology was 97% overall.
- However, data submitted pre and post-inspection showed compliance rates for the PREVENT (anti-terrorism) mandatory training were low; ranging from 42.9% in divisional support to 59.3% in OP and records. Senior staff explained PREVENT was a national programme and the training took 1.5 – 2 hours to complete. They explained the low compliance rates were due to a lack of availability of places on this course.
- The trust used the Electronic Staff Record (ESR) to record mandatory training and the system flagged up to staff and managers when training was due.

Diagnostic Imaging

- Ten mandatory courses were available for all staff. These included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- Staff told us they were achieving mandatory training targets, but this was not clear from the trust records. Local departmental records recorded dates of attendance but not a percentage of attendance. It appeared, from our review of the local records, that compliance rates were higher than the trust had recorded. Managers we spoke with were aware that this was an issue.
- Mandatory training included e-learning and face-to-face meetings. Staff told us the quality of the training was very good and that they had adequate time allocated to complete it. One staff member told us they completed a number of mandatory training modules at their recent induction.
- One team leader told us they print out the list of mandatory training attendance for each staff member's appraisal to discuss compliance, and how to achieve it.
- Staff in diagnostic imaging received radiation protection training. Up to date records were seen with evidence of good compliance for radiation protection updates.

Assessing and responding to patient risk

Outpatients

- The OP services assessed risks and responded appropriately in order to maintain patient safety.
- Staff in OP clinics held safety huddles every morning. Evidence has shown that effective safety huddles engage all staff in daily safety activity and can reduce the numbers of adverse events.

Diagnostic Imaging

- There was clear radiation hazard signage outside the x-ray rooms to keep staff and patients safe.
- The hospital had commissioned an external medical physics expert who was contactable for consultation to give advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance. Staff told us the support given was excellent.
- The diagnostic imaging department had named Radiation Protection Supervisors (RPS) to give advice when needed to ensure patient safety and minimise radiation risk. They were adequately trained within requirements.
- Quality assurance tests on the x-ray equipment were routinely done and any trends or increases in exposure reported to the RPS for further investigation.
- Dose reference levels were evident for all x-ray rooms and doses were optimised to give the lowest possible dose to patients whilst maintaining good diagnostic quality.
- The world health organisation (WHO) checklist was used for all interventional procedures. We saw copies of the audit of their usage and there was 100% compliance over the last three months.
- A radiation safety policy was in place, which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the

management of contamination, monitoring and spillage of radioactive material and a procedure for the disposal of radioactive waste. Comprehensive records were kept on the disposal of radioactive waste.

- We looked at the minutes from the Radiation Protection Board held in July 2015. Incidents were discussed and we saw the Society of Radiographers 'pause and check' policy was implemented to comply with the IR(ME)R Operator checks.
- The last menstrual period (LMP) policy was seen and met IR(ME)R requirements. Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed the radiographers prior to any exposure to radiation.
- However, staff were concerned that referring clinicians who used the radiology service did not always act on urgent results. It is the responsibility of the referring clinician to act upon any findings reported in a diagnostic test. Without appropriate action, there is a potential risk to patient safety.
- We saw from the minutes of the radiology directorate board meetings, that this had been discussed in the October 2015 meeting. It was also raised with the executive divisional board business meeting in November 2015. A paper for unexpected and normal findings for radiology reports concluded that radiology should email consultants to tell them important findings were available. It stated consultants should read and act on their email communications it was up to the individuals/directorates to ensure a 'safety net' was in place.

Staffing

Outpatients

- There were enough qualified, skilled and experienced staff in OP to meet people's needs. The majority of OP departments visited were fully staffed. For example, ophthalmology was fully staffed.
- Senior staff told us OP used 'very little' bank and agency staff. Data submitted by the trust following this inspection confirmed this and showed that 0.59 WTE bank and agency staff had been used across OP at CRH during January 2016.
- Data submitted by the trust following the inspection showed the total number of nursing and support staff in OP across the trust was 93.5 WTE; 40.72 of these were nursing staff (bands five to 8a). This included staff at HRI, Calderdale Royal Hospital, Acre Mills and Todmorden Health Centre and was not supplied by site.
- Senior nursing staff told us there were plans to extend the roles of the healthcare assistants in surgical OPD, to allow them to carry our dressings and minor procedures. Band 3 staff had extended roles in ophthalmology; orthoptists trained them and signed off their competencies.
- Senior nursing staff told us all staff were flexible between OP clinics and moved around within their own specialty. Staff rotated between the two hospital sites and there was a shuttle bus available.
- Senior nursing staff told us staffing rotas in medicine were available for staff six weeks in advance; they said this was because the rotas were the same every week. In other specialties, staff rotas were not planned so far in advance. For example, in surgery and orthopaedics rotas were prepared / available two weeks in advance.
- Senior staff told us they would issue provisional rotas to staff, based on what they know about the clinics. They said this was because they did not always know the doctors' rotas and commitments.
- Senior nursing staff told us OPD did not use e-rostering. They said there were peaks and troughs in demand; for example, most clinics were quieter in the summer months.
- Staff held safety huddles every morning; this helped with allocation of staff to different areas and jobs and optimised the skill mix.
- Senior staff in physiotherapy told us the department was using locum physiotherapists. This was due to the number of vacant posts in the department and difficulties recruiting these staff.
- Information submitted by the trust showed that on 14 December 2015, there were 8.5 vacancies for staff in physiotherapy (bands two to seven) across the trust out of an establishment of 42.5 staff.
- Waiting times had increased during 2015, peaking at 17 weeks in September 2015. In December 2015, the waiting time for appointments was 12 weeks and there had been complaints from consultants about waiting times. Four band six positions had been recruited to; however, there was a national issue with recruitment of physiotherapy staff.

Diagnostic Imaging

Outpatients and diagnostic imaging

- There were dedicated nursing and health care assistant staff across the diagnostic imaging department to assist with the smooth running of the service. Staff rotated across the hospital sites when required allowing for cross cover for holiday and sickness and set clinics.
- A recent recruitment drive had seen fifteen radiographer posts recruited. These were due to start in the summer of 2016, once qualified from their degree courses.
- The trust had approved a nurse vacancy post for radiology. This post had been upgraded from a band five to a band six to meet the needs of the department. Senior staff told us this nurse would be based at HRI but rotate to CRH when required.

Pathology

- The pathology clinical director told us there were vacancies for qualified and unqualified technical staff in pathology. They said they had plans for recruitment and better use of skill mix.
- They said there was a high staff turnover within pathology and thought this was because staff would often move hospitals in order to get a job closer to their home.

Medical staffing

Outpatients

- Senior nursing staff told us there were problems with medical staff recruitment in some OP specialities; for example ophthalmology and maxillofacial. The general manager told us there should be 16 consultants in ophthalmology but there had been three consultant vacancies in ophthalmology "for some time." They said there was a locum consultant working in glaucoma.

Diagnostic Imaging

- The department had recently recruited two consultant breast radiologists. At the time of the inspection, there was a whole time equivalent vacancy for a consultant breast radiologist. We noted this was on the radiology risk register. A locum consultant breast radiologist had worked one day per week since May 2014 and another was due to start in March 2016.
- Data submitted by the trust following the inspection showed the total number of medical staff budgeted for in radiology in month 11 of 2015-2016 was 21.35, of which 16.59 were in post. This meant 22% of radiologist posts were vacant.
- Radiologists were on call until 9pm each weekday evening. An external provider provided on-call cover.

Pathology

- The pathology clinical director told us there were three vacant consultant histopathologist posts out of an establishment of eight. They said the department was managing to support the MDT meetings by the use of two locum histopathology consultants and a registrar acting up.
- They said a consultant chemical pathologist was due to leave for another position at a nearby trust.
- They said the trust recruitment process was slow and confirmed there was an ongoing shortage of medical staff across radiology and pathology.

Major incident awareness and training

- The trust had a major incident plan in place and there was evidence of business continuity plans in OP and diagnostic imaging.
- Radiology staff we spoke with were not fully aware of their individual responsibilities but were confident they could ask for support and would know who to contact.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain was inspected but not rated. We found;

- People had good outcomes because they received effective care and treatment that met their needs. Clinical audits supported achievement of good outcomes and promote the quality of service.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Patient protocols and standard operating procedures were in place across services inspected.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal.

- We saw that staff worked collaboratively to meet patients' needs in a timely manner and staff were part of multi-disciplinary team meetings. For example, we observed a multi-disciplinary team in the one stop breast clinic.
- The consent process was embedded with practice and we observed staff seeking consent during procedures. Staff in radiology gave examples of when best interest meetings had been held.
- Staff obtained written and verbal consent to care and treatment, which was in line with legislation and guidance.

However,

- There was a risk of radiology not being able to provide a 24 hour service for nephrostomy and/or stenting in cases of urological obstruction in the management of acute kidney injury.

Evidence-based care and treatment

Outpatients

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. For example, we found occupational therapy (OT) staff followed NICE guidelines by giving each stroke patient five sessions of 45 minutes.
- In ophthalmology, NICE guidance was monitored through the divisional meetings and postgraduate meetings. Staff in ophthalmology audited compliance with current NICE guidance.
- Patient protocols and standard operating procedures were in place and available on the trust website for staff to access.
- An evidence based business plan had successfully funded increases in occupational therapy staff and equipment.

Diagnostic Imaging

- Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines.
- Staff monitored diagnostic reference levels (DRL) and completed audits of the levels on a regular basis. They were within expected ranges.
- The staff in the department had regular contact with the radiation protection advisor (RPA).
- All IR(ME)R protocols were updated and accessible for the staff to view on the electronic system. We saw an IR(ME)R audit schedule was in place for the coming year to ensure staff were, for example, working with the local rules, correctly using dose reference levels and pregnancy checks were carried out. Copies of these audits were seen during our inspection. The audit of the pregnancy status checklist showed 100% compliance by radiographers signing to confirm they had discussed this with their patients.
- One of the advanced practice radiographers told us they were audited on their performance each year by a radiologist.
- Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards and diagnostic guidelines that are published by NICE are discussed in the trust risk committee and cascaded down to the Radiology Board. Clinical effectiveness was a standing agenda item on the Radiology Board minutes. One of the service managers received all NICE alerts in order to update and amend guidelines as necessary.
- The 2014 annual RPA's report showed compliance with radiation regulations and was presented to the Radiology Board in March 2015. The 2015 RPA report has been completed and a summary shared with all staff on the shared drive. The report had been taken to the Radiology Board just prior to the inspection. The department was compliant with all regulations. Extra radiation awareness training had been put in place to ensure all staff were adequately trained.
- In the imaging department, we observed the audit for the World Health Organisation (WHO) checklist for interventions was undertaken three times per year.

Patient outcomes

Outpatients

- The outcomes of people's care and treatment was monitored and actions taken to make improvements. For example, as part of patient reported outcome measures (PROMS) the hospital asked patients to keep a 'patient diary' during their care, which included care on the hospital wards.
- Patient Reported Outcome Measures (PROMs) questionnaires are given to all NHS patients having hip or knee replacements, varicose vein surgery or groin

hernia surgery are invited to fill in. They ask patients about their health and quality of life before and after they have an operation. This helps the NHS to measure and improve the quality of its care.

- From July 2014 to June 2015 there were 410,148 outpatient attendances for first and follow up appointments at the trust overall. Between January 2014 and June 2015 (18 months), there were 290,289 attendances at CRH and 26,471 at off-site OP clinics.
- The trust's follow up to new rate was in the lower quartile and was performing better than other trusts nationally. From July 2014 to June 2015, the trust's follow-up to new rate for all sites was below the England average apart from the Acre Mills site (which opened in February 2015). At trust level, there were 41% of follow-up appointments for every new appointment, a lower rate than the England average of 55%.
- The Trust had implemented partial booking for all specialties; appointments required more than 6 weeks in advance were added to the partial booking-pending list. The percentage of hospital cancellations had reduced month on month since the introduction of partial booking: October 2014 the cancellation rate 19%, November 2015 rate 12.3%. The most frequent reasons for cancellation were given as sickness, on-call, planned absence or vacancies.
- The proportion of patients waiting over 30 minutes to see a clinician was 15.1% (13.2% when including patients seen before their appointment time).
- We saw the families and specialist services (FSS) division monitored indicators at executive board and divisional level every month.

Diagnostic Imaging

- Diagnostic imaging participated in the Imaging Services Accreditation Scheme (ISAS), and had been part of a national pilot when this scheme was first introduced. It was the fifth trust in the country to meet the requirements of the ISAS accreditation scheme.
- All images were quality checked by radiographers before patients left the department. Radiographers were trained in the 'red dot' scheme in accident and emergency x-ray, which enabled them to raise awareness to other clinicians of a potential abnormality. The scheme had also been extended to include adding further comments to an examination, making an initial interpretation on radiographs.
- National audits and quality standards were followed in relation to radiology activity.

Competent staff

Outpatients

- Staff working in the OP departments were competent and received training and development appropriate to their roles and responsibilities.
- We found a high use of advanced practitioners and specialist nurses in all specialties. For example, a band 8a nurse consultant led the one stop breast clinic, a number of specialist breast care nurses worked in that department.
- A number of departments held nurse-led OP clinics. Senior nursing staff told us OP services were developing specialist clinic roles.
- Some staff told us there had been a leadership programme for band sixes and band sevens. However, other staff we spoke with told us this had been discontinued.
- The trust had a link nurse for the Nursing and Midwifery Council (NMC) revalidation process. The trust checked professional registrations for nursing staff centrally.
- Staff we spoke with all told us they had received an appraisal and their appraisals were done within the required timescales. We viewed staff performance development review (PDR) / appraisal records in departments; these were all up to date. Data submitted by the trust following the inspection confirmed this.
- However, we found there were limited training opportunities for some groups of nursing staff, especially at manager level. For example, we found the trust had promoted nurses into more senior roles without providing any managerial training.

Diagnostic Imaging

- An induction plan was in place for all new staff starting within the diagnostic imaging department.
- Continual professional development (CPD) was encouraged throughout the department. Staff told us they were able to access courses and post-graduate training although this had been more difficult due to staff shortages. One senior member of staff told us they tried to support CPD as much as possible and that there was a good culture of advanced practice.
- All radiographer staff within the MRI service had postgraduate qualifications. However, advanced

practice for MRI reporting was not going ahead and this was causing some frustrations. This change was needed due to the increasing workload. There were advanced practitioners in CT, fluoroscopy, mammography, plain film and ultrasound. Duty radiographers were trained to undertake CT head scans. This met the NICE guidelines for suspected stroke patients. Overall, the diagnostic imaging department demonstrated an outstanding approach to advanced practice.

- Staff were encouraged to widen their understanding of different aspects of the service by accessing the comments scheme CPD folder on the shared drive. We saw examples of CPD presentations such as naso-gastric tube insertions.
- All diagnostic imaging staff we spoke with had received an appraisal. They told us they were able to identify specific learning through the appraisal process and were encouraged to develop their professional practice.
- The imaging department were seen to have effective clinical supervision and mentoring systems in place for staff and they were proud to tell us they regularly developed their own staff. One staff member said, "There is great support for advanced practice."

Multidisciplinary working

Outpatients

- Staff in the majority of OP clinics visited told us they worked well with other teams. For example, staff and managers told us about a multidisciplinary cancer strategy working group.
- Staff told us a specialist nurse from the head and neck OP team and a dietician were presenting in Australia, funded by MacMillan.
- The breast care team held multidisciplinary team (MDT) meetings with diagnostics on a weekly basis and there was a therapeutic MDT meeting every Friday to discuss patient treatments.

Diagnostic Imaging

- Diagnostic imaging staff attended multi-disciplinary meetings such as those for breast and stroke services. Staff felt they were invaluable for their work and enjoyed the multi-disciplinary approach to patient care.
- The one stop breast clinic involved patients seeing an advanced radiographer practitioner, radiologist, outpatient consultant and nurse, which ensured efficient delivery of care and treatment to patients attending the clinic. Staff told us the shortage of a radiologist had been difficult but the whole team had worked well together to overcome the problems.

Seven-day services

Outpatients

- Staff in the majority of OP clinics visited told us they held evening and Saturday clinics to keep up with current patient demand. Departmental managers confirmed this.
- The on-site pharmacy was open until 7pm; this was more convenient for patients.

Diagnostic Imaging

- The radiography services were available seven days a week with a combination of regular opening times and on-call services.
- Radiologists were on call until 9pm each weekday evening with the on-call provided by an external provider.
- There were some concerns expressed by referring clinicians about requesting urgent radiology requests out of hours. We noted one incident stated MRI services were not available out of hours. Review of incidents reported between October 2014 and November 2015 showed this was the only incident (out of 1163 reported in this period) relating to this.

Access to information

Outpatients

- Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- Staff told us they were part way through a phased introduction of the electronic patient record (EPR), with a 'go live' date of October 2016.

Diagnostic Imaging

- Staff told us and we saw that they had access to trust policies and procedures on the intranet.
- X ray and diagnostic imaging results were available electronically, which made them promptly and readily accessible to staff.
- Electronic access to radiology results was available.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Consent procedures were in place and were followed. Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance. For example, in ophthalmology, a healthcare assistant demonstrated accessing patient's consent record prior to their procedure. Consent for ongoing treatments in ophthalmology was valid for two years.
- Staff showed us examples of the various types of consent documents in use in OP clinics.
- Staff told us the computer system identified and/or recorded consent. The OP matron confirmed this and explained that staff scanned completed consent forms into the electronic document management system (EDMS).
- Staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards training and were aware of how these applied to their role.
- The OP matron told us they would involve the GP and/or safeguarding and/or an independent mental health advocate (IMCA) if there were issues with a patients' capacity to consent.

Diagnostic Imaging

- The majority of general x-ray procedures were carried out using implied consent from the patient. The staff demonstrated confidence and competence in seeking verbal and written consent from patients.
- All staff we spoke with were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA). There was limited knowledge of the Deprivation of Liberties Safeguards (DoLS) but staff still showed some understanding and were happy to seek further help if required
- Staff knew the procedures to follow to gain consent and understanding from patients, including involving other professionals.

Are outpatient and diagnostic imaging services caring?

Good

We rated the services as good for caring because staff supported people, treated people with privacy, dignity and respect, and involved people as partners in their care. We found:

- We spoke with 27 patients and six visitors and relatives; the feedback we received from all the patients and their relatives showed they were very happy with the care they received. Throughout the inspection, we witnessed examples of good care being given.
- People experienced care, treatment and support that met their needs.
- People understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- People received emotional support to help them cope with their care, treatment and condition.
- Patients were kept informed at all times and emotional support was given. Patients and relatives commented positively about the care provided.
- There was a very strong patient-centred approach across the diagnostic imaging team and this came across clearly from all the staff we spoke with.
- Staff demonstrated a good understanding of the privacy and dignity needs of their patients.

Compassionate care

Outpatients

- During the inspection of OP clinics we spoke with 22 patients and six visitors; their feedback was all positive. Comments included, "the staff are all pleasant" and "it's a nice place." One relative told us they were very impressed with the standard of care and called the staff, "Compassionate at all times."
- We found caring, friendly staff in all clinics we visited and observed positive interactions between staff and people using the service. The general comment s from patients in OP during the PLACE audits in April 2015 showed patients valued the care and service they received from staff.

Outpatients and diagnostic imaging

- We heard staff introduce themselves by name to patients. Staff wore name badges and those working on reception desks had their names on display. This helped put people at ease.
- All of the OP departments took part in the friends and family test (FFT) and scores were on display.
- Patients in medical OP had a care record, which documented whether patients needed additional support, such as assistance to go to the toilet. Each patient had this noted in his or her care plan.
- However, we observed privacy and dignity issues in phlebotomy OP. There were five phlebotomy chairs in the same room with curtains in between. This meant conversation could be overheard.
- Privacy was also an issue in the trauma and orthopaedics treatment room and plaster room. However, we saw staff did their best to treat their patients with respect and dignity.

Diagnostic Imaging

- Staff demonstrated a good understanding of the privacy and dignity needs of their patients and we saw it maintained during our inspection.
- We observed excellent interactions between diagnostic imaging staff and their patients. It was clear that the departments put the patients first and senior managers confirmed this was their ethos.
- We spoke with four patients and two relatives in the general x-ray department. There were no negative aspects of care highlighted to us. We were told that the staff were very kind and friendly. One patient said, "I can't praise the staff enough."
- Staff told us chaperones were available for all patients and we saw signs displayed in the waiting areas.
- We observed patients being greeted in a friendly manner by all the staff they came in contact with

Understanding and involvement of patients and those close to them

Outpatients

- We observed a good supply of easily accessible patient information leaflets in all the clinic areas visited. These included leaflets about a various different medical conditions.
- We saw large information boards in all clinics we visited. These showed information such as environment scores, 'did not attend' (DNA) rates and cleanliness scores.
- We saw the names of the staff on duty that day were on display, usually on whiteboards.

Diagnostic Imaging

- We saw that the diagnostic imaging department had a comprehensive range of patient information leaflets, which meant patients had information about their examinations.
- Explanatory leaflets were available to assist staff to explain the procedures and investigations to patients.

Emotional support

Outpatients

- People received support from staff when they needed it to cope emotionally with their care, and treatment. For example, we saw there were 'breaking bad news' rooms in most of the clinics visited and breast care nurses were trained in counselling.

Diagnostic Imaging

- Patients commented that they had been well supported emotionally by staff. We observed staff acting in a professional way.
- We observed, and patients told us, that the staff were friendly and approachable. One patient told us how good emotional support had been offered to them after a mammogram.
- When interviewing staff, it was clear how passionate they were about caring for their patients and how they put the patients' needs at the forefront of everything they did.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated the responsiveness of these services to be requires improvement because services did not always meet people's needs. We found:

- People were not always able to access OP services when they needed to; there were issues with appointment backlogs and waiting lists.

Outpatients and diagnostic imaging

- Patients in OP experienced long waiting times within the departments, appointment delays and cancellations. There were delays in OP clinics and overbooked OP clinics.
- There were issues with capacity and demand in most of the OP clinics and problems with appointment booking, service planning and delivery. Action to address these issues had not been effective.
- Staff told us, and we observed, OP clinics visited were running late.
- Staff in ophthalmology OP told us bookings staff booked patients into any clinic just to get a patient an appointment, this often resulted in appointments being cancelled and rebooked.
- There was poor continuity of care in some OPD, which meant patients had to repeat their medical history at every appointment. This was a recurrent problem in ophthalmology where the majority of patients we spoke with told us they saw, "a different consultant every time."
- The orthopaedic OPD and phlebotomy waiting areas were cramped and staff and patients told us they needed more space.
- The radiology department was very busy and did not have adequate space to deal with the increasing demand on the service. This was a particular issue with inpatient beds and wheelchairs as there was limited space to wait for their examinations.
- Patients gave negative feedback about car parking; they said there were problems with parking availability, the system for payment and expensive parking charges.
- In OP, there were high numbers of complaints about the services and there was no evidence of trend analysis of complaints.

However;

- In radiology, people were able to access services for assessment, diagnosis or treatment when they needed to and were often given a choice of locations. The trust was meeting national waiting times for diagnostic imaging within six weeks.
- In radiology, the diagnostic waiting times were below the England average meaning patients were receiving a timely appointment.
- There was no evidence that the issues with capacity and demand, bookings, cancellations and service planning had resulted in any patient harm.
- There was good support for patients living with a learning disability and in diagnostic imaging, their easy to read information leaflets had won an award.
- Staff had a good understanding of how to make reasonable adjustments for patients with dementia or a learning disability. There was access to interpreters for patients whose first language might not be English.
- In radiology, there were low numbers of complaints about the services and staff were responsive to complaints. Radiology took account of complaints and comments to improve the service and tried to reach a local resolution where possible.

Service planning and delivery to meet the needs of local people

Outpatients

- Services were planned and delivered to meet the needs of local people. People were given a choice of locations for their appointments but were not always able to access services for assessment, diagnosis or treatment when they needed to.
- Signage to all OP clinics and other departments was clear.
- The ophthalmology service ran clinics at Todmorden Health Centre and in Bradford. The service was looking to extend the services to include more off-site locations, nearer to the patients' homes.
- Appointments for some ophthalmology patients were being moved out from the hospital sites to local opticians' clinics.
- There were one-stop clinics in several OP departments. For example, there was a one-stop breast clinic held once a week.
- The audiology department held open access clinics in every afternoon for hearing aid repairs. Attendances at this clinic were by appointment outside those hours.
- The trust had a SMS text reminder service for OP appointments and patients received a text seven days prior to their appointment.
- Space was an issue in the trauma and orthopaedics OPD clinic and in phlebotomy. The waiting room areas were not big enough for the numbers of patients and patients observed to be standing up while waiting. On the afternoon of the day we visited the orthopaedic OP

waiting and treatment areas, there were 80 patients booked into the fracture clinic. We saw the small waiting area for the plaster room could not accommodate this number of patients.
- Car parking was a significant problem for patients attending the CRH site. Managers told us Healthwatch had produced a report about parking at the CRH site and options identified were part of a 13-week consultation, which was due to start on the 15 March 2016.
- There had recently been expansion of the occupational therapy stroke service to meet increasing demand.
- Several staff told us transport home for patients needing an ambulance was an issue. Staff from different OP areas all waited behind with patients, as there was no central waiting area for patient transport. This meant staff could not leave until the patients had been collected.
- The trauma and orthopaedics department used soft casts for children; this saved them having to come back in to have the cast removed.

Diagnostic Imaging

- Senior staff told us how some diagnostic services needed to be reconfigured to meet patient need and plans were in progress.
- Voice recognition reporting in diagnostic imaging was in place and used effectively.
- The clinical director told us the recruitment of the new consultants would greatly assist with the current workload, although more consultant staff were needed to address the increase in demand for the diagnostic services.
- Radiographers were trained and competent in some aspects of radiology reporting such as plain film and CT head scans. We spoke with an advanced practitioner who reported CT head scans across both sites. They felt the time allocated to this should be increased to meet demand.
- The radiology department was very busy and did not have adequate space to deal with the increasing demand on the service. This was a particular issue with inpatient beds and wheelchairs as there was limited space to wait for their examinations.

Access and flow

Outpatients

- The follow-up to new rate for all sites within the Calderdale and Huddersfield NHS Trust were below the England average from July 2014 to June 2015.
- The percentage of did not attends (DNAs) for this trust was lower than the England average. The trust target for DNA for first appointments was 7% and for follow up (FU) appointments was 8%.
- The trust was meeting their DNA rate targets, apart from in neurology; these were seen on display in clinic areas. For example, in audiology the DNA rate was 6%.
- The Trust was meeting their national indicators. National indicators in this trust were better than the England average and the standard for both non-admitted and incomplete pathways from November 2013 to November 2015 (on average 4% higher than the standard). For example, in October 2015, Families and Specialist Services 18-week incomplete pathway was 97.5%, against the national target of 92%.
- The trust's diagnostic waiting times were lower than the England average for the entire period between November 2014 and November 2015.
- Ophthalmology treated macular degeneration patients as a day case.
- We saw self-check in kiosks in use in all clinic areas visited. Staff told us the use of the self-check in had helped prevent patient queues at check in desks.
- In some of the OP clinics we visited, patients and staff told us patients frequently experienced long waits before the doctor or healthcare professional saw them. We observed appointment times were running over an hour late in surgical OP on the day of our visit. We saw staff kept patients informed of delays via the electronic notice boards or whiteboards.
- Staff at the CRH focus group told us their clinic finished at 6.45pm on the previous day, when it was due to finish at 5pm. They said clinics regularly overran, because either they were overbooked or a doctor who was also on call was running them.
- There were bottlenecks in ophthalmology clinics; staff confirmed these were very busy clinics with capacity and space issues.
- In ophthalmology, new healthcare assistant (HCA) posts had been recruited to and some staff were already in post. Staff told us this would assist patient flow through the department. The longer-term plan was to have one HCA per consultant. Ophthalmology also ran a telephone triage service for patients from 9am – 5pm; a band five nurse staffed this.

Outpatients and diagnostic imaging

- In the one-stop breast clinic, we found capacity was a problem and clinics were frequently overbooked. Patients experienced long waits in the clinics but did experience a 'one-stop-shop' with access to nurse specialists.
- Several OP departments had nurse led clinics, these helped to improve patient flow. For example in ophthalmology, the nurse led clinics managed their own patients. In orthopaedics, advanced practitioners saw the patients in community settings prior to referral for hip and knee operations.
- We saw there was a pharmacy adjacent to the ENT and ophthalmology clinics. This meant patients could collect their prescriptions at the same time as attending their OP appointment.
- We found there were issues with appointment backlogs and waiting lists; one consultant told us the trust currently had 40 waiting list initiatives.
- Data provided by the trust during the inspection showed 33,000 patients were waiting for an appointment. Managers explained this was due to the partial booking system. They told us the actual backlog for appointments (patients who had passed their see by date), on 9 March 2016, was 4,438 patients.
- We spoke with the chief operating officer and senior management team regarding the 4,438 patients who were in the backlog of appointments. They confirmed for routine appointments the trust process was that patients would be offered an appointment within three months of their original date. Of the 4,438 patients, 3,587 had appointment within the three months.
- The trust were reviewing and clinically validating the remaining 851 patients who had not had an appointment within three months. This was monitored on a weekly basis and information was sent to clinical specialities to review patients and identify any risk of harm. The longest a patient had waited was from July 2015 (eight months).
- The management team also explained that they monitored the appointment delays and triangulated this with information from incidents and complaints.
- Managers told us there was a capacity and demand team that looked ahead at how many patients were due to attend and compared this with the number of clinic slots available.
- Patients and staff told us about frequent cancelled appointments. We found some specialities had high hospital cancellation rates. This is where the hospital cancels an appointment (rather than the patient). At the time of the inspection, the hospital cancellation rate in surgical OPD was 13% and in ophthalmology, it was 17%. Between July 2014 and June 2015, the national average for hospital cancellations was 7% and the average across all OP specialties at this trust was 17%.
- Staff also told us clinics were cancelled regularly. For example, staff in surgical OP told us, "Three clinics were cancelled last week and one yesterday." They said the sickness of doctors did not seem to be well managed and the OP clinics were often the last to know when a doctor was off sick.
- We asked staff about the management of consultants' annual leave. They told us there were no issues with getting the medical rotas; these were available six weeks in advance. They said medical staff were good at giving notice of time off, as they had to give six weeks' notice.
- In physiotherapy, referral demand had increased by 6% year on year and there had been a 17% increase in demand since 2012. This meant the department was not able to meet the five-day target for urgent referrals. This was having an impact on the waiting times for routine appointments; in December 2015, the waiting time for a routine appointment was 12 weeks.
- At the time of the inspection, senior physiotherapy staff told us the waiting time to get a routine appointment at the HRI site was seven weeks. They said urgent referrals were telephoned straight away and patients were offered a choice of appointment dates and times.
- We asked OP managers what actions they were taking about the issues we had found. They told us the OPD clinic templates were under review and they were looking at appointment length times and timing consultants to see how long on average they spent on each appointment. They planned to tailor the length of clinic appointments to the pace of the clinician. If they identified appointment length times needed to change, the general managers would have to approve it.
- Staff and managers told us they were monitoring clinic start and finish times and extra evening and Saturday OP clinics when required. Staff were paid overtime for extra clinics.
- Managers told us any clinic room vacancies were being identified early and utilised by consultants to backfill and reduce their waiting lists.
- The informatics manager told us they monitored appointment slot issues (ASIs) on a daily basis. We found the appointments centre had dedicated team in

the bookings centre looking at additional slot issues (ASIs); this team's role was to ensure any spare appointments slots were filled. Senior nursing staff told us they received monthly updates about ASIs.

Diagnostic Imaging

- The directorate team told us they were aware of the pressures on turnaround times for reports. The team were keen to implement new ways of working to bring the waits down including increasing the use of advanced practitioners once the new cohort of band 5 posts were in place.
- Overall, there were low did not attend rates in 2015, with the highest rate of 5% being in the ultrasound service.
- Waiting times for diagnostic imaging were monitored and recorded. The trusts diagnostic waiting times were lower than the England average for the whole period November 2015-October 2015.

Pathology

- In microbiology, a new rapid identification method (using a MALDI-ToF machine) gave same-day identification of bacteria and yeasts isolated from patient samples. The laboratory manager told us this had a positive impact on patient flow and reduced the need for repeat testing.
- The microbiology laboratory manager told us the introduction of influenza testing on site had improved the turnaround times for test results. They said this was much better for patient care and infection control, and there had been "lots of positive feedback" from users of the service.

Meeting people's individual needs

Outpatients

- Staff told us the local population was diverse and included Polish and Asian communities. We observed the self-check in screens had an option to select different languages.
- The trust used an externally contracted translation service and staff reported no problems. The service facilitated three way phone conversations or interpreters visited the clinics if required for face-to-face consultations. There were notices explaining the availability of interpreters the loop system for patients who were hearing impaired.
- When we asked staff whether patient information leaflets were available in other languages, they said these could be requested if needed.
- Patients with urgent needs, due to using patient transport or with additional needs such as dementia or autism, were fast tracked. Dementia awareness was part of staff mandatory training, staff told us there were dementia link nurses within the trust.
- We observed low check-in desks in all OPD reception areas visited, for wheelchair users. We observed patients in wheelchairs using these. We saw accessible / disabled toilets for were available in all areas visited.
- We saw low seating with arms and high backs for elderly patients or those with mobility problems in the waiting areas and consulting rooms. These helped this patient group to sit down and stand up more easily.
- In ophthalmology there was a separate office for patients with guide dogs, these had additional facilities to ensure these patients and their dogs were cared for appropriately.
- Staff pointed out signage with black writing on a yellow background in large fonts; this was the best colour combination for visually impaired people. Ophthalmology sent out letters to patients in a large font, with black text on yellow background. Other OP clinics had easy read information for patients that required it.

Diagnostic Imaging

- All diagnostic imaging staff showed a good understanding of the need to make reasonable adjustments for patients requiring extra support.
- Translation services were widely available throughout the trust and used when required within diagnostic imaging.
- We looked at the trust award winning leaflets for patients with learning disabilities. These leaflets were easy to read and contained pictures of a local patient representative. The leaflets had been shared with other trusts.
- One patient told us they did not have to wait long for their MRI scan and felt the service had been very responsive.

Learning from complaints and concerns

Outpatients

- Complaints were recorded on the trust's Datix system. The OP matron told us both informal and formal complaints were recorded on Datix. They said the main complaints in OP were about appointment 'mix-ups', they said these were usually resolved informally.
- Minutes of the OP and records board meetings and patient safety and quality committee showed complaints were discussed at these meetings. However, we did not see any evidence to show that current trends and themes from incidents and complaints were monitored.
- The OP matron showed us letters relating to two complaints by patients. We saw staff had dealt with these according to the trust policy. However, the matron was unable to confirm whether the complainants had been satisfied with the outcome of their complaint.
- Data submitted by the trust showed there had been 87 complaints submitted relating to the OPD service areas at CRH between December 2014 and November 2015, 41 of which were upheld. We saw 19 (22%) of these related to either access or appointment issues.

Diagnostic Imaging

- There was evidence that patient feedback was sought and welcomed across diagnostic imaging services. Comment cards were available and annual feedback surveys were done across all the modalities.
- Complaints were handled in line with the trust policy. Complaints were reviewed and discussed at the Radiology Board meetings.
- Three complaints were received for the diagnostic imaging department at Calderdale from December 2014 - November 2015; two involved the attitude of radiology staff. These complaints had been investigated and lessons learnt communicated to staff. There was evidence recorded that staff had reflected on their practice in order to make improvements.
- Staff were able to explain the complaints procedure to us and viewed any learning as an opportunity to improve.
- Compliments were also shared at the Radiology Board meeting.

Are outpatient and diagnostic imaging services well-led?

Good

We rated the well-led domain for this service to be good because the leadership, governance and culture promoted the delivery of high quality person-centred care. We found:

- Staff and managers had a clear vision and strategy for the future of the department and were aware of the risks and challenges they faced.
- Staff we spoke with were aware of the trust vision. They were proud to work at the hospital and felt supported and valued.
- In radiology and pathology, there was a well-established culture of continuous quality improvement, supported by robust governance, risk management and quality monitoring.
- Staff in all services we visited were happy and felt well-supported. There was evidence of good team working, both within and between teams and a positive, open culture.
- There were opportunities for staff to develop and progress within the organisation.
- Staff talked about an open culture where they were able to raise concerns and put forward ideas for improvement of services. We found the teamwork to be exemplary.
- Staff stated the senior managers were visible and approachable. The staff we spoke with said the chief executive provided clear leadership and that the interim general manager responsible for ophthalmology had had been a good appointment and had helped move the department forward.
- There were good examples of innovation and improvement in most of the services inspected.

However,

- Governance processes in OP were under development. Senior staff and managers in OP and the newly formed FSS division were working on developing and extending existing processes. These included the OP audit programme, the management reporting structure and appropriate escalation of risks.
- There was a desire to see more advanced practice within the MRI service.

Vision and strategy for this service

Outpatients and diagnostic imaging

Outpatients

- There was a high proportion of newly appointed staff, especially at band six and seven, in OP departments; this meant teams and structures were still under development. Senior nursing staff confirmed they were "still embedding" their systems and processes. The matron for OPD had been in post for six months and there had been a recent reconfiguration where OP had moved into the families and specialist services (FSS) division.
- The OPD supported off-site clinics (not visited during this inspection) in GP surgeries locally e.g. Todmorden. This provided care closer to home for patients. Senior nursing staff and the general manager said they would like to increase the throughput at Todmorden by encouraging more GP engagement and use of the facilities there.
- The OP management team had visited OP clinics at two other hospital sites to see best practice. They told us they had adopted ideas from these other hospitals to improve services for patients and staff. For example, the large display boards showing cleanliness and friends and family test scores.
- Senior nursing staff told us they were planning to introduce more nurse-led OPD clinics and telephone reviews / consultations in future. Upskilling of nursing and support staff was ongoing and succession planning was in place.
- They were also trialling 'virtual clinics' in some areas, including endocrine, this helped speed up the patient journey and there were plans to expand this.
- Services in OP were looking to increase the use of 'health apps' technology to help monitor patients in the future.
- Staff told us of the innovative expansion of the stroke service in occupational therapy to meet demand and improve patient access. New funding had been provided for an increase in staff and equipment to facilitate this.

Diagnostic Imaging

- All the staff we spoke with were aware of the trusts vision and values. They saw 'putting patients first' as the primary value and told us they felt it was definitely part of the culture of the trust.
- We were told they felt listened to and could always share their concerns with others. They said the senior staff rotated well across the sites and were easy to access.
- We looked at the development plan for radiology for 2016/17. This included looking at developments to meet the impact of seven day working and new cancer targets. Some staff felt there needed to be more advanced practice within MRI to help meet the demand for reporting.
- Staff were positive about the move to the Families and Specialist Services Division. Radiology and pathology services felt this made them more cohesive as teams with a shared vision and goal.
- All the staff spoke with pride about their services. They felt increasing capacity was their greatest concern. The departmental development plan for 2016/17 showed an increase from Calderdale Clinical Commissioning Group for direct access referrals to all modalities shows an overall increase from 32,000 to 43,000 referrals over a four-year period. This was a 34% increase in workload.

Governance, risk management and quality measurement

- The divisional management structure had been in place since December 2015; the pathology and radiology directorates each had a clinical director and general manager and the OP and records directorate had a general manager and a matron. Managers in informatics human resources provided divisional support for the FSS division, finance and business support.

Outpatients

- The OP management team were working to establish a culture of continuous quality improvement, supported and by robust governance, risk management and quality monitoring within the FSS division.
- The general manager in surgery and anaesthetics said some of the reporting structures needed to be formalised. For example, the OP matron had taken on professional responsibility for nursing staff working in ophthalmology but this was still to be ratified.
- Managers and senior nursing staff within the division had an established meetings structure. Monthly meetings were held at three different levels; sisters, management and trust. The senior management team routinely reviewed and monitored the division's overall

governance performance, including incidents and complaints. However, at the time of the inspection, OP departments did not identify and monitor trends of either incidents or complaints.
- We found staff carried out a numbers of audits on a regular basis in OPD. For example, there were weekly hand hygiene audits, front line ownership (FLO) audits, cleaning audits, waste management audits and audits of the availability of records for OP clinics. Patient-led assessment of the care environment (PLACE) audits had been carried out in April 2015; the results were positive overall.

Diagnostic Imaging

- Governance arrangements were in place. Staff were aware of these and participated in them such as undertaking risk assessments, audits and attendance at meetings.
- Staff told us that the risks they were concerned about were accurately reflected on the risk register for their directorate.
- We noted the performance dashboards for the FSS division and discussed these with senior staff. They felt there were a large number of performance measures but they kept up to date of all their requirements and further discussed any performance issues in weekly leadership team meetings.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints. Communication mostly happened via email and the shared drive. We observed staff receiving and opening their work related emails. One member of staff told us the communication was great and there were no issues. A monthly question and answer session was held for all staff and we saw the minutes of these meetings. Staff told us they found this meeting helpful, informative, and always tried to attend.
- Audit systems were in place to measure the quality and accuracy of work carried out within the departments. This included audit half days for staff to attend.
- Good governance processes were in place for radiation safety monitoring. We saw the action plans related to the 2014 radiation safety report and these had been completed.
- There were clear lines of accountability across the department and we found the diagnostic imaging staff worked well as a team.

Pathology

- Governance, risk management and quality measurement within pathology was excellent.
- The pathology departments undertook the Royal College of Pathologists annual survey, which benchmarked results against those of other trusts.
- All of the on-site pathology departments were accredited with the United Kingdom clinical pathology accreditation (CPA) service or the United Kingdom Accreditation Service (UKAS). UKAS assesses laboratories for their compliance against the ISO 15189:2012 standards for medical laboratories.
- The microbiology laboratory manager told us all of the findings from their most recent UKAS inspection, in November 2015, had recently been cleared. Histopathology had undertaken their initial UKAS assessment in May 2015.
- The Human Tissue Authority had inspected the on-site mortuary in 2015 as part of the trust's histopathology inspection; this inspection found CRH met the majority of the HTA standards; a few minor shortfalls were raised. At the time of this inspection, these had all been addressed.
- The laboratory director told us service delivery within pathology was monitored against the Key Performance Indicators of the Royal College of Pathologists on a monthly basis.
- Pathology department had a quality manager and an IT manager, to support the clinical managers and staff in each discipline.

Leadership of service

Outpatients

- The outpatients, radiology and pathology directorates were part of the families and specialist services (FSS) division, pathology managed phlebotomy. The ophthalmology directorate was part of the surgery and anaesthetics division.
- There was a recently appointed matron in OPD and an interim general manager in the surgery and anaesthetics directorate who had been in past since November 2015.
- We had positive feedback from staff about improvements over past few months; they said the

management team and systems were still 'evolving.' Staff told us the managers and matron were approachable and open to new ideas. They said there was a positive approach.
- Staff told us the chief executive and senior managers were visible within the hospital. They told us there were regular walk rounds by senior staff and the executive team.
- Staff told us they had good local support from their managers.
- Staff in audiology and occupational therapy told us they felt their services were well-led.

Diagnostic Imaging

- We found competent staff managing each of the clinical areas we visited. Staff told us they had confidence in their leadership. They made comment that the interim general manager had been a good appointment for the trust and they felt optimistic for the future as a robust handover process was in place for the newly recruited substantive post starting in April 2016.
- The radiology service was well led by a team of competent radiologists and radiographers and they had managed to continue a quality service in the face of some extreme workforce pressures. The senior team were very proud of their staff.

Culture within the service

Outpatients

- Staff told us they felt happy and supported in their roles. They also told us team working was good and they would be confident to ask questions. When asked about the culture within services most said it was 'open and honest.'
- Most staff told us they felt valued and listened to, they said morale was good and they were proud of their teams and the teamwork. However, two OP staff at a focus group at the CRH site told us staff in OP felt, "Demoralised, there is no thank you just criticism."
- We found staff were well motivated and the majority of OP departments were well managed.
- Senior nursing staff told us they felt more part of a team since the move to the FSS division. They said the managers were supportive and approachable.
- The majority of staff told us they were kept well informed and information was cascaded in a timely way. They said the OPD matron fed back to the band six and band seven nursing staff every week.

Diagnostic Imaging

- We heard of a friendly, open culture within the diagnostic imaging department. It was evident that quality and patient experience was seen as a priority for the services and was everyone's responsibility.
- Staff felt the senior staff were very visible and willing to help solve problems.
- Good working relationships and support networks had been built with the local hospitals, universities and with external services such as radiation protection.
- The majority of staff described a positive working environment. Many of the staff had worked at the hospital for many years and there was a low turnover of staff. Staff felt they could raise concerns and be listened to.
- We noted a culture of adaptable working. Staff would work across sites to develop new skills and be flexible in their approach.
- Staff in the diagnostic imaging department felt valued by their managers and enjoyed working as a diverse, multi-cultural team.
- There was evidence of a strong education culture and good support for student radiographers. Many of the staff we spoke with had trained at the hospital.
- Some staff spoke highly of the trust's leadership investment and felt it had been helpful for their role.

Public engagement

Outpatients

- Senior staff told us the FFT score for the trust was currently 92% (patients that would recommend the service). They said they used text messages to capture FFT feedback but the response rate was low. Many patients thought they would be charged for the text, so did not respond. They had identified the need to use different methods for gathering feedback from different patient groups. For example, they had phoned older patients on their landlines during December 2015.
- Data submitted by the trust confirmed what staff had told us about the FFT results. In December 2015, for the

FSS division overall, 91.6% of patients would recommend the service and 4.7% would not recommend it. However, response rates were low, at 13.1%.

- The general manager told us the February 2016 data had shown 91% of patients would recommend the service and the response rate was 12.8%.
- We saw friends and family test (FFT) results for individual OP departments were on display in clinic areas. We also saw examples of 'You said, we did' comments on display. Staff told us this had been introduced in response to FFT feedback.
- Outpatients had carried out a patient experience workshop in 2015 and had produced an action plan from the patient feedback. Actions included improving the clarity of information in appointment letters to better prepare patients for their experience of the service.
- Following feedback from service users, 'Agent Calling' had been added to the reminder service for patients aged over 65, who have not registered a mobile contact number. This patient group now receive a telephone call to remind them about their appointments.

Diagnostic Imaging

- The departments actively sought feedback from patients. They collated feedback from all areas of the department once a year.
- In 2015, the results for CT patient experience showed that 88.3% of patients would recommend the service and 79% gave positive comments. The nuclear medicine patient experience results for 2015 showed that 96.6% of patients would recommend the service and 89% gave positive comments. Comments included feedback such as, 'good communication, speed and efficiency,' and 'all staff fantastic.'

Pathology

- Pathology audited and captured feedback via the Q-pulse electronic document control and quality management system QMS). The QMS functioned well in identifying and acting on the feedback of staff and users to improve the services provided.
- For example, the warfarin clinic had recently changed the format of paperwork used by patients. Patients using the service completed feedback forms and 90% said they liked the new format.
- Information submitted following the inspection showed pathology carried out a management review of the quality management system in February 2015. This surveyed service users, including undertakers using the mortuary and patients using the new andrology sample collection room. Feedback from the andrology patients resulted in a quality improvement note to look at options to regulate the temperature in the room.
- The Royal College of Pathologists had carried out a user satisfaction survey of pathology services at Calderdale and Huddersfield NHSFT between May and July 2015. The report showed 96.3% of the 32 users surveyed "would recommend this laboratory service to a colleague."

Staff engagement

Outpatients

- The majority of staff we spoke to told us they felt actively engaged in the delivery of their service. Staff and managers were all enthusiastic about their work.
- Staff in all areas told us there were 'huddles' every morning, even in phlebotomy. They explained these had been recently introduced following visits to other sites to see best practice. They said these helped and identified any issues early in the day. Clinics kept a record of these huddles, staff told us this helped with communication.
- Most clinic staff told us they had regular staff meetings.
- Staff told us about 'celebrating success' awards for staff within the trust, the trust also had annual awards for nursing staff.
- Senior nursing staff told us mechanisms for capturing staff feedback within OPD was evolving; suggestions had been recently ratified at the NMC committee. They said this feedback and progress would be monitored and audited.

Diagnostic Imaging

- Staff were encouraged to complete the NHS staff survey.
- Senior staff told us they sent out regular emails to the staff and the staff confirmed this was a good method of communication.
- Staff were able to ask questions of the senior management team during the regular staff question and answer sessions.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

Outpatients

- The eye clinic liaison officer had won 'Professional of the Year' from the Macular Society for her support for adults and children after their diagnosis.
- The trust's clinical neurophysiology service was the first in the country to gain national accreditation from UKAS after visits to observe practice and talk to patients

Diagnostic Imaging

- The Trust's Radiology Department was one of only 14 across the NHS to be fully accredited against the United Kingdom Accreditation Standards (UKAS)
- The department had been a pilot site for the ISAS accreditation and had maintained the award for six years. The latest report noted that despite pressures, "the service continues to have effective systems in place and provides a safe service to patients, referrers and staff. The service is patient focused; evidence showing that patients' needs are considered and feedback acknowledged and acted on where possible."
- Advanced practice was evident in the radiology department with reporting radiographers across many modalities. This meant the trust had invested in the on-going quality of the service and maintained a sustainable way forward in the light of consultant vacancies and increasing workload.

Pathology

- The clinical director told us the department had been a finalist in the trust award scheme for innovation, for their innovative use of band three staff within the department.

Outstanding practice and areas for improvement

Outstanding practice

- The development and growth of the ambulatory care service to support the hospital sites and meet local need. The trust had vulnerable adult's leaders to ensure the vulnerable adult care principles and process was embedded into practice.
- Engagement support workers had been appointed to provide engagement, socialisation and companionship, cognitive and physical support for patients with dementia and/or delirium. The team supported patients during the day with either group or one-to-one activities which promoted sleep at night. Through providing suitable engaging activities during the day, less 1:1 care was required during the day and night. This also helped other patients experience by reducing sleep disruption on the wards.
- The trust had worked closely with local higher education facilities and offered an enrichment programme to 'A' level students to experience working in a hospital environment but particularly with patients living with dementia or experiencing delirium.
- The development of NEWS and 'Nerve centre' technology to identify deteriorating patients for prompt care escalation and intervention.
- The use by critical care outreach of the NEWS and Nerve Centre technology to drive effective identification of the deteriorating patient in ward areas. This supported early admission to critical care, and in turn better patient outcomes. The team could use the system to prevent readmission of critical care discharges.
- A proactive, positive and energised discharge coordination team together with an integrated MDT working to provide care to the patient in the most appropriate environment.
- The diagnostic imaging department worked hard to reduce the patient radiation doses, and had presented this work at national and international conferences.
- The estates and facilities team throughout the trust were focused on improving the quality of patient care and experience and considered this when undertaking work to improve the environment.

Areas for improvement

Action the hospital MUST take to improve

Action the trust MUST take to improve

- The trust must continue to 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 continue to embed and strengthen governance processes within the clinical divisions and at ward level.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
- The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.
- The service must ensure staff have an understanding of Gillick competence.
- The trust must continue to identify and learn from avoidable deaths and disseminate information throughout the divisions and the trust.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role. The service must also ensure all relevant staff are aware of Female genital mutilation (FGM) and the reporting processes for this.
- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.
- The trust must ensure that interpreting services are used appropriately and written information is available in other languages across all its community services.

Outstanding practice and areas for improvement

- The trust must ensure that appropriate risk assessments are carried out in relation to mobility and pressure risk and ensure that suitable equipment is available and utilised to mitigate these risks.
- Within maternity services the service must focus on patient experience and ensure women feel supported and involved in their care.
- The trust must review the provision of a second emergency obstetric theatre to ensure patients receive appropriate care.
- The trust must continue work to reduce the numbers of third and fourth degree tears following an assisted birth and the incidence of PPH greater than 1500mls following delivery.
- The trust must continue to review arrangements for capacity and demand in critical care.
- The trust must ensure that patients on clinical decision unit meet the specifications for patients to be nursed on the unit and standard operating procedures are followed.
- The trust must ensure there are improvements to the timeliness of complaint responses.
- The trust must ensure there is formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant.

Action the hospital SHOULD take to improve

- The trust should review the availability or referral processes for formal patient psychological and emotional support following a critical illness.
- The trust should review the handover arrangements from the hospital at night team to the critical care team to ensure continuity of patient care across the hospital.
- The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.
- The trust should provide consultation opportunities and team collaboration in the development and completion of its business strategy and vision for end of life care.
- The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.
- The trust should ensure there is access to seven-day week working for radiology services.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users How the regulation was not being met: Medicines were not always managed appropriately. Within the medical, surgical and maternity divisions there was inconsistent monitoring of medicines requiring refrigeration. For example out of range fridge temperatures were not always acted upon. On one of the medical wards visited we identified that a controlled drug date expired but this had continued to be administered on a further five occasions over three days before a replacement supply was obtained Within maternity services controlled drug checks were not always checked in line with trust policy and recorded. In critical care services there were delays in discharges and admissions which led to patients being cared for in the theatre recovery area. There was no formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

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 was a governance framework in place however there was a need to embed and strengthen governance processes within the clinical divisions and at ward level.

During the inspection there were a number of concerns raised within maternity services there was limited assurance that the systems in place for sharing information, monitoring and identifying risks were effective in addressing these concerns.

At the inspection there were issues with flow and these had not been identified and therefore adequately addressed and patients were being admitted to the CDU for inappropriately long times.

There was a lack of comprehensive data for community adult services which impacted on the ability of the service to measure its effectiveness and responsiveness.

Data provided by the trust was not always accurate with different information provided for the same time period. Mandatory training and appraisals data was unreliable with trust and divisional data differing from ward level records.

There was a backlog across the trust in responding to complaints and this failed to meet the trust timescales.

This section is primarily information for the provider

Requirement notices

Within children's services there were some patient safety issues identified on the inspection. The trust's own systems had not highlighted these risks. For example resuscitation trolleys behind locked doors, button batteries in unlocked cupboards in an area accessible to children.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 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 accident and emergency for nursing and medical staffing, medical care, children's services and adult community services. 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: Staff appraisals were below trust target in some areas.

This section is primarily information for the provider

Requirement notices

There were variable rates of appraisals across the divisions within the trust. In some services there was inconsistency in the way staff received clinical supervision and this required standardising and strengthening.

At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 39% 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, children's services and community adult services.

Level 2 and Level 3 children's safeguarding training compliance in children's and maternity services was below the trust target of 100%.

Within maternity services there was variable knowledge and understanding of female genital mutilation.

Level 2 safeguarding adults training was also below the trust target in maternity services, surgical services and medical services.

There was variable understanding of the mental capacity act and deprivation of liberty safeguards.

There were occasions where critical care patients were cared for in recovery. Theatre nursing staff were not trained in critical care competencies and access to ITU staff for support and advice was limited.