

Harrogate and District NHS Foundation Trust

Harrogate District 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

Accident and emergency

Medical care

Surgery

Intensive/critical care

Maternity and family planning

Services for children & young people

End of life care

Outpatients

Summary of findings

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Summary of findings

Overall summary

Harrogate District Hospital is the main acute hospital managed by Harrogate and District NHS Foundation Trust. It has 396 beds, a 24-hour A&E, maternity and children's departments, and a range of other services. It serves the population of Harrogate, parts of North Yorkshire, York and North and West Leeds. The trust employs more than 3,500 staff and has a budget of £175 million.

Overall, Harrogate District Hospital provided care that was safe, effective, caring, responsive and well-led. The hospital was clean and it had systems in place for infection control.

However, there were some areas, in terms of being safe, effective and responsive, that the trust could improve.

Staffing levels in some areas, particularly in the care of older people, meant that although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly. Pain control on some surgical wards was not always effective. Some patients we talked to did not feel that their pain was effectively controlled. The completion of 'do not attempt cardio pulmonary resuscitation' (DNACPR) records in end of life care was not consistent. The trust's thresholds for reporting serious incidents were not comparable with most trusts.

There were some areas of good practice. These included the way in which the trust valued and used volunteers, and the use of telemedicine in patient care.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Services were generally safe. Staff assessed patients' needs and provided care to meet those needs. The hospital was clean and there were procedures in place to keep people safe, for example from infections. However, we found inconsistencies in the completion of 'do not attempt cardio pulmonary resuscitation' (DNACPR) records in end of life care. The trust's thresholds for reporting serious incidents were not comparable with most trusts.

Are services effective?

Overall, services were delivered effectively and focused on the needs of patients. Outcomes for patients were mostly as expected. We found no evidence of concerns about mortality or infection rates. In some areas within surgery, pain relief services were not always effective. Some patients we talked to did not feel that their pain was effectively controlled.

Are services caring?

Most people we talked to were positive about their care. Much of the care we observed was good. Patients said that they were satisfied with how they had been treated and that doctors, nurses and other staff were caring and professional. Staff respected patients' dignity and privacy and involved them in their care.

Are services responsive to people's needs?

Complaints and concerns were handled appropriately. In most services, patients were treated promptly. However staffing levels in some areas, particularly in the care of older people, meant that although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly.

Are services well-led?

The hospital was well-led. The trust board showed a good understanding of key issues. Individual services were also well-led.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The A&E department provided safe, responsive and effective care. The trust was consistently meeting the national target of admitting, transferring or discharging 95% of patients within four hours of their arrival in A&E. Almost 89% of patients said they would recommend the A&E department to their family and friends. The trust was addressing some issues in recruiting medical and nursing staff. The emergency department was well-led.

Medical care (including older people's care)

The medical wards generally provided effective care. Patients told us that staff were caring and were responsive to their needs. The wards we visited were well-led. We had some concerns about staffing levels. This included junior doctor staffing on medical wards and nursing staffing levels on elderly medical wards, particularly at night. Although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly.

Surgery

The surgery services were generally safe and effective. Patients told us that the surgery wards had enough staff to meet their needs and they thought staff were caring. The wards were visibly clean and good infection control practice was largely followed. We had some concerns about the effectiveness of pain relief services on some wards, as some patients told us they did not feel that their pain was effectively controlled.

Intensive/critical care

Care on the critical care unit was generally safe and effective. There were enough specialist staff to meet people's needs and ensure that they had appropriate 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate. Patients said that staff were caring and the service responded to patient's needs. The services were well-led, with a visible presence of senior leaders within the unit.

Maternity and family planning

Maternity care was generally safe, caring, responsive, effective and well-led. Women spoke highly of the staff and said they felt involved in developing their birth plans and had sufficient information to make choices during labour.

Services for children & young people

Children's care services were safe, effective, caring and responsive to children's needs and well-led. Children were cared for by specially trained staff. Staff engaged well with children of different ages and the facilities were good, particularly on the children's ward. The environment was well maintained and there were toys and activities available for children, which were age-appropriate and kept clean.

Summary of findings

End of life care

The hospital used the Liverpool Care Pathway, version 12 and had a Specialist Palliative care team to support staff. This ensured a safe approach to end of life care. Staff we spoke with were committed to providing positive end of life care and demonstrated that they were caring and compassionate. There were systems in place to monitor the quality of end of life care and the End of Life Care Facilitator completed daily monitoring of patients on the end of life care pathway.

We found inconsistencies in the completion of do not attempt cardio pulmonary resuscitation (DNACPR) documentation in some areas.

Outpatients

Patients received safe and effective care and treatment from the outpatients department. People reported positively on their experience as outpatients. We found the department was well-led.

Summary of findings

What people who use the trust's services say

Overall, CQC's Adult Inpatient Survey 2012 showed that the trust scored within the expected range for all 10 areas of questioning. The trust scored better than most other trusts for two questions about A&E and anaesthetics.

There were no individual questions where the trust scored worse than most other trusts.

In the inpatient Friends and Family Test for August 2013, the trust had a score of 71. This was 1 below the national average of 72. The trust scored 62 for the A&E department, significantly above the national average of 56.

The trust performed within the top 20% of trusts nationally for 25 questions in the 2012/13 Cancer Patient Experience Survey and was rated in the bottom 20% for six questions.

In the Patient Environment Action Team (PEAT) Assessment, the hospital scored "excellent" for privacy and dignity, food, and environment.

Areas for improvement

Action the trust **COULD** take to improve

- Review staffing levels in wards, particularly those caring for older people.
- Improve pain control in some areas in surgery services.
- Improve do not attempt cardio pulmonary resuscitation (DNACPR) recording in end of life care.
- Review thresholds for reporting serious incidents.

Good practice

Our inspection team highlighted the following areas of good practice:

- The trust valued volunteers and worked closely with them. Volunteers at the trust respond to patients' needs in many ways, including being used as 'secret shoppers' in the outpatients department and as hospital guides. The Patient Voice Group, run by volunteers, played an important role in monitoring patient experience within the trust.
- The trust provides some care using telemedicine. This allows care to be provided 24 hours, seven days a week in response to people's needs.

Harrogate District Hospital

Detailed findings

Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Celia Ingham Clark, Medical Director for Quality, NHS England (London region)

Team Leader: Sandra Sutton, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, senior NHS managers, nurses, a patient and public representative and 'Experts by Experience'. Experts by Experience have personal experience of using or caring for someone who uses this type of service.

The doctors on the team included an executive medical director, a consultant and a junior doctor. The nursing staff included a board level nurse, a senior nurse manager, a matron midwife and a student nurse. The team also included an allied healthcare professional.

Why we carried out this inspection

We chose to inspect Harrogate District Hospital as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. Harrogate and District NHS Foundation Trust was considered to be a low risk provider.

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 always inspects the following core services at each inspection:

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

The lines of enquiry for this inspection were informed by our Intelligence Monitoring data.

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave us. We received information from people who use the services, Monitor, the Medical Royal Colleges, General Medical Council, Health Education England, the National Peer Review Programme, Royal College of Midwives and the local Clinical Commissioning Group.

We carried out an announced inspection visit on the evening of 13 November and during the day on 14 and 15 November 2013. As part of the inspection we observed how staff cared for patients and talked with people who use the service, and we looked at the personal care and treatment records of people who used the service. We also talked with carers and family members.

We held focus groups with staff. We spoke with and interviewed a range of staff including the Chief Executive, Chair, Medical Director and Chief Nurse.

We placed comment boxes around the trust and received comments from people who used the service and staff.

We used the Short Observational Framework for Inspection (SOFI) in one area of the hospital. SOFI is a specific way of observing care to help us understand the experience of people who may not be able to communicate with us.

We held a listening event on the evening of 14 November 2014. About 45 people came to this event and were able to talk to us about their experiences and share feedback on how they think the trust needs to improve.

We carried out an unannounced visit on 22 November 2013. As part of this visit we looked at staffing levels within specific areas, observed how people were being cared for and talked with staff and patients.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced in sharing their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Services were generally safe. Staff assessed patients' needs and provided care to meet those needs. The hospital was clean and there were procedures in place to keep people safe, for example from infections. However, we found inconsistencies in the completion of do not attempt cardio pulmonary resuscitation (DNACPR) documentation in end of life care. The trust's thresholds for reporting serious incidents were not comparable with most trusts.

Our findings

Patient care

Across the areas we inspected, we found that systems were in place to assess patients' needs and plan their care. For example, to ensure that people living with dementia got the right care and support, wards were using the Butterfly Scheme. Under this scheme, a butterfly symbol informs staff when a patient has dementia so that staff can give the appropriate support.

We saw that staff completed documentation appropriately in most cases. However, we did find that there were some gaps. For example, we found inconsistencies in the completion of do not attempt cardio pulmonary resuscitation (DNACPR) documentation in end of life care. There was incomplete information about discussions with the patient and their relatives, review dates, reason for the decision and a lack of signatures and countersignatures by consultants. This meant that there was no up to date record of consultation with patients or their relatives regarding their wishes. Patients confirmed that they felt safe and at ease with staff. The majority of comments received from patients across the trust were positive. For example, one commented that "I have felt safe throughout my stay, most definitely". This showed that patients felt safe and cared for at the hospital.

We found that the trust met people's fundamental care needs. We saw patients being given appropriate support so that they received sufficient food and drink. Wards had risk assessments, care plans and appropriate tools to monitor how much patients were eating and drinking. This meant that staff were aware of the needs of people that required care and treatment.

Cleanliness and infection control

We found that wards were clean and safe. We spoke with domestic staff who told us that infection control was an integral part of their role. Hand sanitizers were available outside the wards, bays and side rooms. Patients and visitors were provided with information on infection control, which was displayed in the wards at various points throughout the hospital. Personal and protective equipment such as gloves, and aprons were available in sufficient quantities. We observed nurses and healthcare assistants entering an isolation room using appropriate protective equipment, washing their hands and using alcohol gel after leaving the room. A number of patients commented on the safety and suitability of the premises. One said, "They've cleaned my room loads." Another patient commented that "the environment and cleanliness was of excellent standard".

The trust had systems in place for infection control. There was an infection control policy in place. Infection rates for C.difficile and MRSA were within an acceptable range, taking into account the trust's size and the national level of these infections. Infection control and rates within the trust is monitored at board level through the HCAI steering group. We reviewed some of these reports from this group, which showed that the trust had a robust process for monitoring infection control.

Staffing

The trust has acknowledged that one of its highest priorities and biggest challenge is making sure there are enough staff with the right skills and experience to deliver safe and high quality care.

We reviewed the NHS Staff Survey 2012. The trust was identified as tending towards worse than expected in relation to staff feeling satisfied with the quality of work and patient care they were able to deliver. Although patient satisfaction with care was generally good, we found that staffing levels, and how staff were used, was a concern for staff in most of the areas we visited, particularly on wards caring for older people. We asked staff what improvements could be made to provide better outcomes for people. They told us that staffing was the key issue.

Some of the junior doctors expressed concern that there were only two resident junior doctors to cover all of the medical bed provision at night.

Are services safe?

Discussion with the Chief Nurse and a review of the information provided by the trust showed that the board has a good understanding of the issues in relation to staff and has put actions in place to address them. A review of the nursing workforce on adult inpatient wards is underway. The review has been completed in terms of daytime nursing staffing levels and ratios agreed using a recognised dependency tool. The review has not yet been completed for night staffing levels. This is planned to be completed by April 2014. The review has identified that the trust should prioritise investment in wards that care for older people. We spoke with staff who confirmed that staffing numbers, during the day, had been reviewed and agreement had been given to increase the number of nurses and health care assistants.

Safety indicators

Systems are in place to monitor and maintain safety, such as the use of a safety thermometer. We reviewed Board reports, which show that pressure ulcer rates, falls, catheters and venous thromboembolism are robustly monitored. Any fluctuations in rates are reviewed and actions put in place to address them. This, and information we hold about the trust, indicates that systems were in place to respond appropriately to safety concerns.

We saw good practice in the prevention and care of patients in relation to pressure area damage and falls. Assessments, care plans, equipment, and access to specialist advice were in place to help prevent and care for patients at risk of pressure damage and falls.

Incidents and incident reporting

The trust had five serious incidents between October 2012 and September 2013. Ward areas and the outpatient

department together accounted for two thirds of these serious incidents. We discussed serious incident reporting with senior managers. The trust does not include inpatient grade 3 and 4 pressure ulcers or fractured neck of femurs sustained while in hospital as serious incidents. This is not in line with most comparable trusts.

However, the trust has a robust system for reviewing all incidents. All incidents are reviewed daily, and a weekly complaints and risk management meeting (CORM) reviews any high risk incidents and complaints. This is attended by the Chief Nurse and Medical Director. Task and finish groups are established after every serious incident to ensure that all actions are completed. A falls group reviews all Root Cause Analysis (RCA) where harm is caused by a fall. The tissue viability group reviews all RCAs for grade 3 and 4 pressure ulcers, and an infection control group reviews all Healthcare Acquired Infection RCAs.

The trust ensures that any lessons learned are implemented and when we spoke with staff they gave us examples of this happening in practice. This showed that systems were in place to respond appropriately to incidents.

Information provided by the local clinical commissioning group shows that they are aware that the trust does not currently report inpatient grade 3 and 4 pressure ulcers as serious incidents. It has confirmed that the trust has agreed to review its approach to this. However, the commissioners are satisfied that in all cases, a Root Cause Analysis is completed and that any lessons learned are implemented.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall, services were delivered effectively and focused on the needs of patients. Outcomes for patients were mostly as expected. We found no evidence of concerns about mortality or infection rates. In some areas within surgery, pain relief services were not always effective. Some patients we talked to did not feel that their pain was effectively controlled.

Our findings

The trust had clear governance structures for assuring good quality and effective treatment and care. This system had been updated and refined following national developments such as the Mid Staffordshire NHS Foundation Trust Public Inquiry. It had a fully integrated system to ensure the accountability and reporting arrangements at the trust were effective.

Performance indicators

Before our inspection visit we reviewed a range of indicators relating to the effectiveness of the care provided at Harrogate District Hospital. This included data on mortality, infection control, maternity, readmission rates and national audits such as patients eligible for thrombolysis.

We found that the trust's mortality rates, across a range of measures, were similar to expected for most areas. Where these rates may have been higher than expected, the trust was able to explain the reason why, and show that it had already been identified and what action was being taken to address any potential issues. The trust monitors mortality data through the Director of Performance and Delivery reports. Work relating to improving mortality rates is also presented through the Chief Executive reports. We reviewed some of these reports, which showed that the trust had a robust process for monitoring and improving mortality rates.

Clinical guidelines and audits

Evidence based guidelines and pathways were available in services, for example, fractured neck of femur pathway and

the enhanced recovery programme in surgery. There was a programme of clinical audits across the trust. This indicated that staff had access to appropriate guidance and that the trust checked this was being used.

Training and development

Information provided by the trust indicated that it provided appropriate training and continuous professional development opportunities to support staff to deliver care and treatment safely and effectively. For example, we reviewed mandatory staff training information, which showed that compliance in this area was being achieved. Staff we spoke with also confirmed this and told us there was training available to support their roles. Comments included, "It's a learning culture." Appraisals are also in place for staff. Information provided by the trust indicated that medical staff appraisal is currently at about 90% with arrangements in place to complete this process. Staff confirmed that appraisals had taken place, which were used to identify any learning needs and professional development.

Pain management

Overall, people's pain was managed effectively across services. The trust had an acute pain service staffed by one advanced nurse practitioner with a non-medical prescribing qualification. The service operated from 9am to 5pm, Monday to Friday. There was also one acute pain consultant ward round a week. There was no cover for holiday or sickness. A business case is being drafted to expand the trust-wide pain services. This business case is not yet complete and is in the process of being drafted.

We spoke with some patients on some surgical wards about pain control. They said that, at times, their pain was not effectively controlled. The trust had recently audited the recording of pain scores of 51 patients who were assessed on the ward prior to surgery and on return to the ward following surgery. This showed that approximately half of patients were not assessed for pain. This meant that pain control was not managed effectively for some patients. We saw there was an action plan in place to address the recording of pain, which was to be completed by January 2014.

Are services caring?

Summary of findings

Most people we talked to were positive about their care. Much of the care we observed was good. Patients said that they were satisfied with how they had been treated and that doctors, nurses and other staff were caring and professional. Staff respected patients' dignity and privacy and involved them in their care.

Our findings

During our inspection we held a listening event and left comment cards and boxes around the hospital. The listening event was attended by approximately 45 people, and there was a mix of both positive and not so positive experiences of Harrogate District Hospital.

We received six comment cards. Of these, five gave very positive comments about the care at the hospital. One person commented, "I was treated promptly, with compassion and care".

Patient and public involvement

Discussion with the Chief Executive and Chief Nurse confirmed that the trust was very focused on delivering good patient experience. The trust had a Quality of Experience Group (QEG), chaired by the Non Executive Director with responsibility for quality. This group recorded and discussed patient stories about their experience at the hospital and used them to improve care and treatment.

Minutes from this group showed there was a mix of positive stories and others that required lessons to be learned. The use of a patient story is good practice and is an indication that the Board put patients at the centre of their work.

The Patient Voice Group played an important role in involving members of the public and patients in monitoring patient experience within the trust. This group has 15 lay members and one governor and meets every month to ensure that the experiences of patients are captured and monitored. The group's reports about its findings on wards and departments are available on the trust's website and on display at the entrance to wards. The reports are also discussed at the Quality of Experience Group.

Friends and Family Test

Patients using NHS services are now asked whether they would recommend a hospital to their friends and family if they required similar care or treatment. Harrogate District Hospital had performed close to the England average for inpatient care, and A&E was significantly above the national rate.

Patient dignity and respect

In all the areas we observed during the inspection, staff treated people with dignity and respect. They were caring, supportive and maintained people's privacy. Patients and their relatives were involved in their care.

The environment and layout of wards and departments promoted privacy and dignity, with single-sex bays, single side rooms with en-suite facilities and screens.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Complaints and concerns were handled appropriately. In most services, patients were treated promptly. However staffing levels in some areas, particularly in the care of older people, meant that although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly.

Our findings

A&E wait times

The trust has consistently met the national target of admitting, transferring or discharging 95% of patients within four hours of their arrival in A&E. Between 12 May and 13 October 2013, the trust has been consistently above this target, only dipping below one week in July 2013.

Information from the Department of Health indicates that the trust has performed consistently better than the England average for patients waiting between four and 12 hours between the decision to be admitted and being admitted, and no waits of four to 12 hours have been recorded since June 2013. This indicates that A&E manages patient flows effectively.

Cancelled operations

The Department of Health monitors the proportion of cancelled elective operations (operations that are not required because of an emergency). This can be an indication of the management, efficiency and the quality of care within a trust. Harrogate and District NHS Foundation Trust was rated as similar to expected in comparison with other trusts. This indicates that people who require surgery had their operations and did not have their surgery cancelled.

Secondary care

Some patients in England still wait too long for secondary care. We found Harrogate and District NHS Foundation Trust was performing better than the national average for access to secondary care through A&E and from general practice.

Discharge

The way in which a trust handles discharges is an indication of how it responds to patient need. Patients need to be discharged when ready with any information

and support provided to ensure they do not need to be readmitted into hospital. We looked at the Adult Inpatient Survey 2012 for Harrogate and District NHS Foundation Trust and found that the results were consistent with other hospitals.

Complaints

The trust handled complaints appropriately. In early 2013, the trust identified that improvements were needed in complaint response times and the quality of responses. As a result, a new complaints system has been introduced, with all services having a senior investigation officer who is responsible for investigating the whole complaint. Staff were very positive about these changes as they felt it was more responsive to have face-to-face meetings with complainants.

The Chief Executive reviews all complaints and signs off all responses. The Quality of Experience group reviews all information about complaints and actions taken, and identifies areas for improvement. This ensures that the organisation learns from complaints.

Volunteers

The trust valued volunteers and worked closely with them. The Patient Voice Group, run by volunteers, played an important role in monitoring patient experience within the trust. This group has 15 lay members and one governor and meets every month to ensure that the experiences of patients are captured and monitored. The group's reports about its findings on wards and departments are available on the trust's website and on display at the entrance to wards. The reports are also discussed at the Quality of Experience Group. We spoke with a member of the group who confirmed that, overall, their reports showed patients were very satisfied with the care they received. The group meets with the Chief Executive, Chair and Chief Nurse every three months and answers any questions openly and honestly. A group member stated that the trust is very interested in patients' views and wants to put issues right.

Volunteers at the trust respond to patients' needs in many ways and have been used as "secret shoppers" in the outpatients department and as hospital guides.

Patient care

As part of our unannounced inspection visit, we visited the hospital on a Friday evening and looked at how many nursing staff were available on the medical wards. On Byland and Jervaulx ward, staff were very busy and patient

Are services responsive to people's needs?

(for example, to feedback?)

call bells were continuously ringing. Although staff were keeping patients safe and meeting their needs, they were not able to do so promptly. Staff who were assigned to provide one-to-one support had been asked to watch more than one person.

Patient feedback

The trust encouraged patient feedback and actively gathered views of patients. It carries out surveys in areas such as outpatients and end of life care. There was also a process called 'You said, we did', which enabled people who used services to make suggestions and comments and receive feedback on what the trust had changed and/or improved. This was prominently displayed on wards and departments.

Accessible information

Wards and departments had patient information available, and displayed information about the Patient Experience Team, results of completed audits and the Family and Friends test, information on the Patient Voice Group and nurse-to-patient staff ratios.

Translation services were available to patients and these services were based on individual need. There were menus to meet people's specific dietary needs.

Telemedicine

Stroke thrombolysis is provided out of hours with the support of telemedicine. This enabled care to be provided 24 hours, seven days a week. By using telemedicine, consultant cover is provided in collaboration with nearby trusts. This meant that the trust could respond to patients with these specific needs in an effective way.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The hospital was well-led. The trust Board showed a good understanding of key issues. Individual services were also well-led.

Our findings

Leadership

The Board had remained stable over the past few years, with the Chairman being in post since 2008 and the Chief Executive in post since 2009. A stable board is often viewed as an advantage.

The trust had a clear organisational structure. There was also a clear governance and risk management structure. Staff at all levels within the trust are clear about what they are responsible for.

Patients, staff and governors were very positive about the Chief Executive and Board. We were informed that they were open, visible and passionate about quality of care given to patients at the trust. Consultants feel that they are listened to by senior managers, and gave an example of the significant investment undertaken in the new endoscopy unit.

The executive team carry out patient safety walkabouts with non-executive directors. Between January 2012 and March 2013, they had completed 26 visits of wards and departments. These visits had resulted in issues being resolved for both patients and staff.

The trust completes executive director team inspections. These visits are unannounced and look at issues such as tidiness and infection control, as well as observing patient care and obtaining patient views.

The Chief Executive holds monthly team briefs to update all grades of staff on developments within the trust. These team briefs are usually well attended.

All of the areas we inspected were well-led. Staff we spoke with said they felt well supported and could raise issues of concern or suggestions for improvements in care with their line manager.

Most staff told us they felt well supported. They told us that they felt proud to work at the hospital and there was a sense of community. This indicated satisfaction with how the service is led.

Risk is managed well at the trust. The board has a good understanding of the key risks within the trust and this is indicated in the corporate risk register. Each service also has a risk register, which reflects the issues within the corporate risk register. However, discussion with some staff in clinical leadership positions indicated that they were not aware of the corporate risk register.

We saw that the trust was developing plans to manage winter pressures. This is essential to ensure the service is well-led through a period where the number of patients requiring care and treatment is likely to increase. The trust sees this as one of its key challenges.

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The accident and emergency (A&E) department provides a 24-hour, seven days a week service for people in Harrogate and the surrounding area. About 48,000 patients attend the department annually. The department includes facilities for rapid assessment (triage), minor injuries and for life threatening and serious injuries. There is a separate three-bay resuscitation room and a dedicated children's room. The department is led by a clinical director, a general manager and a matron in conjunction with consultant staff.

Summary of findings

The A&E department provided safe, responsive and effective care. The trust was consistently meeting the national target of admitting, transferring or discharging 95% of patients within four hours of their arrival in A&E. Almost 89% of patients said they would recommend the A&E department to their family and friends.

The trust was addressing some issues in recruiting medical and nursing staff. The emergency department was well-led.

The trust is considering the feasibility of providing a more formal separation between the areas for minor injuries and major or life-threatening cases.

Accident and emergency

Are accident and emergency services safe?

Patients were seen and assessed promptly on arrival at A&E. Clinical tools to record patients' observations and assessments were clear and easy for staff to use and were completed fully. Qualified staff undertake assessments. Observation charts were completed hourly. Staff had confidence to act on information if a patient's condition deteriorated. If their needs were urgent they were seen by a doctor quickly. Patients told us they appreciated their treatment and being kept informed throughout.

Equipment

The facilities for rapid assessment (triage) were supported by well stocked and clearly labelled equipment of a high standard. For example, airways packs were made up and airways trolleys were tagged shut to ensure safety. The service was fully equipped for major incidents. The staff had a clear understanding of where to locate equipment and how to use it safely.

Training

Staff received training in how to use new equipment. All staff had received advanced life support and cardiopulmonary resuscitation (CPR) training, which minimised safety risks for patients. They had all also received safeguarding training to the advanced level (3) and procedures were in place for safeguarding patients from the risk of abuse.

Incidents

The trust reported comparatively few incidents (21) involving the A&E department. Of these, we looked for possible trends in the type of incidents and whether there was evidence that the trust learned from its mistakes. We looked at three clinical incidents of the same type and spoke with the member of staff involved with two of them. Although the incidents had been investigated, we did not find clear, documented evidence that any learning had become embedded to improve practice. However, nursing staff told us they felt supported in reporting incidents. One patient told us they "really admired the doctors" after a doctor had misdiagnosed a fracture but admitted responsibility to the patient so that the error was found and corrected within 48 hours.

Staffing

The A&E department had experienced issues with staffing. Although the turnover of staff was historically low, there were problems when either several staff left or were absent from work over a short time. The number of consultant and medical staff was close to the required level, although there was a shortage of nursing staff, particularly at night. Only four qualified nurses were working after 10pm. One-to-one nursing in the resuscitation bays was not always possible. When the department was very busy ambulance staff sometimes helped to prepare the cubicle for the next patient. The trust documented the situation on its risk register and was actively recruiting staff to achieve full establishment (the required level of staff). Staffing and recruitment was discussed by the senior leadership team, who made prompt decisions to replace staff who were leaving and, in some instances, to review their roles. A member of agency staff told us they were well briefed and understood what they were doing. Even though staff numbers were limited, staff were friendly and professional in their approach and remained dedicated to delivering quality care.

Are accident and emergency services effective?

(for example, treatment is effective)

Training and development

Services in the A&E department were delivered effectively by suitably qualified and competent staff. We spoke with a range of grades of nursing staff, who felt there were adequate training opportunities. Qualified staff spoke positively about the inter-professional team they worked in, and the good skills mix they found among nursing staff. There was a buddying system for newly-qualified staff. Temporary staff received a thorough induction and then worked 40% of their time with a mentor. Health care assistants felt they had "access to so much training" and were well supported. Student nursing staff said they had a balance between education and regular duties so that they had time to learn. However, they also told us that there were no forums in the trust specifically for students and no education days aimed specifically at student nurses.

Multidisciplinary working

The A&E department could demonstrate that it supported collaborative, multidisciplinary working across services

Accident and emergency

within the trust. There was evidence of very effective care when patients were transferred between other services, including ambulance services. The escalation protocol and plans were clear and comprehensive. When a patient's condition required escalation beyond the A&E department, their needs were being properly managed. Patients received care promptly and in the right place.

Staff followed recognised clinical guidelines and standards. We asked staff to describe the best practice guidelines they followed when treating sepsis and acute kidney injury. They understood the recognised approach to treating sepsis and gave acceptable responses for treating acute kidney injury. The use of assessment tools to diagnose the condition and clinical pathways for care and treatment were in place.

We also discussed the treatment of other, more common conditions. Staff used recognised best practice to deliver treatment that met patients' needs. We discussed with medical staff the results of their own review of compliance with clinical guidelines and standards. Compliance was below average. Staff identified from the review that they needed to be more consistent, particularly in recording.

Are accident and emergency services caring?

Listening to patients' views

The A&E department involved patients and members of the public in shaping its services. Representatives of the Patient Voice Group told us the trust paid attention to its reports and responded to its suggestions. The group appreciated the department's honesty about its limitations and the ease with which they communicated with staff. Each patient discharged from A&E was given a 'token' at reception to post in the appropriate box on their way out to indicate their level of satisfaction with the service they received. The department analysed these responses to improve services.

Views of patients

Staff usually communicated effectively so that patients and their families understood what was happening to them during their stay and why. Patients we spoke with were almost entirely very positive about their experience in the department. One patient told us they came in a lot and were always treated well. Another patient told us the doctor was very considerate. One patient felt they should

have been offered food and water during their wait. They had misunderstood that this wasn't allowed because they were due to have a specific test. Frail and elderly patients were supported to eat and drink. We concluded that patients generally received the support they needed to cope with their visit to the A&E department.

Dignity and privacy

Patients' privacy and dignity was usually respected, although it was sometimes difficult for staff to attend to patients in a caring manner as the department was relatively small. Some patients in the assessment cubicles did not experience the level of privacy required as staff did not completely close the curtains all the time. Although there was a separate children's room, there was no segregation between the adults and children's areas. The department was aware of the issues with privacy and had identified this problem on its risk register. The trust is considering the feasibility of expanding its facilities to address some of these issues.

Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Responding to needs of patients

The A&E department planned its services around the needs of the local population. The number of people attending A&E from outside the immediate catchment area of Harrogate was growing significantly, partly because they recognised the department's achievement in seeing patients promptly. The trust was consistently meeting the national target of admitting, transferring or discharging 95% of patients within four hours of their arrival in A&E. Several patients told us about their experience of being seen "straight away." One patient told us he had arrived at A&E during the night and was impressed that he was admitted to a ward within two hours. Another patient told us he had a quick turnaround time and said, "I feel I had very good care." Two further patients we spoke with had similar experiences.

Staff used an admission checklist for each patient and their progress was monitored on a manually operated whiteboard in the middle of the department, which

Accident and emergency

showed up-to-date information for each patient. We found this was operated alongside a computer system, which duplicated the effort for staff. We saw staff responding promptly when a patient used their call bell.

Patients from all communities could access services, but services for some smaller groups were not well developed. For example, services for patients with alcohol or substance misuse issues. In this particular group, only one younger patient a week presented at the A&E department. Although relatively infrequent, there appeared to be no set pathway to manage the care and treatment for these patients. Information for patients using these particular services needed to be updated and was not well linked with external services.

Discharge

Patients were discharged from A&E when they were well enough and with the right support in place. Patients were clear about the information they received to support their discharge, which was usually a verbal briefing. The department also wrote separately to the patient's GP to supplement this information.

Wherever possible, transport was arranged for patients who were discharged in the evening after the discharge ambulance service was unavailable. The department had links with the fast response team, which operated 24 hours a day, seven days a week. The department also had a contract with a private ambulance service to avoid some patients having to be admitted to hospital overnight.

Are accident and emergency services well-led?

Leadership

As well as consultants, the department was led by a clinical director, a general manager and a matron. Middle grade medical staff were on site 24 hours, seven days a week with

a consultant on call out of hours. Following recruitment, the department would extend the periods with an on-site consultant to include weekends, with on-site consultant cover from 8am to 8pm Monday to Friday, and six hours on Saturdays, Sundays and Bank Holidays. The department still planned to have a consultant on-call service outside these hours.

The department's governance framework was clear and well understood by staff. We observed the senior leadership team meeting attended by consultants, the clinical director, general manager, and matron. We saw good working relations between the consultants and other senior staff. A culture of openness was apparent. We discussed several examples with staff of how they identified risks and these were being managed proactively.

Staff were very clear about their area of responsibility and did not act beyond their competence. Staff at all grades were aware of their professional limitations. They could account for their decisions and performance against the agreed objectives for their role. They received regular supervision. Staff felt they worked in an open and honest culture where they felt confident to air any issues. Managers were friendly, approachable and supportive. We observed good relationships and communications between all staff.

Patient feedback

The department ensured that its vision and culture remained engaged with patients and focused on their care and treatment. Representatives of the Patients Voice Group told us the trust paid attention to its reports and responded to its suggestions. The group said they appreciated the department's honesty about its limitations and the ease with which they communicated with staff. Almost 89% of patients said they would recommend the A&E department to their family and friends. We concluded that the emergency department was well-led.

Medical care (including older people's care)

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The acute medical services at Harrogate Hospital are provided across a number of wards. We visited all of the wards that provide medical care during our inspection. Fountains Ward and Bolton Ward are the acute medical wards from which patients are usually admitted. Fountains Ward has four coronary care beds.

Patients may be admitted directly from A&E, the outpatient clinic or through the Clinical Assessment Team (CAT), which is based on Bolton Ward. Byland and Jervaulx Wards provide care for frail elderly patients. Oakdale Ward provides stroke, neurology and haematology services. Granby Ward provides respiratory and general medical care.

During our visit we spoke with around 15 patients, three visitors and around 35 staff, and we used information from comment cards completed in the waiting area. We attended a number of focus groups and observed care using the Short Observational Framework for Inspection (SOFI) on Byland Ward. SOFI is a specific way to observe care to help us understand the experiences of people who may not be able to communicate with us.

Summary of findings

The medical wards generally provided effective care. Patients told us that staff were caring and were responsive to their needs. The wards we visited were well-led. We had some concerns about staffing levels. This included junior doctor staffing on medical wards and nursing staffing levels on elderly medical wards, particularly at night. Although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly.

Medical care (including older people's care)

Are medical care services safe?

Patient care

Patients told us they felt safe and had no complaints about their care or treatment. Comments included, "I have felt safe throughout my stay, most definitely. I could talk to staff if I had any concerns."

Patients' needs were assessed and care and treatment was planned to meet those needs. Patients' clinical records contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. The records we saw were clear and well written. The staff we spoke with felt they were delivering safe care to their patients.

To ensure that people living with dementia got the right care and support, wards were using the Butterfly scheme. This uses a butterfly symbol to inform staff when a patient has dementia, so that staff can give appropriate support. Staff told us that the butterfly care plans were developed with the help of people's relatives/carers. They provided information about people's individual needs and preferences. This helped to ensure that people who may find it difficult to express their needs received the right care and support during their stay in hospital. Some staff said this document should be completed on admission so that the information was available when people were admitted to wards.

Managing risks

The wards had risk assessments, care plans and appropriate tools to monitor patients' nutritional needs. There was a good system in place to refer patients with risks concerning nutrition to the dietetic service. We saw people being given appropriate support on wards so that they received sufficient food and drink.

We spent time on each ward talking to staff and looking at records in relation to pressure area care. The wards had risk assessments, care plans and equipment in place to monitor and support patients at risk of pressure sores. Staff told us that all pressure sores were logged and that they could get advice and support from the tissue viability nurse, who provided support to the wards and monitored and reported on pressure sores throughout the hospital.

Pressure relieving equipment was available when needed and we saw it in use during our visit. This meant that there were appropriate systems in place to minimise the risks of pressure sores.

On the Fountains Ward, we were told that 60% of admissions were due to falls. The frailty of patients admitted to the medical wards coupled with dementia presented a real challenge to experienced staff. The wards used risk assessments, care plans and equipment such as alarm sensors and high/low beds (beds with adjustable heights) to help minimise the risk of falls. Byland Ward needed additional alarm sensors and staff told us this had been identified and agreed. A datix system was used to record and monitor the number of falls. There was an escalation process to review any falls that had resulted in harm. Where risks were identified, additional staffing could be deployed to provide one-to-one support to patients identified as being at high risk. Specialist flooring had been fitted in some of the bays, which meant that patients were less likely to injure themselves if they fell. This meant that risk management systems were in place to reduce the risk of falls.

Staffing

We identified some concerns with the level of junior doctor staffing on medical wards and nursing staffing on elderly medical wards, particularly at night. Some junior doctors expressed concern that there were only two resident junior doctors to cover all of the medical bed provision at night. We were told about the pressure of insufficient consultant and junior doctor cover across the elderly medical wards. There were two full-time and two part-time consultants to provide care for up to 60 patients. These staff had to provide support at weekends and be on call. They told us they did not feel this was sustainable in the long term. The trust confirmed that there are eight other consultants who participate in the weekend and on call support.

Nursing staff working across wards told us that staffing numbers during the day had been reviewed and the trust had agreed to increase the number of nurses and health care assistants.

The trust has four coronary care beds. Cardiology support is provided by the acute medical on-call rota with support from a neighbouring trust. Patients who may require any extensive or major cardiology interventions are also taken

Medical care (including older people's care)

to a neighbouring trust. Some medical staff indicated that this support arrangement was satisfactory. However some thought that out-of-hours and weekend support in this area could be improved.

We observed one person receiving one-to-one support. This is provided where patients are identified as being at risk, which could be due to the risk of falls or risk of absconding. The support we saw did not promote person-centred care as the member of staff providing support did not engage with the patient. We discussed this with senior management, who told us that staff had been advised to escalate issues as problems had been identified previously. They also told us that they had implemented risk assessments and policies for vulnerable patients and were considering other options for one-to-one care. They had employed an 'older person's champion' and had reorganised wards so that they were more suitable for patients; for example, patients with respiratory needs were now cared for on Granby Ward.

Cleanliness and infection control

We observed good infection control practice throughout our visit. We spoke with a domestic who told us that infection control and health and safety were an integral part of their role. Medical wards were clean and safe. Patients and visitors received information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and visitors. Staff wore gloves and washed their hands between attending to patients. Patients with contagious infections were treated in side rooms.

Safeguarding

We talked to staff about safeguarding. They told us that they would report any concerns to the nurse in charge or to a ward manager. This helped to protect people from harm and made sure concerns were escalated appropriately.

Are medical care services effective? (for example, treatment is effective)

Patient care

Patients told us that their treatment, care and support had been effective. They told us, "They (the staff) have talked about my care needs both now and on discharge" and "I went to a ward which I did not like, I told the staff and they moved me."

There were initiatives to improve the effectiveness of services. These included the Butterfly scheme for improving services for people living with dementia.

Staff and patients confirmed that in general, there was effective transfer between services. Staff told us that there were good multi-disciplinary support services across the organisation to ensure that the needs of patients were being effectively managed and met.

Patients said their pain relief was well managed. They said that staff responded quickly. There was a concern about prescribing between wards, for example, a prescription written in A&E would need to be rewritten once a patient reached a ward.

Multi-disciplinary working

Staff working across the wards confirmed that meetings to discuss and prioritise patients' needs were effective. These included daily ward handover meetings, multi-disciplinary team meetings and flow meetings. The junior doctors said that access to senior medical opinion was good and staff generally across all grades confirmed that they had access to support and advice where needed.

Staff on the clinical assessment (CAT) unit told us they experienced some difficulties due to the unit's small size and layout. Confidentiality was particularly difficult as although curtains were available, the small size of the unit meant that patients could overhear discussions.

Feedback from staff

Staff on the CAT unit also said the lack of clerical support on this unit impacted on their time. Care support workers told us that there should be three staff on the CAT unit but that on occasions there were only two. This caused them additional pressure as the unit was extremely busy.

Staff told us they were encouraged and supported by management. They had yearly appraisals and attended regular training to keep their skills and knowledge up to date.

When we asked them what improvements could be made to provide better outcomes for people they told us that staffing levels were the key issue.

Environment

Staff on the wards for older people told us that they were hoping to improve the environment for people with dementia. They recognised that it was cluttered and not set

Medical care (including older people's care)

up in a way that supported people with a cognitive impairment. They told us they wanted to introduce coloured signage and doors, which may help to orientate people.

Auditing performance

An infection control audit was displayed on the notice board on Jervaulx Ward. Staff working across the wards told us that regular audits were completed.

Are medical care services caring?

Patient care

Patients told us that in general, their experiences had been positive. Comments included, "I would say I have been looked after well. The staff answer buzzers quickly and they have talked to me about my care." Another patient told us, "I have had superb treatment throughout." One patient told us that their request for an incontinence pad had been ignored repeatedly resulting in a soiled bed. They were distressed about this.

Other comments included, "The care has been absolutely excellent, from nurses to domestics. Everybody is polite and helpful."

Respect, privacy and dignity

Staff were kind and patient and took time to talk to patients and explain what they were doing and why. We carried out a SOFI observation on Byland ward and observed the staff supporting and encouraging people to eat their meal in a sensitive, caring and supportive manner. Assistance was given to patients who needed it. Patients who were able to manage themselves were encouraged and supported so that they maintained their independence. However, we also observed a staff member who was employed by an agency to provide one-to-one support to a patient. This was not provided in a person-centred manner. The staff member was not interacting with the patient, which may lead to feelings of confusion and impact on their well-being. We discussed this with senior management during our inspection. They told us that staff had been advised to escalate issues as problems had been identified previously.

We observed people being treated with dignity throughout our inspection. Curtains were drawn when care was provided and staff made efforts to speak quietly so that

they were not overheard. Staff explained what they were doing and asked for people's verbal consent before carrying out any care and tasks. Staff responded to call bells quickly and provided reassurance and support.

We observed staff using touch to aid communication, for example holding a patient's hand or stroking the head of a patient who remained in bed. Staff across grades provided care and support to patients in a sensitive, warm and caring manner.

Involving relatives or carers

There was clear information recorded in patients' records, which showed that they and/or their relative or carer had been involved in discussions about their care. Most patients and relatives felt that they had been kept informed about their care or treatment. One person raised a concern as they had not seen their consultant for a week. We shared their concern with staff during our visit.

Staff told us they enjoyed working at Harrogate Hospital and that the quality of care was good. Most of the staff we spoke with said that they had worked for the trust for a number of years.

Fountains Ward had a single room assigned for end of life care, which meant that someone at the end of their life could be cared for without being moved to other wards within the hospital. Staff across the wards told us that they completed records where it was identified that someone required end of life care. We observed staff supporting relatives in a kind, caring and dignified manner. Staff told us that the chaplaincy service was "really good". They told us that they responded quickly to end of life issues and had recently run an end of life workshop.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Patient care

A patient on the stroke ward told us, "Staff respond quickly, they have been very good, excellent in fact." They said information had been explained clearly and they had discussed rehabilitation and support that may be required on discharge. The ward worked with local GPs and there were several integrated pathways for stroke care.

Medical care (including older people's care)

Stroke thrombolysis is provided out of hours with the support of telemedicine. This enabled care to be provided 24 hours, seven days a week. Telemedicine enables consultant cover to be provided in collaboration with nearby trusts. It provides at least two full time consultants to support stroke services over any shift period. This meant that the trust could respond effectively to patients with these specific needs.

As part of our unannounced inspection visit, we visited the hospital on a Friday evening and looked at how many nursing staff were available on the elderly medical wards. On Byland and Jervaulx ward, staff were very busy and patient call bells were continuously ringing. Although staff were keeping patients safe and meeting their needs, they were not able to do so promptly. Staff who were assigned to provide one-to-one support had been asked to watch more than one person.

Local needs

The population of Harrogate and the surrounding area includes a greater proportion of older people than the national average. The development of the Clinical Assessment Team (CAT) locally has helped to ensure that non-elective admissions have not risen at an unmanageable rate. We spoke with consultants and junior doctors on this ward, who said that all patients had access to a consultant within a few hours.

Patient feedback

The staff working on the CAT team told us that they asked for patients' views using 'survey monkey' and that these were reported back to the team leader so that they could be addressed. Staff told us they were responsive to patient comments and family queries.

Safe practice

All the staff we talked to felt empowered to raise concerns and report incidents. Staff on the wards for elderly people told us that senior management had responded to concerns about staffing.

Staff attended daily flow meetings, which were useful as they provided multi-disciplinary support to help relieve pressure on beds. Multi-disciplinary meetings were also held daily to discuss when people were medically fit for discharge but required support at home. This helped identify discharge needs of patients.

We looked at a selection of patient records; where they identified risks to patients these risks were responded to. Referrals to appropriate specialists had been made, which included falls co-ordinators, occupational therapists, dieticians and speech and language therapists.

We saw that risks were appropriately monitored and action taken where necessary. We were told that there was an equipment library and that requests for equipment were responded to in a timely manner.

There was an active list of interpreters and staff who were multi lingual and able to provide support. On the stroke unit we saw that a call bell had been modified so that the patient could press it with their toes. This helped to ensure that staff could respond to people appropriately.

Putting learning into practice

Staff told us that after a patient was discharged on a cold night to a nursing home, the trust's Discharge Steering Group agreed that wards would not discharge vulnerable people after 8pm.

Feedback about the complaints process had confirmed that patients were waiting too long for a response. There was now a three-day limit for the investigator to contact the complainant so that people's concerns could be responded to quickly.

A staff member told us, "I raised a concern about staffing two months ago as I couldn't provide appropriate care to patients. They (the trust) responded by increasing the staff on this ward."

Staff across grades told us of plans to respond to winter pressures, which included a recruitment drive to increase the number of nurses. This meant that the trust was being responsive and implementing systems to maintain staffing levels.

Transparency

We saw information displayed in prominent areas in wards, including safety and quality information, audit results, PALS information, the results of 'friends and family' tests, and 'You said/we did' information; this included responses from the trust and wards to issues that had been raised.

Medical care (including older people's care)

Are medical care services well-led?

Leadership

All the staff we talked to said that senior management were visible and they had the opportunity to feed back concerns. One of the ward sisters said, "Management are a lot more visible. They often attend the ward meetings. Staff are able to raise issues." Other staff said, "They do act on things." Staff spoke highly of management and said that there were good support systems in place. They told us that communication was good, and ward management

handovers were clear, transparent and open. They told us that there was an open and transparent culture. Staff across the wards were positive and enthusiastic about the quality of care given to patients.

Engaging patients

A representative of the Patient Voice Group told us that they meet with the Chief Executive, Chair and Chief Nurse for question and answer sessions. They said the trust listened to what patients say and wanted to put issues right. The trust actively sought the group's views and was responsive in implementing improvements as a result.

Surgery

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The adult surgical care services at Harrogate and District Hospital are provided on four wards (113 beds): Littondale, Nidderdale, Wensleydale and Farndale. The main theatre suite has five theatres, which completed approximately 7,400 procedures in 2012/13. There is a separate day surgery unit with 20 trolley spaces and an additional three theatres. The hospital provides a range of surgery including orthopaedics, general surgery, urology, ear nose and throat, maxilla facial, ophthalmology, gynaecology and endoscopy. There is also a limited acute pain service for the hospital.

During our inspection we visited the four wards, the main theatre suite, the surgical assessment unit and the day surgery unit. We spoke with 38 patients, six relatives and 28 staff, including nurses, doctors, consultants, senior managers, therapists and support staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about these services.

Summary of findings

The surgery services were generally safe and effective. Patients told us that the surgery wards had enough staff to meet their needs and they thought staff were caring. The wards were visibly clean and good infection control practice was largely followed. The surgical service was well-led. Staff told us they felt well supported. We had some concerns about the effectiveness of pain relief services in some wards, as some patients told us they did not feel that their pain was effectively controlled.

Surgery

Are surgery services safe?

Patients' needs had been assessed and care was planned to meet those needs. Clinical records contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate.

Safe surgery practice and infection control

Practices and procedures within theatres were safe. Mortality rates were within normal ranges. Theatre teams were using the World Health Organisation's 'safe surgery checklist', which is designed to prevent avoidable mistakes, and this was a well-managed process. One patient said, "I felt I was asked over and over again about particulars but I understood it was to ensure they'd got the right person". This showed care was safe and appropriate checks were in place.

The wards were visibly clean. Hand sanitizers were available outside the wards, bays and side rooms. Information on infection control was displayed in the wards at strategic points for patients and visitors. Personal and protective equipment such as gloves and aprons were available in sufficient quantities. We observed nurses and healthcare assistants entering an isolation room using appropriate protective equipment, washing their hands and using alcohol gel after leaving the room. A number of patients commented on the safety and suitability of the premises. One said, "They've cleaned my room loads." Another patient commented that "The environment and cleanliness was of excellent standard".

Infection rates for C.difficile and MRSA were within an acceptable range, taking into account the trust's size and the national level of these infections.

The recovery area for patients after leaving the operating theatre had only two sinks and we were told there was no sluice within the theatre suite to dispose of waste. Staff said they used the sluice in critical care if required. The lack of a sluice and only two sinks in the recovery increased the potential for cross-infection.

Patient records

We looked at a number of patient records across the surgical wards. Risk assessments were generally completed for each patient. These included MRSA screening and assessments for pressure areas, communication, eating and drinking and mental health wellbeing. Patients'

medical histories and treatment plans were documented in their medical notes. Nurses recorded patients' progress in the relevant section in the nursing folder. Consent forms were completed and signed by patients or their relatives. Records were clear and legible. However, individual care plans were not always related to risk assessments. For example, one patient who had dementia did not have a specific care plan to manage their dementia.

Patient safety

The trust had introduced and monitored initiatives to maximise patient safety. Data displayed within the public areas of the wards showed incidences of pressure ulcers, numbers of patients contracting MRSA and patient falls. This data showed that wards were safe.

The staff we spoke with told us they felt confident that they could raise any concerns and that these concerns would be acted on. We reviewed one of the ward risk registers dated September 2013 and noted that concerns raised by staff were on the risk register and any required actions had been noted. In discussions with staff, we noted that some staff, across all grades, were unaware of the trust's one never event (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented). More junior staff were unaware of the risk register and how audits can change care. This indicated that there were potential gaps in learning from mistakes.

Staffing

We saw that staffing levels were satisfactory. On Farndale ward there were usually three nursing staff and three care support workers during the day. However, staff told us concerns had been raised about the level of staffing especially at weekends and overnight. This had been recorded on the risk register with actions taken to improve levels. Some staff said that staffing levels had increased recently and extra staff were provided at mealtimes to help patients with eating.

Staff in the main theatres told us that concerns had been raised about staffing levels, which were partly due to sickness and partly from the expansion of the department. The main concern was staff cover for theatres out of normal hours. This had been recorded on the risk register with actions taken to improve levels.

Are surgery services effective?

Surgery

(for example, treatment is effective)

Overall, patients told us they felt that their treatment had been effective at each stage, from pre-assessment to successful surgery and recovery. One patient said, “I was treated kindly, everything was explained to me and the service was very accessible”. Other patients said, “I fully understood the process and what would happen to me” and “I was involved in my discharge planning”. This showed the care was effective in meeting patient’s needs.

We saw initiatives to improve effectiveness of services for patients. These included the Butterfly Scheme for improving services for people with dementia, revised care pathways for procedures such as fractured neck of femur and an enhanced recovery programme to improve patient outcomes and speed up a patient's recovery after surgery. These were working well on most wards. However, on the Farndale ward the effectiveness of the Butterfly Scheme was not clear. On reviewing patient notes two patients had not been assessed for dementia and therefore did not receive additional care relevant to their diagnosis. Two others had been assessed, but the butterfly was not displayed for staff to see that they had dementia.

Staff training

We looked at a sample of training records for staff, mainly within the day surgery unit and spoke with staff about training. The majority of the training records we looked at were up to date. Staff told us there was training available to support their roles. Comments included “It’s a learning culture”.

Pain management

The trust had an acute pain service staffed by one advanced nurse practitioner with a non-medical prescribing qualification. The service operated 9am to 5pm, Monday to Friday. There was also one acute pain consultant ward round a week. There was no cover for holiday or sickness.

We spoke with some patients about pain control. Five out of nine patients from Wensleydale and Littondale wards said their pain was not effectively controlled. The trust had recently (October 2013) audited the recording of pain scores for 51 patients who were assessed on the ward prior to surgery and on return to the ward following surgery. The audit showed that 47% had their pain assessed on admission to the ward and 53% had their level of pain

recorded with the first set of observations when they arrived back on the ward from surgery. Approximately half of patients were therefore not assessed for pain. This meant that pain control was not managed effectively for some patients. We saw there was an action plan in place to address the recording of pain, with all actions due for completion by January 2014.

A gap analysis had been completed for anaesthesia service in relation to guidance from the Royal College of Anaesthetists regarding the delivery of an acute pain service, with an action plan for completion by June 2014. We were also shown a draft business plan for the expansion of specialist trust-wide pain services, which was dated August 2013. This was in its early stages of development.

Quality and clinical audits

The trust has participated in all the national clinical audits that were related to surgery except for the pain audit. It has participated in audits of fractured neck of femur, elective surgery (PROMS – Patient reported Outcome Measures) and hip, knee and ankle replacement. The audits helped to show managers evidence of good practice and where they can make improvements to the quality of care when compared with other similar trusts. Participation in the pain audit might have highlighted concerns and therefore result in improvements in the pain service.

We saw records of the department’s monthly “audit meetings”. Staff told us the meetings included training on specific issues, learning from events and usually a ward staff meeting. For example, the November meeting for day surgery included learning about theatre lights and warming blankets.

Are surgery services caring?

Staff were caring and respected patients’ privacy and dignity.

Views of patients

Patients told us they were very happy with the care they received. They said they had found nursing and care staff polite and respectful and confirmed that they were keen to ensure their privacy and dignity. Comments included, “Staff are very pleasant”, “10 out of 10, I can’t speak too highly of the staff”, “I am happy with the support received. My privacy and dignity is respected” and “The care is brilliant, the privacy is OK”.

Surgery

We also spoke with visitors who were mostly positive about the care their relatives received. One visitor said, “I am quite happy with the service.” Another visitor said, “I don’t feel X is well cared for, especially regarding his diabetes and getting him up to walk”.

Privacy and dignity

On the wards there were single-sex bays and single side rooms to ensure privacy and dignity for patients. We saw staff used privacy screens when appropriate. On Farndale Ward the environment helped to maintain privacy and dignity as 17 of the 23 beds were in single rooms with en-suite toilets.

When visiting the pre-assessment unit, we saw patients sitting in dressing gowns in the same area as members of the opposite sex. The trust confirmed that these were relatives of the patients sitting in dressing gowns. This practice is in line with the trust’s mixed sex guidelines that has been approved by commissioners.

Are surgery services responsive to people’s needs? (for example, to feedback?)

Staff responded to the needs of patients promptly and appropriately. We observed this during our inspection and patients told us they felt well supported. One person said, “I have been fully informed and care is good”.

Responding to feedback

The department encouraged feedback and was responsive to it. It had asked for the views of friends and family on their experience within the hospital, and used feedback to improve services. There was also a process called ‘You said, we did’, which enabled people who used services to make suggestions and comments and receive feedback on what the trust had changed and/or improved. This was prominently displayed on wards and in the day surgery unit. We saw a recent audit displayed in the waiting area about the experience of patients who had attended the day surgery service. The results were very positive, for example, 100% of patients thought the information given both pre-operatively and on discharge was adequate and understandable and that the care given by staff was the best it could have been. Information about ‘You said, we

did’ was also displayed, which included appropriate explanations to patients’ comments/concerns about access to disabled toilets, waiting times and “feeling like you’re on a conveyor belt”.

Complaints

The department had an effective complaints procedure. We saw that complaints were logged and responded to appropriately and in line with the trust’s processes. Staff had discussed outcomes with patients and family members where appropriate.

Information and advice

There were specific leaflets available for patients following surgery – for example “Discharge information following laparoscopic surgery” and “Preventing hospital-acquired blood clots”. This helped ensure that patients knew what to expect following their surgery and who to contact if they were concerned about specific symptoms.

Learning from incidents

We were told about learning from previous serious untoward incidents, which indicated that the service was responsive to change to improve patient care. For example, refining specific steps for staff to follow for patients having surgery involving implanting a left or right prosthesis, for example, surgery for a knee replacement.

Are surgery services well-led?

Leadership and management

The surgical services were well-led with a clear management structure in place. The senior managers and clinicians who we talked to had a good understanding of the performance of their department and staff spoke of good team working. There was good consultant level leadership across the general surgery and orthopaedic teams, with lead consultants for both areas.

Nursing leadership and accountability was clearly defined. Staff told us they felt well supported and could raise issues of concern or suggestions to improve care. Comments included, “I feel supported, there is good mentorship and leadership” and “I feel really supported, there is an open culture here”.

Patient feedback, both on the day of the inspection and through audits, indicated that overall people thought the

Surgery

surgical services were good and seemed to be well run. Comments included, “I am quite happy with the service”, “A very professional service” and “The professional care and friendliness was exceptional.”

Intensive/critical care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The critical care services are provided in a combined unit which provides Level 2 (High Dependency) and Level 3 (Intensive Care) beds. The service has 10 beds and associated equipment, although the highest occupancy level has been 8. There is a current maximum staffing capacity for five Level 3 beds, the equivalent Level 2 beds, or a mixture of both (up to 8 beds) depending on demand. The nursing team is supported by an anaesthetist (specialised doctor in intensive and critical care), who is supported by a consultant anaesthetist.

There is also a nurse-led Critical Care Outreach Team, which provides support to patients nursed outside of the critical care unit. This is provided across all ward and department areas seven days a week from 9am until 10pm, and is supported by two dedicated consultant sessions a week.

During our visit, we spoke with two patients, one relative and eight staff, including nurses, doctors and senior managers. We observed care and treatment and looked at care records. We also reviewed performance information about these services.

Summary of findings

Care on the unit was generally safe and effective. There were enough specialist staff to meet people's needs and ensure that they had appropriate 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate. Patients said that staff were caring and the service responded to patient's needs. The services were well-led, with a visible presence of senior leaders within the unit.

Intensive/critical care

Are intensive/critical services safe?

Infection control

Patients were protected against the risk of infection. Hand hygiene gel was available at the entrance and exit of the units. We saw that staff wore gloves and aprons and washed their hands before leaving the unit and between seeing patients. Waste and sharp instruments/needles were disposed of appropriately. The environment was clean and tidy, which helped to prevent any infections. Four side rooms were available, to enable staff to isolate patients who posed an infection risk to others.

Staffing levels

There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas for the last three months showed that there was a balanced skill mix and allocation of staff. The rotas indicated that there was almost always five qualified staff per shift to ensure sufficient numbers of staff to cover the five intensive care beds. On the occasions when there were only four qualified staff on a shift, we were told that the number and needs of patients had been assessed as only requiring four. This matched with the occupancy levels we looked at for the same period. A senior nurse was identified as the lead for the unit, 24 hours a day. When there were unexpected absences, systems were in place to address any staffing shortfalls. This included the using existing staff and occasionally agency staff.

We spoke with some staff who raised concerns about being moved to work on wards, which left the unit potentially short of staff. This concern was also on the risk register for critical care. We raised this with the sister and matron, who confirmed this had happened in the past and was a particular issue when trying to move staff back to the unit. We were told the issue had improved recently following discussions with managers on the ward areas.

Managing adverse events

This service had systems and processes to report and record adverse events. There were systems to ensure monitoring at a local and trust-wide level. The outcomes from a local investigation following a recent event were recorded and managed appropriately. Learning was shared

across the services. Recent audits of central lines (a catheter placed into a large vein to give medication and/or fluids) had resulted in the pathway being amended and a DVD was being produced for staff across the hospital.

We noted that some staff, across all grades, were unaware of the trust's one never event (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented). More junior staff were unaware of the risk register and how audits changed care. This indicated potential gaps in learning from mistakes, which could potentially affect the quality of care.

Are intensive/critical services effective? (for example, treatment is effective)

Performance against national audits

The trust submitted the required data to the Intensive Care National Audit and Research Centre (ICNARC), which aims to foster improvements in the organisation and practice of critical care (intensive and high dependency care) in the UK. The data for 2012/13 showed that the trust performed well across the ICNARC quality indicators, which included mortality rates, hospital acquired infections, non-clinical transfers and out-of-hours discharges to the wards.

Patient transfers

We saw one patient who had been waiting two days for a bed to become available on a ward. Senior staff told us that the overall bed availability across the trust occasionally meant people had to stay in the unit longer than planned or required. This was also indicated by data from the ICNARC annual report 2012/13, which showed that delayed discharges were above the national average. While this may not have had a detrimental effect on any person's care, it is not an effective use of the critical care facilities.

There was a low rate of both clinical and non-clinical transfers from the unit to another hospital. Data from May to October 2013 showed there had only been one non-clinical transfer. This meant that patients were cared for in the place that most suited their needs and was closer to their home or relatives.

For patients transferred to wards, there was a concise "Critical therapy discharge summary" sheet which helped ensure an effective transfer of care from the critical care unit to ward staff.

Intensive/critical care

Consultant cover

There were anaesthetic consultant leads for both critical care and the outreach team. The anaesthetic consultants operated a “consultant of the week” cover for the unit. There were also ‘handover’ meetings for consultants. This meant that consultants knew their patients and there was continuity of care for patients.

The service monitored its effectiveness and displayed information publicly. For example, information on the number of hospital acquired infections and pressure ulcers. It is important to monitor the effectiveness of the service to identify any trends and issues at an early stage.

Are intensive/critical services caring?

Staff were caring and respected patients’ privacy and dignity. For example, we saw staff pulling curtains around patients’ beds while caring for their needs and large ‘Personal care in progress’ signs were attached to drawn curtains. The four side rooms were used to help prevent mixed sex accommodation and to offer additional privacy for patients receiving end of life care. This demonstrated that staff acted appropriately to maintain patients’ privacy and dignity.

The patients and relative we spoke with were informed about their care and treatment. They described their clinical care as “very good” or “excellent”. One patient told us that the staff “always tell me what they are up to. They tell me the results of tests. I have been wonderfully looked after here”.

We saw that staff showed care and compassion. A patient commented that “care has been fantastic, I can’t fault the care. The speed I was responded to was very fast”.

Relatives were involved in patients’ care. The critical care unit had a room where families could relax and have refreshments. There was also a bed for relatives who wished to stay overnight. A relative told us, “The care for X has been fantastic. Everything was discussed with us before we made the decision to have the operation”. However, one relative had completed a trust feedback form, and although they were complimentary about the care given, they were concerned about the way relatives were provided with information. We were told that the sister had spoken with the relative and addressed their concerns.

Are intensive/critical services responsive to people’s needs? (for example, to feedback?)

We found that, overall, services were responsive to people’s needs.

The trust had developed formal networks and arrangements with other local NHS trusts and regional centres. For example, care for people who required specialist services (for example for major trauma or severe neurological head injuries) were transferred through these networks to the regional centres. Arrangements were in place to return patients to Harrogate and District hospital once they were fit enough to transfer. This showed that systems were in place to respond to patient’s needs.

The unit had level 3 and level 2 beds, which meant that the number of beds at each level could be adapted to accommodate the changing needs of patients, both within the unit and across the hospital.

Availability of outreach service

The critical care outreach service supported ward staff to manage patients who had been discharged from critical care or patients on wards who were deteriorating and needed a more specialist assessment/action. The outreach service was available seven days a week from 9am to 10pm; it did not operate overnight. Ward staff contacted the outreach service as part of the protocol for recognising a deteriorating patient when monitoring their vital signs using NEWS (National Early Warning System) scores. Although the nursing staff on critical care were available for telephone advice, they did not routinely visit patients to assess them on the wards. The duty doctor was available overnight. These arrangements were confirmed by the staff we spoke with. The lack of the outreach service overnight could potentially affect the robustness of the out-of-hours support for some patients.

Learning from incidents and feedback

The service learned from previous serious untoward incidents, which indicated that it was responsive to change to improve patient care. For example, it developed specific steps for staff to follow if patients suddenly develop a problem with their tracheostomy (a permanent or semi-permanent hole created in the windpipe to aid breathing).

Intensive/critical care

Patients' experiences and complaints were used to improve the service. The critical care service could not always gain feedback from patients when they were critically ill, so staff held a post discharge clinic for patients and relatives, which provided an opportunity for them to give feedback and get continued support as people recovered. Feedback forms were also available in the relatives' room.

Consent

If patients could not fully understand or be involved in decisions about their care, the service ensured that treatment decisions were made in their best interest, and their relatives and support network were involved. Records showed that consent for an operation had been obtained appropriately. Records also indicated that discussions had been held and recorded, and forms completed for patients requiring a DNAR (do not attempt resuscitation) decision. The patient's relatives remained involved and engaged in their care.

Are intensive/critical services well-led?

Leadership

The critical care unit was well-led. Senior managers and clinicians had a good understanding of the performance of their department and staff were a strong and cohesive team. All staff were involved in monitoring quality of the units and there was a willingness to respond to change.

There was good consultant level leadership across the unit and the outreach team, with lead consultant anaesthetists for both services overall and a consultant of the week for the critical care unit.

Nursing leadership and accountability was clearly defined. Nurse to patient staffing ratios were in line with nationally accepted guidance for specialist areas. Staff told us they felt well supported and could raise issues of concern or suggest improvements to care.

The senior managers we spoke with were aware of the latest national best practice guidance "Core Standards for Intensive Care Units" recently published by the Intensive Care Society (which covers every aspect of intensive care provision including staffing, operational, equipment and data collection) and the "National Competency Framework for Adult Critical Care Nurses". All new staff and some existing staff were working towards completing stage one of the competency framework. Records indicated that most staff were up to date with their training. This ensured there were enough suitably skilled nurses to provide patient care.

Managing quality and performance

The service monitored the safety and quality of care and took action to address identified concerns. The service had an audit clerk who reviewed its performance, including data from ICNARC and hospital based audits. We were told this information was routinely discussed with managers and at staff meetings to help ensure improvements to the service.

We reviewed the risk register dated September 2013; any concerns raised by staff were recorded and any required actions had been noted. In discussions with the matron and a sister, we noted that the two risks rated as 'amber' had been actioned, but the register was yet to be updated.

Maternity and family planning

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Maternity services at Harrogate District Hospital offer care for women from the local area and it is the chosen place of birth for women from neighbouring districts of Yorkshire.

The maternity department is situated over two floors and comprises an 18-bedded ante/post natal ward, a delivery suite with six labour/delivery rooms, a birthing pool room, a recovery room, an eight-bedded observation ward, an assessment/admission room, an obstetric theatre and a bereavement suite. Women also have access to an antenatal clinic, which has six consulting rooms and a treatment room. The clinic provides a five day (Monday to Friday) service. There is also a special care baby unit and early pregnancy assessment unit.

We visited all of the wards and departments. We spoke with six patients, two with their partners, staff of all designations, including an obstetric doctor, three midwives, the Head of Midwifery, the matron and five other staff.

Summary of findings

Maternity care was generally safe, caring, responsive, effective and well-led. Women spoke highly of the staff and said they felt involved in developing their birth plans and had sufficient information to make choices during labour.

Maternity and family planning

Are maternity and family planning services safe?

Managing risks and reporting incidents

The department had a local risk register, which was monitored and managed by the Head of Midwifery. This meant that the service focused on safety and was able to highlight areas that needed improvement or action to help minimise risk to patients and infants. Incidents were reported and staff said that they received feedback and learned lessons.

However, the criteria around the thresholds for reporting incidents took us some time to understand, as this differed from the expected reporting procedures in other hospitals. The maternity unit had recorded one serious untoward incident in the last 12 months. The trust's investigation reports found staff responded well to emergencies on the maternity ward and that there was good interdisciplinary team working. Staff were able to give us examples of where lessons had been learned and showed us the action plans demonstrating what action had been taken. Midwives explained when they would report an issue as an incident and could describe the required process.

During our listening event, we heard about peoples' experiences of maternity services, including one birth that had not been a good experience or as expected, and another that was a total success. There was clear evidence that lessons were learned from incidents and events in the unit. The Head of Midwifery talked us through an incident that had been investigated and explained how it led to changes in practice. Some staff told us they also received feedback from incidents through ward meetings and sharing information between different departments. We looked at some records, which showed that the procedures in place meant that staff knew when to seek further advice from the patient's consultant.

Care planning and assessment

Pregnant women were risk assessed and there were plans of care for identified risks. Women were reviewed at antenatal appointments and at the onset of labour. Staff told us there was good communication between all staff of different disciplines regarding women's care, which we also saw during our inspection. The maternity service monitored the quality and safety of care. The service used a maternity dashboard (a performance reporting and

tracking system using a number of quality and safety indicators) to identify and monitor potential risks to patients. The elective care board reviewed this monthly and any concerns were escalated to the trust board. Maternity care records showed that women's antenatal, labour and post natal needs had been assessed according to their individual needs. For example, the antenatal mobile record included appropriate assessments, checks and discussion of various milestones that may occur during pregnancy.

Many of the staff we met had worked in the maternity unit for a number of years. There was a culture of openness, which helped them to feel comfortable to bring innovative ideas and different ways of working to improve the experience of women who visit the unit.

Cleanliness and infection control

Overall, all areas in the maternity unit were visibly clean. Hand hygiene gel was available and used throughout the maternity unit. We looked at the cleaning schedules and saw that these were completed regularly, showing when areas had been deep cleaned and when they were next due for cleaning.

Staffing and skills mix

Records showed that almost all of the staff team were trained to safeguard women and children. Staff told us about their understanding of child protection and what they would do if they became aware of a problem.

The trust used a staffing tool, similar to the 'Birthrate Plus' national report, which identified the number of midwives required based on clinical activity and risk. It was actively recruiting additional staff to fill vacant posts. The staffing establishment for the ratio of midwives to births was good (1 to 28 patient hospital births) and there is a very clear safe staffing policy with minimum numbers. The rosters showed that safe staffing levels are achieved overall for midwives. However, the number of maternity support workers was low, which could impact on the delivery of care and support to women and their new born babies. The trust has recruited two full time midwives recently, who are yet to start.

The trust has a process for covering short term sickness and the ward managers sometimes come off management days to cover if there is a shortfall in staff. There is a clear escalation policy in place and we saw evidence that the policy was used and was effective. A community midwife is

Maternity and family planning

on call and the supervisor of midwives is called in to the unit as part of that escalation. However, sometimes at night, a midwife is taken from the post natal ward to help in the delivery suite, which leaves the postnatal ward short staffed, potentially impacting on the quality of the care for women and their new born babies. This is undertaken in line with the agreed trust escalation policy.

Staff told us that other staff could be brought from one of the other wards, to assist where required. For example, a midwife could be 'borrowed' from the delivery suite to help with the postnatal women.

A number of staff told us they were concerned about the low staffing levels, which meant they could not always give the quality of care they wanted to. Comments from some patients further demonstrated that they too thought that staffing was a problem and that staff were rushed or not available at all times to support them or provide safe care. In contrast to this, other women did not think there was a problem with the availability of staff. However, this will depend on the women's experience or their particular nursing needs. Staff also talked to us about the increase in the number and the complexity of births at the hospital, which causing added concerns about staffing levels.

The trust's senior managers, including the Chief Executive, told us they were aware of this. We also saw this had been added to the risk register as an issue. There are plans to address this, for example two new midwives had been recruited and the trust was looking at ways to attract applicants to vacant posts. The Head of Midwifery also described how they were looking at reviewing the deployment of maternity staff overall, possibly moving staff from days to nights to cover the shortfall.

Equipment

Equipment was available to meet women's needs. The department received the essential equipment it needed from the hospital's equipment programme. The Head of Midwifery said the department would develop a business case for larger items if the need arose.

Are maternity and family planning services effective? (for example, treatment is effective)

Feedback from patients

Women and their partners told us they were pleased overall with the service. Many women praised the breastfeeding support they received and said this gave them the confidence to breastfeed. One woman told us she had received enormous support, including during the night, to persevere with breastfeeding and this had made a significant difference to her experience. Another woman told us, "I completely trusted what they were doing." One partner described how attentive the staff had been and that staff on duty did not leave the patient until all the procedures were completed.

Information provided by the Royal College of Midwives shows that breastfeeding initiation rates have increased to 84%, which is high in comparison with other trusts across the region. The trust is recognised as a UNICEF beacon of good practice.

Learning and governance

Maternity services have a governance group, which is chaired by the clinical lead for the service along with staff representatives. The Head of Midwifery explained how the group reviews new national clinical guidance, which involves analysing new information to determine what improvements would be gained in comparison with current practice. A risk assessment and feedback session was then presented to the appropriate hospital committee.

The department regularly reviewed care to identify how clinical practice could be improved for patients. An obstetric doctor told us he thought the multidisciplinary relationships worked well across the department and that the care of women and infants was reviewed every day. He also commented about the consultant support that was available, and the records we reviewed confirmed how this support was provided. Other clinical staff told us that notes were reviewed regularly to look at what happens in specific cases, which enabled staff to share learning and discuss whether a particular case could have been handled differently.

Maternity and family planning

Are maternity and family planning services caring?

Patient feedback

Women spoke very highly of staff in the maternity services and almost all of them stressed the positive experiences they had. Women felt involved in developing their birth plans and had sufficient information to enable them to make choices about their care and treatment during labour. Some women told us they had had one-to-one care from a named midwife throughout their labour. Women said they felt well supported and cared for by staff, that care was delivered in a professional way, and that their choices were respected.

Women told us they had received adequate pain relief and were given information about the options available to them, to make their delivery less painful. Women were offered time and support to discuss their care. One woman told us, "My pain relief was kept to a minimum; I got what I asked for." Other words like "compassionate" and "caring" were used to describe the staff who attended to women during their stay in hospital. One woman wanted to emphasise the "gentleness" of one midwife when carrying out a difficult procedure. One woman described to us how her new-born baby was offered to her 'skin to skin' following the birth, which had been her main wish, and was respected.

The department sought people's views in various ways. Women were able to complete feedback cards and the department encouraged women and their partners to share their views. This demonstrated a commitment to finding out if services met women's needs and if their experiences had been in line with their expectations. Patients were positive about their overall experiences. One woman told us, "The staff have been really caring, I couldn't fault them." One woman and her partner commented on how they were kept informed throughout their visit and that every member of staff had introduced themselves and explained what they were going to be doing.

Privacy and dignity

Women told us they could maintain their privacy, dignity and independence. On the antenatal and postnatal wards, curtains could be drawn around beds for privacy. We

observed staff speaking respectfully to women and their families and acting with compassion and kindness. We saw that staff had professional, pleasant interactions with patients while offering open discussion and support.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Accessible information

There were information leaflets in clinical areas about various topics including tests and screening, breastfeeding, and other sources of support, and how to make a complaint. However, all literature was only in English. Staff told us they were able to use telephone interpreters when women were not fluent in English, but they did not often use this service. Access to an interpreting service is important to ensure women understand the options available to them, the results of diagnostic tests and scans.

The maternity unit had systems to safely and effectively manage patients with complications. For example, babies born at 32 weeks or less or with certain complications would be transferred from the hospital's special baby care unit to the regional centre in Leeds. The baby would be transferred through the 'EMBRACE' network, which is a specialist transport service for critically ill children in Yorkshire and Humberside.

Are maternity and family planning services well-led?

Leadership

Maternity services had clearly defined leadership roles. The midwives and senior staff reported to the Matron for Maternity and Paediatric Services. The Matron reported directly to the General Manager, with professional responsibility to the Head of Midwifery. The management team said that they felt well supported and that they were kept well informed by their line managers, with whom they had regular contact and meetings.

The department had a weekly business meeting to discuss matters arising for the maternity and paediatric services. This showed that the service was well-led.

The governance group monitored quality and service delivery of all the maternity units. Staff told us about their

Maternity and family planning

ward meetings, which were used as a platform to share ideas, discuss developments and any issues. One midwife felt there was a culture of openness within the staff structure and that they were able to bring new ideas, which were tried and discussed. One member of staff thought organisational communication was not as good as it could be at times and that the hospital's "executive team" was sometimes hard to engage with due to their lack of presence at ward level. This showed that overall communication systems were in place but that some staff did not always feel these were effective.

Staff support and development

Staff received support to develop and maintain the skills needed to provide safe and effective care. The Head of Midwifery explained that current 'supervisor of midwives' roles were in place and that they were responsible for a team of staff, depending on their own experience and availability. However, some staff said they didn't always get opportunities to further their own development as the midwives tended to stay at the hospital once they had arrived and because they enjoyed their work and the team

they worked with seldom moved. Student midwives received good support from their supervisor and had the opportunity to become involved in the care of women to develop their skills while under the supervision of a midwife. All grades of staff we met told us they felt they were part of a close working team with a "family atmosphere." One member of staff told us they all cared about the service to women but also about one another. All the staff we talked to told us they received an annual appraisal and that they had accessed the hospital's mandatory training programme, specific to their individual job description.

Managing quality and performance

The service monitored the quality and safety of care and took action in response to identified concerns. This included reporting on performance indicators through the maternity dashboard and monitoring of incidents, complaints and patient feedback. Concerns were monitored at both board and directorate level and action was taken to address these and learn lessons from them.

Services for children & young people

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The children's service (or paediatric service) is based at Harrogate District Hospital and comprises a 22-bed ward (Woodlands) and a seven-bed Special Care Baby Unit, as well as Outpatient Services and a Child Development Centre. The Paediatric Unit is staffed by six Paediatric Consultants who are supported by the Directorate Management Team, including the Operational Director, General Managers, Associate General Managers and Matrons. Children who attend the accident and emergency department are seen by a paediatrician, who may have to be requested from elsewhere in the hospital. They are assessed in the general triage room but have access to a separate waiting area, designated room or a separate bay in the resuscitation area when required.

We visited all of the units during our inspection. We observed care and treatment, looked at a sample of records, and spoke with five patients and a number of parents, and talked to staff including a consultant, doctors, nurses and ancillary staff.

Summary of findings

Children's care services were safe, effective, caring and responsive to children's needs and were well-led. Children were cared for by specially trained staff. Staff engaged well with children of different ages and the facilities were good, particularly on the children's ward. The environment was well maintained and toys and activities were available for children, which were age-appropriate and kept clean.

Services for children & young people

Are services for children & young people safe?

The children's service was focused on safety. The parents and children we talked to were very complimentary about the service they received at the hospital. Parents told us they were confident in the care provided by staff. The parents of children who had complex needs felt their children were particularly well looked after.

Managing risks

Children who needed to be admitted to the inpatient wards were risk assessed on admission and care was planned accordingly. Ward nurses attended medical handovers to ensure there was good communication between doctors and nurses about each child's care.

Children's care services were monitored and the trust took action to minimise risks. The department maintained a local risk register, and the Matron explained to us how it was used and managed. Safety alerts were received and action taken as required. There were effective systems for identifying and learning from incidents. This is important for promoting safety. The department followed the trust's own incident reporting processes. The Matron told us that staff were "very prompt" at reporting incidents. All incidents were reviewed and discussed within the governance group, which was overseen by the Matron for Maternity and Paediatric Services and a Consultant Paediatrician. The Matron told us that staff received written feedback about incidents so that they could learn from them. There were one-to-one meetings to support individual members of staff, where necessary, so that they learned from particular incidents which they may have been involved in. Staff told us they received feedback about reported incidents.

The service also used a paediatric dashboard (a reporting system to measure performance against quality and safety indicators) to show potential risks.

Staffing

Wards were generally well staffed by nurses but there were times when additional support staff were needed but not provided. For example, additional staff cover was not provided when nurses left the general children's ward to transfer a child to another hospital. Staff also told us about times when they were overstretched. At one of our 'focus groups' which were open for all staff to attend, we heard

that there was only one play specialist available on the children's ward and when the ward was full it was difficult to provide support for all of the mixed groups, which included new born to young adolescents. Staff told us of examples where the play specialist was carrying out routines such as pre-assessments, accompanying children to theatre, moving cots around or making snacks for children when there weren't enough health care assistants available. Despite this, we observed that children did not receive unsafe care.

The Matron told us there was always a senior nurse on duty for every shift so that staff were adequately supported. Patients and their families told us that staff attended to their needs promptly. We confirmed that junior doctor cover was available for children's care services, and we found that there was 24-hour access to a consultant paediatrician seven days a week. The consultant was also available for all clinical areas where children may attend, including accident and emergency. This was regarded as good practice. These arrangements ensured that children had access to appropriately skilled professionals at all times.

Everyone we spoke with said the staff team did a "marvellous" job and made sure their child was well cared for.

Safeguarding children

A trust report showed that the majority of staff had received training around safeguarding children. This meant they were aware of the potential signs that a child might be at risk and what they should do about it.

Hygiene and the environment

All areas in the children's unit were visibly clean. We saw staff cleaning equipment, and labelling equipment as having been cleaned. Hand hygiene gel was available and used by staff, parents and visitors on the ward.

The children's unit environment was well maintained. Staff told us they had access to the equipment they needed. Toys and activities were available for children, which were clean and in good condition. We spoke to one teenager who was receiving treatment in hospital. They told us there was plenty to keep them occupied if they were on bed rest; then when they were able, they could go to the dedicated 'adolescent' room, which had a football table and pool

Services for children & young people

table which they enjoyed. We also saw other toys and facilities for younger children, which were well used. There was also an outside area which was safe and included play equipment.

Are services for children & young people effective?

(for example, treatment is effective)

The parents and children we talked to said they received care and attention which was “of the highest standard”. They praised staff for their expertise, with one parent describing the staff as “on the ball.” Parents told us their children had prompt and adequate pain relief when they needed it.

Staff skills

Children were cared for by staff specially trained to care for and treat children. Day surgery services were provided by nurses, surgeons, and anaesthetists who had completed extra training in paediatrics. When needed, specialist paediatric doctors provided support to staff in accident and emergency, who were not specifically trained to care for and treat children. There were good arrangements for children on the neonatal unit to transfer to other NHS hospitals where staff had expertise in caring for exceptionally sick children. The consultant anaesthetists arrange visits to operating theatres at nearby trusts to ensure that they maintain their paediatric anaesthetic skills updated.

There were nurses who specialised in specific areas of care, for example asthma and diabetes. This meant that they could dedicate their time in preventative treatment and support parents and children who were affected by these conditions, meaning their stay in hospital could be shorter or prevented.

The trust had specific groups which met to discuss clinical and operational procedures. These groups looked at best practice and ways of improving the children’s services. The groups met at both board and ward level, and showed the trust’s commitment to ensuring clinical practice is evidence-based and in line with national guidelines.

Collaborative working

The trust uses a system developed regionally for hospitals that send critically ill children to the ‘paediatric intensive care unit’ in Leeds. The system, known as the ‘paediatric

advanced warning score’ (PAWS), is based around five age-related colour coded observation charts and guidelines. These charts allow the clinical team to quickly identify when a child’s condition may be outside the normal range. The colour codes on the charts then assist the decision-making processes regarding the stabilisation and transfer of critically ill children to a regional specialist hospital. The staff said this system was a critical tool in the early identification of critically ill children, allowing them to see when a child needs to be transferred. This means that the service responded appropriately to the needs of children whose condition was deteriorating and needed specialist input.

The hospital is part of the ‘EMBRACE’ network – a specialist transport service for critically ill children in Yorkshire and Humberside. Staff told us this service worked very well. The trust also had contingency arrangements for when the EMBRACE service was not available. These processes demonstrated that the hospital had safe and effective systems in place to ensure a critically ill child can be promptly identified and transferred to a regional specialist paediatric centre.

All of the staff we spoke with told us they had extremely good working relationships with other departments in the hospital and other trusts in the area. This means that interworking allows for best practice to be shared and relationships to be nurtured, resulting in better care for patients visiting the department.

Are services for children & young people caring?

Patient feedback

Parents and children said staff were kind, and responded to their needs. Parents told us their children’s treatment and care was explained to them in a way they could understand, and they felt comfortable discussing any concerns with staff. They said they felt well supported and could get help from staff when they needed it.

Parents said their children received pain medication quickly when they arrived on the children’s ward and they were given information about their child’s medication.

Parents of children who had had surgery told us they were given information about any risks involved with the procedure, how to prepare for their child’s operation, and

Services for children & young people

what to expect after discharge. The children we talked to said they enjoyed the food and had enough to do when in hospital. One child showed us the school work they were doing so that they did not fall behind due to their hospital stay. Children felt well cared for and parents and carers were fully involved in care planning, treatment and discharge. One parent told us how discharge planning had started at the beginning of their stay, and they were able to provide examples of the types of arrangements that had been made once the family returned home. This parent explained how they had been fully supported, kept well informed and fully involved in all aspects of their child's stay.

Support for children and their families

There were arrangements to ensure children felt secure and comfortable, and less anxious about being in hospital. Parents were able to stay with their children overnight and accommodation was provided to make this possible.

Toys, games, books, and other forms of entertainment were available for children of all ages. The area used by children was brightly decorated with attention to detail to help young children settle.

Women who had young children on the ward were supported to feed their children as they wished. Some parents were still feeding their babies and told us they were encouraged to carry on as if they were at home.

Are services for children & young people responsive to people's needs?
(for example, to feedback?)

Patients' feedback

Parents' and children's experiences of care were used to improve the service. Parents were encouraged to give feedback about their child's experience, and where possible staff said they would try to accommodate specific requests. One parent explained how the hospital had responded to their request to be able to have direct access to the ward, rather than having to take their child through accident and emergency due to their recurring chronic condition. This had a positive impact on their child's care and they felt the access to medical attention was quick and effective.

Accessible information

Information about care and treatment was available on the wards. There were leaflets about various topics including clinical procedures, breastfeeding, and other sources of support. There was also information about how to make a complaint. However, all literature was only in English. We saw a small number of parents on the wards who did not speak fluent English, who would benefit from an interpreter. Staff told us they were able to use telephone interpreters when children and their families were not fluent in English, but that they did not often contact them.

Are services for children & young people well-led?

Leadership

There was good operational leadership on all the wards and departments we visited. All the staff we met showed a high level of enthusiasm for their work and the service was clearly developed around the needs of children. Staff told us they "loved" working for the trust and that they were valued as people overall. Staff worked together as a team and there was good communication between the surgical and ward staff at all levels.

Senior managers in the children's care service had a clear vision for developing the service in the future. For example, they told us about the consultant cover and how this could be best used, as they were keen to see the children's ward used for both inpatient and day attendances so that children's treatment was not delayed.

Managing quality and performance

Children's care services had clearly defined leadership roles. The Senior Sisters of both the paediatric ward and the neonatal unit reported to the Matron for Maternity and Paediatric Services. The Matron reported directly to the General Manager, with professional responsibility to the Head of Midwifery. The management team said that they felt well supported and that they were kept well informed by their line managers, with whom they had regular meetings. The department had a weekly business meeting to discuss matters arising in maternity and children's services. This showed that the service was well-led.

The department held a range of meetings to review and monitor the effectiveness of children's services. The Matron told us about the various forums. Any matters arising that needed to be escalated for wider discussion would go

Services for children & young people

forward to the combined maternity/paediatric business meeting or appropriate hospital-wide group. Staff told us they had regular ward meetings, and felt they were kept informed and involved about decisions relating to the service. Staff were positive about their work and described the team as effective and closely bound. This showed communication systems were in place to ensure staff were engaged and issues could be raised.

Training for staff

The management team support staff in developing the appropriate skills to meet the needs of families and

children. Staff said they received an annual appraisal and had access to the hospital's mandatory training programme, which was delivered either in a classroom, face-to-face or by e-learning. The Matron explained that staff also received child-focused training such as children's safeguarding and child resuscitation. Staff said they were supported with additional learning and practice development.

End of life care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The Specialist Palliative Care Team is jointly funded by the trust and the local hospice and has an operational policy and referral criteria. The team is available Monday to Friday between 8am and 5pm. There is an out-of-hours facility provided by the local hospice. The team responds to referrals within 48 hours.

The trust employs an End of Life Care Facilitator (EOLCF) whose role is to monitor and support staff and patients with care at the end of life.

The trust reviewed its end of life pathways in July 2013 and decided to continue to use the Liverpool Care Pathway (LCP) version 12 until the new national model is developed.

Summary of findings

The hospital used the Liverpool Care Pathway, version 12 and had a Specialist Palliative care team to support staff. This ensured a safe approach to end of life care. Staff we spoke with were committed to providing positive end of life care and demonstrated that they were caring and compassionate. There were systems in place to monitor the quality of end of life care and the End of Life Care Facilitator completed daily monitoring of patients on end of life care pathway.

We found inconsistencies in the completion of do not attempt cardio pulmonary resuscitation (DNACPR) documentation in some areas.

End of life care

Are end of life care services safe?

Patient experience

There were no patients on the end of life care pathway during our visit. However, we were able to look at three patient records for people who had died recently. The Liverpool Care Pathway is only used in a small number of deaths at the hospital. Two patients had followed the Liverpool Care Pathway and one patient had not. We could see that nutrition, pain relief and hydration had been provided according to the needs of all three patients, including those patients who followed the Liverpool Care Pathway. The records showed that regular discussion about patients' wishes and preferences had taken place and been agreed with them.

The hospital had safe systems to ensure that patients were identified accurately following death. The bereavement office ensured that documentation, and issuing death and cremation certificates was completed in a timely way. The office also provided supportive and practical information for relatives following the death of a loved one.

Resuscitation decisions

We reviewed 15 do not attempt cardio pulmonary resuscitation (DNACPR) orders across a cross section on wards (this is when a person states they do not want to be revived if they stop breathing or their heart stops beating, or the responsible clinician has discussed with the patient or relative that it would be inappropriate, unsuccessful or not in the patient's best interest to do this). Four orders were completed fully. In the remaining 11 orders, we found incomplete information about discussions with the patient and their relatives, review dates, reason for the decision and a lack of signatures and countersignatures by consultants. This meant that there was no up to date record of consultation with patients or their relatives regarding their wishes. However, we found that those orders completed for people staying in wards specifically for care of the elderly were completed fully.

Our findings were in line with the trust's audits and were reflected in the DNACPR Action plan dated September 2013.

Are end of life care services effective? (for example, treatment is effective)

Clinical management and guidelines

End of life care was provided by the clinical team originally looking after the patient, which meant patients are cared for by people they are familiar with. The trust had systems in place to ensure patients' end of life care was managed effectively through multi-agency working with local commissioning groups and hospices.

The End of Life Care Facilitator takes responsibility for monitoring patients approaching the end of life on a daily basis, to monitor and ensure end of life pathways are put in place. This helps ensure that patients are consulted about treatment, pain relief, spiritual and emotional needs. The End of Life Care Facilitator also offers ward-based 'lead by example' support for staff and ensures timely referrals to the Specialist Palliative Care Team. Staff we spoke with confirmed that this support had improved their confidence in delivering good quality end of life care and that the Specialist Palliative Care team responded to referrals swiftly.

Patient experience and support

Staff told us that wherever possible, patients are supported in a side room. They acknowledged that this was not always possible, and when patients were being nursed in a bay they used 'privacy clips' to indicate that a patient was receiving end of life care, which ensured their privacy and dignity was respected as much as possible.

We reviewed a complaint relating to end of life care, and people at the listening event spoke about delays in accessing pain relief. We talked to two ward managers about this: one told us that the prescribing systems sometimes caused a delay in accessing pain relieving medication. The other ward manager said this was less of a problem, but acknowledged that the ward offered post-surgery care where pain relief was a routine aspect of the patient's treatment. Information from the Local Bereavement Survey 2013 indicated that although 86% of people felt pain relief had been provided, seven out of 13 people felt that their relative experienced pain 'some' or 'all of the time'. The trust has identified improvements with regard to palliative care and comfort and the End of Life Care Facilitator is developing links with other primary care agencies to develop a palliative care patient register. This

End of life care

will predict and help to plan for end of life. The hospital is reviewing electronic prescribing systems to improve how it provides immediate and timely administration of anticipatory pain relieving and syringe driver medication.

Are end of life care services caring?

Support for patients

Staff were caring and compassionate. A chaplain and staff gave us examples where staff had “gone the extra mile” to ensure patients and relatives experienced good quality end of life care. We heard particular examples of support provided when relatives were alone; where patients were supported to return home to die and where patients were given help to make advanced decisions for and after their death.

There are two chaplains at the hospital who provided 24-hour support for patients and staff. They work closely with the End of Life Care Facilitator to monitor people receiving end of life care. Chaplains support and train 20 volunteers who visit patients on wards to offer spiritual support. The hospital chaplaincy has developed local networks to support patients to access support from different faiths and cultures. Following a death in hospital, the bereavement coordinator makes sure families receive their relative’s personal belongings and essential documents and provides information and support about the bereavement service.

Information from the Local Bereavement Survey 2013 indicated that most people were satisfied with the care and support they and their loved one had received.

Feedback from patients and their relatives.

We heard from a range of people at our listening event and also from people who contacted us to describe their experiences of end of life care. A minority of people felt their experience could have been improved through better communication between staff and relatives and more effective and timely pain relief. The trust had identified this through complaints and the bereavement survey, and is putting improved systems in place to address this.

Are end of life care services responsive to people’s needs?

(for example, to feedback?)

The trust completed a Local Bereavement Survey with 20 relatives of patients who had died. The overall results were positive, but gave the trust a clear indication of where to make improvements. Reporting structures, together with the appointment of the End of Life Care Facilitator and End of Life Care Steering Group, demonstrated improvements were moving forward. For example, the End of Life Care Facilitator reviewed patients who had followed the Liverpool Care Pathway and identified trends and provided mentoring and additional training in areas identified as needing improvement.

Staff training and development.

The trust has acknowledged that staff have experienced a lack of confidence in delivering end of life care – in particular delivering bad news. Additional training is planned and the End of Life Care Facilitator is also supporting staff through mentorship and leading by example on the wards.

A rapid process improvement workshop is planned in November 2013, to improve the process to enable patients to have their preferred place of death, particularly for patients who wish to go home to die. We saw examples of good practice. One patient had wanted to return home to die, so the hospital facilitated all clinical and social support to enable them to return home within seven hours of making their wish known.

We visited the mortuary as part of our inspection. We found the staff and facilities were sufficient for the trust to be able to respond to people’s needs; a recent audit had identified the need for a bariatric fridge, which was being secured.

Are end of life care services well-led?

Leadership

The service is well-led. The trust is committed to providing high quality end of life care and has completed surveys and audits to identify where it needs to make improvements.

Managing quality and performance

The end of life steering group has undertaken clinical audits to check quality and monitor performance, effectiveness and areas for improvement in end of life care services.

End of life care

Staff confirmed that they were well supported in delivering end of life care and requests for support were responsive.

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The trust provides outpatient appointments at its main outpatient department at Harrogate District hospital and at outreach clinics in outlying areas. Appointments usually originate from GP referrals through 'choose and book', which is an electronic web-based appointment system that offers patients a choice of where to receive health care. In 2012/13, 70,000 new outpatient appointments were booked with over 150,000 follow-up appointments. The trust provides 237 clinics a week across several different specialties, including ophthalmology, ear nose and throat, urology, general surgical, breast and a dedicated oncology department.

We visited the main outpatient department for ophthalmology, general surgery and urology and the specialist oncology unit (Macmillan Dales Unit). We spoke with patients, their relatives and staff, including the outpatient manager, sisters and booking in staff. We received comments from our listening event and from people who contacted us to tell us about their experiences.

Summary of findings

Patients received safe and effective care and treatment from the outpatients department. People reported positively on their experience as outpatients. We found the department was well-led.

Outpatients

Are outpatients services safe?

Hygiene and the environment

The outpatient areas were clean, with access to antiseptic hand gel and prompts for use. There was sufficient seating and access to drinking water to make it a comfortable waiting area.

Patient safety

As a result of patient surveys, a pressure relieving trolley had been purchased for patients visiting the department with a high risk of pressure sores. This meant the needs of these patients could be accommodated and they were made to feel more comfortable.

The outpatient manager told us that appointments were reviewed to predict if a patient required specialist moving and handling equipment or needed additional emotional support, for example, for patients with dementia or a learning disability.

The manager explained how audits were completed to ensure a high quality service. Reported incidents were analysed for patterns and trends. For example, when equipment fails there are arrangements to use equipment in the endoscopy department, which enables clinics to continue rather than be cancelled.

The hospital had a recent major incident in the outpatient department. Staff told us emergency procedures worked well and the hospital returned to normal very quickly.

Safeguarding patients

Staff understood safeguarding processes and what to do if they needed to raise an alert. They said they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. This meant that any suspicions of abuse would be reported appropriately so that children and vulnerable adults would be protected from harm.

Are outpatients services effective? (for example, treatment is effective)

Clinical management and monitoring

Patients were allocated sufficient time for their consultation. This had been monitored and resulted in longer appointment times for some clinics. The department had secured the use of a family room and

access to specialist nurses to support patients receiving bad news. This reduced the disruption in the smooth running of the clinic and provided time and privacy for patients; and the opportunity to speak with a nurse about their diagnosis.

The department had taken into account the increased frailty of patients attending outpatients, and had introduced outpatient clinics in the community. If patients were receiving routine information this could be completed as a telephone consultation, which reduced the need for patients to travel long distances.

As a result of feedback from patient surveys about waiting times for consultations, staff made announcements to patients on arrival if appointments were delayed by 20 minutes; if there was a 30-minute delay, patients were directed to the coffee shop and called by clinic staff when their appointment was ready. We talked to patients who confirmed this, and said delays were infrequent.

Managing quality and performance

Regular auditing and monitoring to ensure patients received a satisfactory service were effective. The outpatient department reviews its risk register to ensure the service meets patients' needs and responds to patient feedback. The 'behind the line' booking-in system was introduced in response to patient surveys. This provided people with privacy to talk to the clerk.

Staff skills

Staff said that training was promoted to develop skills and knowledge. They explained they regularly met to discuss the running of the department and had held a coaching session the day before to share and debate good practice. This meant that they had the knowledge and skills appropriate to their role.

Are outpatients services caring?

Patient feedback

Patients all said that staff were kind, patient and caring. They said they received consultation in private and appointments were not rushed. Everyone told us that information was clear about diagnosis, treatment and next steps; people said they had the opportunity to ask questions and were given reassurance.

Outpatients

The 'behind the line' booking-in system meant that patients' privacy was respected and any discussion with the booking in clerk was as confidential as possible.

We spoke with patients attending the oncology unit for chemotherapy. Without exception, patients were complimentary of the staff. Comments included, "so caring and supportive" and "the staff make my chemotherapy bearable, they are so kind and we have a giggle."

We spoke to people with lifelong illnesses at our listening event who complimented the outpatients departments. One person said that they had developed positive relationships with staff, who understood their condition and made allowances for this and would change appointments if needed.

Are outpatients services responsive to people's needs? (for example, to feedback?)

The department carried out patient surveys and responded to results to implement improvements. For example, announcing waiting times. The department made use of 'secret shoppers'; volunteers who sat in waiting areas noting waiting times, observing staff and the privacy and dignity of patients.

The department had taken account of patients' changing needs and had secured funding for a pressure relieving mattress. Facilities could be made available for patients who required a trolley. This meant patients did not suffer any discomfort while waiting for their appointment.

A new oncology outpatient building is currently under construction and is due to open in March 2014. Patient groups have been involved in its design and facilities.

Are outpatients services well-led?

Leadership

The outpatient manager had a clear vision for the safe and smooth running of the department and they understood the challenges in providing a number of different clinics. The manager demonstrated a commitment to ensuring staff worked together collaboratively to ensure patients received timely appointments that met their needs.

Staff we talked to said that line management was supportive and fair. They said they were actively supported to enhance their skills and experience. One member of staff reflected on their new position and the time allocated for them to develop their knowledge. Staff clearly enjoyed working in the department and had made innovative changes to improve patients' experience.

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice:

- The trust valued volunteers and worked closely with them. Volunteers at the trust respond to patient's needs in many ways, including being used as 'secret shoppers' in the outpatients department and as hospital guides. The Patient Voice Group, run by volunteers, played an important role in monitoring patient experience within the trust.

- The trust provides some care using telemedicine. This allows care to be provided 24 hours, seven days a week in response to people's needs.

Areas in need of improvement

Action the hospital **COULD** take to improve

- Review staffing levels in wards, particularly those caring for older people.
- Improve pain control in some areas in surgery services.
- Improve do not attempt cardio pulmonary resuscitation (DNACPR) recording in end of life care.
- Review thresholds for reporting serious incidents.