# York Teaching Hospital NHS Foundation Trust

# Bridlington Hospital

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this hospital | Requires improvement |
| Medical care | Requires improvement |
| Surgery | Good |
| End of life care | Good |
| Outpatients and diagnostic imaging | Requires improvement |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Bridlington Hospital was one of three main hospitals forming York Teaching Hospital NHS Foundation Trust. The trust provided some hospital services to the local population. The trust also provided a range of other acute services from York and Scarborough hospitals to people in the wider York area, the north-eastern part of North Yorkshire and parts of the East Riding of Yorkshire. In total, the trust had approximately 1170 beds, over 8700 staff and a turnover of approximately £442,612m in 2013/14. Bridlington Hospital had 88 beds.

Bridlington Hospital provided medical, surgical, outpatients and diagnostics and end of life care for people across the Bridlington and Driffield area of East Yorkshire.

We inspected Bridlington Hospital as part of the comprehensive inspection of York Teaching Hospital NHS Foundation Trust, which includes this hospital, York and Scarborough hospitals and community services. We inspected Bridlington Hospital on 17 and 19 March 2015.

Overall, we rated Bridlington Hospital as 'requires improvement' overall. We rated it 'good' for being caring, effective and responsive but it requires improvement in providing safe care and for being well led.

We rated surgical services, and end of life care as 'good. However, medical care and outpatient and diagnostic services 'require improvement'.

Our key findings were as follows:

- The trust was half way through its five year plan in integrate services following the acquisition of Scarborough & North East Yorkshire NHS Trust in 2012.There was some concern by staff at Bridlington hospital about how the integration was progressing and they did not feel engaged with the process.
- Care and treatment was delivered with compassion and patients reported that they felt treated with dignity and respect.
- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, on the whole, they were content with the quality and quantity of food.
- There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.
- There was effective communication and collaboration between multidisciplinary teams across the services and within the community.
- We found the hospital was visibly clean however there were concerns regarding the type of seats in the outpatients departments which were contrary to infection control best practice guidelines.
- There was good multidisciplinary working. The elderly medical strategy included the development of community schemes. An example of this was already in place, and involved working with a nursing home that provided interim less clinical placements for patients who were not ready for active rehabilitation. Patients who were non-weight bearing for a period of time could be cared for in a more homely environment until they were able to weight bear. Patients would then be transferred back to Bridlington Hospital for proactive rehabilitation with a planned expected date of discharge.
- Surgical nursing staff raised concerns about staff being regularly moved at short notice to cover staffing shortages on medical and surgical wards in Scarborough. Staff said that they were moved to areas outside their area of clinical expertise. There were some staff shortages on the medical wards.

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

- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels

# Summary of findings

- Review the uptake and monitoring of training, and ensure that staff at Bridlington Hospital are compliant with mandatory training requirements, especially in the areas of moving and handling, fire safety, safeguarding vulnerable adults, and safeguarding children.

In addition there were actions the trust should take and these are listed at the end of the report.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Medical care | Requires improvement  | Although managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service, staff at Bridlington felt removed from the wider trust, and lacked clarity regarding their future and the value of their service. A number of changes to the leadership of the medical directorate had impacted on relationships with senior post holders, and there was a lack of clarity regarding roles and responsibilities. There was no system in place for ensuring there was always a matron present at the hospital to provide senior nursing support to the wards.<br>Staff were unable to tell us if their establishments were based on the use of an acuity tool. The average registered nurse (RN) staffing levels were just over 86% on both wards throughout January 2015. There were additional support staff available during the night and day on Waters Ward to mitigate the risk of actual RN staffing being less than that planned, but Johnson Ward was only able to average a fill rate of 80.3% on day duty for support staff. Data indicated that compliance rates for some elements of mandatory training were low.<br>Policies and pathways were based on national guidance and were accessible to staff. There was good multidisciplinary team (MDT) working. Patients were happy with the care they received; most found the service to be caring and compassionate and they had been treated with dignity and respect. Staff met the needs of individual patients.<br>Patients were protected from avoidable harm and abuse. Incidents were reported and learnt from. The clinical areas were clean and tidy. |
| Surgery | Good  | Staffing establishments and skill mix were reviewed regularly. However, optimum staffing levels and skill mix across surgical services was not being sustained at all times of the day and night. The resident medical officer (RMO) RMO was required, in an emergency, to accompany patients to Scarborough Hospital, which meant that there was no doctor on site during this time. |

# Summary of findings

The service provided effective and evidence-based care and treatment. The 'five steps to safer surgery' procedures included in the World Health Organization (WHO) surgical safety checklist were not always completed fully. Staff were seen to be caring and compassionate while delivering care. Services were responsive to patients' individual needs.
Senior leaders understood their roles and responsibilities to oversee the standards of service provision in surgical areas. However, work was continuing to integrate surgical services and deliver common standards of care across the three hospital sites. Although directorate-level governance arrangements were in place, the frameworks were not fully embedded throughout the organisation. Standardised protocols, guidelines and pathways of care across the three sites were variable and not yet fully established.

## End of life care

**Good**

We saw that end of life care services were safe, effective, caring, responsive and well led, Specialist nurses and medical staff provided specialist support in a timely way. Staff were caring and compassionate and we saw the service was responsive to patients' needs. There was good use of auditing and action had been taken against the issues identified. The trust had a clear vision and strategy for end of life care services.
However, do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were not always reviewed when patients arrived at Bridlington and District Hospital and mental capacity assessments and decisions were not always documented clearly.

## Outpatients and diagnostic imaging

**Requires improvement**

Overall the care and treatment received by patients in Bridlington Hospital outpatients and diagnostic imaging departments required improvement.
Some policies and procedures were not being followed and there was a lack of evidence of staff attending mandatory training. No action had been taken to ensure that staff had attended fire safety and moving and handling training. Checks of resuscitation equipment were not routinely recorded so equipment may not have been available in an emergency.
The managers told us that they reported any radiation incidents to the Care Quality Commission

# Summary of findings

under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action and been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

Morale of staff we spoke with was low. Staff survey results had deteriorated from the previous year's results. According to staff, the takeover of Scarborough and Bridlington Hospitals by the York Hospital trust had not been sensitively thought out and managed. They said this had resulted in staff at Bridlington Hospital feeling excluded, forgotten when organisational changes were discussed and decisions were made. The management within radiology was unable to provide us with evidence about the way the department managed incidents and complaints. There was a lack of evidence that clinical governance, audits and team meetings took place regularly and that lessons learned from complaints and incidents were disseminated to staff.

Patients were very happy with the care they received they found staff to be caring and compassionate. Services were on the whole responsive to patient needs, but patients experienced long waits because some clinics overran significantly. The care patients received was effective.

# Bridlington Hospital

## Detailed findings

**Services we looked at**

Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients & Diagnostic Imaging

# Detailed findings

## Contents



## Background to Bridlington Hospital

York Teaching Hospital NHS Foundation Trust provides a range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. The trust provides community-based services in Selby, York, Scarborough, Whitby and Ryedale. Trust-wide there are approximately 1,170 beds (with 88 beds in Bridlington hospital), 8,700 staff and a turnover of approximately £442,612m in 2013/14.

Bridlington is in the East Riding of Yorkshire and has a relatively high deprivation indices compared with other parts of the East Riding. The annual death rates in the Bridlington and Driffield area, at 11.9 deaths per 1,000 people, are higher than the East Riding average of 10.0 deaths per 1,000 people. Bridlington North has the highest annual death rate and the East Wolds and Coastal area has the lowest annual death rate, at 15.4 deaths per 1,000 people and 8.2 deaths per 1,000 people respectively. (Annual District Death Occurrence files & Vital Statistics [Office for National Statistics] & Exeter System)

Major disease and illness is more prevalent in the Bridlington and Driffield area than in the East Riding as a whole. For example, coronary heart disease, affects 6.1% of patients in the Bridlington and Driffield area compared with the 4.7% East Riding average. There is the same prevalence in the Bridlington and Driffield area and the East Riding for dementia, which has a 0.4% prevalence rate in both areas. The most prevalent chronic illness in the Bridlington and Driffield area is hypertension, which affects 16.8% of patients. (Quality and Outcomes Framework, NHS Information Centre).

The trust acquired Scarborough & North East Yorkshire NHS Trust (which included Bridlington hospital) and community services for the wider York catchment and the north-eastern part of North Yorkshire in 2012. There is a five year integration plan in place: 2012 - 2017.

We inspected Bridlington hospital as part of the CQC comprehensive inspection programme.

## Our inspection team

Our inspection team was led by:

Chair: Stephen Powis, Medical Director, Royal Free Hospital, London

Head of Hospital Inspections: Adam Brown, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical and surgical consultants, junior doctors, senior managers, nurses, palliative care nurse specialist, allied health professionals, and experts by experience who had experience of using services.

# Detailed findings

## 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?

At Bridlington hospital we inspected the four core services which were provided on this site: medical care, surgery, end of life care and outpatient and diagnostic services

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

We held listening events in Scarborough on the 12 March 2015, where 12 people attended and in York on the 16 March 2015 where 17 people attended and shared their views and experiences of the Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups to hear people's views and experiences.

We held focus groups (at the York and Scarborough sites) and drop-in sessions with a range of staff including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

## Facts and data about Bridlington Hospital

Bridlington Hospital is a satellite hospital of the acute hospital in Scarborough. It provides elective surgical, rehabilitation, and outpatients services to the local Bridlington community and the wider East Coast. The hospital has two rehabilitation wards Waters and Johnson. Lloyd ward and Kent ward are the surgical wards. There is also the Shephard Day Case Unit and Lawrence Unit for medical elective services. The hospital also has other services on site, such as a minor injuries and GP access centre, the GP MacMillan Wolds Unit, Buckrose Ward and a renal dialysis unit which are run by other providers.

## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Surgery | Requires improvement | Good | Good | Good | Good | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Requires improvement | Not rated | Good | Good | Requires improvement | Requires improvement |
| Overall | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |

**Notes**

1. We are not currently confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & diagnosis.

# Medical care (including older people's care)

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

## Information about the service

Bridlington Hospital forms part of the York Teaching Hospital NHS Foundation Trust, and at the time of our inspection Bridlington Hospital had two medical rehabilitation wards, Waters and Johnson, and an ambulatory care unit, the Lawrence Unit. The medical wards did not take acute admissions; all patients were transferred from the York or Scarborough hospitals when assessed as medically fit to step-down into a rehabilitation bed.

The Lawrence Unit, as well as hosting an ambulatory care service, also provided a number of outpatients' services, such as falls assessment, a dizzy clinic, a stroke clinic, and more general elderly care outpatient clinics. The ambulatory care service provided planned treatments and monitoring, such as blood transfusions, therapeutic drug levels, and venesection for patients with long-term conditions, and accepted urgent referrals from GPs for assessment and diagnostic testing for conditions such as suspected deep vein thrombosis (DVT) and pulmonary embolism (PE).

During our inspection, we visited both of the medical wards, and the Lawrence Unit.

We spoke with a wide range of staff, including all grades of nursing staff, healthcare assistants, domestic staff, consultants, doctors, junior doctors, pharmacists, allied healthcare professionals (AHPs) and porters. We spoke with patients currently undergoing treatment on the medical wards, and those close to them. We also observed care and treatment, and looked at patients' electronic and paper records, including medical notes, nursing notes, and drug charts. Before our inspection, we reviewed performance information from, and about, the trust.

# Medical care (including older people's care)

## Summary of findings

Although managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service, staff at Bridlington felt removed from the wider trust, and lacked clarity regarding their future and the value of their service. A number of changes to the leadership of the medical directorate had impacted on relationships with senior post holders, and there was a lack of clarity regarding roles and responsibilities. There was no system in place for ensuring there was always a matron present at the hospital to provide senior nursing support to the wards.

Staff were unable to tell us if their establishments were based on the use of an acuity tool. The average registered nurse (RN) staffing levels were just over 86% on both wards throughout January 2015. There were additional support staff available during the night and day on Waters Ward to mitigate the risk of actual RN staffing being less than that planned, but Johnson Ward was only able to average a fill rate of 80.3% on day duty for support staff. Data indicated that compliance rates for some elements of mandatory training were low.

Policies and pathways were based on national guidance and were accessible to staff. There was good multidisciplinary team (MDT) working. Patients were happy with the care they received; most found the service to be caring and compassionate and they had been treated with dignity and respect. Staff met the needs of individual patients.

Patients were protected from avoidable harm and abuse. Incidents were reported and learnt from. The clinical areas were clean and tidy.

## Are medical care services safe?

**Requires improvement**

Medical care provided at Bridlington Hospital was rated as requires improvement for safety, due to regularly being unable to meet planned staffing levels and poor compliance with mandatory training.

Staff were unable to tell us if their establishments were based on the use of an acuity tool. The average registered nurse (RN) staffing levels were just over 86% on both wards throughout January 2015. There were additional support staff available during the night and day on Waters Ward to mitigate the risk of actual RN staffing being less than that planned, but Johnson Ward was only able to average a fill rate of 80.3% on day duty for support staff.

Although staff we spoke with at Bridlington indicated that they were up to date with mandatory training, and that this was easily accessible, data indicated that compliance rates for some elements of training were very low. As only aggregated data was available for Scarborough and Bridlington it was difficult to establish the degree to which this applied to Bridlington staff; however, compliance with mandatory training needed to be improved across medical services at both hospitals.

However, patients were protected from avoidable harm and abuse. Incidents were reported, learnt from and, in the large, fed back to staff. The trust and ward staff were aware of areas in which it needed to improve (such as falls), and there was an established falls panel which evaluated the investigation, findings and learning from falls incidents. The department was clean and tidy, and there were regular cleaning schedules in place. The trust used the National Early Warning Score (NEWS), and staff could call the on-site senior house officer (SHO) or resident medical officer (RMO) if they had concerns regarding a patient's condition.

### Incidents

- There had been 756 incidents reported in the medical care service at Scarborough and Bridlington, during the period from October to December 2014. Thirteen of these were classified as resulting in moderate harm or above. The largest category of incidents were those relating to slips, trips and falls.

# Medical care (including older people's care)

- Incidents were reported using 'Datix', the trusts electronic incident reporting system. The senior sister told us that they encouraged staff to report incidents.
- Incidents were investigated in line with trust incident management policies and procedures using root cause analysis (RCA) methodology, and the senior sister aimed to have responses for patients and families ready within a two week time frame.
- Safety briefings occurred each morning, and incidents were discussed there to identify whether the incident could have been avoided, and what could be done to reduce future incidents occurring.
- The senior sister provided us with an example of how staff learning was promoted following pressure ulcer incident reporting. This involved the tissue viability specialists visiting the ward twice weekly to review the incidents reported and provide staff with support and advice.
- The staff from the Lawrence Unit were able to tell us about the investigation and learning from a drug related incident, and how key messages were shared with staff.
- We saw that the Duty of Candour information was publicly displayed, and the duty was included as a mandatory field for completion within the incident reporting and management system.
- Staff understood the principles of Duty of Candour and when this should be implemented.
- Consultant mortality reviews were undertaken on every death, and there was a monthly summary discussion of all cases.

**Safety Thermometer**

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- We were shown the Safety Thermometer information, which was held electronically on the 'signal system', the trusts electronic safety report system.
- We saw that the system included a range of safety information, recorded monthly for the past 12 months. Safety incidence information included falls, pressure ulcers, catheter-associated urinary tract infections (CaUTIs), deteriorating patient, venous thromboembolism (VTE), hand hygiene and infections.
- The information held on the 'signal system' was used to populate the ward governance and assurance chart, which was on display for staff to review.
- We saw that the safety information displayed on the chart did not reflect the up-to-date monthly performance from the 'signal system'. This was confirmed by both the deputy sister and matron at the time of our visit.
- Over the previous year, the medical directorate had maintained a consistently low rate for pressure ulcers, except for one peak in May 2014. Falls and catheter-associated urinary tract infections remained low throughout the year.
- Information regarding the results of the Safety Thermometer was routinely displayed on all of the wards.

**Cleanliness, infection control and hygiene**

- Environment cleaning schedules were publicly displayed, and we saw up signed and up-to-date cleaning records.
- Two white boards situated opposite the kitchen area listed the nursing staffs daily and weekly cleaning of equipment, such as lifting hoists, trolleys, patient transfer (PAT) slides, seated weigh scales, infusion pumps, drip stands and gel dispensers. The daily cleaning checklists were initialled as completed, and up to date. The majority of the weekly equipment checklists beginning 9 and 16 March 2015 were not initialled as completed. Therefore, we were unable to determine whether these weekly equipment cleaning checks had been carried out.
- The overall ward environment and equipment were visibly clean, with the exception of one toilet area where staining was noticed. The main ward corridors and patient areas were uncluttered. We saw that cleaning checklists for the dirty utility area were up to date. Equipment such as portable commode chairs were labelled with cleaned stickers, and mops and buckets were stored correctly.
- We saw a range of infection prevention and control information displayed, which indicated 1,006 days since the last case of MRSA, and 96 days since the last case of C. difficile on the ward.
- We saw one patient had an extended-spectrum beta-lactamase (ESBL) infection, and that there were

appropriate precautions in place, including isolation in a single room with en suite toilet and washing facilities. There was personal protective equipment (PPE) and appropriate signage outside of the door.
- On one occasion we observed a healthcare assistant (HCA) assist a patient, who needed to be isolated due to infection, to the toilet, without using PPE. The HCA did wash their hands appropriately following patient contact.
- PPE was available throughout the ward, and on most occasions we saw staff washing their hands and using PPE appropriately during the delivery of care and treatment. Hand-washing techniques were clearly displayed.
- The Saving Lives audit from October 2014 showed 100% compliance.

**Environment and equipment**

- The environment in the ward areas appeared clean, tidy and well maintained. Cleaning schedules were in place.
- Staff said that equipment was available to meet patient needs.
- We looked at equipment and refrigeration, and found that they were appropriately checked, cleaned and maintained. All electrical equipment had been portable appliance tested (PAT) within the last 12 months, and all equipment was cleaned regularly and labelled as such.
- Resuscitation equipment, along with oxygen and suction, was available. Resuscitation defibrillators were checked daily, and seals were intact on equipment drawers. The daily and weekly checks from 1 to 4 March 2015 were not recorded. The remainder of the checks from 4 March 2015 were completed.
- The wards had their own blood gas analyser, which made diagnosis easier and provided vital information for deteriorating patients.
- Clinical rooms and storage rooms were all clean, tidy and well labelled.

**Medicines**

- Bridlington Hospital did not have access to an on-site pharmacy. Medicines were ordered and supplied from Scarborough Hospital. Ward top-up medicines were ordered weekly.
- Patients were transferred from the other hospitals to Bridlington with a seven day supply of medicines. However, when a drug dose was changed, this potentially led to omitted doses, due to the ordering and supply chain from Scarborough Hospital.
- Omissions of critical medicines were monitored monthly, but the results were not regularly shared with ward staff to identify areas for improvement. Johnson Ward was reporting a high number of omissions compared to the trust average; the reasons for this had not been investigated.
- On the wards we found that medicines were stored, prescribed and administered safely.
- Nursing staff told us that they had ready access to pharmaceutical advice, but a pharmacist did not visit each ward on a frequent basis. The chief pharmacist confirmed this, and told us that clinical pharmacy staff prioritised wards where management of medicines was perceived to be a greater risk.
- Ward staff received medicine refresher training and the training record on Waters Ward indicated that 16 out of 17 staff were up to date with this training.
- We reviewed a sample of medication administration records, and we saw that most of the medication had been administered as prescribed, and medicines had been administered at appropriate times. Three patients were receiving oxygen; however, for two patients, a prescription had not been written to authorise this, and for the other patient, the flow rate in use was different to that written on the prescription.
- Medicines were stored securely, and pharmacy staff audited medicines security and the management of controlled drugs on a regular basis.
- Fridge temperatures were monitored daily and recorded appropriately.

**Records**

- Patients' records were a combination of both electronic and paper records. We looked at the electronic records and saw that all the patients on the ward were listed on the system.
- A range of risk assessments were included within the electronic records, such as falls, manual handling, Waterlow scores, nutrition and BMI, bed rails, early warning scores, and neurological observations to manage the deteriorating patient.

- We saw how patients assessed at risk of falls were identified, and that these patients were provided with non-slip red socks, which highlighted to the staff to pay particular attention when observing and assisting them to mobilise.
- We looked at three patient electronic records, and saw risks were assessed and up to date in relation to the individuals care and treatment needs. We saw within the records referrals to other specialists, such as the dieticians, physiotherapists, and speech and language therapists.
- We saw that one patient had a pressure ulcer to her heel, and there were some inconsistencies in documentation. Wound care assessments and records were completed; however, the 'activities of daily living' sheet indicated that all pressure areas were intact. It was also documented that the patient did not have a pressure-relieving mattress. Following a discussion, it became apparent that the patient had refused the use of the air flow mattress, but the patient's refusal had not been documented.
- Staff on the Lawrence Unit told us that it was extremely rare for records to be unavailable, and if this did occur, it would be likely that there was enough information in electronic records to safely see and treat a patient.

**Safeguarding**

- Staff we spoke with were aware of their roles and responsibilities in safeguarding adults, and they were able to explain safeguarding referral processes.
- There was a safeguarding e-learning programme available.
- We saw a range of safeguarding information displayed on notice boards for staff reference.
- Aggregated Scarborough and Bridlington data for the elderly medical care wards showed 61% compliance with adult safeguarding training for nursing staff, and 29% compliance for medical staff, against a target of 75%. Children's safeguarding training compliance was at 61% for nursing staff, and 21% for medical staff, against a target of 75%.
- No data specific to the Bridlington wards was provided.

**Mandatory training**

- Staff we spoke with on the wards and the Lawrence Unit told us that they were up to date with mandatory training, and that this is relatively easy to access through a mixture of e-learning and face-to-face training. Some staff were undertaking 'train the trainer' courses, so that training could be delivered locally for Bridlington staff.
- There was no site-specific data available for the Bridlington site. At the time of the inspection the trust target for compliance was 75% for all categories. Compliance rates with mandatory training for Scarborough and Bridlington elderly medical directorate varied. From the data provided no medical staff had achieved the 75% for any of the categories. The nearest to the target was basic life support training at 65%. Other training ranged from dementia awareness 15%, infection prevention and control 42% and person with a learning disability awareness at 25%. For nursing staff there were only four of 18 areas of mandatory training that were above 75%. Areas below included: Moving & Handling Training (practical) 14%; Person with a learning disability awareness 23% and infection prevention and control 64%.

**Assessing and responding to patient risk**

- Both wards used the National Early Warning Score (NEWS) system to identify patients' whose condition was deteriorating. Patient observations were recorded appropriately, and concerns were escalated in accordance with the guidance.
- Basic observations, such as blood pressure, pulse and respirations were recorded electronically, and these were up to date. We saw that there were standard operating procedures and escalation procedures displayed for managing the deteriorating patient. The staff we spoke with were able to explain the procedures for managing the deteriorating patient.
- We looked at the safety information for the deteriorating patient retained on the electronic 'signal system', and we saw that safety information on this aspect had not been recorded since July 2014. This was raised with the senior staff, who told us that they had not been requested to provide this information.
- The unit had its own blood gas analyser, making it easier to diagnose a deteriorating patient.
- Where necessary, acutely unwell patients were transferred by emergency ambulance to Scarborough Hospital if their condition warranted it. Staff experience of this was that the system worked well, and no delays had been experienced.

# Medical care (including older people's care)

- Risks associated with falls, pressure ulcers, VTE, and CaUTIs were assessed on a monthly basis using the NHS Safety Thermometer assessment tool.
- Multidisciplinary team (MDT) meetings occurred daily to discuss patient progress, goals, and any patient safety issues.

**Nursing staffing**

- When we looked at staffing rotas on Johnson Ward we could see it achieved a ratio of 1:8 qualified nurses to patients, Monday to Friday on a morning shift, with 1:12 on an evening shift and during the night. It was noted from the off duties we viewed for the period from 20 October 2014 to 22 February 2015 that there were less qualified nurses on duty at the weekend, and a 1:8 ratio was only achieved on two weekend shifts during this time.
- Planned and actual staffing levels observed included the ward manager in the rota, unless she was having protected management time.
- Staff were unable to tell us if their establishments were based on the use of an acuity tool. Board papers indicated that the staffing establishment was set on the number of beds on each ward.
- In January 2015, Johnson Ward had an average fill rate of 86.7% for registered nurses on day shifts, and 80.3% for support staff. During the night, the fill rates were 83.4% for RNs and 100.8% for support staff. Waters Ward had an average fill rate of 86.4% for registered nurses on day shifts, and 111.8% for support staff. During the night, the fill rates were 98.4% for RNs and 114.3% for support staff. Waters ward showed an over 100% fill rate for care staff which was due to the enhanced supervision requirement of some patients. The ward manager on Johnson Ward stated that there were 1.7 whole time equivalent (WTE) registered nurse (RN) vacancies and 2.3 WTE health care assistant vacancies. Staff told us that shifts were filled with bank staff, and that the hospital had its own staff bank to draw upon. There were no vacancies on Waters Ward.
- The ward manager reported that vacancies were difficult to recruit to, but that the trust had a rolling advert for nurses. Additionally, the ward manager could request bespoke adverts to aid recruitment to her ward.
- It was reported that a number of substantive staff were registered on the bank, and worked additional shifts on the unit or elsewhere in the trust.
- Staff commented that although nursing gaps were filled with bank shifts, this did not apply to therapy staff, who were not covered when on leave or off sick. The ward-based staff took on additional duties or workload to fulfil some aspects of rehabilitation.
- Nursing staff on the wards told us that they felt they could not always deliver the standard of care or amount of rehabilitation they would like to, due to insufficient numbers. There were processes in place to escalate staffing concerns should they arise.
- Within the Lawrence Unit staffing levels were based upon a number of factors, including the number of patients expected to attend, and the number, type and complexity of treatments planned; however, there was no specific acuity tool used. Staff we spoke with said that there were enough staff available to meet patient needs.

**Medical staffing**

- There was a senior house officer based on each of the medical wards from 8am to 8pm, seven days a week. Night cover was provided by an advanced operating practitioner (AOP) (band 7 nurse), trained to deliver advanced life support (ALS). Medical and nursing staff felt the night time cover was appropriate for the acuity level of the patients.
- There was a registered medical officer on-site, who would attend emergency calls during the night, and, where necessary, acutely unwell patients were transferred by emergency ambulance to Scarborough Hospital.
- The stroke consultant and elderly medicine consultants visited the wards twice a week, and attended a weekly multidisciplinary team meeting.
- The SHOs were readily able to contact a registrar when a patient deteriorated, or if they needed advice or support.
- Ambulatory care was in the main, a nurse-led service, with treatments provided under consultant direction or according to strict protocols or pathways. Senior medical staff were accessible to nursing staff when the need arose.

**Major incident awareness and training**

- The trust had a major incident plan, which provided guidance on the actions to be taken.

# Medical care (including older people's care)

There was a business continuity plan for the trust, and site-specific plans were also available.

## Are medical care services effective?

Good

Medical care services at Bridlington Hospital were rated as good in terms of delivering effective care. Policies and pathways were based on NICE and Royal College of Physicians guidelines, and were available to staff, and accessible on the trust's intranet site. National and local audits were contributed to. During 2013/14, the York Teaching Hospital NHS Foundation Trust participated in national clinical audits and national confidential enquiries, as well as undertaking a programme of local clinical and quality audits.

Overall, re-admission rates were better than the England average. We witnessed strong multidisciplinary team working during our inspection, and this was corroborated by feedback from all disciplines spoken with.

### Evidence-based care and treatment

- Policies and pathways were based on NICE and Royal College of Physicians guidelines, and were available to staff, and accessible on the trust's intranet site.
- The Lawrence Unit had care plans and pathways for a number of presenting conditions, which included DVT, cellulitis and PE, as well as a number of care plans for regular planned treatments.
- Not all pathways and documentation had been harmonised following the merger of the Scarborough and York trusts, and there was some uncertainty on occasions, regarding the correct paperwork or protocol to use.
- Ward managers had an audit day every month (QUEST), to monitor compliance with guidance and quality indicators.
- Wards had information files for all staff to read, which included compliance against a number of key quality indicators for staffing, sickness, appraisals, capacity, the Friends and Family Test (FFT), and multidisciplinary team (MDT) effectiveness.

### Pain relief

- Pain relief was managed outside of the electronic patient record, and these assessments and records were held at the bedside.
- We saw that a 0 – 10 pain assessment score was available on the trust's electronic system. There was not an alternative pain assessment tool in use that prompted staff to make a full assessment of a patient's pain incorporating the assessment of body language or facial expressions when patients were unable to score their pain. We also did not see clearly documented evaluations of pain in relation to the effectiveness of medication given.
- One patient reported that pain medications were not always offered at the same time every day, and that the medicine rounds were unpredictable. It was also reported that 'as required' analgesia was not routinely offered before physiotherapy sessions, and this resulted in excessive pain.
- Other patients commented that they rarely had problems getting analgesia on time, and that they could ask for painkillers when they needed to.
- Regular comfort rounds were carried out and included asking patients regularly about their level of comfort.

### Nutrition and hydration

- A nutritional screening and assessment tool were incorporated into the patient admission record to assess patients on admission.
- Nutrition and hydration risks were assessed and monitored via the electronic records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside.
- We looked at patient menus, and saw a range of food choices were available to the patient. The menus also highlighted choices such as healthy, gluten free, diabetic and soft consistency options.
- Four hourly comfort rounds included offering the patient oral fluids and nutrition as appropriate.
- Staff told us that the ward did not always receive enough food or the right mix of food for all of the patients. Toast, cereal and biscuits were kept on the ward for patients who needed something between mealtimes.
- Patients told us that the food was of a good quality.
- The wards had protected mealtimes for patients.

### Patient outcomes

# Medical care (including older people's care)

- During 2013/14 the York Teaching Hospital NHS Foundation Trust participated in national clinical audits and national confidential enquiries, as well as undertaking a programme of local clinical and quality audits.
- Patients receiving medical care at Bridlington Hospital may have received part of their treatment or care relevant to part of the following national audits. As the majority of care would be likely to occur at Scarborough Hospital, the audits are reported against Scarborough.
  - Although Bridlington does not take acute stroke patients, it does provide rehabilitation to stroke patients following the acute phase. In the Sentinel Stroke National Audit Programme (SSNAP) 2014, Scarborough had improved its rating since October 2013, but had remained at a D rating since January 2014. The scale used is A – E, with E being the worst. The stroke pathway across the trust was being reviewed to facilitate improvements to effectiveness and patient safety.
  - Results from the National Diabetes Inpatient Audit (NaDIA) in September 2013, indicated that Scarborough was performing worse than the national average in 14 of the 19 measures of the Audit. Of the indicators that performed below the national average, these predominantly related to staff knowledge, visit by specialist diabetes team, medication errors, meals and foot risk assessment. No data was available for whether or not patients were involved in their treatment plans.
- Consultant mortality reviews were undertaken on every death, and there was a monthly summary discussion of all cases.
- Length of stay at Bridlington Hospital was much longer than the England average for non-elective admissions in geriatric medicine, respiratory medicine and general medicine. Average length of stay overall was 25 days, compared to the England average of seven days (HES 2013/14). This was to be expected, as the hospital only admitted patients for rehabilitation, and did not take shorter stay acute patients.
- Emergency re-admissions to Bridlington Hospital within 28 days of discharge from medical wards was better than the England average for all of the top three categories of elective admissions. The re-admission rate for non-elective admissions in geriatric medicine was equal to the England average, and worse than the England average for cardiology. Overall, non-elective re-admission rates were better than the England average.

**Competent staff**

- Annual appraisal rates for the Bridlington medical wards in the period from July to November 2014 were 82.61% for nursing staff, 80.77% for additional clinical services, and 50% for estates and ancillary staff.
- In addition to mandatory training, training was facilitated by a number of staff groups and specialist nurses, such as the AOP, who provided intermediate life support training, and the palliative care team, who provided training regarding end of life care.
- Training records could be accessed by the ward manager online, and the IT hub within the training and development department alerted managers when training updates were needed.
- Medical staff rotated on-calls between the Scarborough and Bridlington hospitals to ensure adequate acute experience was gained.
- Medical staff reported that training days were infrequent, but it was always possible to attend when they took place.
- Senior house officers (SHOs) reported that they could call the specialist registrar (SpR) for help and advice when needed, and they had regular, planned, twice weekly contact with consultants at the ward rounds / multidisciplinary team (MDT) meetings.
- Induction and preceptorship processes were in place for new staff.

**Multidisciplinary working**

- We saw how occupational therapists and physiotherapists were part of the ward multidisciplinary rehabilitation team. A dedicated exercise / activity area was available for patients to use as part of their rehabilitation care and treatment.
- Multidisciplinary team (MDT) meetings were held daily, including weekends. These meetings were attended by ward nursing and therapy staff, medical staff, social care staff and the site co-ordinator, whenever possible.
- Nursing staff from the Lawrence Unit reported good working relationships with GPs, A&E, community nursing

teams, consultants and social care, and described how many of their regular patients were supported by multiagency teams in order to manage their long-term conditions.

**Seven-day services**

- The rehabilitation wards were supported by a dedicated physiotherapist and occupational therapist, working Monday to Friday.
- The Lawrence Unit was open Monday to Friday, 8.30am to 4.30pm, for urgent and planned treatments.
- Medical cover was from 8am to 8pm, and nights were covered by an advanced operating practitioner (AOP) (band 7 nurse) trained to deliver advanced life support (ALS).
- Emergency medical cover was provided out of hours by a resident medical officer (RMO), who carried the emergency bleep, and patients were transferred to Scarborough Hospital if their condition warranted.

**Access to information**

- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information, such as x-rays, medical records and physiotherapy records, appropriately, through electronic and paper records.
- Patient records were almost always available for clinic and ambulatory care attendances.
- Not all pathways and documentation had been harmonised following the merger of the Scarborough and York trusts, and there was some uncertainty on occasions, regarding the correct paperwork to use.
- Specialist nurses, such as the palliative care team and medical staff, were available and easy to access when nurses needed specialist advice or support.

**Consent, Mental Capacity Act and deprivation of liberty safeguards**

- Staff demonstrated a good understanding of consent, mental capacity and best interest decisions, and accessed training through an e-learning platform.
- Staff had readily accessible guidance and information, and knew who to contact for advice and support if needed.

## Are medical care services caring?

Good

We rated the medical services good for caring. Throughout our inspection we witnessed good care being given. Interactions between staff and patients appeared natural and easy-going - communication was respectful, but friendly. Patients were happy with the care they received, and found the service to be caring and compassionate. Most patients and relatives spoke very highly of staff, and told us that they, or their relatives, had been treated with dignity and respect.

The Friends and Family Test (FFT) information for February 2015 showed a much higher response rate than both the trust and the England averages, and a lower percentage of patients who would recommend the services.

The trust performed in the top 20% of all trusts taking part in the cancer patient experience survey 2013/14 for 18 of the questions, and around the same as other trusts for the remaining 16. The trust performed around the same as other trusts in relevant questions in the national inpatient survey 2014.

**Compassionate care**

- Throughout our visit we saw staff speaking to patients in a caring and kind manner. We saw curtains being drawn around beds, and side room doors closed to support the patient's dignity and maintain privacy.
- We saw that regular comfort rounds were in place, and records indicated that these were adhered to in a timely manner.
- We saw that staff on the ward actively encouraged patients to leave feedback on their experience, and that Friends and Family Test feedback for February indicated that 91% of patients leaving Johnson Ward and 71% of those leaving Waters Ward would recommend the service. This was against a national average of 95%. Response rates for the survey were 79% and 77%, which were much better than the England average of 40%.
- We spoke with 11 patients and relatives throughout the inspection. Most patients and relatives told us that they or their relatives had been treated with compassion, and that staff were polite and respectful.

# Medical care (including older people's care)

- One patient told us that he had been told off for ringing his call bell when he had thought another patient was going to fall, and of another occasion, when he had to call for help for another patient who was exposed and soiled for an extended period of time.
- Other patients told us that staff were excellent, friendly, and warm, and that the ward was calm.
- The trust performed around the same as other trusts in relevant questions in the national inpatient survey for 2014.

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

- We spoke with one patient and their relative whilst they were waiting in the ward day room for admission following transfer to the ward from the outpatients clinic. They told us that the staff in clinic had been excellent, and had provided sufficient and timely information for them to make care and treatment decisions. Whilst waiting for admission to the ward, the ward staff had introduced themselves, and had kept them fully informed, and provided refreshments.
- We saw that the ward staff actively encouraged patient and family feedback, and results and actions from surveys, such as the Friends and Family Test, were displayed for patients and visitors to see.
- Posters were visible advising patients and relatives what to do if they had any concerns or complaints.
- Most patients we spoke with told us that they felt involved in their care as much as they wanted to be. Patients commented that they did not know the specifics of their treatment aims, but that they did not need to.
- One patient told us that he was unsure as to why he was on the ward, and did not know who his doctor was, or when he would be discharged. Other patients mentioned not knowing who their named doctor was, but stated that they could speak to a doctor if they wanted to.
- We observed staff discussing care issues with patients and relatives, and these were generally clearly documented in patient's notes.

**Emotional support**

- We saw staff providing emotional assistance to patients when appropriate.
- There was a multi-faith chapel available that held information relevant to people from different faiths and religions. The chaplaincy services within the trust provided support for patients and their relatives, irrespective of their individual faith, or if they did not follow a faith. There was also a prayer room available.
- Staff had received training from the palliative care team regarding communication skills, and care and treatment issues at the end of life. This training included supporting patients and family members who were distressed.
- There was a range of material around the hospital offering information, advice and signposting to people with mental health problems.

## Are medical care services responsive?

Good

Medical care provided at Bridlington Hospital was responsive to patients' needs. Staff worked to meet the needs of individual patients. The elderly care wards had developed practices and the environment to meet the needs of patients living with dementia. However, patient information was not readily available in languages other than English.

The ward staff had established relationships with primary care and community services, and work was ongoing to improve integration to help maintain people with long-term conditions at home.

Ambulatory care services were available, and were being further developed to alleviate patient flow pressures, by working closely with Scarborough Acute Medical Unit and A&E staff, to proactively initiate the transfer of appropriate local patients into their area for treatment.

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

- The major challenge for the trust was to provide medical care services for an increasing elderly population, which was expected to increase significantly over the next five years. There was also expected to be a significant service requirement for the management of dementia and other long-term conditions.

# Medical care (including older people's care)

- The trust had identified that re-configuration, particularly of the acute medical beds, was required to meet patient needs. The re-configuration was in progress, and some changes had already been implemented.
- Work was also ongoing to improve integration with community services, to help maintain people with long-term conditions at home.
- Ambulatory care services were being further developed to alleviate patient flow pressures by working closely with the AMU and A&E staff, to proactively initiate the transfer of appropriate local patients into their area for treatment.

**Access and flow**

- The service at Bridlington consisted of 48 rehabilitation beds split between two wards. The service accepted referrals from the Scarborough and York hospitals, but in the main, patients were referred for rehabilitation from the Scarborough site.
- Access to a bed was managed through the site co-ordinator or matron, who identified when beds became available.
- Referrals were sanctioned by a consultant physician, who assessed that the patient as medically suitable for transfer. A member of the medical team at the referring hospital telephoned the receiving doctor at Bridlington and gave a verbal handover, and an inter-hospital handover form was completed and sent with the patient on transfer.
- There was a shuttle bus from both Scarborough and York to Bridlington Hospital to facilitate access for both patients and visitors.
- Patient transport services were used for transfers.
- Discharge planning commenced on admission to the ward, to facilitate social care packages being in place at the same time as the patient was medically fit for discharge.
- Length of stay at Bridlington was much longer than the England average for non-elective admissions in geriatric medicine, respiratory medicine and general medicine. Average length of stay overall was 25 days, compared to the England average of seven days (HES 2013/14). This was to be expected, as the hospital only admitted patients for rehabilitation, and did not take the shorter stay acute patients.
- Senior staff told us that delays in discharge were frequent as they mainly related to arrangements in relation to social care packages. These delays had an effect upon access and flow.
- Trust-wide data indicated that the major reasons for delays in transfer of care were awaiting a care package in own home (37%); and waiting for nursing home placement or availability (22%).
- The ward manager told us that multidisciplinary meetings occurred at weekends, but that there were few weekend discharges largely due to accessibility of social services.
- There was an arrangement in place with a local nursing home, who would take patients who required an extended period of rehabilitation. For example, non-weight bearing patients could be transferred to a nursing home bed until they were able to weight bear. Patients would then be transferred back to Bridlington for proactive rehabilitation with an expected date of discharge.
- Access to the ambulatory care service was mainly via professional referral (GP, district nurse, allied healthcare professional) to a consultant. Some patients, if they lived locally to Bridlington Hospital, were referred from Scarborough A&E for diagnostic testing and initiation of treatment, such as those with cellulitis, DVT or PE.
- There were systems and processes in place for patients who became acutely unwell at Bridlington. Cases were escalated to the on-call specialist registrar (SpR), and transferred directly to Scarborough AMU. The medical staff had experience of such situations and reported that they had gone smoothly, with no delays experienced. If there was no bed available in AMU, then a patient would go to A&E.
- The wards at Bridlington did not board out patients, and bed moves were extremely rare.

**Meeting people's individual needs**

- We saw a wide range of information publicly displayed, to provide patients and families with information relating to home from hospital services and discharge planning.
- Information for people with mental health problems was also widely available.
- Relatives told us that parking was often difficult, and they had to park off site, and that visiting times (2.30-4pm and 6.30-8pm) were not long enough, especially if they had to travel a long way.

# Medical care (including older people's care)

- The ward sister on Johnson Ward told us that she was flexible regarding visiting hours when people approached her with any difficulties or concerns. We were also told that the gap between 4pm and 6.30pm was to offer patients protected mealtimes. However, the principle of protected mealtimes is to protect patients from medical and nursing interventions, not necessarily from visitors who may actively encourage or assist their relatives with meals.
- Patients we spoke with told us that their care was individualised, and we observed discussions around care and treatment, and documentation that demonstrated this.
- Staff had access to information about different cultural, religious and spiritual needs and beliefs, and interpreting services were available for patients who did not speak English, or who had other communication difficulties.
- Staff told us that they liked working at Bridlington, and felt that there was a good team, who tried very hard to provide the best care possible.

**Learning from complaints and concerns**

- The trust had a Patient Advice and Liaison Service (PALS), which was available to all patients. Patient Advice and Liaison Service information, on how people can raise concerns and/or complain, was publicly displayed and available.
- Responses to formal complaints received by the medical directorate were shared with ward staff by the matron, and action plans were developed and implemented with ward staff, where appropriate.
- Safety briefings were carried out each day, and we were told that these included learning and action points from complaints and incidents.

No formal complaints had been received against the medical wards at Bridlington during 2014.

## Are medical care services well-led?

Requires improvement

We rated medical services at Bridlington as requires improvement for being well-led because; staff felt they were removed from the wider trust, and that a number of consecutive changes to the management structure and post holders had impacted on relationships with operational managers. There was a lack of clarity regarding roles and responsibilities of matrons and middle managers, and how they all fitted together with regard to day-to-day running and oversight of the service. There was no system in place for ensuring there was always a matron present at the hospital to provide senior nursing support to the wards. At the time of the inspection, it was apparent that changes were recent, and some matrons and managers were relatively new in post.

Senior managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service. There were a number of business plans with the trust board for strategic development of services. Long-term strategies were in place for the medical and elderly medical departments. However, staff told us they were not engaged in the development of services outside of their immediate work area.

There were examples of innovation and improvement in public engagement and community involvement.

**Vision and strategy for this service**

- Medical care service staff were aware of the trust vision, but were unclear about what was intended for services provided at Bridlington Hospital, and how they fitted in with the bigger picture.
- Ward staff had a clear vision for their own service, which was to promote patients independence, and to give the best possible care they could with the resources available.
- Senior staff for ambulatory care were aware of plans to develop ambulatory care at Bridlington and across the Scarborough and York sites, to alleviate pressures on A&E. They were also aware that consideration was being given to whether urgent and planned treatments should be separated in some way but had not been involved in any discussions with senior managers regarding this.
- There was a five year strategy in place for the directorate of elderly medicine.

**Governance, risk management and quality measurement**

- Risk registers were in place for the medical and elderly medical directorates.
- There was an approval process in place for submission of risks onto the directorate risk register.

- Staff we spoke with knew that staffing was on the risk register and actions were being taken regarding recruitment.
- On the wards complaints and risk/ safety alerts were discussed with incidents at morning safety briefings.
- They had the morning safety briefing most days and weekly MDT meetings.
- Team meetings were planned but staff commented that they were a bit ad hoc.
- The ward managers undertook monthly audits against a number of quality and performance indicators.

**Leadership of service**

- We saw evidence of good local leadership at ward level, but due to the hub and spoke management model of York trust, some staff felt segregated from the rest of the trust. Staff were not always aware or involved with initiatives on other sites. For example, staff we spoke with were not aware of 'Operation Fresh Start', an initiative to improve patient flow at the York and Scarborough hospitals.
- Some staff did not feel that the executive team were visible at Bridlington, but others were aware that the chief executive held surgeries on-site for staff to drop in to.
- It was reported that there had been a number of changes at matron level, and it had been difficult to build rapport because of this. Staff told us they felt "like we have had had to get on with it".
- The site was covered by six matrons for various services, including surgery and general medicine. The matrons covered all three sites at the trust, which meant that a number of matrons visited this site on an ad hoc basis, but no one was based there.
- Although matrons were accessible by telephone if not on-site, staff expressed the view that they would like a more structured approach to when matrons were visiting the hospital to improve access to senior nursing support. At the time of our visit there was no regular pattern or rota for matrons covering or visiting the site.
- Staff told us that the site had been managed by a hospital manager, and this had worked well for about three months until the post holder left. It was also reported that a second post holder had left after a very short period of time, and that it was difficult for the new hospital manager who was relatively new in post and part-time.
- The matron and ward sisters we spoke to had very little information in relation to the role and remit of the new hospital manager, and how this affected oversight of the medical wards and reporting / escalation arrangements.
- We were told that ambulatory care staff were invited to a full team meeting with staff from the Haworth Unit at Scarborough four times a year, but staff reported that it was difficult to get to these meetings. The sister felt that she could give ideas, and that they would be listened to and given consideration. The percentage of staff able to contribute towards improvements at work had been a negative finding in the trust staff survey (2013).
- Staff were positive about the appointment to the head of department position, and hoped this would improve the communication and relations with the wider trust.

**Culture within the service**

- The service appeared to have an open and honest culture, and staff were willing to try new ways of working to improve services for patients.
- Staff on the rehabilitation wards stated that they regularly reported incidents and near misses.
- Trust-wide data from the 2013 staff survey reported a negative finding regarding fairness and effectiveness of procedures for reporting errors, near misses and incidents.
- There was a good ethos of multidisciplinary working, and respect and value for multiprofessional skills and knowledge. There were a number of examples of training and support offered across disciplines.

**Public and staff engagement**

- The wards displayed the FFT results on 'You said, we did boards', so that patients and the public could see changes made as a result of their feedback.
- Staff were actively engaged with patients and members of the public in fundraising for equipment for the ward.
- The wards actively worked with young people who volunteered over the Summer break.
- Staff reported that the local community were actively engaged with the hospital, and there were often activities going on at the Bridlington site, with support in the local press.
- Although the trust had undertaken a programme of engagement activities with staff regarding the integration with York Teaching Hospitals Foundation Trust and development of services at Bridlington, some

staff reported that they felt removed from the wider trust and they were not sure what the long-term plans were for Bridlington Hospital and the services it provided.
- Staff hoped that the appointment of a new manager would improve engagement.

**Innovation, improvement and sustainability**

There were a number of examples of innovation, improvement and sustainability:

- The elderly medical strategy and work towards development of community schemes, including hubs and care home in-reach schemes. An example of this was already in place, and involved working with a nursing home that provided interim placements for patients who were not ready for active rehabilitation. For example, patients who were non-weight bearing for a period of time: they could be transferred to a less clinical environment in the nursing home until they were able to weight bear. Patients would then be transferred back to Bridlington Hospital for proactive rehabilitation with a planned expected date of discharge.
- Planned development of shared care, particularly with surgical specialties.
- Active work with patients and the public to fundraise, and a proactive approach to volunteering opportunities for young people.

# Surgery

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

## Information about the service

Surgical services at Bridlington Hospital included general surgery and orthopaedic surgery. There were 38 surgical inpatient beds across two wards. There were three theatres. We visited Lloyd and Kent wards and the operating theatres.

We spoke with 10 patients and eight members of staff, including matrons, ward managers, nursing staff (qualified and unqualified) and medical staff. We observed care and treatment and looked at care records for two patients. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

## Summary of findings

Staffing establishments and skill mix were reviewed regularly. However, optimum staffing levels and skill mix across surgical services was not being sustained at all times of the day and night. The resident medical officer (RMO) RMO was required, in an emergency, to accompany patients to Scarborough Hospital, which meant that there was no doctor on site during this time. Staff were not always able to complete mandatory training such as safeguarding due to workload pressures.

The service provided effective and evidence-based care and treatment. The 'five steps to safer surgery' procedures included in the World Health Organisation (WHO) surgical safety checklist were not always completed fully. Staff were seen to be caring and compassionate while delivering care. Services were responsive to patients' individual needs.

Senior leaders understood their roles and responsibilities to oversee the standards of service provision in surgical areas. However, work was continuing to integrate surgical services and deliver common standards of care across the three hospital sites. Although directorate-level governance arrangements were in place, the frameworks were not fully embedded throughout the organisation. Standardised protocols, guidelines and pathways of care across the three sites were variable and not yet fully established.

# Surgery

## Are surgery services safe?

Requires improvement

Staffing establishments and skill mix were reviewed regularly. However, optimum staffing levels and skill mix across surgical services were not being sustained at all times of the day and night. Pressures on the wards at Scarborough Hospital impacted on staff at Bridlington, who were moved regularly to cover wards that were outside their clinical expertise. Data for August 2014 to March 2015 showed that staff had been moved 157 times to ensure that wards at Scarborough had sufficient staffing levels.

An RMO was available on site 24 hours a day, seven days a week. However, in an emergency the RMO was required to accompany patients to Scarborough Hospital, which meant that there was no doctor on site during this time. Mandatory training required improvement: 57% of trust staff in surgery and theatres had completed level one and two training in safeguarding adults and children against a trust target of 75%. Overall completion of statutory and mandatory training for surgery and theatres at Bridlington was 62% and 67% for orthopaedics.

The 'five steps to safer surgery' procedures (included in the WHO surgical safety checklist) were not always completed; this was particularly the case with the debrief section. Effective handovers took place between shifts and included daily safety briefings to ensure continuity and safety of care.

There were effective arrangements in place to minimise risks of infection to patients and staff. Medicines were managed appropriately; however, where omissions were identified, the results were not always shared with ward staff to identify areas for improvement. Staff were encouraged to report incidents and most received feedback on what had happened as a result.

There were processes in place for staff to recognise and respond to changing risks for patients. These included processes for responding to the warning signs of rapid deterioration of a patient's health.

### Incidents

- Staff were aware of the process for reporting incidents and were confident in their explanations of the reporting mechanisms and categories of incidents to report. Most staff said they received feedback and learning from incidents to improve patient care.
- A monthly safety publication, 'Nevermore', included key learning from serious incidents, complaints and claims. All serious incidents were reviewed and learning discussed at clinical governance meetings, which were held each month.
- There was good awareness among staff about the principles of the Duty of Candour, and the specific requirements of the new regulations that had come into force in November 2014. The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. We saw that the regulations were displayed in ward areas.

### Safety Thermometer

- The trust used the NHS Safety Thermometer. This is a national implementation tool for measuring, monitoring and analysing harm to patients and 'harm-free' care. Monthly data was collected on pressure ulcers, falls, catheter-associated urinary tract infections for people with catheters and venous thromboembolism (VTE or blood clots).
- There had been six urinary tract infections for patients with catheters between April and December 2014.
- Trust data for January 2015 showed 97% compliance with VTE risk assessments on admission against a trust target of 95%.

### Cleanliness, infection control and hygiene

- Ward areas appeared to be clean and we saw that staff regularly washed their hands between patient appointments and interventions. Staff were 'bare below the elbows', in line with trust policy and national guidelines for best practice hygiene.
- There had been no methicillin-resistant Staphylococcus aureus (MRSA) infections within surgery over the last 12 months. There had been no reported cases of Clostridium difficile (C. difficile) at Bridlington Hospital between April 2014 and January 2015.
- Elective patients undergoing orthopaedic surgery were screened at pre-assessment for MRSA and patients with MRSA were isolated in accordance with infection control policies.

# Surgery

- We observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps).
- Ward and equipment cleaning frequency schedules were in place and in accordance with NHS national cleaning standards.
- The unit participated in ongoing surgical site infection audits run by Public Health England. The last published results, which were for April 2013 to March 2014, showed that there were no surgical site infections for the trust relating to total knee replacements.
- There were no surgical wound infections reported for elective orthopaedic surgery between April 2014 and January 2015.
- Infection control and environmental audits were regularly carried out in clinical areas. Overall results were compliant with trust targets in most surgical areas and action plans were in place where improvements were required.

**Environment and equipment**

- Ward-based staff reported having sufficient equipment to enable them to carry out their duties.
- There were effective systems to ensure that resuscitation equipment, including emergency drugs, were readily available in surgical areas, including theatres. Records showed that daily checks had been carried out on this equipment.
- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.
- Staff told us that if a piece of equipment failed in theatres, it was sent to Scarborough for servicing, and this sometimes caused delays to operating lists. Data for September 2014 to February 2015 showed that eight operations had been cancelled because of equipment issues.
- Theatre trays were sent to Scarborough Hospital for decontamination. Staff told us that deliveries could sometimes be delayed due to adverse weather, but that otherwise the system worked well. Issues relating to sterile equipment was logged and discussed with the team leader at Scarborough Hospital each month and appropriate action was taken.
- The estates department was centralised at York Hospital. Staff told us that the process for requesting maintenance was slow and it took a considerable length of time for requests to be actioned.

**Medicines**

- New patients had medicines written up immediately. All medicines were signed for and patient allergies recorded**.**
- Staff carried out daily stock checks of controlled drugs. After administration, the stock balance of an individual preparation was confirmed as correct and the balance recorded.
- The wards used patient group directions (PGDs). This allowed some registered health professionals to supply and/or administer a specified medicine(s) to a predefined group of patients, without having to see a doctor. The PGDs and a list of authorised staff to supply medicines were up to date.
- There was no regular pharmacy presence on the wards. Staff told us this did not pose a problem.
- Omissions of critical medicines were monitored monthly but the results were not always shared with ward staff to identify areas for improvement.
- Medicines were stored securely and pharmacy staff audited the security of medicines and the management of controlled drugs on a regular basis. However, medicine fridges on wards were not monitored fully in line with trust policy.
- The wards kept supplies of commonly used pre-labelled medicines to facilitate faster discharge of patients and a full audit trail was maintained to account for all medicines supplied. However, nursing staff told us that patient discharges were sometimes delayed because medicines were not available and had to be ordered and delivered from Scarborough Hospital.

**Records**

- Care pathways were used for patients undergoing elective surgery. The pathway incorporated the patient journey from pre-assessment to admission, surgery, recovery and discharge. Records we looked at were completed accurately.
- There was access to electronic patient records on the wards. These listed the essential patient care requirements, including completion of the early warning tool for adult inpatients and risk assessments for falls, pressure ulcers and malnutrition.
- There was a comprehensive preoperative health screening questionnaire and assessment pathway.

- Dementia screening tools were in place and completed for patients over the age of 65. Records showed that, where a diagnosis of dementia had been made, patients received further investigations.

### Safeguarding

- There were safeguarding policies and guidelines in place for the protection of vulnerable adults and children. The trust had a designated safeguarding lead who provided advice and training for staff and linked into the multi-agency safeguarding networks.
- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and were aware of the hospital safeguarding systems and processes.
- Figures showed that 57% of trust staff in surgery and theatres had completed level one and two training in safeguarding adults and children against a trust target of 75%.

### Mandatory training

- Overall completion of statutory and mandatory training for surgery and theatres at Bridlington was 62% and 67% for orthopaedics. The trust target was 75%.
- Data for all staff in surgery and theatres showed that training had been completed in areas such as infection control (78%), medicines management (72%), health and safety (85%) and manual handling (46%).
- Staff told us that it was difficult to attend training due to workload pressures. The trust had launched a learning hub, which was an innovative approach to the management of statutory and mandatory training. This enabled all staff to understand their training requirements and how they could be delivered, including through face-to-face sessions and e-learning. Management teams could also see which staff had not refreshed their training.

### Assessing and responding to patient risk

- A critical care outreach service was not provided at Bridlington Hospital. However, advice could be sought from critical care outreach and the intensive care unit at Scarborough Hospital.
- The surgical wards used the National Early Warning Score (NEWS) system, a recognised early warning tool for the management of deteriorating patients.
- The geographical distance from the acute site at Scarborough meant that each patient placed at Bridlington had to be carefully risk assessed. Any patient whose perioperative physical status score was higher than two was referred to Scarborough or York for anaesthetic review.
- Protocols were in place for the marking of surgical sites. All checklists were completed before the patient was transferred to theatre.
- We saw guidance for theatre staff on the 'five steps to safer surgery' (part of the WHO surgical safety checklist); these included team brief, sign in, time out, sign out and debrief. Staff told us that there was good compliance with the team brief. However, the debrief section of the checklist was not always completed fully.
- Surgical staff used a sepsis screening tool as part of the assessment under the early warning score. This enabled staff to alert medical staff to patients with clinical indicators of possible infection.

### Nursing staffing

- There were 4.79 whole-time equivalent (WTE) nursing vacancies across surgery and orthopaedic wards.
- Nursing staff raised concerns about staff being regularly moved at short notice to cover staffing shortages on medical and surgical wards in Scarborough. Staff said that they were moved to areas outside their area of clinical expertise. Data for August 2014 to March 2015 showed that staff had been moved 157 times to ensure that wards at Scarborough had sufficient staffing levels.
- Wards and departments had planned and actual staff numbers on display. The wards we visited during our inspection showed that the number of staff meant to be on duty was achieved.
- An acuity and dependency audit had commenced in January 2015 using the Safer Nursing Care Tool; this was ongoing.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed roster. Daily staffing meetings took place to deploy staff to high-risk areas. Where there was low activity, staff were moved to other wards in order to improve staffing levels. There was evidence of skilled surgical nurses having to deal with medical patients.
- During periods of high patient activity, matrons and assistant directors of nursing met twice daily to ensure the safe deployment of staff.
- Work had been undertaken by the trust to reassess staffing levels on wards. The trust was in the process of increasing levels, including by recruiting staff from

abroad. Recruitment was ongoing in most surgical areas and a number of vacancies had been filled or interviews were scheduled during the following months. This was to ensure that staffing establishments reflected the acuity and dependency of patients.

- Staff reported good cross-department working to support patient care. Bank and agency staff were used to fill any deficits in nursing staff numbers. Staff could also work extra hours.
- Theatres were staffed seven days a week from 8am to 6pm, this rota was covered by four staff. Out-of-hours cover was provided by staff from Scarborough. There was one post-anaesthesia care unit nurse who was supported by two operating department practitioners. The team leader told us that interviews had been completed for an additional two band 5 nurses in theatres and there was an advert to appoint one healthcare assistant.
- When a patient became acutely unwell and required escalation to medical staff or critical care outreach, the registered nurse and medical staff communicated using the Situation, Background, Assessment, Recommendation (SBAR) tool.

**Surgical staffing**

- Arrangements were in place to ensure that the surgical directorate had access to and the support of consultant surgeons and anaesthetists during normal working hours. An RMO was available 24 hours a day, seven days a week. However, in an emergency the RMO was required to accompany patients to Scarborough Hospital, which meant that there was no doctor on site during this time. The senior management team told us that a business case was being developed to identify resources required for the implementation of a retrieval team based at Scarborough. However, it was not clear when this would be actioned.
- There was access to the on-site clinical co-ordinator who was trained in advanced life support skills.
- A consultant ward round took place each day. This ensured that all patients were reviewed within 12 hours following admission.
- Medical staff shift lengths were in line with the European Working Time Directive. The General Medical Council National Training Survey 2014 identified no risks with regard to doctor workloads.

**Major incident awareness and training**

- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who could be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency. Staff were familiar with their role in an emergency response.

There was a business continuity management plan (January 2015) in place. This provided a clearly defined framework to ensure the resilience and continuation of the trust's critical activities.

## Are surgery services effective?

Good

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. There was effective communication and collaboration between multidisciplinary teams.

Patients were able to access suitable nutrition, hydration and pain management. Patient surgical outcomes were monitored and reviewed through formal national and local audits.

Staff had the right qualifications, skills and knowledge to do their job. Staff undertook competency-based assessments to show that they met the requirements of their role.

**Evidence-based care and treatment**

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- The directorate took part in all the national clinical audits for which it was eligible. It also had a formal clinical audit programme in which national guidance was audited and local priorities for audit were identified.
- A fractured neck of femur audit showed 100% compliance, which was better than the standards set by the British Geriatrics Society. This audit assessed the level at which the targets for best practice were being met for patients at discharge.

- Patients receiving post-surgical care were nursed in accordance with NICE guideline CG50: 'Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital'.
- Patients followed an enhanced recovery programme for hip replacement surgery. This was an evidenced-based approach that allowed patients to play an active role in their care and helped them to recover more quickly following major surgery and to return to a normal life as soon as possible.

**Pain relief**

- Patients were asked regularly about their pain levels, particularly immediately after surgery, and these were recorded using a pain scoring tool. Care pathway records showed that pain relief for patients undergoing a variety of procedures was documented.
- Patients said that they had their pain assessed by nurses and they had been given pain relief promptly.
- An enhanced recovery pathway was in place for patients admitted for orthopaedic procedures. Patients who underwent surgery followed a pathway developed to ensure that they were provided with defined preoperative, perioperative and postoperative analgesia, which resulted in early patient mobilisation and independence and earlier hospital discharge.

**Nutrition and hydration**

- Fluid input and output records were used appropriately to monitor patients' hydration. We looked at a sample of records on the surgical wards, which were completed to a good standard.
- A nutritional screening tool for inpatients was in place. This was completed within the first 24 hours after admission, repeated weekly, and action taken where required.
- Dietary boards were used on the orthopaedic wards to identify patients who were diabetic or required special diets.
- Staff followed guidance from the Royal College of Anaesthetists regarding preoperative fasting. A postoperative nausea and vomiting protocol was also completed.
- Mealtimes were protected on wards and we observed staff giving positive encouragement and assistance where possible, and with involvement from family and carers where required.
- Patients were satisfied with their meals and said that they had a good choice of food and sufficient drinks throughout the day.

**Patient outcomes**

- There were no current CQC mortality outliers relevant to surgery at Bridlington Hospital. This indicated that there had been no more deaths than expected for patients undergoing surgery at the hospital.
- The relative risk of readmissions was better than the national average for both elective and non-elective procedures.
- The hospital outcomes for the Patient Reported Outcome Measures (PROM) for April 2013 and December 2013 for hips, knees and groin hernia repair showed that the percentage of patients who had improved following each procedure was in line with the percentages reported nationally.
- The average length of stay was shorter than the national average for elective procedures and longer for non-elective procedures in trauma and orthopaedics and upper gastrointestinal surgery.
- Between May 2014 and February 2015, 2,812 elective hip and knee joint replacements were carried out.

**Competent staff**

- Staff had the right qualifications, skills and knowledge to do their job. Nursing staff undertook competency-based assessments to show that they met the requirements of their role.
- Staff had the opportunity in their annual review to discuss their performance and identify learning and development needs. However, 67% of wards at the trust reported that the percentage of staff appraisals completed was below the trust target of 95%. This was due in part to sickness and staffing shortfalls on the wards.

**Multidisciplinary working**

- There was effective multidisciplinary team working on the wards. Daily ward rounds were carried out in which the clinical care of every patient was reviewed by members of the multidisciplinary team, which was led by the consultant managing the patient's care.
- Staff told us that there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

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- Discharge letters were sent to the patient's GP and a copy of the letter provided to the patient.
- There was evidence of multidisciplinary working for patients on the enhanced recovery programme, with input from dietetics, occupational therapy and physiotherapy.

### Seven-day services

- The RMO provided cover 24 hours a day, seven days a week.
- There was one radiographer available during the week from 8am to 6pm, and there was access to an on-call radiographer at weekends.
- Referrals for computerised tomography (CT) scans and magnetic resonance imaging (MRI) could be made 24 hours a day, seven days a week to Scarborough Hospital.

### Access to information

- All local policies and guidelines could be accessed electronically on the trust systems. For example, there were local guidelines for preoperative assessments and these were in line with best practice.

### Consent, Mental Capacity Act and deprivation of liberty safeguards

- The elective surgery care pathway incorporated formal consent forms and supporting information for both staff and the patient. These consent forms were in line with current Department of Health guidance.
- Consent forms identified the procedure to be undertaken and its associated risks. There were documented records of the healthcare professional responsible for consulting the patient, and the forms also included the patient's signature to indicate that they had provided consent to undergo any proposed procedure.
- All patients we spoke with told us that they had been asked for their consent before surgery. They said the risks and benefits had been explained to them and they had received sufficient information about what to expect from their surgery.
- Staff were aware of their responsibilities relating to the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DOLS), although more training and reinforcement was necessary.

## Are surgery services caring?

Good

We observed positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received.

Patients felt that they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.

### Compassionate care

- We observed positive, kind and caring interactions on the wards between staff and patients. Staff introduced themselves appropriately to patients.
- Patients on Kent and Lloyd wards said that the standard of care they had received was very good and all their needs had been met.
- Call bells on the wards were answered promptly and were in reach of patients who needed them.
- Patient-led assessments of the care environment (known as PLACE) for 2014 showed that the trust was better than the England average for cleanliness, privacy, dignity and well-being but slightly below average for food and facilities.
- Hourly comfort rounds (checks to make sure patients were comfortable and had what they needed) took place to ensure that staff were aware of any emerging needs that patients had.
- Bridlington Hospital had a high response rate for the NHS Friends and Family Test and scores between 86 and 100% for recommending the service to others.
- The CQC Adult Inpatient Survey 2013 did not identify any evidence of risk and the trust was rated 'about the same' as other trusts.

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

- Patients said they felt able to talk to ward staff about any concerns they had, either about their care or in general.

- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure that they had adequate support after discharge.
- Patients on the enhanced orthopaedic recovery programme were given a patient data booklet that they completed daily. This provided details of the goals achieved by the patient each day and provided staff with information to further support the patient. Additional information was also available on DVD and the internet and in information leaflets.

**Emotional support**

- There was information within care plans to identify whether patients had emotional or mental health problems. Assessments for anxiety and depression were done at the pre-assessment stage. Nursing staff provided extra emotional support for patients both pre- and post-operatively.

## Are surgery services responsive?

Good

We found that staff were responsive to people's individual needs. Surgery had systems in place to plan and deliver services to meet the needs of local people, including plans to move all orthopaedic elective work to Bridlington Hospital during 2015.

Information about the trust's complaints procedure was available for patients and their relatives.

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

- The directorate was in the process of moving all orthopaedic elective work to Bridlington Hospital during 2015. This would be supported by a programme to develop a service providing outpatients, treatment and rehabilitation, all co-located for ease of access. Once elective orthopaedics was embedded, scoping work would start to see what other specialties would benefit from this acute/elective split. The directorate was also looking at opportunities to work with GPs and neighbouring acute trusts to facilitate maximum utilisation of the facilities and site.
- The trust had an escalation policy and procedure to deal with busy times. This gave guidance to staff on how to proceed when bed availability was an issue.

**Access and flow**

- Patients having a general anaesthetic were pre-assessed at Scarborough Hospital and referred for surgery to Bridlington.
- There were no medical patients being cared for on the surgical or orthopaedic wards.
- Discharge planning began at preoperative assessment stage for elective patients and on admission to the unit for trauma or emergency patients. Staff reported that, where community services were required, these were arranged through referral to social services.
- There was a good electronic discharge process that could be finalised only when all risk assessments had been completed. However, staff told us that some consultants were still using handwritten discharge letters, which meant that 100% compliance in this area was not achieved.

**Meeting people's individual needs**

- Support was available for patients with learning disabilities. A learning disability specialist nurse was available in the trust. Staff told us that the nurse would usually be aware of the patient's admission and would visit the patient to offer support and advice. A 'This is me' form was completed so staff were aware of the patient's likes and dislikes.
- Staff were able to access and refer patients living with dementia to the specialist dementia nurse, who was supported by two mental health liaison nurses. The trust had introduced 'Forget me not' stickers on case notes; these reminded staff that patients with dementia may have memory problems.
- As part of the enhanced recovery programme in orthopaedics, patients were active in the preparation and planning stages before admission, preoperative assessment, recovery and early mobilisation. Patients were better prepared to manage when they were back at home.
- A physiotherapist was based on the elective orthopaedic ward to provide patients with support and advice for early mobilisation.
- Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission, with specialists such as physiotherapy and

occupational therapy identified and arranged while the patient was in hospital. Delays to discharges were said to be mainly related to external factors, such as community-based needs and referrals for a social services assessment.
- A translation telephone service was available for patients who did not speak English as their first language. There were multiple information leaflets available for different conditions and procedures. These could be made available in different languages.

**Learning from complaints and concerns**

- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes for dealing with complaints at ward level and through the trust's patient experience department.
- A 'Your experience matters' booklet was given to patients during their admission. The booklet explained how patients could provide different types of feedback to the trust.
- Complaints about surgery at Bridlington were minimal.
- Complaint officers met regularly with the management team to review current complaints, identify any problems, and offer support and advice.
- Staff from surgery attended the patient experience steering group on a quarterly basis. The key focus of the group was to consider complaints referred to the Health Service Ombudsman, NHS Friends and Family Test feedback, national patient surveys, complaints and Patient Advice and Liaison Service feedback.

## Are surgery services well-led?

Good

Senior leaders understood their roles and responsibilities to oversee the standards of service provision in all surgical areas. However, work was continuing to integrate surgical services and deliver common standards of care across the three hospital sites.

Although directorate-level governance arrangements were in place, the frameworks were not embedded fully throughout the organisation. Standardised protocols, guidelines and pathways of care across the three sites were variable and not yet fully established.

The culture within the service was positive and open. Staff wanted to work more collaboratively with Scarborough and York hospitals and felt this area was improving. There was limited evidence to show how patients and staff contributed to the running of the service.

**Vision and strategy for this service**

- A five-year strategic plan was in place for orthopaedics and the general surgery strategic plan was under development. The plans were aligned with the trust's vision and values. There was evidence that staff had been consulted for their comments on the development of the strategy and any future reviews.
- In July 2012, York acquired Scarborough and North East Yorkshire Healthcare NHS Trust, bringing Bridlington Hospital into the organisation. Work was continuing to integrate surgical services.
- Orthopaedic elective work was being developed at Bridlington. This was supported by a programme to develop a service providing outpatients, treatment and rehabilitation, all co-located for ease of access. A mobile laminar flow theatre was to be procured to further develop the capacity required for elective work.

**Governance, risk management and quality measurement**

- Clinical quality in the directorate was managed through the performance management process. Performance improvement quality and safety meetings were held in the directorate. These meetings were chaired by the medical director and used to monitor and drive forward clinical practice.
- Although directorate-level governance arrangements were in place, the directorate was in the process of developing standardised protocols, guidelines and pathways of care across the three sites. Therefore, at the time of the inspection, this was variable and not integrated fully.
- We saw that risk registers were in place for orthopaedics. The level of risk was identified, and actions were described to manage gaps in controls and assurance, with associated review dates and executive leads.

# Surgery

- Directorate risk registers were discussed at the performance management meetings and locally in the directorate. Significant risks identified from the directorate risk registers were added to the corporate risk register and considered by the board of directors.
- The directorate held joint governance meetings across the three hospital sites each quarter. The meeting minutes showed that patient experience, complaints, incidents, audits and quality improvement projects were discussed and action taken where required; this included feedback being given to staff about their individual practice.
- The wards used a quality, effectiveness and safety trigger tool. This showed that wards at Bridlington were 100% compliant with the quality indicators during December 2014 and January 2015.

**Leadership of service**

- Each surgical specialty was led by a clinical director, director of nursing and general manager.
- The senior leadership team had a good understanding of their roles and were aware of the risks and developments required to improve the quality of patient care.
- Matrons and ward managers were in post within the directorate to oversee operational issues and assist with daily workforce planning to ensure that staff were distributed according to clinical needs. Staff told us that the matron was based at the hospital one day a week.
- A hospital manager had been appointed within the last few months and was based at the hospital. Staff told us that there had been positive improvements in developing the service and managers were supportive.

**Culture within the service**

- Staff reported an open and transparent culture on the surgical wards. They reported good engagement at ward level and felt that they were able to raise concerns and these would be acted on.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Staff told us that they worked closely with Scarborough Hospital and that there was regular cross-site working, but less so with York. Ward managers were invited to attend meetings at Scarborough.
- Theatre staff said it was difficult to access e-learning training and to report incidents online due to the lack of computer terminals available in the theatre staffroom.
- Staff told us that they felt part of the trust and did not feel isolated.

**Public and staff engagement**

- Data from the NHS Staff Survey 2013 showed that the trust scored as expected in 23 out of 29 areas. There were negative findings in areas such as job satisfaction, training, staff being able to contribute to improvements at work, and the fairness and effectiveness of procedures for reporting incidents.
- The wards were starting to receive quarterly laminated patient experience information. This was displayed at ward level and informed patients, relatives and staff about the NHS Friends and Family Test results and 'You said we did'. The trust's patient experience team worked closely with ward sisters to ensure that information reflected the actions the wards had taken when improvements were required.

**Innovation, improvement and sustainability**

- There were systems in place to enable learning and improve performance. These included the collection of national data, audits, and learning from incidents and complaints. However, there were varying degrees of integration across the three hospital sites.
- The trust had developed the Bridlington site to deliver elective orthopaedic surgery and there were plans to expand this further by looking at other elective surgery that could be safely relocated to Bridlington.

# End of life care

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

## Information about the service

Bridlington and District Hospital forms part of the York Hospitals NHS Foundation Trust and provides end of life care services on site and in partnership with York Hospital, Scarborough Hospital and community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. Specialist palliative care was provided by the team at Scarborough Hospital as part of an integrated service across both hospital and community teams. At Scarborough Hospital the specialist palliative care team comprised of four sessions of a palliative care consultant, 2.0 whole time equivalent (WTE) specialist palliative care nurses, 1.4 WTE end of life care facilitator posts, and an administrator/coordinator post. We saw that referrals to the integrated service from April to November 2014 totalled 1,452, 90% of whom were patients with cancer.

During our inspection, we spoke with a palliative care consultant, the lead end of life care nurse, the medical director, director of nursing, specialist palliative care nurses, mortuary staff, chaplaincy staff, porters, medical staff, ward managers, nursing staff, allied health professionals, quality managers and administrative staff. In total, we spoke with 22 staff about end of life care at Bridlington and District Hospital. We visited two rehabilitation wards at Bridlington and District Hospital, the mortuary and the chapel. We reviewed the records of two patients at the end of life and reviewed nine do not attempt cardio-pulmonary resuscitation (DNA CPR) orders. We spoke with two patients and we reviewed audits, surveys and feedback reports specific to end of life care.

# End of life care

## Summary of findings

We saw that end of life care services were safe, caring, responsive and well led, although there were improvements required in order for them to be effective. Do not attempt cardio-pulmonary resuscitation DNA CPR forms were not always reviewed when patients arrived at Bridlington and District Hospital and mental capacity assessments and decisions were not always documented clearly. Specialist nurses and medical staff provided specialist support in a timely way. Staff were caring and compassionate and we saw the service was responsive to patients' needs. There was good use of auditing and action had been taken against the issues identified. The trust had a clear vision and strategy for end of life care services.

## Are end of life care services safe?

Good

There were effective procedures in place to support safe care for patients at the end of life and staff demonstrated a good understanding of reporting procedures. There was evidence of learning from incidents. There were good examples of incidents being shared and discussed at board and end of life care forum meetings, so that learning could be identified and used to develop the service. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of life.

Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were generally completed consistently. Of the nine forms we viewed, most were appropriately signed and dated and there was a clearly documented decision provided, with reasoning and relevant clinical information to back it up, although one had not been approved by a consultant and another had not been approved until a month after the initial form was completed. A risk register showed specific risks relating to end of life care and we saw that the trust had adequate equipment and appropriate safety checks in place for end of life care.

### Incidents

- There had been no Never Events (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented), or serious incidents relating to end of life care reported in the twelve months prior to our inspection. We did not see specific incident reports relating to end of life care. We were told that all incidents were reviewed on a weekly basis by the director of nursing, the chief executive and the medical director and that, if they related to end of life care, they would be passed on to the end of life care lead nurse for review.
- Staff were aware of their responsibilities in reporting incidents.
- Staff told us they generally received feedback from incident reports they had made and that incidents were discussed, where appropriate, at staff meetings. We saw that a section titled compliments and complaints had

been added as a standing agenda item to the end of life care forum meetings. The end of life care lead nurse would provide feedback around investigations and share outcomes.

- Members of the specialist palliative care team told us that incidents were historically recorded based on the directorate in which the team sat. In this case, the medicine directorate. We were told that recent work had been carried out to redesign the reporting system so that end of life care incidents and complaints would be more easily identifiable.
- Patient stories were taken to end of life care forum meetings and strategic partnership board meetings. As a result, learning was identified and action taken to improve services for patients at the end of life.

**Environment and equipment**

- We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we viewed manual handling training records that showed staff had been appropriately trained in its use.
- There was specialist mortuary equipment available, including bariatric and height adjustable trolleys and storage units.
- At the time of our visit, maintenance work was being carried out on the mortuary 'body store' and we saw that arrangements had been made to use community funeral director services in the meantime, if a patient died at Bridlington and District Hospital.
- Staff told us that, generally, there were no issues with obtaining relevant equipment for the care of patients at the end of life and that equipment was stored centrally but easily accessible to ward staff.
- We were told that McKinley syringe drivers were used on the wards and that nursing staff had been trained in the use of the pumps. We viewed a syringe driver policy that included the use of a syringe driver monitoring chart, with safety checks every four hours of the administration of medicines via the pumps required.

**Medicines**

- We saw that the trust used the Palliative Care Formulary 4 (PCF4) Fourth Edition as guidance in prescribing medicines at the end of life. The specialist palliative care team provided up-to-date guidance in the form of algorithms and clinical handbooks for use on the wards. These were also available to staff electronically via the intranet.
- The guidance included the use of medicines in the management of symptoms including pain, nausea and vomiting, breathlessness, chest secretions and anxiety. Medical and nursing staff we spoke with were aware of the guidance and told us they could access it via the trust's intranet and in end of life care folders, which were kept on the wards.
- Nurses within the specialist palliative care team were nurse prescribers or were working towards this qualification.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that patients may need to make them more comfortable). The guidance they provided was in line with end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- One doctor we spoke with told us that most patients were transferred to Bridlington and District Hospital from Scarborough Hospital and they would have anticipatory medicines with them, on admission, if these had been prescribed. The doctor told us they had not experienced any problems accessing end of life care medicines for patients.
- The trust had implemented a syringe driver chart that included information on discontinuing unnecessary medicines at the end of life. The chart included advice around diluents, the type of syringe to use with the pump, medicine combinations and advice specific to patients with renal failure or diabetes.
- We reviewed two medication record charts of patients who were considered to be at the end of life and, in all cases, we saw that anticipatory medicines were prescribed appropriately and were in line with the guidance.
- We saw that controlled drugs were stored, administered and recorded in line with controlled drug guidance and that medicines for anticipatory prescribing for key symptoms were available and accessible.

**Records**

# End of life care

- We saw that, on admission, all patients were assessed and that these assessments were recorded, including patient details, medical, nursing and risk assessments, as well as care plans.
- Patients identified as being in the last days of life were cared for using a specific care plan that had been developed by the specialist palliative care team. The 'last days of life' care plan included daily reviews and regular assessments of the patient's condition.
- We did not see any patients at Bridlington and District Hospital who were considered to be in the last days of life. Therefore, we did not see the 'last days of life' care plan in use, however, staff we spoke with were aware of the care plan and told us they could access it as required.
- We reviewed nine DNACPR forms. In all cases, we saw that decisions were dated and forms kept at the front of patient files. Most had been approved by a consultant, although one had not and another had been approved one month after the decision. A ward manager we spoke with told us most DNA CPR forms were completed prior to a patient being transferred to Bridlington and District Hospital.
- Discussions about DNA CPR with patients and relatives were recorded in sufficient detail within the patient notes when they had been held.
- As part of the policy for the administration of subcutaneous medication via the T34 syringe pump, we saw there was a syringe pump infusion monitoring chart available as part of the newly devised syringe driver chart. We did not see any patients receiving medicines via this route at the time of our inspection.

**Safeguarding**

- We viewed mandatory training records and saw that all members of the palliative care team had attended safeguarding training at level 1 or 2.
- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns.
- We saw that a safeguarding system was in place for reporting all incidents and concerns and staff told us the safeguarding team were accessible and responsive to concerns and issues.

**Mandatory training**

- We viewed training records and saw that members of the palliative care team had attended training in a number of mandatory areas. Examples included moving and handling and basic life support.
- End of life care awareness training was part of the trust's mandatory training programme. End of life care training was incorporated into induction programmes for band 5 nurses, healthcare assistants and junior doctors.

**Assessing and responding to patient risk**

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls and nutrition and hydration risks.
- Early warning tools were in use throughout the hospital, with regular assessments guiding staff in identifying a patient whose condition was deteriorating.
- Members of the specialist palliative care team told us that, in addition to a weekly multidisciplinary team meeting, they would discuss patient issues and care on a daily basis while prioritising their workload. Issues relating to risk and patient need would be incorporated into these discussions.
- End of life care guidance documents included advice on identifying when a patient may be at the end of life and who should be involved in that decision.
- We viewed a risk register relating to end of life care. A particular area of risk related to data collection and poor IT systems that did not allow for data to be shared across services. Staff had identified this as being a potential risk to patients if information was not readily available and they were concerned that that this could result in patient wishes not being known or shared. Staff worked to reduce the risk of this by sharing information in multidisciplinary meetings and discussing when patients were deteriorating. The aim was to eliminate the risk and drive forward the changes at board level.

**Nursing staffing**

- There were 2.0 whole time equivalent (WTE) specialist palliative care nurses and 1.4 WTE end of life care facilitators based at Scarborough Hospital.
- Specialist palliative care nurses were available from 8.30am to 4.30pm, Monday to Friday. There was no on-call specialist palliative nursing cover out of hours.
- Staff we spoke with on the wards were aware of how to access the specialist palliative care team. Although the

team were based at a separate site, we were told arrangements were in place to free staff to visit patients at Bridlington and District Hospital on an 'as required' basis.

- Generally, nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise. However, we were told that staffing challenges had an impact on nurses from some wards being able to attend end of life care training.
- The palliative care team provided training and education programmes for ward-based nursing staff within the trust. Since 2014, end of life care was mandatory as part of the trust induction programme. The palliative care team had developed an additional one day end of life care training session for nursing staff. Records showed that 40% of nursing staff at Bridlington and District Hospital had attended end of life care training. Staff on the wards confirmed that they had received training in the use of the last days of life care plan.
- Training covered aspects of end of life care including the five priorities of care: symptom management, advance care planning, preferred place of care and spiritual care.

**Medical staffing**

- There was a service level agreement (SLA) in place with a local hospice to provide four specialist palliative care consultant sessions per week. We were told that these were provided by the hospice medical director with flexible cover built into the agreement. We were also told that, although the consultant input was scheduled for certain days, there was flexibility and arrangements would be made based on patient need. This flexibility included visits to see patients at Bridlington and District Hospital, as required.
- Junior doctors attended an end of life care training session as part of their induction into the trust. The junior doctors we spoke with told us they felt confident to care for patients at the end of life and that advice was readily available from the specialist palliative care team.
- Out of hours, 24-hour specialist palliative care telephone advice was available from the on-call palliative medicine consultant in the region who could be contacted via either of the two local hospices.
- Ward staff told us they would refer to the written guidance out of hours and that they could access more specialist advice from local hospices.

**Major incident awareness and training**

- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included in a call out when a major incident occurred.

## Are end of life care services effective?

Good

The trust had taken action to plan and develop services in line with national guidance, with the implementation of a 'last days of life' care plan for the assessment and coordination of care and symptom management of patients at the end of life. We saw that the Liverpool Care Pathway was no longer in use since the national phase-out date of July 2014. Assessments of patients' pain were generally consistently carried out, although there was limited use of pain assessment tools. Nutrition and hydration assessments were carried out and staff we spoke with were aware of quality of life issues relating to nutrition and hydration at the end of life. We saw that the trust had an action plan in place to address areas identified as being part of the National Care of the Dying Audit and that a number of areas had been addressed at the time of our inspection.

We saw that, where patients were identified by staff as lacking the mental capacity to be involved in DNA CPR decisions, family members were consulted and decisions taken in the patient's best interests. However, we did not see the trust's mental capacity assessments completed in relation to DNA CPR and we did not see details of mental capacity assessments recorded in patient notes. We also saw an example of a patient who had participated in discussions about other aspects of their health, but who had not been included in the decision about DNA CPR.

**Evidence-based care and treatment**

- We viewed end of life guidance and a 'last days of life' care plan, which had been introduced in November 2014.
- We saw that end of life care documentation had included national guidance from sources such as the

# End of life care

Leadership Alliance for the Care of Dying People, the Department of Health (DoH) National End of Life Care Strategy and the National Institute of Health and Care Excellence (NICE).

- An internal audit of the 'last days of life' care plan had identified changes to improve the document following discussion with staff that had used it.
- The Liverpool Care Pathway had been phased out nationally by July 2014 and staff we spoke with at Bridlington and District Hospital told us it had not been used since this time.
- The specialist palliative care team had been involved in developing services for people with heart failure at the end of life. This work had been based on research undertaken by one of the clinical leads from a local hospice who provided sessional hours at Scarborough Hospital.

**Pain relief**

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available, as needed, both during the day and out of hours. We were told that many patients were transferred from Scarborough Hospital and that, if in the last days of life, they would be transferred with end of life care medicines.
- The wards we visited had adequate stocks of medicines in line with anticipatory prescribing guidance around the five key symptoms most commonly experienced at the end of life.
- We saw that a zero to 10 pain assessment score was available on the trust's electronic system; however, we did not see this in use in relation to patients at the end of life. There was no alternative pain assessment tool in use that prompted staff to make a full assessment of a patient's pain, incorporating the assessment of body language or facial expressions when patients were unable to score their pain. We also did not see clearly documented evaluations of pain in relation to the effectiveness of medication given.
- Regular comfort rounds were carried out and included asking patients regularly about their level of comfort. Staff were also prompted to assess patients' pain as part of the last days of life care plan.

**Nutrition and hydration**

- A nutritional screening and assessment tool was incorporated into the patient admission record to assess patients on admission.
- The 'last days of life' care plan incorporated both medical and nursing assessments of nutrition and hydration. Incorporated into this was guidance around the use of clinically assisted hydration and nutrition. There were also prompts to involve patients and their families in discussions around hydration and nutrition. In addition, nursing assessment/intervention prompts were undertaken every four hours, these included offering the patient oral fluids and nutrition, as appropriate.
- Staff we spoke with told us they were led by patient wishes in relation to oral intake of food and fluids and we were given examples of when patients had been able to access food and drinks of their choosing.
- We viewed guidance on the use of mouth care in the last days of life that included action to be taken in the event of a patient having a dry mouth, coated tongue or pain/ulceration.

**Patient outcomes**

- The trust had taken part in the 2013/14 National Care of the Dying Audit where they had not achieved six out of seven organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust performed below the England average in some of the clinical key performance indicators, including communication relating to a patient's plan of care for the dying phase, a review of interventions during the dying phase and a review of care after death.
- The trust had addressed a number of issues following the audit, including the appointment of a layperson to the trust board with specific responsibility for care of the dying, the development of bereavement care, ensuring training in end of life care was mandatory for staff caring for dying patients and the development of the 'last days of life' care plan.
- The implementation of the 'last days of life' care plan addressed a number of clinical areas identified as part of the National Care of the Dying Audit, including

assessment of nutrition and hydration, the identification of spiritual needs and the ongoing communication and involvement of patients and family members in planning care.
- We viewed examples of internal audit programmes. One example included the trust's own care of the dying audit, which focused on examining care of the dying practice prior to the implementation of the 'last days of life' care plan. The aim of the audit was to establish current practice to ensure the care plan was focused on supporting sustained quality practice in end of life care.

**Competent staff**

- There were 2.0 whole-time equivalent (WTE) specialist palliative care nurses and 1.4 WTE end of life care facilitators based at Scarborough Hospital, who provided end of life care support services to Bridlington and District Hospital. We also saw that other specialist nurses would work across sites and liaise with ward staff and the specialist palliative care team. For example, we viewed a patient's records that included end of life care advice from a lung clinical nurse specialist (CNS).
- We were told that the specialist nurses did not visit the wards on a routine basis, but that they could be accessed by phone and would review patients, as required.
- Nursing staff also told us there was a GP-led Macmillan unit run on site called the Macmillan Wolds Unit. This unit was not part of York Hospitals NHS Foundation Trust, but staff could access them for advice if necessary and sometimes patients would be transferred there to die.
- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- Records showed that almost 40% of nursing staff at Bridlington and District Hospital had attended end of life care training. The end of life care lead nurse told us that at least one member of nursing staff on each ward had attended the training and we saw records that demonstrated this. Specifically, 25% of nursing staff on Johnson Ward and 54% of nursing staff on Waters Ward had attended end of life care training.
- Ward staff and the specialist palliative care nurses told us that training around the use of the 'last days of life' care plan had been delivered on the wards so that nursing and medical staff felt confident in its use.
- Ward-based nurses were able to shadow the specialist palliative care nurses so that they could develop more specialist knowledge and there was a programme in place for specialist nurses to mentor staff who were undertaking the programme.
- An end of life care facilitator role had been developed to support ward staff in the delivery of ongoing learning around end of life care on the wards.
- Key members of the specialist palliative care team had particular interests and specialist areas they kept up to date on. For example, two nurses had undertaken heart failure modules as part of their degree courses as this was an area the team had identified to focus on.

**Multidisciplinary working**

- Members of the specialist palliative care team participated in multidisciplinary team meetings, working with other specialists to support good quality end of life care across clinical specialties.
- Members of the team also attended specialist lung and upper gastrointestinal multidisciplinary team meetings and were involved in heart failure and chronic obstructive pulmonary disease (COPD) multidisciplinary team working.
- The specialist palliative care team told us they met daily to discuss patient care and workloads and had a weekly multidisciplinary clinical meeting, which was attended by other professionals. They told us these meetings would include discussions about patients at Bridlington and District Hospital.
- A member of the specialist palliative care team also attended the community multidisciplinary team meetings each week.
- Regular end of life care forum meetings were attended by multi-professional hospital and community staff.

**Seven-day services**

- The specialist palliative care team provided a five-day, face-to-face service from 8.30am to 4.30pm, with no out-of-hours input.
- Out-of-hours advice was available on a 24-hour, seven day a week basis by telephone via the local hospices.

# End of life care

- Plans to implement a pilot of a seven-day, face-to-face service had been discussed at board level and we saw plans for the pilot to start in 2015.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover via an internal on-call system.

**Access to information**

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being in the last days of life staff would use the Trust's guidance for care of patients in the last days of life. The guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss values and spiritual needs and agree options regarding hydration and feeding.
- We viewed records that included detailed information about the management of symptoms, as well as discussions and interventions. We also saw that when patients were seen by the specialist palliative care team information and advice was clearly recorded so that staff could easily access the guidance given.

**Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards**

- The trust's 'resuscitation and do not attempt cardio-pulmonary resuscitation' policy provided guidance for completing a DNA CPR form for an individual who does not have capacity, stating that, when a specific care decision was to be made, the 'best interests' process under the Mental Capacity Act 2005 must be followed.
- Of the nine DNA CPR in the hospital, three were for patients who staff identified as lacking mental capacity to be involved in resuscitation decisions. In addition, there were two patients whose mental capacity status was unclear, including one where there was evidence from nursing staff that their mental capacity would fluctuate. In addition, we saw two patients who were identified as having mental capacity, but who were not involved in the discussion about DNA CPR, one of whom had participated in discussions about other aspects of their health. We did not see the trust's mental capacity assessment form in use specifically for resuscitation decisions and we did not see details of mental capacity assessments recorded in patient notes.
- In most cases, we saw that the decision was discussed with the patient's family in order to make a decision that was in the person's best interest and staff told us that, if a patient did not have family, then a court appointed independent mental capacity advocate (IMCA) would support the process of decision making on the patient's behalf. We saw that one patient had been appointed an IMCA to support decision making about treatment, but this had not included the decision about resuscitation.
- The trust had identified issues relating to involving patients in resuscitation decisions through a process of audit and review. As a result, they had developed specific training for medical staff relating to this, including the development of a DVD and e-learning resources. In addition, we were told of plans to develop advance communication training for clinical staff around initiating discussions about treatment and care, including resuscitation decisions.
- Nursing staff we spoke with told us DNA CPR decisions would often be made prior to a patient being transferred to Bridlington and District Hospital from one of the other hospitals in the trust. DNA CPR forms were not always reviewed on admission. Only one of the nine DNA CPR forms we viewed had included a review.

## Are end of life care services caring?

Good

End of life care services were seen to be caring. Patients and relatives told us that, in general, they were happy with the quality of care they received and that staff were kind, caring and compassionate in their approach. Emotional and spiritual support was considered to be a priority within the trust and we saw this through the use of comfort boxes, the input from staff and the support offered.

Whilst Bridlington and District Hospital did not have a dedicated chaplain or specialist palliative care team on site, we saw evidence of input from chaplaincy and specialist staff to support the emotional and spiritual needs of patients.

**Compassionate care**

# End of life care

- During our inspection, we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that showed respect for their individual choices and beliefs.
- Patients and relatives we spoke with told us that, in general, they were happy with the quality of care they received. One patient told us, "The care is generally very good."
- Patients told us that although staff were often busy, this had not affected the quality of care they received.
- Bereavement follow-up support would be given to relatives from nursing staff on the wards. A bereavement support leaflet was available for relatives, offering guidance on how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.
- We saw that care after death honoured people's spiritual and cultural wishes. There was no chaplain based at Bridlington and District Hospital, but the York Hospital and Scarborough Hospital chaplains would provide a call out service and had the contacts within the community to ensure people's individual needs were met. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.

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

- Patients we spoke with told us they felt involved in their care.
- We saw that staff discussed care issues with patients and relatives and these were generally clearly documented in patient notes.
- The end of life care guidance used by the trust included prompts for discussing issues of care with patients and relatives.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen. There were also information leaflets available for patients and their relatives around the 'last days of life' care plan and the processes involved in caring for patients at the end of life.
- The trust was participating in the National Bereavement Survey (VOICES) 2011. The survey worked to collect information from relatives and friends about the quality of care provided at the end of life. The research looked at areas such as respect and dignity, pain relief and whether the person died in their preferred place of care. At the time of our inspection, there was no data available relating to the survey, however, staff confirmed that some families had participated and the data had been submitted. We did not see specific bereavement survey data relevant to Bridlington and District Hospital.

**Emotional support**

- Members of the specialist palliative care team participated in the delivery of communication skills training to staff in relation to discussing care and treatment issues at the end of life. This training included supporting patients and family members who are distressed.
- We saw that visiting times were flexible for family and friends when patients were at the end of life and we were told that relatives were able to stay with patients at the end of life if they wished.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy and dignity was maintained and that they had time with their relatives. When this wasn't possible, staff would pull the curtains round the bed to give more privacy and, where possible, would ensure patients were nursed in a quiet part of the ward.
- There was a multi-faith chapel available that held information relevant to people from different faiths and religions. The chaplaincy services within the trust were geared towards providing support for patients and their relatives, irrespective of their individual faith, or even if they did not follow a faith. There was also a prayer room available.
- Patients and visitors were able to add requests for prayers in the chapel.
- We were told that the chaplain based at Scarborough Hospital would also cover services at Bridlington and District Hospital. The Scarborough Hospital chaplaincy post was vacant at the time of our inspection, but we were told that, in the meantime, chaplaincy support could be accessed via York Hospital.

In line with initiatives across the trust we were told that comfort boxes were available for relatives who were staying with patients at the end of life.

# End of life care

## Are end of life care services responsive?

Good

All patients requiring end of life care had access to the Scarborough Hospital specialist palliative care team. We saw that referrals to the Scarborough Hospital specialist palliative care team between April and December 2014 totalled 341 and this included some patients from Bridlington and District Hospital, although specific data relating to this hospital was not recorded. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs. Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. Complaints, compliments and incidents were reviewed to identify learning and this learning was explored and fed back through a number of processes, including board and locality meetings. Preferred place of care was recorded by the specialist palliative care team and was incorporated into training for general staff in end of life care. There was no mechanism in use to monitor achievement of preferred place of death.

### Service planning and delivery to meet the needs of local people

- Preferred place of care at the end of life was recorded by the specialist palliative care team, but not as part of routine admission data collected on the wards. This meant that patients who were referred to the specialist palliative care team would have their preferences recorded, but those who weren't referred may not.
- The end of life care lead nurse participated in the end of life care strategic partnership board that was run by local clinical commissioning groups (CCGs) and was, therefore, involved in the development of a regional strategy for end of life care. The specialist palliative care team was also represented at the Scarborough Hospital locality board meetings for end of life care.
- The trust had developed its own end of life care strategy, identifying key priorities relating to meeting the needs of people in the region. Emphasis included work on raising awareness of issues relating to death and dying among the local population. One aspect of this that has been identified was to develop local initiatives to engage more with people during the annual 'Dying Matters' week.
- We were told that 32% of patients referred for specialist palliative care had a diagnosis other than cancer. In response to increasing numbers of referrals into specialist palliative care of patients with a non-cancer diagnosis, the integrated team have worked to develop clinical pathways for patients at the end of life with specific conditions. Examples we were given included patients with heart failure and patients with chronic obstructive pulmonary disease (COPD).

### Meeting people's individual needs

- Staff on the wards told us that patients with complex needs would be referred to the specialist palliative care team for additional support, particularly when there were issues around managing their symptoms effectively. We also saw that clinical nurse specialists from other specialties would be involved in care as necessary. Examples we saw were oncology and lung clinical nurse specialists who worked with ward staff to ensure appropriate care at the end of life.
- Patients we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- Staff told us that interpreting services were available for patients who didn't speak English and for those who had other communication difficulties.
- Assessment documentation by the specialist palliative care team included recording the patient's preferred location of care at the end of life.
- We saw that advance care planning had been identified as one of the trust's priorities in terms of developing end of life care services. We viewed advance care planning documentation and information on the wards, although we did not see an advance care plan in place. We saw that the specialist palliative care team were developing initiatives around advance care planning, including teaching other staff about the processes involved and the communication needed to ensure patients' wishes and individual needs were met.

# End of life care

- We were given an example of a referral to the specialist palliative care team where a patient was struggling with a DNA CPR decision, so the palliative care consultant and CNS spent time with the patient discussing ceilings of care and reassuring them that a DNA CPR decision did not mean an end to all treatment.

**Access and flow**

- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways. The aim of the specialist palliative care team was to review urgent referrals within 24 hours and routine referrals within 48 hours. Staff we spoke with told us that the palliative care nurses would generally see patients on the same day if they had problems with symptoms.
- Staff on the wards told us they were able to access the specialist palliative care team for any issues or concerns.
- Members of the specialist palliative care team and ward staff alike told us that, generally, patients would be seen within hours of a referral to the specialist team. The palliative care consultant told us that, although the team were not on site at Bridlington and District Hospital, they were able to manage referrals and patient visits and incorporate them into their work at Scarborough Hospital based on individual patient need.
- We saw an example of a specialist palliative care nurse recording a patient assessment on the same day as the referral was made.
- We saw that resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team was not available.
- The chaplaincy service was accessible seven days a week via an on-call system.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose to be cared for at home.
- We were told that staff were able to refer patients to a GP-led end of life care unit based on site at Bridlington and District Hospital if the patient was in the last few days of life and going home was not an option for them.
- We were shown a 'rapid discharge at end of life integrated pathway' for all rapid discharges. This had recently been developed to improve the documentation, coordination and sharing of information.
- There was no data available measuring end of life care discharges against preferred place of care and fast-tracked discharges had not been recorded at Bridlington and District Hospital. However, we were told that plans were in place to record data relating to fast-tracked discharges from April 2015.

**Learning from complaints and concerns**

- We were told that work had been carried out on the reporting and recording system for complaints to ensure that complaints relating to end of life care were categorised appropriately so they could be reviewed by the end of life care lead nurse.
- We viewed end of life care forum minutes that included a section dedicated to compliments and complaints where issues relating to end of life care could be discussed, learning identified and cascaded.
- All complaints were reviewed weekly by the director of nursing and the chief executive. From this, complaints relating to end of life care would be passed to the end of life lead nurse who would review the issues, identify action and learning and disseminate this to relevant staff.
- We did not see reports of specific complaints relating to end of life care. However, we were told that the lead end of life nurse was in the process of reviewing a relevant complaint.

## Are end of life care services well-led?

Good

The trust had a clear vision and strategy for end of life care services and a non-executive director had been appointed to lead on end of life care. The trust was part of regional and locality end of life care planning structures and participated fully in these. Gaps identified as part of the National Care of the Dying Audit had been addressed and there was a clear system of quality and safety measures being developed and reported on, including the use of mortality reviews.

# End of life care

There was motivated and committed leadership in terms of end of life care at board and service levels and a number of initiatives were in place to develop services. Initiatives included the development of non-cancer pathways for patients at the end of life, the development of communication training around DNA CPR discussions and the development of mandatory training in end of life care for key staff.

**Vision and strategy for this service**

- There was a non-executive director nominated as the lead for end of life care within the trust and we saw minutes of meetings they attended where end of life care was discussed both at board level and with specialist staff at the end of life care forums.
- The senior end of life care team was made up of a lead nurse for end of life care, specialist palliative care consultants, the directorate manager and the non-executive board member, who met and produced quarterly reports that were submitted to the executive board to inform them of end of life care issues.
- A clinical commissioning group (CCG) led 'end of life care board' was in operation and was attended by the lead nurse for end of life care. We were told that the board provided the structure for all strategic planning work across the region. A locality board had been developed in Scarborough Hospital to implement work plans and feed into the end of life care board.
- The trust's strategic objectives for end of life care included increasing public awareness of end of life care, ensuring dignity and respect, minimising suffering and focusing on patients' needs and preferences.
- We viewed evidence of strategic priorities being discussed at end of life care meetings and that they were incorporated into the trust's action plans in relation to developing end of life care services. For example, we saw that a patient story relating to poor communication over an advance care plan for a patient with chronic obstructive pulmonary disease (COPD) was discussed at board level. In addition, we saw that training in advance care planning had been delivered to COPD staff and that a pathway had been developed to identify trigger points when discussions about advance care planning were to be initiated with patients who had COPD.
- When reviewing documentation about the strategic development of end of life care services, it was unclear what role Bridlington and District Hospital played in this development. Activity data was recorded for both York Hospital and Scarborough Hospital but not separately for Bridlington and District Hospital.

**Governance, risk management and quality measurement**

- Specialist palliative care reports within the structure of the specialist medicine directorate.
- We viewed minutes from the end of life care forum that was attended by nursing medical and allied health professionals. Quarterly meetings were also attended by the non-executive director who was leading on end of life care. From this, a quarterly report on end of life care within the trust was produced for the quality and safety committee.
- The quality and safety report included the identification of issues affecting end of life care. Examples of issues reported on included complaints, risks, the implementation of the last days of life care plan, improving patients' discharge at end of life, IT risks and data collection and the development of trust-wide bereavement services.
- We saw that the results of the National Care of the Dying Audit had been used to develop an action plan that was led by the end of life lead nurse and the palliative care consultants. We saw that the action plan had been implemented to address all areas identified from the audit. Key areas that the trust had addressed since the audit included the appointment of a non-executive director to lead end of life care, the implementation of the 'last days of life' care plan and the appointment of end of life care educators. The trust had also made end of life care training for medical, nursing and care staff mandatory since 2014.
- The trust had developed an internal audit programme for end of life care, including: a care after death audit, DNA CPR audits, a 'last days of life' audit and audits of the use of specific medicines used for patients at the end of life.
- Weekly multidisciplinary meetings were held where the specialist palliative care team and other professionals would discuss the care of patients at the end of life. We were told this would include patients at Bridlington and District Hospital.
- Weekly mortality reviews were carried out, involving the chief executive, the director of nursing, the medical director and, where appropriate, the end of life care lead

nurse. Learning from patients' experiences would be shared and cascaded through the end of life care forum, the end of life care board and the end of life care locality meetings.

**Leadership of service**

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- At Bridlington and District Hospital, end of life care was a small part of the work being undertaken and there was no dedicated specialist palliative care staff on site. This meant that clear day-to-day leadership for end of life care was the job of ward managers and visiting specialist staff, with advice accessible from a GP-led unit within the hospital that wasn't part of the trust.
- Staff we spoke with told us there was good senior level engagement, including the executive board, in improving end of life care.
- There was a non-executive director with responsibility for end of life care and we saw evidence that they were involved in meetings and discussions about end of life care. We also saw that both the medical director and the director of nursing had a good awareness of the issues affecting end of life care within the trust. We observed a commitment to address these and develop end of life care services that were in line with national guidance.

**Culture within the service**

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- One of the trust's strategic objectives was to shift the perception that 'death is failure' to one where 'a good death is a successful care outcome'. We viewed training programmes and education materials that supported this and the 'last days of life' care plan provided a structure that supported this.

**Public and staff engagement**

- Staff were encouraged to provide feedback and evaluation of training programmes relating to end of life care and this was used to further develop the training programme to meet staff needs.
- Staff had been involved in the audit of the 'last days of life' care plan and were encouraged to provide feedback. We saw that changes were made to the document as a result of this.
- Relatives of patients at the end of life were encouraged to participate in National Bereavement Survey, where they were asked to document their experiences of care in the last days of life, although results of the survey were not yet available.
- We viewed a strategy action plan that included the plan to raise public awareness of advance care planning. Specific actions included suggested activities to engage with 'Dying Matters' week.

**Innovation, improvement and sustainability**

- The specialist palliative care team were focused on continually improving the quality of care and we observed a commitment to this at ward level also.
- Patient stories were taken to the board and end of life care forum meetings and were used as a tool to reflect on practice, in order to learn from the stories and to use this learning to inform practice.
- The trust had developed non-cancer pathways to support quality care for patients who were at the end of life. Specific innovations included pathways for patients with COPD, Parkinson's and heart failure and included working on advance care planning initiatives to ensure patients' preferences and choices were clear.
- Comfort boxes were designed to provide toiletries and other items of comfort to relatives of patients at the end of life in the hospital.
- The trust had developed literature for relatives of patients at the end of life. The information included details of the changes that may occur before death and other issues, including: the use of medication, food and drink and the last days of life care plan.
- The trust had developed a mandatory end of life care training programme for medical, nursing and care staff that addressed issues identified through audit, feedback and observation. For example, the trust had identified that conversations about DNA CPR decisions were not happening or being recorded as they should. As a result,

the trust had identified the need for advance communication skills training specific to these types of conversations and were developing training to meet those needs.

# Outpatients and diagnostic imaging

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

## Information about the service

Bridlington Hospital outpatients and diagnostic imaging (radiology) departments and radiology department are situated on the main hospital site on the outskirts of Bridlington. There were a total of 44,775 outpatient appointments between July 2013 and June 2014. The ratio of new appointments to review appointments was approximately 1:2.

The outpatients and diagnostic imaging departments were part of the theatres, anaesthetics and critical care directorate. Radiology services were provided from one main location. There was a wide range of outpatient clinics, some nurse led, some allied health professional led and some led by doctors across a large number of specialties.

The acute clinical work of the trust was concentrated at York Hospital and Scarborough General Hospital, which offer a range of other diagnostic imaging and interventional procedures, as well as substantial plain film reporting and an ultrasound service. Bridlington Hospital provided plain X-ray film (radiology) and ultrasound services.

Radiology services across the trust were managed by a directorate business manager who was based at York Hospital. The departmental manager at the Scarborough site was the clinical lead for the three sites. There was a departmental manager at the Bridlington site who was responsible for the day-to-day running of the unit.

During the inspection we spoke with four patients and five relatives, two nurses of different grades, one doctor, three allied health professional and two members of administrative staff.

We observed the radiology and outpatient environments, checked equipment and looked at patient information.

# Outpatients and diagnostic imaging

## Summary of findings

Overall the care and treatment received by patients in Bridlington Hospital outpatients and diagnostic imaging departments required improvement.

Some policies and procedures were not being followed and there was a lack of evidence of staff attending mandatory training. No action had been taken to ensure that staff had attended fire safety and moving and handling training. Checks of resuscitation equipment were not routinely recorded so equipment may not have been available in an emergency.

The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from Bridlington Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action and been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

Morale of staff we spoke with was low. Staff survey results had deteriorated from the previous year's results. According to staff, the takeover of Scarborough and Bridlington Hospitals by the York Hospital trust had not been sensitively thought out and managed. They said this had resulted in staff at Bridlington Hospital feeling excluded, forgotten when organisational changes were discussed and decisions were made. The management within radiology was unable to provide us with evidence about the way the department managed incidents and complaints. There was a lack of evidence that clinical governance, audits and team meetings took place regularly and that lessons learned from complaints and incidents were disseminated to staff.

Patients were very happy with the care they received they found staff to be caring and compassionate.

Services were on the whole responsive to patient needs, but patients experienced long waits because some clinics overran significantly. The care patients received was effective.

### Are outpatient and diagnostic imaging services safe?

**Requires improvement**

The level of care and treatment delivered by the radiology department required improvement.

Staff in the radiology department were unable to evidence how they dealt with incidents and complaints and made sure lessons were learned. Information provided to us about incidents did not clearly identify whether radiation-related incidents had been reported to the appropriate authorities. Other incidents were reported using an electronic reporting system and all the staff we spoke with were able to report incidents using the system if they needed to. Within the outpatients departments, incidents were investigated and lessons learned were shared with all of the staff.

Additionally, there was poor documentation relating to resuscitation equipment checks and therefore poor evidence that checks were carried out in line with trust policy.

The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from Bridlington Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action and been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99 or whether there were any problems that required action.

We found that some seating did not comply with infection control best practice in the outpatients departments because they were made of absorbent material. Other than this, the general cleanliness and hygiene in the departments were within acceptable standards. There was sufficient personal protective equipment in all of the areas we inspected and staff were aware of how to dispose of it safely and within guidelines.

# Outpatients and diagnostic imaging

We requested site specific mandatory training information about Bridlington Hospital, but this had not been received at the time of writing the report. We therefore could not comment on whether staff were up to date with their mandatory training. There were some staff vacancies and some sickness across the radiology and outpatient departments. We were told these were managed locally.

Staff in all departments were aware of the actions they should take if there was a major incident.

**Incidents**

- Across the trust, there had been 85 incidents between October 2014 and March 2015: 52 caused no harm, 28 caused minor harm, one caused moderate harm and four were still under investigation.
- The trust used an electronic system to record incidents and near misses.
- The outpatients departments had a system in place to report and learn from incidents, to reduce the risk of harm to patients. All staff who worked in the outpatients departments were able to access the system to record incidents. We spoke with staff about their knowledge of the incident reporting system. Staff said they could access the system and knew how to report incidents.
- The radiology department was unable to demonstrate that they had such a system in place.
- There were no Never Events reported in 2013/14 (Never Events are serious, largely preventable patient safety incidents that should not occur if the available, preventable measures have been implemented).
- In 2014, the departments reported three serious incidents to the Strategic Executive Information System. Two related to radiology/scanning incidents and the third related to delayed diagnosis.
- We requested information about IR(ME)R reportable incidents from Bridlington Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action and been taken by the unit to promote safety.
- We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99 or whether there were any problems that required action.

**Cleanliness, infection control and hygiene**

- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons were available to staff.
- After use, personal protective equipment was disposed of safely and appropriately.
- The outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas using appropriate wipes to clean equipment between patient use, thus reducing the risk of cross infection or contamination between patients.
- We noted that some of the chairs in the outpatients departments were made of cloth. This was contrary to infection control best practice guidelines. The manager told us that new chairs had been ordered some time ago, but had not yet been delivered despite the delivery being followed up a number of times. They were unaware of the reason for delay.
- All equipment had been labelled to show when it had last been cleaned.
- The diagnostic imaging and outpatients' department's staff took part in regular hand washing and environment audits. We saw that these were part of an ongoing process.
- Patient waiting and private changing areas were clean and tidy. Single-sex and disabled toilet facilities were available and these areas were also generally clean.
- Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control standards.
- The trust had standard operating procedures in place for patients with infections. Infection prevention and control principles were applied.

**Environment and equipment**

- The outpatients departments were pleasantly decorated, however they were small and sometimes struggled to accommodate the number of patients attending for appointments.
- During our inspection we saw that the waiting rooms got busy and staff told us that sometimes there were not enough seats for patients in the waiting areas, particularly if clinics were running late.
- Overall, the outpatients departments were not big enough to meet the needs of all patients and relatives. Staff and the manager told us that demand had outgrown the capacity of the outpatients departments.

# Outpatients and diagnostic imaging

- We saw and staff confirmed that there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.
- We looked at the resuscitation equipment in the departments. The crash trolley equipment in outpatient clinic C had been checked daily as required in March.
- Documentation about the daily resuscitation trolley checks in the radiology department had not been completed: we found gaps in the records. The superintendent radiographer told us that the checks had been completed but they had not kept accurate records of the checks.
- On the whole, equipment was cleaned regularly and serviced in line with manufacturers' guidance.
- Staff showed us how they cleaned equipment. The equipment we looked at was clean and had been labelled as such.
- The departments were able to replace broken equipment in a timely manner and to order new equipment if the equipment was needed for clinical reasons.
- We requested a copy of the latest radiation protection adviser report from the trust. The trust informed us that there had never been a report for the trust
- We saw the department had radiological protection/ hazard signage displayed throughout the department. Illuminated treatment room 'no entry' signs were clearly visible and in use throughout the department at the time of the inspection.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas.
- There were systems and processes in place to ensure the maintenance and servicing of imaging equipment.

**Medicines**

- The outpatients departments kept a limited supply of medication.
- Medication that needed to be refrigerated was stored in locked fridges.
- We looked at the temperature record charts for the fridges. We found that there had been regular checks carried out, in line with requirements.
- Some staff used patient group directives to dispense drugs to patients. We checked these and found that they had been reviewed appropriately.
- The trust had a system in place for quickly informing GPs about changes to patients' medication.
- There was no information available to us about how many staff in the outpatients departments or radiology department had completed medicines management training.
- Patients who needed medication such as insulin were asked to bring their own supply when they visited the outpatients departments.
- Within radiology, medicines were stored correctly in locked cupboards or fridges.
- There was no on-site pharmacy at Bridlington Hospital and therefore patients were given prescriptions that could be dispensed in any pharmacy.
- We looked at the controlled drugs register and saw stock counts were recorded correctly.

**Records**

- Most records in the outpatients departments were electronic, but some paper records were sent to the departments from other hospitals.
- There were occasions when patient records were not available for clinics. When this happened, temporary records were set up using previous clinic letters held on the electronic system. Staff told us patients would not be seen if there were no medical records available. The frequency of this was not recorded and is therefore unquantifiable.
- All staff had been trained to use the patient records system.
- Within the diagnostic imaging department, records were digitised.
- Records contained patient-specific information relating to patients' previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatients departments. We observed people being weighed and measured during our inspection.
- At the time of inspection within radiology, we saw patient personal information and medical records were managed safely and securely.
- In the x-ray department, a paper-based imaging request system was still in place. Requests were filled in on patient notes after imaging had been carried out.
- Patient x-ray records were held electronically. We looked at three records and saw these records were up to date and completed correctly.

# Outpatients and diagnostic imaging

### Safeguarding

- There was a lack of available information about whether staff in the radiology or outpatients departments at Bridlington Hospital had attended safeguarding children or vulnerable adults training.
- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.
- We saw evidence of information available to staff and patients about who to contact if they had any concerns about the safety of children or vulnerable adults. This was displayed in some staff rooms and on the noticeboards of some outpatients departments.
- Within radiology, we observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity, for example, name, date of birth and GP.

### Mandatory training

- The departments had systems and processes in place to ensure staff training was monitored.
- The superintendent radiographer told us they monitored the training matrix to make sure that staff kept up to date with their mandatory training.
- We looked at staff mandatory training levels provided to us by the trust. The information provided did not identify the mandatory training levels of staff who worked at Bridlington Hospital.
- Staff did some mandatory training online using e-learning and some during classroom-based days. Staff told us it was difficult to find time to do online training.
- The outpatients' departments' manager told us that new mandatory training had been added to the list, some of which, such as on care of patients with diabetes, was difficult to access.
- The outpatients' departments' manager told us that training sessions were sometimes organised for governance afternoons.

### Assessing and responding to patient risk

- There was a process in place for managing patients who were deteriorating. This included transferring patients to the Accident and Emergency department when required, which was off site at Scarborough hospital.
- There were policies and procedures in the diagnostic imaging department to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- We were told that requests for imaging were vetted by consultant radiologists before making an appointment.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation.

### Nursing and allied health professional staffing

- The outpatient departments were staffed by a mixture of registered nurses and healthcare assistants.
- There was no specific information provided by the trust of the number of vacancies within the outpatients or radiology departments. One member of staff in radiology told us there was one vacancy in the radiology department. The manager of the outpatients departments told us there were currently two vacancies.
- Vacancies were mostly being covered by current staff, or occasionally staff who worked for the trust bank agency. Where possible, staff worked flexibly to cover shifts. There had been no visible impact on patient care, such as the need to cancel clinics. However staff told us that the required mandatory training levels were not being achieved.
- Recruitment to staff for the outpatients departments was underway. There had been a vacancy in the radiology department for approximately one year and recruitment was ongoing.
- We asked whether the services were able to access agency or bank staff to fill any gaps, or if staff went on long term sick leave or maternity leave. We were told that bank or agency staff could be used if there was no alternative and could replacement staff could be advertised for if a business case for the replacement was approved.
- There had been no recorded agency use by the outpatients or radiology departments in the previous year.
- From the information provided to us by the trust, there was no specific information about sickness levels in the Bridlington outpatients or radiology departments. The manager of the outpatients departments told us that there had been some recent issues with sickness in the departments but that these were being managed locally.

# Outpatients and diagnostic imaging

- All of the staff we spoke with told us that they worked hard but that they enjoyed their jobs. They said that staff pulled together and worked as a team to support morale.
- There was no formal system, such as an acuity tool, being used to decide the staffing levels needed in the outpatients departments to cover clinics. This was because each clinic needed different numbers and skill mix of staff according to the levels of support patients and doctors needed as well as the type of clinic. The nurse in charge explained that staff numbers were based on the knowledge and experience of the manager to judge how many staff were needed and were required to be flexible.

### Medical staffing

- Medical staffing was provided to the outpatients departments by the various specialties that ran clinics. Medical staff who undertook clinics were of all grades, but we saw that there were always consultants available to support lower grade staff when clinics were running.
- Staff told us that locums were used within the outpatients' clinics depending on the staffing levels of the specialty.
- There was a national shortage or radiologists and this trust also had a shortage. Out-of-hours reporting was outsourced to a private company in Australia.
- There was no information about the specific levels of locum use in the radiology department at Bridlington Hospital.

### Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- Business continuity plans were in place to make sure that specific departments were able to continue to provide the best possible safe service in the event of a major incident.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We found that the services provided by the outpatients and diagnostic imaging departments were good.

Care and treatment were evidence-based and patient outcomes were within acceptable limits. On the whole, staff understood their responsibilities when taking consent, or working with patients who lacked or had fluctuating capacity.

Although the managers for the respective departments told us their staff were competent, there was no evidence of formal clinical supervision in place. We found that there was poor preceptorship for newly qualified staff in the radiology department.

There was evidence of multidisciplinary working and some limited out-of-hours radiology and phlebotomy service provision.

### Evidence-based care and treatment

- We saw that National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments throughout the trust with a lead clinician taking responsibility for ensuring implementation. Staff we spoke with were aware of NICE and other guidance that affected their practice and were able to talk to us in detail about patient treatment pathways.
- We saw that the departments were on the whole adhering to local policies and procedures. Staff we spoke with were aware of how they affected patient care.
- The trust had a standard operating procedure in place for Ionising Radiation (Medical Exposure) Regulations.
- The diagnostic imaging department carried out quality-control checks on images to ensure that imaging met expected standards.

### Pain relief

- Staff told us that the departments did not keep pain-relief medication but that the doctors in clinic could prescribe medication for any patient needing pain relief during their attendance.
- Patients we spoke with had not needed pain relief during their attendance at the outpatients departments.

### Patient outcomes

- In the last 12 months, there were 44,775 outpatient appointments of which 12,089 were new appointments and 20,148 were review appointments. The follow-up to new ratio for appointments at the trust was consistently worse than the national average from September 2013 to April 2014: York Hospital had performed worse than

average, however Bridlington and Scarborough performed better than the national average throughout the period. At the time of the inspection, there was no further national data available.
- All images were quality-checked by radiographers before the patient left the department.
- The outpatients departments took part in trust-wide audits, such as on record-keeping, but there was little clinical audit being carried out that was initiated within the department.

**Competent staff**

- We received mixed information from staff about whether they had undergone an appraisal within the last 12 months. There was no information from the trust specific to staff appraisal at Bridlington Hospital.
- Staff told us that they did not receive formal clinical supervision. We asked the trust for information about this. The trust's clinical lead at Bridlington Hospital told us that clinical supervision did take place but it was not formalised and therefore they were unable to provide evidence for it.
- Staff did however tell us that they felt supported and that the department managers were accessible if support was needed.
- In both the outpatients and radiology departments there were formal arrangements in place for induction of new staff. All staff completed full local induction before commencing their role.
- Staff in the radiology department told us there was no continuous professional development and newly qualified staff had been unable to attend additional training or continuous professional development necessary for their role because of staff shortage.
- In the outpatients departments, performance and practice were monitored through competency assessments.
- Medical revalidation was carried out by the trust. There was a process in place to ensure all consultants were up to date with the revalidation process.

**Multidisciplinary working**

- There was evidence of multidisciplinary working in the outpatients and radiology departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as radiology and community staff to promote a seamless service and in the interests of patients.
- Radiologists were part of the multidisciplinary teams (MDTs) working between specialities, for example, gastrointestinal and breast MDTs. However, radiographers told us that they were not routinely included in MDT meetings.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys, such as GPs and support services.
- A range of clinical and non-clinical staff worked within the outpatients departments and they told us they all worked well together as a team. We observed staff working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, audiologists, nurses, booking staff and consultants.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

**Seven-day services**

- The outpatients departments often ran clinics on a weekend, however most activity within the outpatients departments happened between Monday and Friday.
- Weekend clinics were held because of capacity and space problems in the outpatients departments, which the manager and staff told us had been outgrown by demand.
- The radiology services across all of the trust's locations provided a range of services. Some covered seven-day a week and out-of-hours services, while some locations provided services within normal working hours five days a week.

**Access to information**

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information, such as imaging records and reports, medical records and physiotherapy records, appropriately through electronic records.
- Radiology reports were partly outsourced with an external provider under contract.
- Information leaflets in relation to diagnostic imaging, for example CT and MRI, were sent out in the post with the patients' appointment times.

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**Consent, Mental Capacity Act and deprivation of liberty safeguards**

- Staff we spoke with were aware of how to obtain consent from patients. They were able to describe to us the various ways they would obtain consent from patients. Staff told us that in the outpatients departments, consent was obtained verbally. This was the case for the majority of imaging procedures.
- According to information given to us by the trust, non-medical consent was not part of mandatory training for radiology and outpatients staff at Bridlington Hospital.
- Patients told us that staff were very good at explaining what was going to happen to them before asking for consent to carry out procedures or examinations.
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients undergoing diagnostic procedures.

## Are outpatient and diagnostic imaging services caring?

Good

During the inspection we saw and were told by patients that the staff working in the outpatients and radiology departments were caring and compassionate at every stage of their journey. People were treated respectfully and their privacy was maintained. There were services in place to support patients and their families emotionally and spiritually. Patients were involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

**Compassionate care**

- All of the patients we spoke with spoke highly of the care and treatment they received in the departments. There were no negative aspects about care highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- People's privacy and dignity were respected.
- Patients reported that, most of the time, staff made sure they were kept up to date with waiting times in clinic.
- We saw that patients and staff had a good rapport. Staff were friendly and made sure that patients were at ease.
- Staff were observed to knock on doors before entering rooms and curtains were drawn and doors closed when patients were in treatment areas.
- We spoke with four patients using radiology and outpatients services and five relatives. They told us they were very happy with the services provided.
- Staff presented themselves as skilled, caring and helpful.
- Staff were courteous when caring for patients and they were seen responding to patients' individual needs in a timely manner.

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

- We spoke with 22 patients and their relatives in the outpatients and diagnostic imaging departments. All patients we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they were given clear information and time to think about any decisions they had to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care, however they respected the decision of patients when they chose not to involve their loved ones.
- We saw patients and people close to them being consulted before radiology procedures and staff were attentive to the needs of the patients.
- There were no delays evident in patients' care and treatment during the course of our visit to the radiology department.

**Emotional support**

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were given the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who

# Outpatients and diagnostic imaging

were further along their patient journey. There were posters on the walls advertising these groups, for example for patients who had cancer, hearing loss or who were facing blindness.
- There was formal counselling support available for patients who needed it.

## Are outpatient and diagnostic imaging services responsive?

Good

Waiting times were mostly within acceptable timescales, with the exception of two-week cancer waits. The 'did not attend' rate at the hospital was better than the England average. Outpatient clinics were only occasionally cancelled at short notice. Patients were able to be seen quickly for urgent appointments if required. Patients reported that clinics often overran, however the trust did not collect information about the frequency of this.

There were mechanisms in place to ensure that the service was able to meet the individual needs of people, such as those living with dementia, a learning disability or those whose first language was not English. Catering facilities were available, but there were times when clinics were running that catering facilities were not available.

There were systems in place to capture concerns and complaints raised within the outpatients departments.

### Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort.
- Additional outpatient clinics were run to meet extra demand to ensure that waiting time targets were met.
- Patients were able to attend the radiology department for plain film x-rays without an appointment between 9am and 5pm with open access for chest x-ray by GP referral available from 9.30am to 4pm.
- Staff told us that if the clinic was busy they would stay and make sure that every patient had been x-rayed before closing.
- The diagnostic imaging department was only able to provide a limited service in Bridlington Hospital with more complex cases being sent to either Scarborough or York. There was limited out-of-hours cover in place.
- The diagnostic imaging department had the capacity to deal with urgent referrals.
- The phlebotomy service provided daily clinics between 8am and 5pm.

### Access and flow

- The 'did not attend' rate for Bridlington Hospital was about 6%. This was better than the England average of about 7%.
- Eighteen weeks referral-to-treatment times for non-admitted patients were better than the England average from March 2014 to October 2014. The trust was better than the England standard from March 2013 to October 2014.
- Eighteen weeks referral-to-treatment times for incomplete pathways were better than the England standard of 92% from September 2013 to October 2014. The standard states that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral.
- Since April 2013, the trust had fallen below the England average for percentage of people seen by a specialist within 2 weeks of an urgent GP referral for suspected cancer.
- Since April 2013 the trust achieved better than the England average for percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers other than in October, November and December 2013, when performance dipped. As of July 2014, the trust was better than the England average.
- Since April 2013 the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for cancer was better than the England average.
- The waiting times at the trust for people waiting longer than six weeks for a diagnostic appointment fluctuated between 0.5% and 3.5% between March 2013 and November 2014. The trust waiting times mirrored the England average waiting times for this period.
- The trust did not routinely collect information about the average waiting time for patients once they had arrived

at outpatient clinics but before they were being called in to their appointment. This meant there was no data on delays experienced by patients once in clinics and the reasons for the delay.

- On the afternoon of our inspection, three patients told us that they had been waiting more than one hour to be seen by the consultant. Staff had informed them of a delay and this was displayed on the noticeboards, but patients had not been given an explanation of the reason for the delay. Patients we spoke with were very dissatisfied about the delays.
- Staff told us that there was capacity in clinics to see patients who were referred urgently and that double-booking two patients into one clinic slot happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore it is not quantifiable.
- On the day of our visit patients with appointment times in the radiology department were not left waiting for long periods of time before being seen for their appointment.
- Patients arriving from outpatient clinics and inpatients were booked into time slots within the departments on an as-required basis and according to the acuity of the referral.

**Meeting people's individual needs**

- Staff told us that they were able to access interpreting services if they needed to.
- Staff told us there was a limited supply of patient information available in different languages. They told us that they would make sure any information patients needed, for example about after care, was explained to them by the interpreter and that the patient understood.
- We saw that the outpatients and radiology departments had leaflets for patients.
- Staff were aware of the support that was available within the trust for people with learning disabilities, if it was needed. Staff told us they would allow a patient's carer to stay with them if that was what the patient wanted.
- The learning disability team were available to work with patients who needed extra support. For example, some patients were able to attend mock appointments and be supported by the learning disability team, who explained appointment and diagnostic processes to help to allay people's fears and phobias.
- Within the outpatients departments, healthcare assistants had been trained to be link trainers for dementia issues.
- Staff told us they were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly. Staff were keen to point out that they would be careful not to make people feel awkward or different by treating them differently. Staff spoke of assessing each person as an individual and not jumping to conclusions about what support they may need.
- The departments had access to food and drinks for vulnerable patients or patients who had conditions such as diabetes. There was a system in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.
- There were catering facilities on site; however these were only open for limited hours. For example, they were closed between 10.30am and 12noon every day, between 2pm and 4.30pm Monday to Wednesday and after 2pm on Thursday and Friday. This meant that there were times when people waiting for appointments were unable to buy hot drinks.
- The departments were able to accommodate patients in wheelchairs or who needed specialist equipment.
- There was clear signage throughout the departments.

**Learning from complaints and concerns**

- There had been one complaint about the outpatients departments and radiology departments. This was about the treatment received by a patient.
- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the patient advice and liaison service or make a complaint was available within waiting areas.

# Outpatients and diagnostic imaging

- The outpatient's manager and staff told us that complaints and concerns were discussed at local team meetings and any learning from them was shared. We looked at two sets of team meeting minutes that confirmed this.
- According to staff, there had been no team meetings in the radiology department for some time. The superintendent radiographer was unable to provide us with any evidence to show that complaints and concerns were discussed within the team.
- None of the patients we spoke with had made a formal complaint. On the whole they were happy with the care they received in the departments, other than having long waits to be seen.

## Are outpatient and diagnostic imaging services well-led?

Requires improvement 

We found that the leadership within Bridlington Hospital radiology department required improvement. The management was unable to provide us with evidence about the way the department was managed in relation to incidents and complaints. There was a lack of evidence that clinical governance, audits and team meetings took place regularly and that lessons learned from complaints and incidents were disseminated to staff. We were told that the radiology management did not attend clinical governance meetings. No action had been taken to ensure that staff had attended fire safety and moving and handling training.

Radiology staff were not encouraged to engage in continuous professional development. Staff were not confident and had not received training on supporting new staff. Staff had not undergone regular performance and development reviews or appraisals and there were no checks of the quality of work undertaken by staff in the radiology department.

The outpatients department were well led at a local level. Changes and improvements had been made to ensure that the department worked effectively and efficiently. New standard operating procedures had been introduced and the staff were supported to develop professionally if they wanted to.

Staff on the Bridlington site felt that the acquisition of the hospital had not been well managed and that there was a disconnect between the executive trust team and staff working in Bridlington. Staff told us they felt less regarded and less important than at other sites. Staff felt that general morale across the organisation was low, and especially low among the staff who worked on the Bridlington. The national staff survey results showed that the trust was worse than expected for six questions. Additionally, the results had dropped from the previous year's results.

Within the outpatients and radiology departments at Bridlington Hospital, senior and executive team managers had a vision for the future of the departments and were aware of the risks and challenges faced.

### Vision and strategy for this service

- The outpatient's department manager and senior managers we spoke with were aware of the challenges faced by the departments and the trust as a whole.
- Staff we spoke with in the outpatients departments were unsure if there was an outpatients strategy in place.
- Staff within the services were aware of the challenges faced by the organisation, for example the financial challenges faced. Most told us they were aware that there was a strategy for the trust, but were mostly interested in doing their jobs well on a daily basis.
- There was a directorate strategy/aspirations for radiology across the trust. This was a five-year plan from 2014 to 2019 and set out changes needed within the department to make it more efficient, cost effective and future-proof.

### Governance, risk management and quality measurement

- There were governance arrangements in place across the trust, which staff from the outpatients departments were aware of and participated in. The departments had regular staff meetings where clinical governance topics were discussed. These audit sessions were held one afternoon every month. Sometimes training was offered to staff as part of the meeting. From what we were told when we inspected the radiology department at Bridlington, the same did not happen in radiology.
- The organisation had systems in place to appraise NICE guidance and ensure that any relevant guidance was put into practice.

# Outpatients and diagnostic imaging

- Radiology reports were partly outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of outsourced radiology reports.
- We saw that radiation safety audits were carried out. The latest audit sent to us by the trust dated 14 April 2015 showed that the radiology department at Bridlington was not meeting standards in five out of 12 sections of the audit: risk assessments, management of radiation protection, equipment inventory, contingencies and incidents and staff training.
- We looked at the directorate risk register for any risks in the outpatients departments at Bridlington Hospital. There were no risks recorded on the register.

**Leadership of service**

- Most staff told us that they found the senior managers of the services to be approachable.
- Staff told us they felt that the outpatients departments was often forgotten about when the executive team visited Bridlington Hospital as most visits were to the wards rather than other departments**.**
- Some staff working in Bridlington Hospital did not feel that they were part of the York Teaching Hospitals Foundation Trust. They felt that integration with the trust had left them "as the poor relation". Staff on the whole did not feel that the takeover had been managed well, taking into consideration existing structures and staff concerns.
- Some staff told us that the management style in the trust was negative. They told us they were never thanked for their hard work and only ever received negative feedback about the things they had not done well.
- Staff told us that morale was low across the trust and particularly in the radiology departments.
- The managers of the departments were seen as fair and flexible with staff.
- Radiology staff we spoke with reported mixed feelings about local leadership.
- All of the staff were aware of the trust leadership and could access the relevant information from the intranet about how to contact senior managers.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although this was not as easy as in the past because of staffing level and financial pressures.

**Culture within the service**

- Staff told us that the chief executive was approachable if they had any concerns and was open to hearing from them However, because the executive management team was based in York, staff felt that there was a disconnect between the executive team and staff in Bridlington. This was despite knowing that the executive team occasionally visited the site to attend meetings. Staff said that the executive team was not easily accessible.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Staff were aware of their responsibilities in relation to 'duty of candour', to be open and honest with patients when incidents or accidents occurred and where appropriate to involve them in discussions and investigations.
- Managers told us that they felt supported by the organisation.
- Managers across the trust felt that consultation was true consultation. Opinions were listened to and taken into consideration before decisions were made. People were asked what they would like to happen rather than told what was going to happen.

**Public and staff engagement**

- We saw that governance arrangements were in place in the outpatients departments. Complaints and comments were discussed at team meetings. This did not happen in the radiology department in Bridlington.
- The outpatients and radiology departments had started to take part in the NHS Friends and Family Test in the first quarter of 2015. Results showed that at Bridlington 95% of people were either likely or extremely likely to recommend the outpatients departments to their friends or family.
- There was no specific information from the staff survey relating to the outpatients and radiology departments, but the trust as a whole performed within expectations or better than expectations in all but six elements of the

2013 national staff survey: percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff receiving health and safety training in the last 12 months; percentage of staff saying hand washing materials are always available; fairness and effectiveness of reporting errors, near misses and incidents; percentage of staff able to contribute to improvements at work; and percentage of staff having equality and diversity training in the last 12 months. All had fallen since the previous survey in 2012.

**Innovation, improvement and sustainability**

- Staff all told us that they were being encouraged to look at ways the trust could work more efficiently, make savings and improve quality of care for patients. They told us about how they were encouraged to try changes and then evaluate them to make sure quality of care did not fall when money was saved.
- Staff and managers reported that they were able to influence changes in the way the outpatients and radiology departments were organised and run. We were given examples of changes that had been made to the way the services were run that had improved the patient experience and made the clinics run more efficiently.
- 64% of all staff within the trust who responded to the NHS staff survey felt they were able to contribute towards improvements at work. This was worse than the England average of 68%. There was no specific information for the outpatients or radiology departments.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- The provider must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels; especially in relation to staffing of the medical and surgical areas.
- The provider must review the uptake and monitoring of training, and ensure that staff at Bridlington Hospital are compliant with mandatory training requirements, especially in the areas of moving and handling, fire safety, safeguarding vulnerable adults, and safeguarding children.

### Action the hospital SHOULD take to improve

#### Medicine

- The provider should review the management and cover arrangements of managers and matrons providing senior nursing support to the wards at Bridlington Hospital, and ensure that staff are made aware of managerial and support arrangements.
- The provider should review the involvement of staff at Bridlington Hospital, to ensure that staff are fully aware and engaged with the trust vision, strategies and objectives, and can contribute to the development of services

#### Surgery

- The provider should ensure there is adequate medical cover out of hours at Bridlington Hospital
- The provider should ensure improvements are made in the 18 week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
- The provider should continue to work towards integrating surgical services and deliver common standards of care across the three hospital sites, including standardised protocols, guidelines and pathways of care.

#### End of Life Care

- The provider should agree a consistent process for recording mental capacity assessments when making DNA CPR decisions, whether on the trust's mental capacity assessment form, or within the patient's notes. There needs to be consistent, clearly recorded information regarding the patient's ability to understand, retain and weigh the information specific to the DNA CPR.
- The provider should ensure DNA CPR decisions are reviewed when patients are transferred from one site to another.
- The provider should develop the use of pain assessment tools particularly for patients who may have difficulty in expressing their pain verbally and on the end of life care pathway

#### Outpatients and diagnostic services

- The provider should ensure that all patient areas comply with infection control best practice, specifically the seating areas
- The provider should ensure that the staff are supported and effectively managed in the radiology department at Bridlington Hospital including ensuring all staff receive appraisals in a timely manner, every 12 months.
- The provider should ensure that checks on fridges and resuscitation equipment are carried out in line with policy and are accurately recorded.
- The provider should ensure that compliance with the radiation safety audit is improved.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing.<br><br>How the regulation was not being met: The provider did not have suitable arrangements in place in order to ensure that persons employed for the regulated activity are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely and to an appropriate standard including by receiving appropriate training, professional development, supervision and appraisal. This was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>The provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of safeguarding training so that they are working to the up to date requirements and good practice. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Regulation 18(1) HSCA (RA) Regulations 2014 Staffing. |

This section is primarily information for the provider

# Requirement notices

How the regulation was not being met: The provider had not taken the appropriate steps to ensure that, at all times, there are sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels especially in relation to staffing of the medical and surgical areas.