Care Quality Commission

Bradford Teaching Hospitals NHS Foundation Trust

Bradford Royal Infirmary

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Bradford Teaching Hospitals NHS Foundation Trust is an integrated trust, which provides acute services and a limited number of community in-patient health services. The trust serves a population of around 500,000 people from Bradford and the surrounding area and employs around 5,000 staff. The acute services are provided in two hospitals, Bradford Royal Infirmary and St Luke's Hospital. The trust has four community hospitals; Westwood Park, Westbourne Green, Shipley and Eccleshill.

Bradford Royal Infirmary has around 900 beds and provides urgent and emergency services, medical and surgical services including general surgery, gynaecology; orthopaedics; ear, nose and throat (ENT); critical and high dependency care services; children's and young people's services. The hospital also provides an acute stroke service, consultant led maternity services, outpatient services for adults and children. There are also rehabilitation and therapy services provided.

We inspected the trust, which included this hospital from 21 to 24 October 2014 and undertook an unannounced inspection on 4 November. We carried out this inspection as part of our comprehensive inspection programme.

Overall, we rated Bradford Royal Infirmary as requires improvement. We rated it inadequate for safety, good for being caring and requires improvement for being effective, responsive to patient's needs and being well-led.

We rated surgery, end of life, maternity and gynaecology services as good. Urgent and emergency care (ED), medical, children and young people's services were rated as requires improvement. We rated outpatients' services as inadequate. The ratings within the report were based on the evidence gathered at the time of the inspection.

Our key findings were as follows:

- There had been changes in the leadership team at trust level, with some changes in the leadership and management within the divisions and clinical services at the hospital. Along with these changes there had been the introduction of new governance and assurance arrangements, which had yet to be embedded.
- We had serious concerns over the very large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. The trust had taken steps to address this and was validating the information on patients in the back log. However, we had concerns over the length of time it had taken to put in suitable actions and the time it would take to assess the impact on individual patients.
- Following the inspection we requested further information from the trust in accordance with Section 64(1) of the Health and Social Care Act 2008 (HSCA) regarding this backlog. The trust's response indicated that actions were in place and that the backlog was reducing. The timescale for completing the review of all these patient pathways was March 2015.
- We were concerned about the skills and experience of some staff, particularly in the stabilisation room used for children waiting to be collected for transfer to another hospital for paediatric intensive care. An outcome from a serious incident related to the stabilisation room had not been acted upon. We raised these concerns with the trust. The trust acted on the concerns raised.
- The hospital building and estates were old and many areas were no longer suitable to meet the needs of patients or staff. In some areas space was compromised making moving patients and accessing hand wash sinks difficult and direct observation was limited. There were insufficient side rooms and in some areas such as children's services there were insufficient bathing facilities.
- There was work in progress to increase and improve on the facilities within the hospital including the addition of a new wing to house the children's service, critical care and improve endoscopy services. There was some anxiety amongst the staff working at the trust as to how the services would be reconfigured as part of the estate development.

Summary of findings

- There was a dedicated infection prevention and control team with arrangements in place for the prevention of infection. However, the layout in many areas in the hospital presented challenges. For example the inadequate number of side rooms (including a lack of ensuite facilities), meant that patients were not always suitably isolated. Access to hand wash sinks was compromised in a number of areas such as the critical care unit. Not all infection prevention practices were adhered to at all times putting patients at risk. The trust was on target for its trajectory for Clostridium difficile infection rates but had breached the zero tolerance level for Methicilin-resistent Staphylococcus Aureus (MRSA).
- There were staff shortages across all areas. Staffing levels and skill mix did not regularly meet best practice or national guidance. We were particularly concerned about the number of qualified staff working in children's services, in the recovery areas of the operating theatres and maternity services. There had been some improvements made in the urgent and emergency care department and medical services. The trust was actively recruiting into vacant posts and staff were working additional hours to cover gaps on shifts. Some bank and agency staff were also used to cover shortages.
  - Not all staff had completed their mandatory training, particularly for safeguarding training at Levels 2 and 3 or had received an appraisal. Access to training for some staff groups had been affected by the staff shortages as they were unable to attend courses. However, there was positive reports from medical staff about the quality of their training in the hospital.
- We were concerned about the skills and experience in some areas, particularly in the stabilisation room used for children waiting to be collected for transfer to another hospital for paediatric intensive care.
- We were also seriously concerned about the care of patients being treated with non-invasive ventilation, who were placed in wards across the hospital under the care of physiotherapists, which did not meet with best practice and national guidance. Subsequent to the inspection the Trust provided us with information that they were acting on these concerns

We observed areas of good practice including:

- Generally, treatment and care followed best practice and national guidance and outcomes for patients were positive.
- Patients reported good experiences and were treated with kindness with their dignity and privacy protected. Patients and their relatives reported that they felt involved in decisions about their care. Women on the maternity unit reported good experiences and were happy with the care they received. Staff received feedback from complaints so that improvements in their service could be made.
- The support from the chaplaincy service was excellent. However, the facilities for spiritual support were inadequate impacting on the experience of those wishing to access this service.

We observed areas of outstanding practice:

- The surgical services had introduced a complementary system of 'green bands' worn by patients on their wrists displaying personal and procedure information. This was an effective additional safety measure to the World Health Organization (WHO) Five Steps to Safer Surgery checklist.
- Working in collaboration with Macmillan Cancer Support, the hospital specialist palliative care team (HSPCT) were awarded the International Journal of Palliative Nursing multidisciplinary teamwork award for the positive impact that their work had on the care they provided.
- The HSPCT were the first team in the country to link the AMBER care bundle to the Gold Standard Framework for end of life care register, which showed an increase of 38% to 57% in the identification of patients in their last year.
- The palliative care liaison service work with ethnic minorities had won a Department of Health and Social Care award under the category 'Improving Lives for People with Cancer' and was awarded with a commendation.
- The elderly care wards, particularly Ward 29 and Ward 30, had made improvements to the care of older people, including those living with dementia. The environment had been adapted and was an exemplar for dementia-friendly environments.

Summary of findings

- In diagnostic imaging, all ultrasound sonographers were independent reporters. There was a high proportion of advanced practitioners which had helped improve access to services.

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

Importantly, the trust must:

- "Ensure that the significant backlog of outpatient care pathways is promptly addressed and prioritised according to clinical need. Ensure that the governance and monitoring of outpatients' appointment bookings are robust and able to identify any potential system failures so that action can be taken in a timely manner.
- Ensure that there are appropriate arrangements for the prevention and control of infection including the isolation of patients throughout the hospital, including the urgent and emergency care department; that infection prevention and control practices are adhered to, particularly on Ward 9. Ensure that there is suitable access to hand wash sinks, particularly on the critical care unit and high dependency unit. Review the number of side rooms available with ensuite bathroom facilities for the management of patients with infections. Ensure the procedures for cleaning and disinfecting endoscopes are consistent with accepted practice.
- Ensure that the environment and facilities meet the needs of patients on wards, particularly on Wards 2, 16 and 17. Ensure that there are adequate bathroom facilities on Ward 2 to meet the needs of the children on that ward. Review and improve the environment on Ward 7, Ward 9, and Ward 24 and in the Diabetes Centre.
- 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, particularly on medical wards, including the provision of staff out of hours, on bank holidays and at weekends; children's and young people's services including the children's stabilisation room and that staffing levels meet planned staffing levels; critical care; the recovery areas of operating theatres, maternity services and within the urgent and emergency care department to ensure the safe streaming (triage) of patients attending reception area.
- Embed the use of a dependency acuity tool in practice and ensure that written guidance/ or protocol is developed to support staff whilst assessing a patient's acuity.
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring non-invasive ventilation to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.
- Ensure that equipment is checked according to best practice guidance and trust policy. Ensure that all checks are appropriately recorded, including resuscitation equipment.
- Ensure staff receive appropriate training and support through supervision and appraisal including the completion of mandatory training, particularly the relevant level of safeguarding training so that they are working to the latest up to date guidance and practices.
- Ensure that patient records are maintained up to date, are patient centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.
- Ensure formal arrangements are developed for the receipt, recording and storage of surgical instruments.
- Ensure medicines are stored safely on all wards and fridge temperatures are checked in line with national guidance.
- Ensure staff understand and engage with the trust and division visions, values and strategies. Increase staff engagement and consultation within the hospital particularly on the development of services.
- Ensure staff receive feedback on incidents and that shared learning occurs.
- Review the patient flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.
- Review the care pathway for children undergoing surgical procedures including individual fasting times and timings for theatre.
- Review the access to and capacity of the child development service, especially in relation to access to autism services.

Summary of findings

- Ensure patients have their medicines reconciled in accordance with trust targets.
- Ensure that improvements are made to provide effective bereavement, chaplaincy and mortuary facilities.
- Ensure that safe manual handling procedures are in place in the mortuary through the use of suitable equipment.

In addition the trust should:

- Review the queuing arrangements for patients in the ED reception area; consult with, and involve, reception and administrative staff in the redesign and improvement of the ED.
- Review and ensure that NICE 83 guidelines for rehabilitation in critical care, mainly in relation to post-discharge follow-up, are followed.
- Review the provision of ED facilities for patients living with dementia.
- Provide patients in the ED waiting area with information about waiting times.
- Improve lighting and access to the ED at night.
- Review the use of the public address system used to address patients in the ED.
- Review the provision of side rooms in the ED.
- Record the cleaning of children's toys in the paediatric emergency area.
- Review public and staff access to results of the Safety Thermometer dashboard for their area.
- Ensure the referral system is fit for purpose and maintains an audit trail.
- Ensure staff receive information regarding audits and reviews of practice so that trends and good practice can be identified.
- Review the trust's approach and uptake of clinical supervision.
- Review access to patient information in languages other than English.
- Review dedicated management time allocated to ward managers.
- Review the adequacy of facilities for staff and waiting patients within the endoscopy unit.
- Address issues so that critical care delayed discharges are reduced and that patients are discharged from critical care to a ward within four hours of the decision to discharge being made.
- Re-commence audits of Ventilator Associated Pneumonia (VAP) to assess outcomes for ventilated patients.
- Review the processes for providing critical-care outreach support from 5pm and overnight.
- Review the handover arrangements to improve their effectiveness.
- Make the phlebotomy service available for patients if clinics are not running to time.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We found that overall the department required improvement, specifically in relation to safety and responsiveness. Incidents were reported, investigated and learning implemented. Systems were in place to safeguard vulnerable adults and children. However, patients often waited a long time to be assessed. Receptionists were not qualified to make initial assessment decisions, which could put patients at risk . A shortage of side rooms impacted adversely on patient flow. Patients were cared for with privacy and dignity, however, there were only a limited number of cubicles with doors in the department where privacy and dignity could be fully maintained. Pain relief was offered for most patients and administered promptly. However, pain scores were not recorded consistently. The number of consultant and medical staff had recently increased substantially. No staffing tool was used to calculate the required number of nurses and skill mix. Out of hours the mental health crisis support arrangements did not enable a responsive service . The National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines were used and supported by local guidelines. Staff had regular appraisals and personal development. The senior management team demonstrated a clear strategic vision for the department and provided effective and visible leadership. Risks were identified and regularly reviewed. The department routinely undertook a range of audits to improve performance.
Medical care	Requires improvement 	Systems were in place to report incidents, but feedback and analysis was not consistent. Wards monitored safety and 'harm-free' care and results were positive, overall. The results were not readily available to staff or patients.

Summary of findings

Wards appeared visibly clean. The environment caused limitations in meeting some patients' needs. For example, there was a lack of en suite facilities in side rooms used for people with infection risks. Medical staffing had improved since our previous inspections. Nurse staffing had improved, although there remained a number of occasions when the number of staff on duty was below the planned level to enable staff to provide safe care. We were particularly concerned about the staff to patient ratios for patients requiring non-invasive ventilation who were being nursed on general ward areas. Most patients and relatives told us that they, or their relatives, had been treated with compassion and that staff were polite and respectful. Pain relief and nutrition and hydration needs were met. Policies and guidelines were available and audits were undertaken. There had been very recent changes to the leadership of the medical division as part of a wider trust restructure. Most staff were clear about the vision and strategy for the service. Changes to the risk management processes were in place, but required further embedding in practice.

Surgery

Good

We rated effective, caring, responsive and well led as good, with safety as requiring improvement. There were arrangements in place for reporting patient and staff incidents and allegations of abuse. Staff did not always receive feedback on reported incidents. The recovery areas were poorly staffed on the day of inspection, with only one recovery nurse for two theatres.

There was a lack of isolation and side rooms throughout the division's wards. This meant that some patients were not always cared for in the most appropriate environment. There were concerns about the receipt, recording and storage of some surgical instruments and the adequacy of facilities for staff and waiting patients within the endoscopy unit.

Staff understood their individual roles and responsibilities and there was good ward leadership. Staff felt supported at a local level. However, a number of staff described the management structure within the division as being 'disconnected'.

Summary of findings

We observed positive, kind and caring interactions on the wards and between staff and patients. Most patients spoke positively about the standard of care they had received. The service reviewed and acted on information about the quality of care that it received from complaints. The division had implemented change as a result of the learning gained from audits.

Critical care

Requires improvement

We found that caring was good but all other domains required improvement. The environment within the critical unit was inadequate to meet the needs of the service in terms of layout and facilities. There were concerns over the medical staffing skill mix. There were some delays in the discharge of patients, which impacted on the patient experience and bed occupancy rates were high.
Outcome data showing the effectiveness of the care provided was positive. The staff provided compassionate care and were respectful towards patients and/or their family and friends. There was a strong team approach to ensuring the best outcomes for patients.
There had been recent leadership changes, including clinical leadership, and some newly introduced systems and processes had yet to become fully embedded. Some changes to the service had recently been proposed, but it was felt that change wasn't effectively managed and that there was limited consultation.

Maternity and gynaecology

Good

Overall, maternity services were good in all domains with the exception of safety, which required improvement. Staffing establishments and the skills mix did not always meet national recommendations during the day and at night. The completion of mandatory training was between 60-78%, which meant staff may not have accessed up-to-date knowledge and skills. The arrangements for handovers were not always effectively managed, which, at times, resulted in overlap between teams and some delays.
Women were treated with kindness, dignity and respect while they received care and treatment.

Summary of findings

Services were planned to meet women's needs, including those in vulnerable circumstances. The service took complaints and concerns into account and took action to improve the quality of services. Maternity ward areas were visibly clean and equipment was in date and in working order. However, the recording of equipment checks was not consistent in all areas. Medicines were managed appropriately, although issues were found with the safe storage of some medicines. Arrangements were in place to safeguard adults and children from abuse. Serious incidents were monitored and action taken when things went wrong. There were effective governance and risk management systems to support the delivery of good quality care. The leadership and culture encouraged openness and transparency.

Services for children and young people

Requires improvement

Overall, children's and young people's services required improvement. We found safety inadequate. There were systems in place to report incidents, although staff did not always receive feedback from these. The children's ward environments were old and limited in meeting patient needs. The majority of side rooms did not have en suite facilities and Ward 2 did not have a bathroom. The actual number of staff on duty frequently did not meet that planned or best practice guidance. The dependency acuity tool for staffing was not embedded in practice.
We had serious concerns over the arrangements for the stabilisation room on Ward 16 as staff not all staff had the appropriate skills and experience.
There were no specific surgical lists for children and young people and no individual fasting times for children and young people. There were significant waiting times within the child development service.
Care and treatment was generally delivered in line with national and best practice guidance. The service participated in national audits, which monitored patient outcomes and service performance through the specialty dashboards.
We saw that patients and relatives were treated with dignity, respect and compassion. Patients and relatives felt involved and supported by staff within the services.

Summary of findings

The trust's strategy and vision were not well-embedded across children's services. There was uncertainty about the changes to the paediatric wards if they moved into the new build. Staff felt well supported by the ward managers and the senior management team within the directorate.

End of life care

Good

Overall, the rating for end of life services was good. We found some areas of excellent practice in how the service responded to the patients' individual needs. However, we found that improvements were required with regard to ensuring facilities in cases of bereavement were effective, such as the chaplaincy and the mortuary services. The facilities were currently insufficient and limited to meeting the demands of each service. There was insufficient physical space in all areas and a lack of facilities to meet the spiritual and cultural needs of different faiths.

We found that patients received care in line with evidence-based guidelines, national standards, and protocols. Staff were caring and motivated. Patients approaching the end of life were identified appropriately and care was delivered according to their personal care plan, including effective pain relief and other symptoms, which were regularly reviewed.

There were effective governance and risk management systems to support the delivery of good quality care. The leadership and culture encouraged openness and transparency.

Outpatients and diagnostic imaging

Inadequate

We rated outpatients and diagnostic imaging services as 'inadequate' for safety, for responsiveness and well led. There was a very high volume backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. This meant that some patients were waiting considerable amounts of time for follow-up appointments, which could have resulted in delays in patients gaining access to treatment. The trust had recognised this as an issue and had commenced plans on how to address this, but there had been little done to risk assess the impact on individual patients putting them at risk.

Summary of findings

Outpatients and diagnostic imaging staff were caring. Mechanisms were in place to ensure that the service was able to meet the individual needs of people once in the clinics and departments. Systems were in place to capture concerns and complaints raised within both departments, to review these and take action to improve the experience of patients.

We saw that trust policies were based on and included nationally recognised good practice guidance. Staff were competent, and there was evidence of multidisciplinary working. Staff in diagnostic imaging stated that they were well supported by their managers. Most staff and managers told us there was an 'open culture'. Managers at the trust told us they held regular meetings with administrative staff in each specialty. In addition there were specific open meetings with all administrative staff involved in the centralised patient booking service and divisional teams. However, most medical secretaries and some outpatient staff did not feel empowered or listened to.

Requires improvement

Bradford Royal Infirmary

Detailed findings

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

Contents

Detailed findings

Background to Bradford Royal Infirmary

Bradford Royal Infirmary is part of the Bradford Teaching Hospitals NHS Foundation Trust. It is situated in Bradford and serves a population of around 500,000 people in the local area. The hospital has approximately 900 beds. The trust employs around 5,000 members of staff including 636 medical staff.

Bradford Royal Infirmary provides a range of services including: Urgent and emergency care, a range of general and specialist medical services for adults, care for children with surgical and medical problems, surgery for adults including general surgery, gynaecology, treatment for cancer, orthopaedics, ear, nose and throat (ENT), urology, vascular and plastic surgery, intensive and high dependency care, acute stroke services, consultant led maternity services, day surgery for adults and children, outpatient services for adults and children and rehabilitation and therapy services.

The urgent and emergency care services received 129,187 attendances in 2013 and 2014 and just above a quarter of these were admitted to hospital. This meant that, on average, 300-400 patients were treated each day. Almost 30% of patients seen in the department were children. The nearest major trauma centre was in Leeds.

The hospital has 12 medical wards, including an elderly acute assessment unit (Ward 3), a medical admissions unit (Ward 4) and a discharge lounge. The medical division included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, renal medicine, gastroenterology, haematology, neurology and stroke care.

The hospital provided a range of surgical services for the population of Bradford and the immediate surrounding area and also served the population of West Yorkshire. There were thirteen wards providing surgical services and twenty operating theatres.

The critical care service is located at the trust's main site, Bradford Royal Infirmary and includes an intensive care unit (ICU) and a four-bed high dependency unit (HDU), which is situated away from the ICU.

The ICU has 16 mixed Level 2 and Level 3 beds and admits around 1,100 patients per year, placing it amongst the busiest 20 units in England and Wales. Around 40% of admissions are acute post-operative patients admitted directly from theatre and around 60% of admissions are elective.

The maternity service at Bradford Teaching Hospitals NHS Foundation Trust delivered approximately 6,000 babies per annum. The trust offered a full range of maternity services for women and families based in the Bradford Royal Infirmary and community settings, ranging from specialist care for women who needed closer monitoring, to a home birth service for women with healthy pregnancies. There were six teams of community midwives who delivered antenatal and postnatal care in women's own homes, clinics and general practitioner locations across the city. An integrated women's health unit also provided a range of treatments for gynaecological problems.

The children's services included three inpatient children's wards based at the Bradford Royal Infirmary site. Ward 16 was a 10 bed medical ward and included a two bed stabilisation room. The children's assessment unit was also based on Ward 16, which provided a further seven beds and accepted medical referrals from the children's emergency department, direct GP referrals and children with direct access. Ward 17 was a 25 bed medical ward and Ward 2 was a 27 bed surgical ward. At night, the ward capacity was reduced to 16 beds.

End of life care (EOL) services were provided across the hospital. The hospital specialist palliative care team (HSPCT) had a clinical and educational role within Bradford Teaching Hospitals NHS Foundation Trust. The service offered by the team was an advisory one, in which patients remained under the care of the referring medical team. There were also two community palliative care teams (from another NHS trust) and local hospices in the city with whom the team worked closely.

Bradford Teaching Hospitals NHS Foundation Trust provided a wide range of outpatient clinics, predominantly at Bradford Royal Infirmary and St Luke's Hospital. Between 2013 and 2014, 577,619 patients attended outpatient clinics across the two sites, with 239,831 of these patients attending outpatient clinics at Bradford Royal Infirmary.

Detailed findings

At the last CQC inspection in June 2014, the hospital had not been compliant with the Health and Social Care Act (2008) in safe staffing levels (Regulation 22). An action plan had been submitted and the trust had planned to be compliant by December 2014.

Our inspection team

Our inspection team was led by:

Chair: Michael Marrinan, Executive Medical Director, Kings College Hospital, London

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The team of 46 included CQC inspectors and a variety of specialists including medical, paediatric and surgical consultants, junior doctors, senior managers, nurses, midwives, a palliative care nurse specialist, a health visitor, allied health professionals, children's nurses and experts by experience who had experience of using services.

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at Bradford Royal Infirmary:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatient 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 hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Bradford on the 20 October 2014, where 21 people shared their views and experiences of the Bradford Teaching Hospitals NHS Foundation 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 and drop-in sessions with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from all the 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.

Detailed findings

We carried out the announced inspection visit between 21 and 24 October 2014 and undertook an unannounced inspection in the evening on 4 November 2014.

Facts and data about Bradford Royal Infirmary

Information on the trust:

The trust gained foundation trust status in April 2004

The trust's revenue: £356.6m

Full Cost: £360m

Surplus (deficit): £3.8m

The Bradford area sits within the 10% most deprived local authorities in the country, due to this they have a higher level of chronic disease than neighbouring areas. Areas of particular concern are cardiovascular disease, diabetes and respiratory disease.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

The urgent and emergency care services received 129,187 attendances in 2013 and 2014 and just above a quarter of these were admitted to hospital. This meant that, on average, 300-400 patients were treated each day. Almost 30% of patients seen in the department were children. The nearest major trauma centre was in Leeds.

The department included treatment areas for resuscitation, majors, minor injuries and paediatrics. Within the children's area there were two cubicles for minor injuries and four cubicles for more poorly children, of which, one of these was allocated for older children and teenagers. There was also a separate waiting area for children. In the major's area there were 18 cubicles in total, three of which were used for a rapid assessment 'see and treat' service. There was a separate area with four cubicles to receive all patients that arrived by ambulance between midday and midnight. The resuscitation room contained three patient bays. One of these was used for trauma patients, one for medical patients, and one was equipped for both children and adults. Adjacent to the resuscitation area, seven bays provided a 'step down' facility for higher dependency patients. Within the adult area, there was a separate minor injuries facility, which had five consulting rooms and one treatment room. The department also held a number of morning clinics on weekdays, although these were being reduced. A dedicated x-ray facility with a separate waiting area was located in the ED.

We were informed of plans to redesign the emergency department (ED). This would introduce two further resuscitation bays to increase the total to five; two of which were to be equipped for children and three for adults. Work was expected to start in early 2015. The redesigned emergency facilities were also to include an ambulatory care ward (with reconfigured arrangements, rather than new beds) for diagnosis and treatment of a range of conditions that did not require an inpatient stay.

We spoke with 12 patients, eight relatives and 50 members of staff of different disciplines. We observed daily practice, reviewed paper and electronic records and documentation and reviewed information provided to us prior to our inspection.

Urgent and emergency services

Summary of findings

We found that overall the department required improvement, specifically in relation to safety and responsiveness. Incidents were reported, investigated and learning implemented. Systems were in place to safeguard vulnerable adults and children.

However, patients often waited a long time to be assessed. Receptionists were not qualified to make initial assessment decisions, which could put patients at risk (stream or triage is a process of identifying priorities for care) . A shortage of side rooms impacted adversely on patient flow. Patients were cared for with privacy and dignity, however, there were only a limited number of cubicles with doors in the department where privacy and dignity could be fully maintained. Pain relief was offered for most patients and administered promptly. However, pain scores were not recorded consistently.

The number of consultant and medical staff had recently increased substantially. No staffing tool was used to calculate the required number of nurses and skill mix. Out of hours the mental health crisis support arrangements did not enable a responsive service .

The National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines were used and supported by local guidelines. Staff had regular appraisals and personal development.

The senior management team demonstrated a clear strategic vision for the department and provided effective and visible leadership. Risks were identified and regularly reviewed. The department routinely undertook a range of audits to improve performance.

Are urgent and emergency services safe?

Requires improvement

The reception staff were requested to 'stream' patients when the department was busy, this meant unqualified and non-clinical staff needed to decide which treatment area the patient should be treated in and how urgent their condition was. Receptionists were not qualified to make such decisions and this impacted on patient safety. Depending on available staff, the separate children's department was not always open in the morning. There were no facilities to isolate patients, although an isolation cubicle was planned. A review of patient notes identified some errors and gaps in recording.

The trust reported they used professional judgement and activity to identify the current nursing establishment. However we found in the absence of an established local tool it was not possible to tell whether the nursing establishment was adequate. Staff shortfalls occurred almost daily, which could not always be covered by temporary staff. However, staff worked flexibly between areas of the department, depending on need and communication between staff was effective in responding to these changes.

There was learning from incidents. Cleanliness and infection control practices were supported by regular audits. Stocks of equipment were good and the maintenance and procurement of replacement equipment was planned. Medicines were stored and administered safely.

The department had systems in place to safeguard vulnerable adults and children. Staff had undergone safeguarding training. The required mandatory training levels were achieved by staff. However, the trust's mandatory training records did not accurately reflect the levels of mandatory training held within the department.

Staff commented favourably on the visibility of consultants and doctors and on the substantial recent increases in the numbers of medical staff in the department. Major incident plans were well rehearsed and equipment held in the ED for responding to major incidents was comprehensive.

Incidents

Urgent and emergency services

- The number of serious incidents reported was in line with expectations for the size of the trust. Four serious incidents had occurred since April 2013, one relating to a child death, which was under investigation by the trust at the time of our inspection.
- The trust had a serious incident and a Never Event policy in place, which covered information governance arrangements around incidents and supported staff learning from serious incidents.
- There were no recent incidents of pressure ulcers, except in December 2013, and no recent incidents of catheter-acquired urinary tract infections, except in November 2013. No falls incidents were reported since July 2013.
- The department reported serious incidents using an electronic incident reporting system widely used in the NHS. We checked a recent serious incident, which showed that the reporting system was used appropriately.
- We found that the department also used a system called clinical emergency medicine books (CEM books) to help manage incidents, which linked to other aspects of governance.
- We found evidence of staff learning from the investigation of incidents that had resulted in change of practice. For example, incidents related to the treatment of head injuries correlated with pathways not being followed appropriately. Another incident involved a patient being discharged inappropriately without evidence of checking investigations. An issue with handover arrangements was identified, which was changed to use a written document, supported by revised local guidelines.
- We found that learning from incidents was discussed in staff meetings and learning was supported by simulations based on incidents that had occurred. However, one nurse who had completed six incident reports in the previous month expressed some frustration at not receiving feedback.
- A representative of the department attended meetings to review mortality and morbidity when this was appropriate.

Initial assessment and treatment

- Ambulance time to initial assessment was consistently better than the England average.
- Ambulance handover delays: between November 2013 and March 2014 there were 174 ambulance handovers delays of over 30 minutes. The trust performed better than most other trusts.
- The 15 minute to nurse triage target was at 80% prior to the inspection
- The further target of “One hour to see a doctor assessment' was at 70% at the time of the inspection due to no cubicles being available in which patients could be seen.
- The CQC national survey report on A&E patient experience 2014 indicated that Bradford ED scored the same as the national average for questions regarding ambulance handover and patients waiting to be seen and assessed.

Cleanliness, infection control and hygiene

- Medical and nursing staff were observed to follow trust policy for hand washing and wearing clothing ‘bare below the elbows’ in clinical areas.
- The department was clean and there was evidence of regular adherence to cleaning schedules.
- We observed equipment being cleaned after use, before the next patient entered the cubicle.
- Mandatory training for staff, including infection control and competency assessments, was completed.
- Cleaning audits were undertaken to identify risks and issues. We reviewed the cleaning inspection report for August and September 2014, which covered functional areas within the department, identified lapses and specified action to be taken.
- Completed audits informed an infection control board report. Audits were completed on a bi-monthly cycle, except for hand hygiene and Methicillin-resistant Staphylococcus Aureus (MRSA) screening, which were monthly. Hand hygiene audits since April 2014 scored above 95%. The department maintained a copy of their audit results, so that they could use the data to inform local actions and correct any shortfalls in performance.
- The department had identified a lapse in pre-admission screening for MRSA in one instance. No blood culture was taken on admission and no note of previous MRSA flagged as an alert. The lapse was discussed at an ED governance meeting to ensure adherence to trust policy was consistent.
- There were no facilities to isolate patients in the ED. However, a bay in the major’s area had been identified

as the location of an isolation cubicle and arrangements to implement this were in progress. We were informed that the timescale for installation was two weeks from the time of our visit.
- In the paediatric area, we found that, although children's toys were cleaned, this was not recorded or monitored.
- Disposable screening curtains were not in use although we were informed these had been trialled. The trust told us curtains were changed when the cubicles were deep cleaned.

Environment and equipment

- The department included treatment areas for resuscitation, majors, minor injuries and paediatrics. The paediatrics area provided a treatment cubicle, a minor injuries cubicle and a stabilisation bay, in addition to two further cubicles, one of which was used for adolescent patients. A resuscitation bay equipped for children was located in the adult's area.
- The children's waiting area was separate from adults, with murals and toys for children of different ages.
- A dedicated x-ray facility with a separate waiting area was located in the ED.
- We were informed that recent building work had been undertaken on the flood defences, which addressed previous issues the department had experienced in storm situations.
- There were adequate stocks of equipment. Equipment trolleys were labelled and matched with an equipment bay checklist. Resuscitation equipment stocks were checked by a housekeeper specific to the ED and a designated member of nursing staff completed equipment checks in the resuscitation area.
- Equipment in the paediatric area was appropriate for children. There was child appropriate equipment in the children's cubicles, children's waiting area, and in the paediatric resuscitation area, although this was sometimes also used by adults. To reduce the risk to sick children, resuscitation equipment was provided in paediatric cubicles.
- Equipment was regularly cleaned, tested for electrical safety, and serviced. The hospital's clinical engineering (medical physics) staff worked proactively with the ED to maintain and replace equipment. Anticipatory maintenance and procurement of replacement capital equipment was planned, so that the department did not need to submit a replacement request or prepare a business case. The database of service reports for equipment was easily accessible.

Medicines

- Medicines were stored correctly in locked cupboards or fridges, as necessary. Fridge temperatures were monitored and were within recognised normal temperature ranges.
- Controlled drugs were stored appropriately.
- Medicines were observed to be appropriately prescribed and administered throughout the ED.
- Mandatory training for staff included the administration of medicines.
- We observed a colour-coded chart displaying children's dosing schedules and tables for use with paediatric patients in the resuscitation area.

Records

- Patient records were maintained in hard copy format. A project was underway in the hospital to move to electronic format over an 18 month timescale.
- Other records and documents in use in the ED, particularly for the tracking of patients through the ED, were held in electronic format and their use was well established. Staff were familiar with patient information presented in this format.
- We reviewed 10 sets of patient notes. We found the notes were detailed and written in a timely manner. However, some errors and omissions were also noted. For example, there were gaps in the recording of triage times, with only five being recorded; and an incident of an acutely unwell patient handed over to another doctor, but with no documentation from the original receiving doctor. This was raised with the department at the time of our inspection and action was taken.
- We observed that senior medical staff reviewed a selection of patient notes in the course of handover arrangements to ensure junior medical and nursing staff were recording and using the information correctly.

Safeguarding

- The department had systems in place to safeguard vulnerable adults. Staff were fully aware of their responsibilities and used safeguarding pathways appropriately.

- Vulnerable adults and children were appropriately identified by staff, who had undergone safeguarding training. Where concerns were identified, staff were aware of the correct escalation process, and provided examples of where this procedure was used.
- Consultant medical staff for paediatrics explained that the extended triage/streaming arrangements for children allowed for appropriate safeguarding questions to be asked at assessment.
- Staff commented to us that, partly in response to learning from incidents, the department had seen an increase in the number of safeguarding referrals. The Department had appointed a senior nurse to lead and liaise in safeguarding children.
- For mandatory safeguarding training information provided by the trust indicated the hospital met the target of 75% for training in safeguarding adults (97% of staff were trained to Level 1) and 79% of staff were trained in safeguarding children to Level 1. Consultant medical staff were trained to safeguarding Level 3 for children. Consultants had either received Level 3 training, or, in one instance, had made arrangements to attend the training.
- We observed in the department that noticeboards contained information about safeguarding adults and children to support the professional development of staff.

Mandatory training

- Mandatory training figures supplied to us by the trust showed that mandatory training was not up to date within the ED. Of the 14 training categories that were mandatory for staff, the trust's own target of 75% was met in only four of these. However, the training records that we reviewed in the ED showed that more than 75% of nurses and healthcare assistants (HCAs) had completed mandatory training.

Assessing and responding to patient risk

- When the department was busy, or there was a shortage of nursing staff, reception staff were requested to stream patients, this meant unqualified and non-clinical staff signposted patients to which treatment area they should be treated in and how urgent their condition was. The reception staff used an internal guidance document ("Streaming to Minors"), which included a list of conditions that were appropriate to be sent to the minor treatment area. However, reception staff we spoke with felt ill equipped to make these decisions and were concerned that they may be making mistakes. A nurse told us they did not feel patients should be streamed to the minor's area from reception. One receptionist told us that she and her colleagues were unhappy about the process. Receptionists were not qualified to make triage decisions and this put patients at risk should a patient's symptoms be misinterpreted and they were sent to the wrong area.
- We were told that, when long waits for triage occurred, extra nurses used an additional cubicle to triage patients as quickly as possible. However, we were informed there were rarely enough nurses to do this effectively. We observed the triage of patients arriving at reception in the evening. We witnessed two patients with potentially serious conditions who waited up to 40 minutes to see a triage nurse. These included a pregnant patient who had presented with significant abdominal pain, and an elderly patient who had exhibited symptoms of sepsis, and was noted to be barely able to walk. Other patients who waited 30 minutes included a person who had swallowed a dental bridge, a person with a knee and wrist injury, and a patient with a deep finger laceration. Because of the position of the waiting area in relation to the reception, staff had little visual awareness of patients in the waiting room. Also, emergencies entering the building could not be observed from reception.
- The national early warning score (NEWS) escalation process, for the management of acutely unwell adult patients, was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. Senior nursing staff told us they would ring the ward, the bed manager and the medical registrar on duty for the speciality to support any escalation.
- The ED ran the Bradford Rapid Assessment and Treatment Service (BRATS) during the afternoon and evening. People presenting with conditions requiring primary care were seen by a senior doctor who ran the service. For example, patients with a urinary tract infection.

Nursing staffing

- The ED employed 100 nursing staff including: 58 whole time equivalent (WTE) registered nurses (RN), four advanced clinical nurse practitioners, five emergency nurse practitioners and 18 (eight WTE) healthcare assistants. Nine staff were on maternity leave.
- In the absence of a current national tool to establish nurse staffing numbers in Accident and Emergency departments the trust reported they used professional judgement and activity to identify the current nursing establishment. However we found in the absence of an established local tool it was not possible to tell whether the nursing establishment was adequate..
- Within the ED, nurse managers allocated staff to teams on a daily basis. This was based on their assessment of the requirements for staff in the various areas of the department, and reflected the higher dependency of patients in some areas, for example majors and resuscitation.
- Nursing handovers took place at 7am, 12 noon, 4pm, and 8pm. We observed the evening handover, at which shortages of nursing staff for the next day were identified. No bank or agency nurses were available to provide cover, although agency healthcare assistants were available. We observed another handover in which nursing staff shortages were also identified. Again, no bank or agency nurses were available to provide cover. In response, nurse managers cancelled study leave for two members of nursing staff. The department escalated the concern over staff shortages and text messages were sent to off-duty staff, with requests to work extra time to cover identified gaps in the rota.
- The main reason for staff shortages on a daily basis was short-term staff sickness. We found gaps in the rota were usually filled at short notice by the department's own staff, or through an internal staff bank arrangement. External agency staff were rarely used. During their shift, staff also worked flexibly between areas of the department, depending on need. We observed that communication between staff was effective in responding to these changes.
- We spoke with portering staff, who stated that patients were accompanied to the ward by a porter, without nursing staff in attendance. This was confirmed by the ED matron. However, we were also informed that the intra-hospital escort policy was being updated so that porters would be accompanied by a nurse or an appropriately trained healthcare assistant.
- We visited the paediatric emergency area in the morning, but found it was closed. Children were assessed in the adult's area until the paediatric area opened. Depending on available staff the separate Children's Department was not always open in the morning. During our visit this occurred at 11am. The consultant paediatric staff on duty were not aware of the time the department would open. However, we were told that, once opened, the children's department remained open through the night until the last child left. Most children were triaged within the paediatric department.
- Additional paediatric trained nursing staff were due to commence in post and managers anticipated being able to open the paediatric department over 24 hours within one month of our inspection visit.

Medical staffing

- There were 56 WTE medical staff employed in the department, including 14 consultants and 15 middle-grade doctors. Staff commented favourably on the visibility of consultants and doctors and on the substantial recent increases in the numbers of medical staff in the department.
- An ED consultant was on site 16 hours per day, seven days per week. Two consultants were usually on duty from 3pm until midnight. Medical staff operated a 15 person rota, which included two decision makers (usually registrars) on duty in the department. A separate medical staff rota was maintained for paediatric consultant and middle grade staff. A paediatric emergency consultant was on duty each day, in addition to two paediatric doctors.
- Medical handovers took place at 8am, 3pm, and 10pm. We observed the evening handover, at which the allocation of workload to consultants was reassessed. Consultants shared the 'team leader' role for the department. A comprehensive handover took place to other consultants and doctors. We observed there was some delay in accessing junior doctors for the evening handover, which was led by senior nurses.
- We observed that the rapid assessment area was staffed by senior clinicians and a dedicated paediatric consultant was present in the children's ED.
- From midnight to 8am, three middle grade and five SHO grade doctors were usually on duty. Depending on

demand, one of these might leave the department at 4am. We also found that the consultant who was due to finish at midnight could stay longer to provide support, if this was needed.
- The department had a significant budget allocated for expenditure on locum medical staff. This was mainly to support long-term locums. To assist in recruiting and retaining medical staff, locums were recruited to trust-grade doctor posts.

Major incident awareness and training

- Equipment held in the ED for responding to major incidents was comprehensive and maintenance was up to date.
- Major incident plans were well rehearsed. We found the plans were reassessed and improved on a regular basis.
- Staff training in responding to major incidents took place three or four times per year. This included training for responding to incidents involving hazardous materials.

Security

- A security office was located outside the ED entrance, which was monitored until midnight by security staff. We saw that security staff could view entrances to the department and some waiting areas. There was no direct way of viewing patients who were waiting in the corridor, although this was observable on CCTV.
- Security staff were trained in control and restraint techniques jointly with the police service.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines were used to support local guidelines. Specific pathways were used for certain conditions and separate emergency clinical pathways for adults and children. Audits conducted in conjunction with the CEM were well established in the department and informed the development of local guidance and practice.

The department contributed to the national clinical audit programme and used the results proactively to improve outcomes for patients. A high proportion of patients were seen by an emergency doctor when compared with other trusts nationally. The department had improved its performance and was better than many other EDs. Unplanned re-attendances within seven days of discharge were consistently better than the England average.

Nursing and medical staff we observed appeared to be highly competent in their contact with, and treatment of, patients. Staff felt supported by their managers, and had received regular clinical supervision, appraisal and staff development. Medical staff were encouraged to develop into more senior roles in the department and received personal development that supported this.

Medical and nursing staff could readily access information for each patient in the department and information was presented in a clear and accessible format. Patients were consented appropriately and correctly. We found supportive multidisciplinary team-work both within the department and externally. The department engaged proactively with specialities and with neighbouring trusts.

Appropriate pain relief was offered for most patients and administered promptly. However, pain scores were not recorded consistently. Therefore, patients transferred to the minor's area through streaming might not receive immediate pain relief medication.

Evidence-based care and treatment

- NICE and CEM guidelines were used to produce local guidelines and these also reflected learning from incidents. For example, following an incident, the guidelines for the treatment of head injuries were amended to improve the identification and care of patients.
- There were specific pathways for certain conditions. The department used a management pathway for fractured neck of femur, which included a pre-operative checklist and guidance on pain management. The screening tool for sepsis was based on national guidance and included a simulation example.

- There were separate emergency clinical pathways for adults and children. Guidance for use with paediatric patients was available in the department. For example, in the resuscitation area; a paediatric resuscitation preparation folder was used.
- Standard operating procedures (SOPs) in use in the department were developed specifically for emergency medicine. We found that Clinical Emergency Medicine books had been used in the department since April 2014. The SOPs generated using issues identified through Clinical Emergency Medicine books were signed off by the speciality lead and the Clinical Executive Group. The department's guidelines and policies were available to staff in real time through this facility. We found that 10 standard operating procedures had been developed this year for use in the ED.
- We observed that guidelines were referred to in the medical handovers. For example, relating to antibiotic prescribing. We observed in the medical handovers that the use of correct pathways was promoted. For example, with junior medical staff.
- Audits conducted in conjunction with the CEM were well established in the department and informed the development of local guidance and practice.

Pain relief

- In a review of patient notes, we found evidence that appropriate pain relief was offered to most patients. Analgesia was delayed for one patient, but pain scores were recorded for only four out of nine patients we reviewed. We discussed the low completion of pain scores with department managers during our inspection.
- We found that patients transferred to the minor's area through streaming might not receive immediate pain relief medication. Also, medication could be arranged for these patients, but not documented.
- We reviewed the report of a recent serious incident and found evidence that pain relief was administered to the patient appropriately.
- A specialist chest pain nurse was accessible in daytime hours for patients from the ED.
- The department participated in the CEM clinical audit for pain in children, which showed the median for most results compared with other trusts nationally. The trust scored better than the national mean for the promptness of giving pain relief and for pain relief given in line with national guidance.
- In the national clinical audit for fractured neck of femur, results had improved since the previous audit, but pain relief was still not administered as quickly as national guidelines suggested.
- Information in the CQC national survey report on A&E patient experience 2014 indicated that pain control was in line with the national average rating.

Nutrition and hydration

- We observed that staff made drinks and snacks for patients if they required it during their short stay in the department.

Patient outcomes

- Unplanned re-attendances to the ED within seven days of discharge were consistently better than the England average, apart from a rise to 8.1% (above the planned target of 5%) in March 2013.
- The ED contributed to the CEM clinical audit programme. Audit activity included sepsis, fractured neck of femur and a number of other areas identified in the programme. The department improved its performance for feverish children, renal colic and fractured neck of femur. The department used the results proactively to improve outcomes for patients. For example, the department was in the upper quartile when compared with other trusts nationally for the measurement of respiratory rate in febrile children, and for the availability of ambulance notes for patients with fractured neck of femur that arrived by ambulance. For patients with renal colic, 91% of patients left the department within two and three hours compared with 84% of patients nationally.
- The CEM national clinical audits included a review of consultant sign off in 2013. A high percentage of patients were seen by an emergency doctor when compared with other trusts nationally. The department improved its performance and was better than many other EDs.

Competent staff

- Nursing and medical staff we observed appeared highly competent in their contact with and treatment of patients.
- Nursing and medical staff told us they felt supported by their managers, and had received regular clinical supervision, appraisal and staff development.

- Staff we spoke with had undertaken an appraisal. Information supplied by the trust showed that 73% of appraisals were completed for the ED overall.
- Nursing staff who achieved a competency in a recognised skill area were awarded a signed competency document. For example, before commencing to work in triage, nursing staff received one day's formal training and were then supervised by a sister until they achieved competence. They then received a signed competency document.
- Medical staff were encouraged to develop into more senior roles in the department and received personal development that supported this.
- Nursing staff induction was comprehensive. The welcome pack for new staff included an orientation checklist. Each member of staff had their own preceptor.
- Nurse training and development was supported by a senior nurse in a training and development role that commenced in May 2014. Senior nursing staff were responsible for approving staff competencies. Competency assessments were undertaken for cannula insertion, phlebotomy, intravenous drug administration, completion of early warning scores, electrocardiograms, triage, x-ray, patient group directives, infection control and lifting and handling, amongst others.
- We observed that informal teaching sessions were included in medical handovers when time allowed for this.
- Simulation was used to support training. A focus on simulation training in the department served particularly to empower nursing staff. Teaching was described to us as being "on the job" and was constantly reinforced through workplace assessments and supported by a dedicated consultant in the department. The department also supported two fellowships, in musculoskeletal medicine and simulation, as well as research.

Multidisciplinary working

- We observed consistent and supportive multidisciplinary teamwork in the department. For example, we observed a patient who had experienced trauma. To overcome difficulty in obtaining orthopaedic medical expertise, the department had developed a system of automatic admission rights to the orthopaedic service to support patient flow. Another example concerned a patient who had experienced a seizure. We saw that a proactive approach was taken to ensure the person's follow up MRI scan was completed before they attended the neurology outpatients department. Appropriate safety precautions were in place to support the patient.
- A senior member of nursing staff was responsible for liaison with the ambulance service and recently won an award for this work. We observed that, as well as a separate ambulance entrance, a "blue light phone" was used to receive a courtesy call from the ambulance service, to confirm that (for example) the resuscitation area was ready to receive an incoming patient.
- Occupational therapy staff helped to assess the patients' suitability for discharge seven days per week (except overnight) and were well regarded for their role in supporting safe discharge, in facilitating the discharge of patients with complex social needs, and in signposting to physiotherapy or social services. These staff formed part of the clinical support division. Occupational therapists also maintained close links with the virtual support (community) team to facilitate admission avoidance.
- In addition, the clinical support division of the trust provided the portering, emergency x-ray, and radiology services for the department. Computerised tomography (CT) radiographers were not present on site overnight, although they were available on call. The trust informed us this was within 30 minutes of request.
- We also observed that the department engaged with specialities to assist in solving particular issues encountered with patients. For example, the use of the correct blood tests for surgical patients, or to transfer acute care plans ahead of surgery.
- We reviewed the minutes of the emergency care performance committee for April 2014, which showed that the new protocols put in place to improve the rapid transfer of patients to the medical assessment unit had markedly improved effectiveness and patient experience.
- During medical handover, we observed liaison with a patient's GP to support follow-up after their discharge. The nursing staff also spoke directly with GP practices about inappropriate referrals and attendances at the department.
- The department was working jointly with the neighbouring care trust in engaging health visitors and community matrons to prevent ED visits. A nursing liaison post for children's safeguarding was supported jointly with a neighbouring mental health trust.

Urgent and emergency services

Seven-day services

- An ED consultant was on site 16 hours per day, seven days per week. Two consultants were usually on duty from 3pm until midnight. Medical staff operated a 15 person rota, which included two decision makers (usually registrars) on duty in the department.
- From midnight to 8am, three middle grade and five senior house officer (SHO) grade doctors were usually on duty. Depending on demand, one of these might leave the department at 4am. We also found that the consultant who was due to finish at midnight could stay longer to provide support if this was needed.
- Occupational therapy staff helped to assess patients' suitability for discharge seven days per week, but not overnight.
- The local GPs out-of-hours service was available to receive out-of-hours calls from patients seven days per week and sometimes accepted patients referred from the ED.

Access to information

- Medical and nursing staff could access current information for each patient in the department. The information was displayed on large, clear, but discretely placed screens in each of the main areas of the department. We observed that summary information about patients was readily available to support medical and nursing handovers.
- Information about patients was presented in a clear and accessible format, which, for example, identified the priority of the patient through the use of a colour code (amber, red, black) and marked the known or preferred gender of the patient with coloured text (blue for male, pink for female).
- Handover screens at four locations around the department were available for the use of ambulance staff to book in and handover their patient on arrival.
- We observed the computerised 'Request a porter' screen, which we were informed was designed by a staff nurse. For a portering request, nurses entered brief details. The request then appeared on the porters' computer screen and was quickly dealt with. This process improved the speed of movement of patients within the department, and to wards.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Verbal consent was obtained before care was delivered. We reviewed consent information for three patients and found this was obtained and completed correctly. For a fourth patient who experienced a trauma incident, we saw that photography was taken with the patient's written consent.
- The trust target of 75% of clinical staff attending Mental Capacity Act 2005 and Deprivation of Liberty Standards training was not met. Only 50% of staff in the additional clinical services division had attended this training. We did not see separate information presented for the ED. However, staff we spoke with demonstrated a clear understanding of the Mental Capacity Act 2005, of their responsibilities and of Deprivation of Liberty Safeguards procedures.

Are urgent and emergency services caring?

Good

We observed that overall patients and relatives being treated with dignity, respect and compassion.

Treatment was appropriate and supportive once the patient had gained access to the treatment area. Patients were cared for in privacy, with doors closed where possible. However, there were only a limited number of cubicles in the department with doors where privacy and dignity could be fully maintained

Patients and relatives were involved in the planning of their care and treatment. Staff demonstrated a good level of rapport, overall, and relatives were included in discussion. Patients were given a clear explanation at discharge and advised what to do if their symptoms occurred again. Patients were involved in their own care plans, where appropriate. Staff provided appropriate emotional support to patients and relatives.

Compassionate care

- In the Care Quality Commission (CQC) inpatient survey 2013, the trust scored similarly to other trusts for being given enough information on their condition and treatment in the ED and for them being given enough privacy when being examined or treated.

Urgent and emergency services

- We also observed a medical handover in the minor injuries area where the staff office door was open and patients outside the door could hear what was being said about other patients. However, the patients moved away of their own accord. Another medical handover that we observed took place in the corridor, in which the voices of some staff were quite loud so that information about patients was not necessarily kept confidential.
- A patient told us they were happy with the service. At a recent visit they said they took just 59 minutes to be seen and discharged. They said staff were friendly, explained things really well and appeared to be well trained. Another patient suggested it would be useful if an explanation was offered to help new attendees understand the triage process. A third patient stated that they felt "moderately comfortable". Another patient told us, "Staff have been really good," and, "privacy and dignity were maintained."
- During our inspection, we observed patients and relatives being treated with dignity, respect and compassion. Staff were mainly seen to be considerate towards patients and other people. An exception we observed was in reception when a sick patient with a relative appeared to be ignored by staff. In another instance, we observed a triage nurse who did not face a patient while assessing them, making it difficult to communicate effectively.
- Treatment was appropriate and supportive once the patient had gained access to the treatment area. We observed a paediatric patient who arrived in the ambulance with their relative. This patient required assistance with moving and handling. The patient and their relative were offered help and supported promptly and sensitively. It was evident that time was taken to ensure the patient and their relatives experienced appropriate care.

Understanding and involvement of patients and those close to them

- Patients and relatives were involved in the planning of their care and treatment. A patient who was waiting told us they had been informed of what was happening.
- We saw that patients and their relatives were treated with respect while staff provided some humour and demonstrated a good level of rapport overall. We saw that staff were very caring and relatives were included in discussions.
- Staff demonstrated good communication skills during the examination of patients. They explained what the patient could expect to happen next and answered any questions from the patient directly.
- Patients were involved in their own care plans, where appropriate. Care plans were reviewed at least annually, and were based on outpatient clinic reviews.
- The CQC national survey report on A&E patient experience 2014 indicated that Bradford ED scored 'worse than expected' on 20% the questions and was one of the worst performing trusts nationally. The worse than expected areas included timely test results, access to food and drink and patients being able to resume usual activities.

Emotional support

- We observed staff providing emotional support to patients and to relatives.
- In response to staff concerns that dying patients lacked dignity in a busy, noisy ED, a room had been identified where a dying patient could be nursed with their family. The room could be observed by staff, but it was quieter area.
- A viewing room was used for deceased patients, which, although clinical, was quiet and was supplied with appropriate religious books, texts and other resources to provide support. The department also had plans in place to refurbish the area.
- To provide support for relatives experiencing infant death and still birth, memento boxes were available, which were supplied in conjunction with a local charity.

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

(for example, to feedback?)

Requires improvement

The reception lacked a queuing system, with no clear lines or barriers. It was not obvious where patients should wait; many sat in the corridor. Access to the ED at night was poorly lit and difficult to find.

There was little privacy for patients in the waiting area. Reception staff encountered difficulties accessing nursing

staff when an unwell patient presented to the front desk. The public address system used to address patients in the waiting room and public areas was loud, but unclear, and potentially distressing for some patients.

A shortage of side rooms in the department impacted adversely on patient flow when no cubicles were available in which patients could be seen. Mental health crisis support arrangements did not enable a responsive service to be provided for patients. There were actions to address this, however the trust was not in a position to resolve this independent of other stakeholders support and agreement. The paediatric emergency area was sometimes closed in the morning, however children were seen in the adult area during these times.

Although a range of mechanisms were used to communicate with patients and relatives whose first language was not English, we were unable to confirm whether the service had access to leaflets or other information in different languages.

The dedicated 'meet and greet' nurse for ambulance arrivals resulted in patients being transferred to a cubicle to be assessed with minimal or no wait. Patients with a learning disability received care that was appropriate to their needs. The department operated a virtual ward for patients who were well enough to be discharged but who might require a subsequent test or other follow-up.

In the main, patients were aware of the complaints procedure. Complaints were handled sensitively, confidentially, and with respect for the patient's concerns. Complainants received an explanation of the action the department was taking in response to their complaint.

Service planning and delivery to meet the needs of local people

- The department held a number of morning clinics on week days, although these were being reduced. We spoke with senior medical staff, who ran six review clinics each week within the department. Patients who had previously visited the department could be asked to attend one of these clinics if they required specialist input, for example, from a specialist musculoskeletal doctor. The number of clinics had recently been reduced in response to external advice to the department.
- We found that, depending on the time of day and on the numbers of patients attending the department, children were also cared for and treated in the adult areas of the department where they were not separated from adults.
- For patients who were unwell and required support with their mental health, a specific cubicle was used to support the safety of the patient. The cubicle was risk assessed, but we noted the entrance was enclosed by a curtain. We were informed that specialist nurses from the mental health crisis team were available to support these patients, if required. This included an out-of-hours service. When we discussed the mental health crisis support arrangements with staff, they told us that they experienced difficulties over response, which meant that there was little support to manage the patient's condition. Patients who were mentally unwell frequently waited in the department for many hours. Of three examples we looked at, one patient waited in the department for over 24 hours before being admitted to hospital. Two further patients were admitted to the medical assessment unit after they waited for three and a half hours, and nine hours, respectively. This was because the crisis team had been unable to assess them in the ED. There were actions to address this, however the trust was not in a position to resolve this independent of other stakeholders support and agreement.
- The department operated a virtual ward for patients who were well enough to be discharged, but who could require a subsequent test or other follow-up. The department followed guidelines that indicated whether a patient was suitable for the service. For example, the patient received a telephone call when their test was arranged.
- Care plans for patients were developed in conjunction with social services, alcohol and homeless services. Where appropriate, these service providers took into account any known risks to the patient.

Meeting people's individual needs

- A range of mechanisms were used to communicate with patients and relatives whose first language was not English. Staff members had skills in languages other than English. Translation services were available through the language line, which provided 24-hour

access to interpreters and we were informed that interpreters were available quickly when required. The department planned to adapt the use of a telemedicine facility to support interpreters.

- We observed that patients were given a clear explanation at discharge and were advised what to do if their symptoms occurred again. A range of information leaflets were available for patients to help them manage their condition after discharge, although written information was not provided for all patients. Staff also liaised with patients' GPs to support follow-up after their discharge.
  - Patient leaflets and verbal advice were available and most patients whose first language was English received a leaflet. However, staff were unable to confirm whether the service had access to leaflets or other information in different languages. Staff expressed concerns about the low level of use of any materials given the range of languages in the local population.
  - Patients were cared for in privacy, with doors closed, where possible, and screens drawn to protect privacy and dignity. However, there were only a limited number of cubicles in the department with doors where privacy and dignity could be fully maintained.
  - We observed a paediatric patient with a learning disability as they arrived and received care in the department. Care and treatment was appropriate to the patient's needs and was provided in a very sensitive way.
  - Some audio-visual resources, writing materials and tool kits to support patients living with dementia were available for use, which helped to decrease agitation levels. Staff described how they would care for a patient living with dementia, by minimising movement between areas. However for patients living with dementia visiting the department, there was no cubicle, bed or other specific provision of facilities.
  - Hearing loops were available on request to assist people with hearing impairment.

Access and flow

- The trust has previously been inconsistent in meeting the four-hour target for the ED. However, from July to September 2014 the trust's performance for the number of patients seen within four hours was at or above 95%, which was consistent with the England averageThe percentage of patients leaving the department before being seen remained quite consistent with the England average throughout the year.
- The total time patients spent in the ED was consistently worse than the England average. Patients spent between 150-180 minutes in the department throughout the year, which was well above the England average of about 135 minutes.
- The trust experienced 79 'black breaches' between 25 February 2013 and 5 May 2014. Black breaches occur when the time from an ambulance's arrival to the patient being formally handed over to the ED is longer than 60 minutes.
- At the inspection, we observed the flow of patients and reviewed current information about waiting times. Patients who arrived at the department were seen by a receptionist, who allocated them to the children's department, the minor injuries area or the rapid assessment see and treat facility. We saw the department was very busy and noisy. Patients were booked in quickly, and then waited for initial assessment. There was no information offered to them about waiting times. An electronic display of waiting times was not working. Some patients waited three hours to be seen and it was not obvious where patients should wait; many were sitting in the corridor rather than the waiting room.
- We discussed the reception arrangements with the administrative staff who worked at the desk. They explained the difficulties that arose because of the lack of a queuing system at reception, with no clear lines or barriers. There was little privacy for patients. Waiting patients were seen as "pushing in". Often, patients waited one hour for triage. Reception staff encountered difficulties accessing nursing staff when an unwell patient presented to the front desk. In these instances, the receptionist was required to make a telephone call to the major's area. A typical situation was described in which an unwell patient waited in a car and more than one telephone call was needed to request a nurse to attend with a wheelchair. If queues were long, patients could wait 20 minutes to be booked in.
- The public address system used to address patients in the waiting room and public areas was loud, but unclear and potentially distressing for some patients. In spite of announcements being rather loud, it was not easy to distinguish what the announcement was as the words

were indistinct. We saw that, if patients could understand what was being said, they still didn't follow the instructions. For example, during our inspection an announcement was made that said: "Mr A to minor injuries unit." This unit was at the far end of the department and was not clearly signposted. Another announcement was: "Mrs B to cubicle two." Again, it was not obvious where this was. The public address system was not used in the paediatric area, where nurses came out into the waiting room to collect patients. This was not done in the adults waiting area unless attempts to call the patient using the public address system were unsuccessful.

- We checked waiting times from arrival to triage for 47 patients arriving consecutively between midnight and 8am on 23 October 2014. There were no breaches of the four-hour waiting time target. However, there were a significant number of patients who waited an unacceptable length of time for triage within the four hours.
- An ambulance reception nurse was on duty from midday to midnight. We saw that this dedicated 'meet and greet' nurse for ambulance arrivals resulted in patients being transferred to a cubicle to be assessed with minimal or no wait. We observed that when a paediatric patient with a learning disability arrived by ambulance they were quickly assisted and received care in the department. The ambulance service was expected to complete handover to ED staff before leaving, but we observed that this did not always occur. When the ambulance reception nurse was not on duty the ambulance arrivals sounded a bell in the central area.
- We observed a shortage of side rooms in the department, which impacted adversely on patient flow when no cubicles were available in which patients could be seen.
- Patients complained of long waiting times to be seen. One patient stated that they, "Always waited over an hour"; another patient suggested an up-to-date waiting system would be useful, especially for anxious patients. A patient with experience in visiting paediatrics suggested more doctors to assess due to long waiting times.
- Prior to the inspection, we were informed through a focus group that patients transferring from St Luke's Hospital to Bradford Royal Infirmary were expected to go through the ED. When we discussed this with managers we found it was not the trust policy. Transferring patients should go to the ward direct, although we understood that approximately two patients per week currently arrived at the ED by mistake. Patients over the age of 77 years who were to be admitted were transferred directly to the care of the elderly ward.
- Access to the ED at night was poorly lit and difficult to find.

Learning from complaints and concerns

- In the main, patients were aware of the complaints procedure. One patient stated they wouldn't know how to complain or compliment, but would just ask staff.
- Methods used to seek feedback, apart from formal complaints, included comment cards and boxes, which were available within the department. Patients could also leave comments on the trust's website.
- Acknowledgement letters were sent to complainants with an information sheet that included contact details to obtain independent advice.
- Complaints were handled sensitively, confidentially, and with respect for the patient's concerns. The patient was contacted by telephone after the complaint was received. If the complainant was unhappy with this initial response, they were offered a meeting. Further contact was made with the complainant to provide updates if, for example, delays occurred in the investigation of their complaint. Complainants received an explanation of the action the department was taking in response to their complaint.
- We reviewed an action plan, which was prepared following the investigation of a complaint in the ED in July 2014. Action to be undertaken was identified and we found that action was taken and completion of this monitored.
- Individual complaints were discussed at clinical governance meetings so that learning was shared. Complaints were also reviewed to identify key themes.

Are urgent and emergency services well-led?

Good

The senior management team provided effective and visible leadership. Senior managers demonstrated a clear

strategic vision for the ED. Staff were positive about the vision and strategy and were committed to supporting it. Staff were very positive about the department and the service they provided for patients. Different disciplines worked well together and staff appeared to be well motivated.

Risks were identified and regularly reviewed. The department held regular clinical governance meetings, which staff were encouraged to attend. An ED performance meeting was held weekly to review quality indicators. The department routinely undertook a range of audits to improve performance and support safety. Learning from the results of audits was shared with staff.

The ED received support from NHS England's emergency care intensive support team (ECIST). An ED improvement project was one of six projects within the urgent care programme, which aimed to promote the safe and efficient flow of patients through the hospital's pathways.

Vision and strategy for this service

- The clinical managers of the ED demonstrated a clear strategic vision for the service, which included an ED improvement programme. This was chaired by the clinical lead consultant and was one of six projects within the national urgent care programme. Staff were aware of the programme and the developments to improve patient flow.
- Senior staff expressed their appreciation of the helpfulness of the Trust Board in supporting the vision for the development of the service. As an example, senior staff told us that the Board was engaging more with the clinical commissioning groups, which had led to increased resources for the department.
- Staff were positive about the vision and strategy for the ED and felt they were committed to supporting it.

Governance, risk management and quality measurement

- The ED maintained a risk register, which identified risks and control measures to mitigate these. The register was reviewed regularly and the next review date was shown on the register. Failure to sustain the emergency care standard was identified as the primary risk for the department. We saw that the register was up to date and reflected the current risks the department had identified.
- The department held clinical governance meetings monthly, which were chaired by consultants and attended by management, senior medical and senior nursing staff. The chief operating officer also attended these meetings, which provided a link to the Board. We reviewed copies of minutes from the three most recent meetings. Items covered included: CEM alerts feedback and learning regarding avoidable deaths, national audits and learning from incidents. For example, a review of patients who fractured their hips led to a change in the pathway and an improvement in care and clinical outcomes. More junior staff were encouraged to attend the clinical governance meeting, although staff told us they were required to withdraw from the previous meeting due to a high number of patients arriving in the department.
- An ED performance meeting was held weekly, at which the following was reviewed: data quality, breaches and quality indicators. Key actions were also identified and agreed on, in order to improve performance against the department's improvement plan.
- Managers were aware of the risk of staffing vacancies and they were actively recruiting to the one vacancy that existed. The matron told us that they rarely had difficulty filling vacancies. However, as no nurse staffing tool was used, it was not possible to tell whether the nursing establishment was adequate. The trust reported they used professional judgement and activity to identify the current nursing establishment. However we found in the absence of an established local tool it was not possible to tell whether the nursing establishment was adequate.
- The trust informed us that any incident form regarding staffing is also viewed by senior nursing staff external to the Department, including the Chief Nurse, and the AED Matron ensures that the outcome of all Datix reports are summarised and provided to the AED Clinical Governance meeting where trends and concerns are discussed and action instigated, including escalation of serious risks.
- An ED sister/charge nurse's meeting was held regularly and key actions and decisions were recorded.
- An emergency care assurance report was prepared for presentation to the trust's performance committee three times per year.
- The department routinely undertook a range of audits to improve performance and support safety. These included the pain assessment screening tool, the peripheral intravenous cannula care bundle, the hand

hygiene observational tool, the falls assessment tool, the urinary catheter care bundle as well as other local audits. Learning from the results of audits was shared with staff.
- The department used a system available called Clinical Emergency Medicine books to manage aspects of its governance arrangements. The application was set up so that consultant medical and nursing staff were able to input the status of the department and any issues they encountered. The system allowed for a quick audit of the department to be generated. For example, a situation report informed the member of staff leading the shift of operational issues relating to staffing.

Leadership of service

- The senior management team provided effective and visible leadership of the ED. The directorate manager for urgent care provided operational leadership for the ED, the medical assessment unit and ambulatory care. They worked closely with the clinical lead consultant and emergency services matron.
- The senior management team worked closely together. This ensured shared knowledge, robust planning and a cohesive framework for strategic change. They were regularly consulted by the chief operating officer, who visited the department several times each week and who, they told us, they found very supportive.
- We observed a number of examples of how the leadership worked in practice. The medical team leader identified for each rota was free to troubleshoot and to redeploy staff. The team leader ensured that medical staff took breaks. Staff were supported and debriefed after distressing incidents. At consultant handovers, consultants demonstrated a high awareness of all patients in treatment areas. Teaching was constant and visibly 'on the job' through workplace assessments and a dedicated consultant on the 'shop floor'. Junior medical staff felt seniors were approachable.
- Healthcare assistant staff felt well supported and comfortable in their role. They felt well trained and able to ask for help if needed. However, the ED reception staff did not feel involved in the improvement and redesign process for the department.

Culture within the service

- Staff were very positive about the department and the service they provided for patients. We observed a supportive rapport between all staff. Different disciplines worked well together and considered each other's needs. Staff appeared to be well motivated.
- Individual complaints were discussed at clinical governance meetings so that learning was shared. Complaints were also reviewed to identify key themes.

Public and staff engagement

- The department sought views from the public through the NHS Friends and Family Test, although this was below the England average apart from modest increases in May and August 2013.
- Results from the NHS staff survey 2013 showed that staff at the trust were about as likely to recommend the trust as a place to work or receive treatment, when compared with other NHS organisations nationally.
- A team was available within the trust to investigate concerns expressed by staff.
- We observed a primary school group visit to the paediatric ED. The department participated in a national programme to support the curriculum for all primary schools in Bradford. Engagement with local schools included training in the department about the role of emergency medicine, including what warranted an emergency, resuscitation, first aid, wound care and cardio-pulmonary resuscitation.

Innovation, improvement and sustainability

- The ED had received support from NHS England's emergency care intensive support team (ECIST). Recommendations made by the ECIST team following their visits were taken forward by an internal improvement team. Improvements that had been implemented included a significant increase in consultant and medical staffing supported by a recruitment plan, an ambulatory emergency care unit was in development as well as revised structures for emergency and acute medicine. Improvements in ambulance handover times had also been made.
- An ED improvement project chaired by the clinical lead consultant was chosen as one of six projects within the national urgent care programme, which were overseen by the urgent care steering group. The programme was promoting the safe and efficient flow of patients

through the hospital's acute pathways and included improved patient flow (rapid assessment, see and treat and an urgent care centre), environmental changes (department redesign).

Medical care (including older people's care)

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

Information about the service

Bradford Royal Infirmary has 12 medical wards, including an elderly acute assessment unit (Ward 3), a medical admissions unit (Ward 4) and a discharge lounge. The medical division included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, renal medicine, haematology, neurology and stroke care.

We looked at the care records of 34 patients. We spoke with 44 patients and relatives and over 40 members of staff, including doctors, nursing staff, therapists and managers. We visited 10 wards, plus the discharge lounge, and carried out observations on the areas we visited. Before the inspection we reviewed performance information from, and about, the trust.

At the last CQC inspection in June 2014, the hospital had not been compliant with the Health and Social Care Act (2008) in safe staffing levels (Regulation 22). An action plan containing two work streams was submitted to CQC. The trust planned to be compliant with the nurse staffing by January 2015 and completion of the revised acute medicine model by November 2015.

Summary of findings

Systems were in place to report incidents, but feedback and analysis was not consistent. Wards monitored safety and 'harm-free' care and results were positive, overall. The results were not readily available to staff or patients.

Wards were visibly clean. The environment caused limitations in meeting some patients' needs. For example, there was a lack of en suite facilities in side rooms used for people with infection risks.

Medical staffing had improved since our previous inspections. Nurse staffing had improved, although there remained a number of occasions when the number of staff on duty was below the planned level to enable staff to provide safe care. We were particularly concerned about the care of patients requiring non-invasive ventilation (NIV); that the trust was not adhering to best practice guidelines including patients not being cared for in a dedicated setting and not having the appropriate staff ratio of one nurse to two patients for at least the first 24 hours of care.

Most patients and relatives told us that they, or their relatives, had been treated with compassion and that staff were polite and respectful. Pain relief and nutrition and hydration needs were met.

Policies and guidelines were available and audits were undertaken. There were a number of indicators from some national audits that were below the national average.

Medical care (including older people's care)

There had been very recent changes to the leadership of the medical division as part of a wider trust restructure. Most staff were clear about the vision and strategy for the service. Changes to the risk management processes were in place, but required further embedding in practice. Not all significant risks, such as the care of NIV patients, were on the risk register.

Are medical care services safe?

Requires improvement

Systems were in place to report incidents, but feedback and analysis was not consistent. Wards monitored safety and harm free care and results were positive, overall. The results were not readily available to staff or patients.

Wards were visibly clean and most staff were observed adhering to infection control principles. There was a planned refurbishment programme. However, this was not evident for all areas, including those where the environment caused limitations in meeting patient needs. This included the lack of en suite facilities in side rooms used for people with infection risks. The elderly care wards, particularly Wards 29 and 30, had made improvements to the care of older people including those living with dementia.

Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Medical staffing had improved since our previous inspections. Nurse staffing had improved, although there remained a number of occasions where the number of staff on duty was below the planned level needed in order to provide safe care. We were particularly concerned regarding the staff to patient ratios for patients requiring non-invasive ventilation who were nursed on general ward areas. Attendance at children's safeguarding training, particularly for those requiring Level 2 and 3, was well below the trust target of 95%.

Incidents

- There had been 658 incidents reported over the previous four months on the medical wards. None of these were classed as serious. The most common reported incidents related to patient falls and pressure ulcers.
- There were systems in place to report incidents. Incidents were reported using an electronic Datix system. Staff told us they were aware of how to use the system to report incidents.
- Feedback on incidents and shared learning varied. Staff were unaware of feedback mechanisms. Some staff reported discussing feedback at team meetings and

some told us they used the safety briefings at nursing handover. One team had analysed the information on Datix to review the impact of the relocation of a ward on the incidence of patient falls. They found the incidence of falls had reduced since they had moved to a new ward environment.

- We saw that the 'Think Glucose' campaign had been used to promote improvements in patient care following incidents involving patients with diabetes and mandatory e-learning regarding diabetes care had been introduced in June 2014.
- Reviews of mortality and morbidity were considered as part of specialty clinical governance meetings. The level of detail recorded and evidence of learning was not consistent between specialties.

Safety Thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- Over the previous year, the percentage of harm free care across the medical wards averaged between 81% to 97%.
- Information regarding the results of the Safety Thermometer was not routinely displayed on most of the wards.

Cleanliness, infection control and hygiene

- Methicillin-resistant Staphylococcus Aureus (MRSA) rates for the trust had been low for the previous seven months. There had been two attributable cases of MRSA for the medical division since April 2013. The target was zero for trust attributable cases.
- Clostridium difficile (C. difficile) rates for the trust had been higher than the England average since December 2013. A total of seven out of sixteen cases of C. difficile were reported in April and May 2014 and were attributed to the medical wards. A post-infection review was held for each case and actions were identified, implemented and reviewed.
- Monthly infection control audits were undertaken. Data from July and August 2014 for the medical division showed good compliance with, for example: hand hygiene, dress code, insertion of central venous catheters, peripheral intravenous catheters and urinary catheters. The ongoing care of peripheral intravenous catheters was an area that fell below the trust target of 95% compliance in August 2014, reaching just over 90%.
- Ward areas appeared clean. The ward environments presented some limitations regarding infection-control practices. There was a lack of side rooms and suitably placed hand washing facilities on wards. For example, staff on in the infectious diseases ward had to use hand sanitising gel or use a hand basin in the kitchen, due to the unsuitable positioning of hand basins in patients' rooms. The trust advised that they were looking to use portable hand-washing stations.
- Personal protective equipment and alcohol hand gel was available at the entrance to, and throughout, the wards we visited.
- We observed that staff wore personal protective equipment and most staff applied the principles of infection control. However, we did note that, particularly on Ward 9, staff did not always adhere to policies. For example, we saw a nurse attend to four different patients without changing their gloves, or washing their hands and another nurse cut a dressing to shape using scissors out of their pocket.
- Equipment was cleaned after use and labelled as clean with the exception of some equipment in the dirty utility room on Ward 9. We saw two commodes that, although visibly clean, had not been labelled as clean in accordance with trust guidance.
- Clear signs, which were understood by staff, were present on the ward where there was an infection risk.

Environment and equipment

- Some areas of the hospital were old and the environment caused limitations in meeting patients' needs. A refurbishment programme was in progress for some areas such as the medical assessment unit (Ward 4). Some wards were cramped, such as Ward 7 and Ward 9. There were no current plans to refurbish these wards.
- On Ward 9, there was limited space between the beds and access to bathroom facilities was limited, with computer screens and shelves at head height for patients who used wheelchairs. This posed a potential safety risk for patients. Clinical procedures were undertaken in a room that was also used as an

administrative office. The therapy room was used as an office base, as well as for providing therapy. A curtain separated the areas. Patient dignity was potentially compromised due to the lack of space.

- There was a shortage of side rooms on wards across the division. These were mainly used for patients with infection risks. We saw, on Ward 23, that a double room had to be used to accommodate one patient due to shortage of single side rooms. This minimised risk, but reduced the number of beds available for patients.
- Side rooms, such as on Wards 4 and 24, did not have en suite facilities. This meant that patients had to use commodes. The removal of potentially infected matter was disposed of in the ward sluice. The lack of facilities could result in an increased risk of infection.
- Some wards had been improved as the result of refurbishment. The elderly care wards, particularly Wards 29 and 30, had made improvements to the care of older people, including those living with dementia. The environment had been adapted and was an exemplar for dementia-friendly environments.
- The diabetes specialty team were not aligned to a particular ward. The speciality ward had closed two months prior to the inspection. Patients were allocated to medical wards as required, outpatients were seen in the diabetes centre. The diabetes centre environment was small and cramped.
- Resuscitation equipment was available and mostly checked regularly. However, we found gaps in the daily records regarding checks in some areas. For example, on Ward 7, there were 36 gaps in the daily check records over the previous 12 weeks prior to the inspection. On Ward 9, there were 15 gaps. Staff were not able to provide a reason for this.
- Staff said that equipment to meet patient needs was available or provided promptly through contracted companies. However, due to the nature of the ward and the limitations of the environment, we found there were insufficient numbers of commodes available on Ward 24.
- We found that equipment checked during the inspection complied with the Portable Appliance Testing (PAT) requirements.

Medicines

- A pharmacy admissions team was in place seven days a week to undertake medicines reconciliation. The latest figures indicated that 53% of patients had their medicines reconciled by a pharmacist against a target of 75%. This had improved from 14% last year.
- Pharmacist input to the wards had increased to two hours per day. Ward staff confirmed that they had regular visits from the pharmacy team.
- The medicines Safety Thermometer was being trialled on one ward.
- Medication incidents were recorded, analysed and reported to the Trust Board.
- An annual medicines audit was undertaken. The most recent audit was in progress.
- An audit of controlled drugs (CDs) was undertaken monthly. The trust reported the results were satisfactory. We looked at the storage, recording and administration of CDs on four of the wards we visited. No concerns were identified.
- We saw that medicines were stored appropriately and drug fridge temperatures were recorded.
- We reviewed a sample of medication administration records on the wards we visited. Most of the medication had been administered as prescribed. We found that medicines had been administered at appropriate times. However, on seven of the records we reviewed we noted that the patient identification details were not recorded on every page where medicines had been administered.
- We saw that oxygen was prescribed in accordance with the medicines policy.

Records

- We found that most patient records were completed appropriately. There were some risk assessments, particularly on the short stay admission units, that were not completed. For example, pressure ulcer risk assessments and venous thromboembolism risk assessments. Staff said they undertook a 'core' assessment in these short-stay areas. However, there was no specific guidance about what this constituted. There were also a number of gaps in records for patients on Ward 9, with core care plans not being completed with reasons for the patient's need for care or updated with the patient's current condition. For example, one care plan specified the patient was on intravenous fluids, confused, agitated and aggressive, but the patient was sat in a chair having a calm conversation and interacting appropriately.

Medical care (including older people's care)

- We saw that, for July 2014, 98.5% of patients across the medical division were reported as having a completed risk assessment for venous thromboembolism (VTE).
- The referral system, for example, for clinical procedures, was reliant on the use of a fax system. Staff identified this as a potential risk as there was a limited audit trail to assure staff that the faxes had been received and acted upon.
- We observed several instances of patient information being visible in public areas on unlocked computer screens or unsecured documents. Staff were advised of this at the time of the inspection.

Safeguarding

- At September 2014, data for the medical care wards showed an average of 89% (of 280) compliance with Level 1 adult safeguarding training. Medical staff across the medical specialities had 74% (of 86) compliance.
- The medical wards had 10% (of 280) compliance with Level 2 adult safeguarding training. The trust policy did not indicate how many staff should be trained to Level 2.
- Across the whole medical division, at July 2014, 90% (of 1352) of staff that required training were trained to safeguarding children Level 1, 31% (1117) trained to Level 2 and 41% (165) trained to Level 3. This was against a trust target of 95% for each level. The safeguarding lead reported sufficient training sessions, but these were undersubscribed.
- Staff we spoke with were aware of who to contact regarding safeguarding concerns. Guidance information was readily available.

Mandatory training

- Staff spoke positively about mandatory training and 'sweeper days', which incorporated the required training.
- We saw that trust figures for the medical division for July 2014 showed that 60% of staff were in date with their mandatory training against the trust target of 75%.

Assessing and responding to patient risk

- Every ward used the national early warning score (NEWS) system. Patient observations were mostly recorded appropriately and concerns were escalated in accordance with the guidance.
- Nursing staff reported good responses from medical staff when a patient's condition deteriorated.
- A critical care outreach team was available to support staff with patients who were at risk of deteriorating.
- We had concerns that patients who required non-invasive ventilation were being cared for across various medical wards and not within a dedicated setting. These patients were at risk of deterioration. The service was led by physiotherapists. Staff raised concerns that they were unable to safely manage patients who were on wards across the hospital. A number of incidents, including those that were 'near misses', had been reported. A total of 290 patients had required non-invasive ventilation between October 2013 and September 2014. Of these, 41% had been cared for on the respiratory ward, 37% on elderly care wards and 22% on other medical or surgical wards.
- Similar concerns were also raised regarding the care of patients with tracheostomies.
- We reviewed the care of patients requiring non-invasive ventilation during our unannounced visit. Since the announced visit, the trust had identified specific wards at the hospital where patients with non-invasive ventilation were cared for by teams that had received appropriate training. This was identified as an interim measure before more long-term solutions could be planned. However, we remained concerned about the arrangements in place and the staffing levels in these areas.

Nursing staffing

- The hospital used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. This was last completed in March 2014.
- In September 2014, there were 62 whole time equivalent (WTE) registered nurse vacancies for the medical division (which included the Emergency department and medical areas at St. Luke's Hospital). Recruitment was in progress and a number of appointments had been offered, leaving 27 WTE posts unfilled.
- Information on planned versus actual staffing numbers was displayed at the entrance to ward areas. These figures were reported to the Trust Board monthly and submitted nationally in accordance with requirements.
- In August 2014, six out of the 12 wards within the medical division filled over 90% of the required shifts for both registered nurses and support staff. Other wards had below 90% fill rates for either day or night shifts, or both.

Medical care (including older people's care)

- Ward 3, the elderly admissions unit, had an average fill rate of 80% for registered nurses on day shifts during August 2014. More support staff were used than planned. There were five occasions where staffing levels were below that required due to unfilled shifts.
- Ward 6 had an average fill rate of 79% for registered nurses on day shifts and 83% on night shifts in August 2014. More support staff were used than planned for day shifts. There were five reported occasions where staffing levels were below that required, due to unfilled shifts, and three occasions when staffing levels were below the level required and the shifts was downgraded to be filled by support staff.
- Ward 9 had an average fill rate of 87% for registered nurses on day shifts and 82% on night shifts in August 2014. More support staff were used than planned for day shifts. There were 11 reported occasions where staffing levels were below the level required, due to unfilled shifts, and five occasions when staffing levels were below the level required. The shifts were downgraded to be filled by support staff. Ward 9 incorporated the acute stroke unit. The ward manager was aware of the national guidance on the need of keeping in place a ratio of one nurse to two patients. Mostly, this staffing ratio was maintained. Staff were moved from the general ward area to support the acute stroke unit.
- On Ward 23, the respiratory ward, there was an average fill rate of 88% for registered nurses on day shifts. More support staff were used than planned for day and night shifts. There were three reported occasions where staffing levels were below what was required, due to unfilled shifts. On nine occasions, when staffing levels were below what was required. In these instances, the shifts were downgraded; to be filled by support staff. It was reported that beds had been closed when staffing levels fell below safe levels.
- However, we had concerns that the planned staffing levels were not based on accurate dependency levels for patients requiring non-invasive ventilation. Between October 2013 and September 2014, there had been 290 patients across the wards that required non-invasive ventilation to provide basic respiratory support. Staffing levels had not been calculated based on them requiring Level 2 care. For example, of the 290 patients, 120 of these were nursed on Ward 23, the respiratory care ward. In accordance with the Intensive Care Society (2009) definitions of levels of care, these patients required Level 2 care.
- Patients needing Level 2 care require a registered nurse to patient ratio of a minimum of 1:2 for at least the first 24 hours to deliver direct care in accordance with the Intensive Care Society core standards for intensive care units (2013) and the British Thoracic Society (BTS) guidelines (2008).
- The registered nurse to patient ratios for Ward 23 were 1:5.6 during the day and 1:9.3 at night. These staffing ratios were for the whole ward and included patients not requiring Level 2 care. There was no dedicated setting on the respiratory ward or elsewhere in the hospital for patients requiring Level 2 respiratory care.
- There was no trust guidance, or written local protocol in place to ensure that staffing requirements matched the number of patients requiring Level 2 care who could safely be admitted to the ward. Additional staff were requested on an ad hoc basis, based on individual need.
- On the evening of our unannounced visit on 4 November 2014 to Ward 23, there were 27 patients, including four patients requiring non-invasive ventilation as part of their acute care. There were three registered nurses to provide care for these 27 patients.
- At the visit to Ward 4 on 4 November 2014 we were told by nursing staff that there had been three patients requiring NIV plus a patient who had come in with their own NIV machine. We saw three of these patients during our visit. This ward is for the management of acute medical problems and patients' length of stay is expected to be less than 48 hours before being discharged or moved to another ward. The acuity and related nursing needs of patients on this ward is high and there are many admissions and discharges each day which staff are required to manage. On 4 November 2014 there had been six registered nurses on duty in the morning, five in the afternoon (two below the planned level of nurse staffing) and six overnight for 22 patients in beds and eight patients who were on trolleys. These staffing figures were for the whole ward, which did not meet the recommended ratio for nurse staffing in accordance with the BTS guidelines 2008. Ward sisters on the acute medical wards had been informed they could not have dedicated management time due to staff shortages. One ward sister was undertaking managerial work on their day off.
- The trust employed their own bank staff. Bank staff said they had received their mandatory training and had had a ward induction. Agency staff were infrequently used.

Medical care (including older people's care)

- Handovers of care occurred at least twice a day on wards. We viewed handover sheets and found these to provide enough detail. Some ward handovers also contained a safety brief, though this was not consistent.

Medical staffing

- There was appropriate consultant cover and junior doctor availability. Out-of-hours cover was provided at weekend and nights. Junior doctors reported good supervision and support from senior doctors and consultants.
- Medical staff reported good communication and handover of patients. Medical staff attended daily board rounds as part of the multidisciplinary teamwork activities, particularly on care of the elderly wards.
- Available medical consultant hours on AMU had improved over the last six to eight months. Consultant on-site presence was provided from 8am to 9pm, Monday to Friday and 8am to 8pm at weekends. Further recruitment was in progress for a further two WTE consultants. It was recognised that the future plans to increase ambulatory care would require additional medical staff.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with were aware of this.
- A manager had been appointed to review access and flow at the trust. Winter pressure arrangements were being considered as part of this. The medical admissions unit was undergoing refurbishment and was due to open fully in November 2014, with additional beds and improved ambulatory care.

Are medical care services effective?

Requires improvement

Policies and guidelines were available, although some of these were noted to be overdue for review. Audits were undertaken. There was limited feedback, particularly from senior staff to nursing teams to monitor the effectiveness of the care provided.

Pain relief, nutrition and hydration needs were met. A pilot of the use of a finger food menu on a ward caring for patients living with dementia was in progress.

The trust participated in national clinical audits. Appraisal rates for the medical division in August 2014 averaged 73% and for medical staff was 95%. Staff reported very good working relationships within the multidisciplinary teams.

A shortfall in capacity within the secretarial team within the division had resulted in a backlog of typing across specialties.

Evidence-based care and treatment

- Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site.
- There were dedicated divisional or directorate intranet sites, such as the acute medicine site, which contained relevant guidelines and pathways. These included such care pathways as the management of adults with suspected diabetic ketoacidosis and the management of patients with chronic obstructive pulmonary disease (COPD) who required Biphasic Positive Airway Pressure (BiPAP) ventilation. It was noted that a number of these were past their review date. For example, the COPD and BiPAP pathway was due for review by March 2013.
- Audits were undertaken to monitor compliance with guidance.
- There was a trust-wide nursing audit timetable for ward sisters to complete. Staff confirmed that they had completed the audits and submitted these electronically. Staff told us that they were aware of their results, but these were not formally collated or presented. Staff did not have information that could identify trends, or demonstrate good practice. There were no action plans available, although staff reported that if there were issues they would be contacted and additional monitoring put in place. Nursing staff reported they had limited time to undertake an additional local audit.
- Medical staff undertook audits. These were discussed at clinical governance meetings, although there was recognition of the need to improve the number of audits that were being undertaken.

Pain relief

- Pain assessments were carried out and recorded.
- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.

Medical care (including older people's care)

- Patients we spoke with had no concerns about how their pain was controlled.

Nutrition and hydration

- Protected meal times were in place and we observed these were adhered to in most cases.
- Patients were assessed regarding their nutritional needs and care plans were in place.
- Systems were in place to identify patients who needed additional support with eating and drinking, such as the 'red tray' system.
- We observed patients being supported to eat and drink.
- Drinks were readily available and we saw that drinks were in easy reach of patients, with the exception of three patients on Ward 3 who were all identified in the records as 'requiring assistance'.
- A pilot of the use of a finger food menu on a ward caring for patients living with dementia was in progress.
- Food and fluid intake were recorded in most cases. Occasionally, charts were not fully completed. For example, on Ward 3, one patient was identified as being at risk. This patient had had no fluid intake recorded for eight hours over the course of one of the inspection days.

Patient outcomes

- During 2013/2014 Bradford Teaching Hospitals NHS Foundation Trust participated in 97.2% of national clinical audits and 100% of national confidential enquiries, which it was eligible to participate in, according to their Quality Accounts.
- Bradford Teaching Hospitals NHS Foundation Trust achieved an overall rating of 'D', on scale of A – E, with E being the worst, in the Sentinel Stroke National Audit Programme (SSNAP) from January to March 2014. This was similar to other stroke services nationally.This had improved on the trust's previous rating. An action plan to further improve the service was in place. This included access to brain scans within set timescales. The most recent report identified further areas requiring development, including access to psychologists, six or seven day working of therapists and personalised rehabilitation discharge plans for patients. Further actions were due to be discussed following the recent receipt of the latest report.
- The trust scored worse than England and Wales on average on every measure except discharge planning in the Heart Failure Audit 2012/2013.
- The Myocardial Ischaemia (heart attack) National Audit Project (MINAP) for 2012/2013 showed patients with non-ST segment elevation myocardial infarctions (NSTEMIs) – a heart attack – were seen by a cardiologist or their team in 98% of cases and admitted to a cardiac unit or ward in 57% of cases. Both of these were better than the England and Wales average.
- Performance in the National Diabetes Inpatient Audit (NaDIA) in September 2013 showed the trust performed better than England and Wales on average in 11 out of 22 indicators. Of the ten indicators that performed below the national average, these predominantly related to staff knowledge and the suitability, timing and choice of meals. No data was available for whether or not patients were involved in their treatment plans.The trust also sent on the 12 November 2014 an audit dated 2013 by the British Thoracic Society (BTS) of the care and outcomes of Bradford NIV patients compared to national figures. The findings indicated that there was less patient involvement; higher NIV failure rates; poor recording of the reason for NIV failure; fewer patients had respiratory follow up and no patients were given oxygen alert cards. No evidence as to how the trust had responded and managed these issues and risks to patient care was volunteered to the Commission by the trust.
- The average length of stay for patients at the trust was below England average for 2013/2014.
- Emergency readmissions to the trust within 28 days of discharge from medical wards averaged around 14% over the previous three months. This was higher than the England average.

Competent staff

- Appraisal rates for the medical division in August 2014 averaged 73%. This ranged from 50% of staff appraised in some areas to 100% in others. Trust-wide work had commenced to simplify the appraisal process, improve the quality of appraisal and to ensure there was a direct link with corporate objectives.
- A report to the Trust Board in May 2014 showed that 95% of doctors in the medical division completed an appraisal in 2013/2014. Sixty-two recommendations were made by the trust to the GMC in relation to 'revalidation' between 1 April 2013 and 31 March 2014. All recommendations were completed on time.
- Senior nursing staff said they did not undertake formal clinical supervision with their staff.

Medical care (including older people's care)

- Medical staff reported that the training was excellent at Bradford Royal Infirmary.

Multidisciplinary working

- Staff across the medical division reported very good working relationships within the multidisciplinary teams. There were examples of good practice with multidisciplinary board rounds held, which included all members of the team, including the domestic staff.
- Speech and language therapists and podiatrists were employed by another NHS trust and worked according to a service level agreement with Bradford Teaching Hospitals NHS Foundation Trust.
- Mental health input was provided by the local mental healthcare trust. Staff reported delays in patients being seen particularly in the acute care areas.

Seven-day services

- Medical staff reported positively about senior medical and consultant cover. Ward rounds were undertaken daily. On some wards, such as the medical admissions unit and elderly admissions unit, there were daily consultant-led ward rounds.
- There were three physiotherapists during the daytime at weekends and an on-call physiotherapist to meet the needs of respiratory patients. There was no physiotherapy support for other medical areas of the trust at weekends, including for patients who had suffered a stroke. No rehabilitation assistants were available during the weekend.
- Pharmacy services were available seven days a week, although there were limited operating hours on a weekend. An out of hours pharmacy service was available through an on-call system.

Access to information

- Staff reported prompt response to information and test results.
- Discharge letters were sent to GPs on discharge.
- A shortfall in capacity within the secretarial team within the division had resulted in a backlog of typing across specialties. This was corroborated by the administrative staff focus group. This impacted on the timeliness of the discharge details being available in patient's notes. The trust was in the process of transitioning to a new secretarial and administrative structure. The backlog of typing was being scoped in order to address the issue.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Information regarding consent and mental capacity were available to staff on the trust intranet. It was noted the review date for the policy was June 2013.
- Divisional information showed that, as of July 2014, no staff were overdue training in the Mental Capacity Act 2005.
- Staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. A number of applications had been to the authorities to deprive patients of their liberty. We saw 14 applications had been made across the trust between September 2013 and August 2014.

Are medical care services caring?

Good

Most patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful.

The percentage of patients who would recommend the services was consistent with or higher than the national average in September 2014. The trust performed around the same as other trusts in relevant questions in the inpatient survey.

Patients we spoke with were aware of what treatment they were having and understood the reasons for this and, in some cases, had been involved in the decisions.

Most patients said they felt supported by staff including clinical nurse specialists who worked at the hospital.

Compassionate care

- The NHS Friends and Family Test response rate was consistent with the England average. The percentage of patients who would recommend the services was consistent with, or higher than, the national average in September 2014.
- The trust performed around the same as other trusts in relevant questions in the inpatient survey for 2013 with the exception of one question. This was regarding whether patients felt they received enough emotional support during their stay.

Medical care (including older people's care)

- The cancer patient experience survey results for 2012/2013 for inpatient stays showed the trust was in the top 20% for three indicators and consistent with other trusts in 33 indicators. They scored in the bottom 20% of trusts in eight indicators. This included provision of information and being provided with enough care.
- Throughout the inspection, we observed patients were treated with compassion and respect and their dignity was preserved.
- We spoke with 44 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. Where this was not the case, staff responded appropriately to concerns raised.

Understanding and involvement of patients and those close to them

- On the whole, patients felt that they were listened to by staff.
- Patients were aware of what treatment they were having and understood the reasons for this and, in some cases, had been involved in the decisions.

Emotional support

- Most patients said they felt supported by staff.
- There was a range of clinical nurse specialists at the trust. Patients and staff spoke positively about their input. For example, the diabetes nurse specialist and the palliative care team and the support they were able to offer.

Are medical care services responsive?

Good

There were processes in place to ensure most patients were cared for in the right place at the right time. Reconfiguration of the services was underway to further develop these pathways.

We found the number of medical outliers outside of the division was not significant and appropriate management arrangements were in place.

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.

Learning from complaints and concerns was inconsistent across the wards.

Service planning and delivery to meet the needs of local people

- The Bradford area has higher levels of chronic disease than neighbouring areas, particularly cardiovascular disease, diabetes and respiratory disease.
- The services at Bradford Teaching Hospitals NHS Foundation Trust are predominantly commissioned NHS Bradford City Clinical Commissioning Group (CCG) and NHS Bradford Districts CCG to meet the needs of the local people.
- Generally, staff we spoke with agreed there were a sufficient number of hospital beds available for the population, but the configuration, particularly the acute medical beds, required further work to meet patient needs. The reconfiguration was in progress.
- The medical assessment unit was in the process of being refurbished. The refurbished Ward 1 was due to open in November 2014 and included eight side rooms with one specifically designed for bariatric patients. Not all of these had ensuite facilities.
- There was a plan to develop the ambulatory care facility. Modelling had been undertaken on patient arrivals and ten ambulatory care pathways had been written and approved for use.
- Since December 2012, a revised model of care for elderly patients who had a fractured neck of femur had been implemented. The patients remained under the care of the elderly physician with the exception of the period of surgery. Nurses caring for these patients were experienced in care of the elderly and had received training in orthopaedic care.

Access and flow

- Patients were predominantly admitted from the emergency department (ED) to either the medical admissions unit or the elderly assessment unit. This was based on established criteria.
- The service on the elderly assessment unit worked effectively for the needs of the patients.

Medical care (including older people's care)

- Patients requiring longer than 24 hours in hospital were then transferred to another ward following the period of assessment.
- We saw that estimated dates of discharge were planned for most patients.
- There was a discharge team at the hospital who supported patients and staff with complex discharges.
- Staff reported there had had been an early supported discharge scheme for elderly patients, which had stopped operating due to a review of intermediate care. When operational readmission rates had fallen from 30% to 5%.
- An early supported discharge scheme for patients with a stroke had started in June 2014.
- Over the previous 12 months, referral to treatment times were better than the England average. Some services such as general medicine, geriatric medicine, neurology and dermatology achieved 100% against the 18-week target.
- No patients were waiting longer than six weeks for diagnostic tests with the division as of July 2014.
- Figures for April to August 2014 showed the trust had consistently achieved their performance targets for national cancer waiting times.
- We found the number of medical outliers (patients placed on a ward that did not routinely manage their clinical speciality) was not significant. A daily list was generated that included patients from one medical specialty occupying a bed designated for another medical specialty. During the inspection, we found that on one day five patients under the care of medical physicians were occupying beds within surgical wards. There was criteria regarding which patients were suitable to outlie on other wards if need. We found the criteria had been followed. All patients that were outlying on other wards had been reviewed daily by their medical team and the nursing staff providing the care had no concerns regarding the care of these patients.
- Seventy-eight percent of patients were not moved to another ward as part of their hospital stay. Seventeen percent of patients had one ward move while the remaining 5% had two or more ward moves during their stay.

Meeting people's individual needs

- Translation services were available and staff knew how to access these.
- We noted that information leaflets were available for patients, but these were not readily available in languages other than English.
- We saw examples of additional staff being employed to provide individual care for patients, as well as support workers from other organisations being accommodated to assist in meeting the needs of patients with complex needs.
- The elderly care wards had developed practices and the environment to meet the needs of patients living with dementia. There were recognised good practices in place, such as memory boxes and one ward was trialling the use of finger foods. The 'forget me not scheme' was in place.
- There was specific documentation available to support the care of patients with learning disabilities. Matrons were informed of admissions and a register was held to help assure their needs were met. Relatives' rooms and quiet areas were available on some wards. Copies of multifaith literature were available within these.
- The lack of psychology input had been noted on the Sentinel Stroke National Audit Programme (SSNAP). Access to psychological services was recognised as good practice due to the prevalence of cognitive and mood difficulties in patients who had had a stroke.

Learning from complaints and concerns

- Learning from complaints and concerns was not consistent across the medical wards. Staff were aware of the complaints process and some areas, such as Ward 7, could provide examples of improvements to practice as the result of complaints and how this information was shared. In most other areas, staff were unaware of complaints or lessons that could be learned.

Are medical care services well-led?

Requires improvement

There had been very recent changes to the leadership of the medical division as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held at speciality, directorate and divisional levels. There was generally good clinical engagement and attendance. Changes to the risk

management processes were in place, but required further embedding in practice. The divisional risk register included some, but not all the issues identified as risks during the inspection. Information on performance was not readily available to clinical staff.

The trust was better than average for staff engagement when compared with trusts of a similar type. However, the data for the division of medicine showed that the division was the lowest scoring part of the trust. Some staff we spoke with said they felt the culture had improved over the last few years.

There were examples of innovation and improvement.

Vision and strategy for this service

- Most staff were clear about the vision and strategy for the service. This was particularly evident in the acute admissions areas where they were undergoing refurbishment to support revised patient pathways. Staff had been involved in the planning and development of these services. However, some areas were unclear about how the changes would affect their areas.

Governance, risk management and quality measurement

- Clinical governance meetings were held at speciality, directorate and divisional levels. A standardised agenda template had recently been introduced across the trust to aid with consistency. We reviewed notes of meetings and saw there was generally good clinical engagement and attendance.
- A risk register was in place for the medical division. This had recently been completely revised. A process had been put in place to align the identified risks from the specialties to the division. There were some discrepancies noted between the divisional risk register and the corporate risk register. The senior management team identified that the processes still required embedding.
- The divisional risk register included some, but not all the issues identified during the inspection. For example, staffing and some environmental issues were documented, but the risks associated with the identification and care of the non-invasive ventilated patients were not noted.
- Clinical audits where outcomes were below the national average were not highlighted as a risk, for example the national heart failure audit.
- Following CQC raising concerns about the care of patients requiring NIV the trust stated in a letter to the Commission dated 12 November 2014 that an audit had been undertaken retrospectively by the respiratory physiotherapy department, which covered a timeframe of October 1013 to September 2014 and it had identified several areas for improvement. These were: that the BiPAP pathway needed immediate review (published 2011, with a review date of March 2013 at the latest); that patients are not 'clustered' in areas where the skill base of both clinicians and nurses provides assurance that clinical competencies match need; that the direct care is extended to involve both physiotherapy and the respiratory nurse specialists; and that equipment must be available to the areas 24 hours a day.
- Information on quality performance was collected. A monthly, updated divisional dashboard was produced.
- Information on performance was not readily available to clinical staff. For example, information regarding the Safety Thermometer was submitted, but there was no feedback report about performance to clinical staff so they could identify trends.

Leadership of service

- There had been very recent changes to the leadership of the medical division as part of a wider trust restructure.
- Staff were generally positive about the leadership and the recent appointments. Staff knew who they could contact and were generally confident to approach trust directors or senior managers in the hospital if they had concerns or lack of response from middle managers.
- Staff reported that the senior management team and the Trust Board were visible. Directors had made regular visits to clinical areas.
- At ward level there was clear leadership of the services. Ward sisters on the acute medical wards had been informed they could not have dedicated management time, due to staff shortages. This had impacted on their capacity to lead their teams effectively.

Culture within the service

- It was evidently a period of change across many of the services we inspected.
- Most staff acknowledged the need for change; some staff were unclear about how the changes would affect their areas. Staff reported that the culture had changed positively over the last few years.

Medical care (including older people's care)

- Staff reported there had been recent improvements in the culture of the service, particularly in areas such as elderly medicine.

Public and staff engagement

- Managers told us how they had engaged with the public regarding ward developments. For example, developments on the care of the elderly wards had been informed by meetings held with carers.
- The trust displayed the NHS Friends and Family Test results on the wards.
- Information from the 2013 national NHS staff survey showed that staff engagement was better than average when compared with trusts of a similar type. However, the data for the division of medicine showed the division was the lowest scoring part of the trust in relation to staff engagement.
- Senior staff were able to tell us about wider issues at the trust; however, more junior members of staff were not aware of any trust-wide updates provided by newsletter or email.

Innovation, improvement and sustainability

- There were examples of innovation and improvement. The elderly care wards, particularly Wards 29 and 30, had made improvements to the care of older people including those living with dementia. The environment had been adapted and was an exemplar for dementia-friendly environments. Memory boxes were in use, finger foods were being trialled and equipment that provided individualised audio-visual stimuli for patients was being used to support patient care. A lead nurse for dementia, who promoted innovation and improvement and engaged with a wider regional network, was employed by the trust. There was no current dementia strategy for the trust, although we were informed this was currently being consulted upon.
- Since December 2012, there had been a revised model of care for elderly patients with hip fractures. The patients were nursed on Ward 30 under the care of an elderly care consultant. Surgical care was provided by the orthopaedic surgeon for the period of surgery.

Surgery

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

Information about the service

Bradford Royal Infirmary provided a range of surgical services for the population of Bradford and the immediate surrounding area and also served the population of West Yorkshire. There were thirteen wards providing surgical services and twenty surgical theatres.

Bradford Royal Infirmary provided elective and non-elective treatments for breast surgery, colorectal surgery, ear, nose and throat (ENT), oral surgery, trauma, orthopaedics, urology and vascular surgery.

During this inspection, we visited the following surgical wards: Ward 5 (day surgery and admissions unit), Ward 11 (general), Ward 12 (gynaecology, plastics and breast surgery), Ward 14 (urology), Ward 18 (ENT, maxillofacial, ophthalmic), Ward 20 (assessment unit), Ward 21 (higher dependency unit – HDU), Ward 27 (orthopaedic, acute plastic) and Ward 28 (elective orthopaedic, arthroplasty). We visited 17 theatres and observed care being given and surgical procedures being undertaken.

We spoke with 81 patients and relatives and 43 members of staff. We observed care and treatment and looked at care records for 28 patients.

Summary of findings

We rated effective, caring, responsiveness and well-led as good, and safety as requiring improvement. There were arrangements in place for reporting patient and staff incidents and allegations of abuse. Staff did not always receive feedback on reported incidents.

There was a lack of isolation and side rooms throughout the division's wards. This meant that some patients were not always cared for in the most appropriate environment. There were concerns about the receipt, recording and storage of some surgical instruments and the adequacy of facilities for staff and waiting patients within the endoscopy unit. The recovery areas were poorly staffed on the day of inspection, with only one recovery nurse for two theatres.

Staff understood their individual roles and responsibilities and there was good ward leadership and felt supported at a local level. A number of staff described the management structure within the division as being 'disconnected'.

We observed positive, kind and caring interactions on the wards and between staff and patients. Most patients spoke positively about the standard of care they had received. The service reviewed and acted on information about the quality of care that it received from complaints. The division had implemented change as a result of the learning gained from audits.

Surgery

Are surgery services safe?

Requires improvement

There were arrangements in place for reporting patient and staff incidents, including those relating to staff shortages and allegations of abuse, which was in line with national guidance. Staff did not always receive feedback on reported incidents.

Staffing establishments and skills mix had been recently reviewed and effective handovers took place between staff shifts to ensure continuity and safety of care.

Information from the NHS Safety Thermometer was not presented in a consistent and clear way on wards and theatre areas.

There was an inadequate number of isolation and side rooms and this had caused problems regarding the appropriate environment for patients and the flow of patients through the hospital.

The arrangements in place for the receipt, recording and storage of some surgical instruments required improvement. Additionally, the adequacy of facilities for staff and waiting patients within the endoscopy unit required improvement, as did the procedures for cleaning and disinfecting endoscopes.

The division had introduced a complementary system of 'green bands' to be worn by patients on their wrists displaying personal and procedure information. This was an effective additional safety measure to the World Health Organization (WHO) surgical safety checklist.

Care records were completely accurately and consistently.

Incidents

- Staff were aware of, and familiar with, the process for reporting and investigating incidents, near misses and accidents using the trust's electronic reporting system (Datix).
- Staff told us feedback on reported incidents was not always given and they felt they were not always appropriately supported. This was particularly mentioned in relation to feedback on incidents with reported staff shortages.
- Staff were unclear what learning had been made, or measures put in place, to avoid recurrences of reported incidents.
- There were no Never Events reported within this division (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).
- Within surgery, 17 serious incidents had been reported in 2013/14 (16 related to Grade 3 pressure ulcers). The reporting of serious incidents was in line with what was expected for the size of the hospital.
- Mortality and morbidity meetings were held monthly in all relevant specialties. All relevant staff participated in mortality case note reviews and reflective practice.

Safety Thermometer

- The trust used the NHS Safety Thermometer, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- Information was displayed on boards on all wards and theatre areas visited, although this was not always presented in a consistent, or clear way.
- Safety Thermometer information included information about all new harms, falls with harm, and new pressure ulcers. The hospital was performing within expected levels for these measures – the numbers of falls, pressure ulcers and urinary tract infections across the division had all decreased, according to the latest available information (July 2014). This was reflected in information displayed within ward areas.
- Care records showed that risk assessments were being appropriately completed for all patients on admission to the hospital.

Cleanliness, infection control and hygiene

- Wards and patient areas were clean and we saw staff wash their hands and use hand sanitising gel between patients. 'Bare below the elbow' policies were adhered to.
- Infection control information was visible in most ward and patient areas.
- All elective patients undergoing surgery were screened for Methicillin resistant Staphylococcus Aureus (MRSA) and procedures were in place to isolate patients, when appropriate, in accordance with infection control policies.

- There was an inadequate number of isolation and side rooms and this had caused problems. This meant that some patients were not always cared for in the most appropriate environment and this affected the flow of patients through the hospital.
- We were told about one particular incident (Ward 12) where a patient had received care on the ward area. This would have been more appropriately given within an isolation room for privacy and dignity reasons. However, the one isolation room on the ward was occupied. This had caused distress to patients, relatives and staff.
- The numbers of cases of MRSA and Clostridium difficile (C. difficile) for the surgical wards had varied across the previous twelve months. Data indicated that were no MRSA cases within surgery from April – August 2014. C. difficile rates for the hospital were slightly above the required level in August 2014.
- Clinical waste bins were covered, with foot-opening controls and the appropriate signage was used for the disposal of clinical waste.
- We saw that separate hand washing basins, hand wash and sanitizer were available on the wards, theatre and patient areas.
- Recent reports to the Trust Board showed that the service was compliant with infection control procedures. Infection control audits were completed every month and monitored compliance with key trust policies, such as hand hygiene.
- Nursing staff had received training in aseptic, non-touch techniques. This encompassed the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The division participated in the ongoing surgical site infection (SSI) audits run by Public Health England. Reports available (from May 2014 to October 2014) identified SSI rates across all specialties running at between 0% (hip replacement) and 9.1% (abdominal hysterectomy) for the latest reporting period, against 'all hospitals' rates of 0.9% and 2.3% respectively.
- Each case of SSI was identified, discussed at formal meetings and actions decided on to avoid a repetition.
- Swab, pack surgical instrument and sharps count audits were completed within theatre and these were discussed at divisional meetings and actions identified, if required.
- We had concerns about the cleanliness of the endoscopy unit. The unit was not adequate, as it was cramped and movement within the unit was obstructed by equipment and supply boxes. The procedures for cleaning and disinfecting endoscopes was compromised by the layout of the unit not allowing for procedures that were in line with accepted practice. Work was in progress to improve the facilities with the refurbishment of one wing to create a new decontamination area.

Environment and equipment

- We observed that checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.
- Records showed that equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was noted to be covered and dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.
- Divisional arrangements were in place for the receipt, recording and storage of some surgical instruments. This was managed by a registered nurse. We saw that not all surgical instrument packs were complete and this process raised concerns about the effectiveness and safety of current arrangements.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use, including enhanced recovery. For example, for fractured neck of femur.
- All wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- There was a comprehensive preoperative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely, in line with the Data Protection Act 1998 principles, to ensure patient confidentiality was maintained.

- Nursing documentation was kept at the end of the patients' beds and centrally within the wards. It was completed appropriately.

Safeguarding

- Staff were aware of the trust's safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take when reporting on an issue.
- Divisional compliance with Level 1 adult safeguarding training was at 96.7%. Level 2 ranged from 4% to 100% across specialities and Level 3 compliance stood at 75%. With Level 1 children's safeguarding training it was 88.9% across all specialties against a trust target of 75%. Children's safeguarding Level 2 was 49% and Level 3 at 73%.

Mandatory training

- Staff in the surgery division were up to date with their mandatory training. Records showed that the compliance of ward staff having attended mandatory training varied between 86% and 92%. We saw that training had been arranged for staff who had not yet completed their training (either face to face, or online). This included attending annual cardiac and pulmonary resuscitation training as well as compliance with adult and children's safeguarding and Mental Capacity Act 2005 training.
- During group and individual meetings, staff confirmed that they felt confident they had received the mandatory training necessary to enable then to perform their role effectively.

Assessing and responding to patient risk

- All wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- The pre-assessment of patients was in accordance with British Association of Day Surgery (BADS) guidelines.
- We observed theatre staff using the 'Five Steps to Safer Surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist. An audit was carried out in October 2014 and showed that the preoperative care section and further information sections were 100% completed by a nurse or healthcare assistant. Results that related to the sign out process, showed a completion rate of 72% and identified actions to improve this rate.
- The division had introduced a complementary system of 'green bands', to be worn by patients on their wrists. The band displayed personal and procedure information. This was viewed as an effective additional safety measure, to work in conjunction with the WHO checklist.

Nursing staffing

- The hospital used the NICE endorsed Safer Nursing Care Tool (SNCT) to determine optimal nurse staffing level. This was undertaken 6 monthly across all adult inpatient areas with required reports presented at public Board of Directors meetings. The reports were then posted on the Trust's web page. The last review was undertaken in May 2014 (presented at July 2014 Board meeting) and the Trust informed us that the next scheduled review was due in November 2014. Work had been undertaken recently by the Trust to reassess the staffing levels on wards. This was to ensure that staffing establishments reflected the acuity of patients.
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster.
- We reviewed the nurse staffing levels on the wards and theatres we inspected and found that levels were compliant with the required establishment and skills mix.
- An exception to this was within theatre recovery areas, where we found one registered nurse responsible for the management of patients from more than one theatre. This was contrary to trust policy and was unsafe practice, due to the numbers of patients within recovery at the same time.
- Staffing within Recovery has been inspected against the standards of the British Anaesthetic& Recovery Nurse's Association (BARNA) however on discussion with the Trust it is evident that they utilise the Association for Perioperative Practice (AfPP). Both of these are recognised frameworks to assess staffing resource however there are some differences in their focus. In light of our inspection & subsequent discussions the

Trust has reflected on the BARNA approach and implemented a review of each theatre list to assess the staffing and skill mix needs for recovery by nature of operating lists to ensure safe staffing adjustments are made within individual theatre areas and across all theatre environments. When we inspected Theatres E1-E5 (ophthalmic, head and neck, ENT surgery theatres) we found that recovery staffing was an issue, with two nursing staff for five theatres, this is lower than BARNA standards. Theatres 1-6 (modular theatres) were located over three floors with two theatres and one recovery area on each floor. The recovery areas were poorly staffed on the day of inspection, with only one recovery nurse for two theatres. The rotas obtained showed two recovery nurses had been scheduled for two theatres. Staff told us that there was 'regularly only one nurse in recovery' (nucleus theatres).

- Following the inspection the trust had acted on our concerns and had implemented a review of each theatre list to assess the staffing and skill mix needs for recovery for each list to ensure safe staffing adjustments are made within individual theatre areas and across all theatre
- For day shifts, the trust average 'fill rates' for nurses in September 2014 was 92.8% and for care staff it was 108.1%. For night shifts the trust average 'fill rates' for nurses was 97.2% and for care staff 122.4%. 'Fill rates' were calculated against planned staffing levels and these figures showed that staffing levels were maintained through the use of additional bank staff.
- There was limited use of bank or agency staff and staff told us they were asked to cover staff shortages. The trust use of bank and agency staff was 2.6% during 2014, against an England average of 6.1%.

Surgical medical staffing

- Surgical consultants from all specialties were on-call for a 24-hour period and arrangements were in place for effective handovers.
- Patients requiring unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant. The hospital published a rota for general surgical emergency provision.
- The general surgery on call team comprises a Consultant General Surgeon supported by a higher surgical trainee and three junior medical staff. There is a separate vascular consultant on call service, along with separate surgical on call specialties for General Surgery, Vascular, Urology, ENT, Maxillo-Facial, Orthopaedics, Ophthalmology and Plastics. Each service had middle grade support
- Consultants were available on-call and out of hours and would attend, when required, to see patients at weekends. Medical staffing within the division was made up of 44% at consultant level (England average 40%), 35% registrar level (England average 38%), middle career 6% (England average 11%), and 14% junior doctors (England average 13%).
- Ward and medical staff told us that there was a lack of availability of junior doctors, which impacted on weekend and out of hours working, as well as discharge planning. Junior doctors spoken with told us they worked excessively long hours, covered across specialties and found it difficult to access training.

Major incident awareness and training

- Business continuity plans for surgery were in place. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England Core Standards for Emergency Preparedness, Resilience and Response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who could be called upon to provide an emergency response, additional services, or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patient care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had developed a number of local audits. Mortality indicators were within expected ranges.

Surgery

Processes were in place to identify the learning needs of staff and opportunities for professional development. Nursing staff did not receive clinical supervision or formal one-to-one sessions, although, informal one-to-one meetings did take place.

There was effective communication and collaboration between multidisciplinary teams, who met regularly to identify patients requiring additional support or to discuss any changes to the care of patients.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients, where appropriate. The role of the primary nurse had been introduced to escort the patient through the care pathways and follow up each patient, ensuring continuing care.
- Local policies were written in line with national guidelines and updated every two years, or if national guidance changed. For example, there were local guidelines for preoperative assessments and these were in line with best practice.
- The surgery division and departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- We also saw a number of local clinical audits designed to assess the effectiveness of identified procedures, for example:
  - Comparison of perioperative and pathological outcomes for open and robotic assisted laparoscopic prostatectomy.
  - Prospective study to assess the patterns of recurrences post-radical cystectomy to guide radiological surveillance.
  - Assessment of early and late outcomes of orthotopic bladder reconstruction in radical cystectomy patients.
- Local audits relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery showed full compliance.

Pain relief

- Preplanned pain relief was administered for patients on recovery pathways.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported that their pain management needs had been met.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST). Where necessary, patients at risk of malnutrition were referred to the dietician.
- Records showed that patients were advised as to what time they would need to fast from. Fasting times varied depended on when the surgery was planned.

Patient outcomes

- There were no current CQC mortality outliers that were relevant to surgery at Bradford Royal Infirmary. This indicated that the number of deaths were within expected limits re had been no more deaths than expected for patients who were undergoing surgery at this hospital.
- Patient Reported Outcome Measures (PROM) for hip replacement, knee replacement, groin hernia and varicose veins showed similar improvements in patients receiving these procedures to the England average results.
- Between April 2014 and August 2014, the number of day case surgical procedures performed was below nationally expected numbers. For trauma and orthopaedics the rate was 48.4%, for ENT – 50.1%, general surgery was 56%, oral surgery – 80.8%, urology – 78.2%, vascular surgery – 67.7%. The British Association of Day Surgery recommended that 90% of certain surgical procedures were completed as day cases.
- Standardised relative readmission rates for elective surgical patients ran higher and were worse than the England average of 100. They were 132 for urology, 191 for general surgery and 113 for ENT. For non-elective patients, standardised relative readmission rates ran higher and were worse than the England average for 100, 123 for general surgery and 111 for trauma and orthopaedics. The rates were better than the England average for urology at 96.

Surgery

- Readmission rates for surgical wards varied between 0% (Ward 19A) to 20.1% (Ward 11: general surgery) in July 2014. The division had undertaken work to identify the reasons for this, as well as identifying actions to reduce readmissions, where appropriate.
- The trust contributed to all national surgical audits for which it was eligible.
- At 100%, the National Bowel Cancer Audit (2013) showed better than the England average results for multidisciplinary team discussion (the England average was 97.8%). It was also higher for clinical nurse specialist involvement (98.7% against the England average of 87.7%) and scans undertaken (93.4% against the England average of 89.1%). 79% of patients undergoing major surgery stayed in the hospital for an average of more than five days (higher than the England average of 68.9%). Mortality rates were below the England average at 30 day, 90 day and two year measures.
- National Lung Cancer Audit results showed that, at 17.7%, the percentage of patients receiving surgery was higher than the England average of 15.5%. At 99.2%, the audit showed results that were better than the England average for multidisciplinary team discussion (the England average was 95.6%) and scans undertaken before bronchoscopy (98.1% against the England average of 89.5%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2013/2014 report showed that the trust was better than the England average in areas such as patients being admitted to orthopaedic care within four hours (52.7% against the England average of 51.6%) preoperative assessment by a geriatrician (62.9% against the England average of 53.8%), patients developing pressure ulcers (0.8% against the England average of 3.5%), the mean length of acute stay (14.9 days against the England average of 15.6 days and post-acute stay (0.04 days against the England average of 3.6 days and the mean total length of stay (15 days against the England average of 19.2 days).
- The trust was worse than the England average for patients receiving surgery within 48 hours (79.5% against the national target of 87%), falls assessment (86.9% against the England average of 96.5%) and bone health medication assessment (76.8% against the England average of 84.9%).
- The division had introduced initiatives to improve adherence with national targets. Focus on additional weekend working was designed to reduce backlogs. For example, current divisional audits show the trust is performing better than the England average for patients receiving surgery within 48 hours (90.0% against the national target of 87%).

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that the majority of staff across all wards in surgery and theatres had received an appraisal, or had had an appraisal arranged.
- Although nursing staff said they did not receive clinical supervision or formal one-to-one sessions, informal one-to-one meetings did take place.
- Monthly staff meetings were taking place and minutes were available to staff.
- Junior doctors we spoke with told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching and were supported by the ward team and could approach their seniors if they had concerns.
- The General Medical Council (GMC) National Training Survey 2014 identified a worse than expected outcome for feedback from consultant staff.
- Revalidation of doctor's outcomes were assessed and monitored by the Deanery.
- Clinical staff told us they had not been sufficiently trained in the use of the patient information or the theatre booking system to enable them to use it effectively.

Multidisciplinary team working

- Therapists worked closely with the nursing teams on the ward, where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed. Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the wards during weekdays.
- Staff explained to us that the wards worked with local authority services as part of discharge planning.

Seven-day services

- Daily ward rounds were arranged for all patients and patients were seen on admission at weekends.
- Access to diagnostic services was available seven days a week, for example, x-rays.

- There was an on-call pharmacist available out of hours. Pharmacy staff were available on site during the week.

Access to information

- Staff reported prompt response to information and test results.
- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and these were started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- A shortfall in capacity within the secretarial team had resulted in a backlog of typing across specialties. This was corroborated by the administrative staff focus group. This impacted on the timeliness of the discharge summaries being available. The trust were in the process of transitioning to a new secretarial and administrative structure. The backlog of typing was being scoped in order to address the issue.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patients had been consented in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patients' care and Deprivation of Liberty Safeguards were referred to the trust's safeguarding team.

Are surgery services caring?

Good

We observed positive, kind and caring interactions on the wards and between staff and patients. Most patients spoke positively about the standard of care they had received. Some patients identified that staff were under pressure and that this affected the standard of care they received.

Most patients we spoke with felt they understood their care options and were given enough information about their condition.

There were services in place to ensure that patients received appropriate emotional support.

Compassionate care

- We observed that patients were being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken with, and listened to, promptly. Patients told us staff were very caring despite the stresses of working on a very crowded ward. One person said, "I have been treated with dignity and respect, there are no concerns or complaints." Another said, "The nurses are brilliant, work very hard, but there seems to be a lack of direction where patients are waiting about for admission," and, "The place is clean and the staff are wonderful and polite, the food is good."
- We observed that staff were attentive to the comfort needs of patients. Patients and relatives were mainly positive about the care and treatment they had received.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment they received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed that patients were being kept informed throughout their time within the anaesthetic room and theatres.
- Some patients did make comments about the perceived abruptness of some members of staff. Patients felt this was due to the pressures that staff were under. Ward managers were made aware of these comments, where appropriate.
- We saw doctors introduce themselves appropriately and curtains were drawn to maintain patient dignity.
- The hospital's NHS Friends and Family Test response rate was higher (35%) than the England average (32%) between April 2013 and July 2014 and scores were similar across all areas against the England average during this period.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and this had been explained to them.

- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw that ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The Care Quality Commission (CQC) inpatient survey (2013) showed an increase in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.
- There was also an increase in patients responding positively to say they received answers they could understand when asking important questions to a nurse.

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had, either about their care, or in general. Patients did not raise any concerns during our inspection.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this.
- Patients were able to access counselling services, psychologists and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and postoperatively.

Are surgery services responsive?

Good

Systems were in place to plan and deliver services to meet the needs of local people and staff were responsive to people's individual needs.

The trust was meeting the referral to treatment targets (RTTs) for patients admitted for treatment from a waiting list within 18 weeks of referral, and for patients on the combined outpatient and inpatient waiting list having waited less than 18 weeks from referral.

The admission of patients with more complex needs to the day surgery and admissions unit was not felt to be appropriate by staff.

Services were available to support patients, particularly those who lacked capacity to access the services they needed. Information about the trust's complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Capacity bed meetings were held to monitor bed availability in the hospital. Managers responsible for reviewing planned discharge data and assessing future bed availability had been appointed.
- During high patient capacity and demand elective patients were reviewed in order of priority for cancellation to prevent urgent and cancer patients being cancelled.
- Staff told us that more patients with complex needs were admitted to the day surgery and admissions unit than they had the training and competence to care for, or treat.
- The elderly care wards, particularly Ward 29 and Ward 30, had made improvements to the care of older people, including those living with dementia. The environment had been adapted and was an exemplar for dementia-friendly environments.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning, or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at the pre-assessment stage and plans were continuously reviewed during the discharge planning process.
- The trust was meeting the referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral, 95% of

non-admitted patients starting their treatment within 18 weeks of referral and 92%, or more, of patients on the combined outpatient and inpatient waiting list had waited less than 18 weeks from referral.

- The RTTs for patients admitted for treatment from a waiting list within 18 weeks of referral were not met within oral surgery. The figure being 75.6% at the time of the inspection. The reasons for these shortfalls had been identified and additional recruitment to consultant posts undertaken, as well as locum cover arranged to reduce the backlog of patients.
- Delays to discharge within the trust were caused mainly by patient or family choice (28.4%), or waiting for further NHS non-acute care (44.7%), both above the England average (13.8% and 21.2% respectively).
- We were told by a number of staff that discharges were often delayed, due to the lack of junior medical staff available to write up discharge notes and letters.
- The further issue of notes being written up at the end of a theatre session rather than at the end of each procedure was raised by a number of ward-based staff. They identified this as a cause of delays to discharges.
- The England target for RTT date was for achievement of 90% of patients within eighteen weeks. The division was meeting this target for all specialties, except for trauma and orthopaedics (88.2%) and oral surgery (88.3%).
- The average length of stay was at, or below, the England average for both elective and non-elective patients, except for elective general surgery (five days against the England average of three days) and elective vascular surgery (nine days against the England average of four days) and non-elective vascular surgery (thirteen days against the England average of twelve days).
- Seven patients had their operation cancelled and were not treated within 28 days during the first six months of 2014. This was better than the England average during this period.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support when caring for people with these needs.
- We saw that suitable information leaflets were available in pictorial and easy-to-read formats and described what to expect when undergoing surgery and postoperative care. We were told that these were available in languages other than English, but these were not displayed within ward or surgery areas.
- Wards had access to interpreters, as required. Requests for interpreter services were identified at the pre-assessment meeting.
- There was access to an independent mental capacity advocate (IMCAs) for when best interest decision meetings were required.
- Compliance with the Mental Capacity Act 2005 training was 90.3% against a trust target of 75%.
- We had concerns about the suitability of the endoscopy unit. The facilities for staff and waiting patients were not adequate. The unit was cramped and movement within it was obstructed by equipment and supply boxes. The availability of changing facilities for staff and toilets throughout the unit were not adequate for the numbers of staff or patients.
- The layout of Ward 5 was in breach of guidance relating to mixed-sex wards. Female patients were located at one end of the ward and had to walk past beds occupied by male patients to access facilities.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff, or the ward manager. Staff were able to explain this process.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.
- We saw that leaflets were available throughout the hospital, informing patients and relatives about this process.
- Complaints and concerns were discussed at monthly staff meetings, where training needs and learning was identified as appropriate.
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Service (ICAS) contact details were visible in the ward and throughout the hospital.

Are surgery services well-led?

Surgery

Good

At ward and theatre levels we saw that staff worked well together and that there was respect between, not only the specialties, but across disciplines. We saw good team working on the wards between staff of different disciplines and grades.

The trust vision, values and strategy were not well embedded with staff and they did not have a clear understanding of what these involved. However, staff were aware of their individual roles and responsibilities and there was good ward leadership and staff felt supported at a local level.

A number of staff described the management structure within the division as being "disconnected". Some staff believed this had an effect on patient care and service development.

Vision and strategy for this service

- The trust vision and strategy was not well embedded with staff. Staff were unable to articulate the trust's values and objectives to us across the surgical wards and they were not clearly displayed on ward areas.
- We met with senior managers, who had a clear vision and strategy for the division and identified actions for addressing issues within the division. Staff spoken with were unable to repeat this vision, or discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

- Clinical Governance meetings were held each month. Meeting minutes showed that complaints, incidents, audits and quality improvement projects were discussed and action taken where required.
- The monthly 'Performance and Productivity Report' presented to the Trust Board identified risks throughout the trust, actions taken to address risks and changes to be implemented in performance. This monitored (amongst other indicators) MRSA and C. difficile rates, RTTs, pressure ulcer prevalence, complaints, Never Events, complaints and mortality ratios
- We saw that action plans for Never Events were monitored across the division and subgroups were tasked with implementing elements of action plans, where appropriate.

Leadership of the service

- We met with the divisional management team, who expressed pride in the clinical and nursing staff within the division and the care given to the population it served. The team explained that the management model (a triumvirate) was replicated throughout the division and believed this to be working well, with engagement being developed within clinical teams. The management team recognised that staff shortages existed within the division and that individual and team stress levels had increased. However, some staff told us that the senior leadership of the service was unresponsive. They said staff morale was poor, although they felt supported at ward level by ward sisters, local managers and matrons.
- Each of the surgical specialties had a clinical lead and there was also a divisional lead.
- Staff spoke positively about the service they provided for patients and emphasised that quality and patient experience was a priority and that it was everyone's responsibility.

Culture within the service

- At ward and theatre levels we saw that staff worked well together and that there was respect between, not only the specialties, but across disciplines. We saw good team working on the wards between staff of different disciplines and grades.
- Staff were not well engaged with the rest of the hospital, but without exception reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff did have reservations about whether or not concerns would always be acted on and felt disconnected from senior management within the division.
- Staff spoke positively about the service they provided for patients. High quality, compassionate patient care was seen as a priority. However, some staff were unhappy about a range of issues they identified as the chronic shortage of high dependency beds causing the

cancellation of procedures, the isolated location of the anaesthetic theatre, pressure on beds and the chronic shortages of doctors, which reduced the number of training opportunities.

Public and staff engagement

- The hospital's NHS Friends and Family Test response rate was higher (at 35%) than the England average of 32% between April 2013 and July 2014. Scores were similar across all areas, against the England average during that period. The response rates for wards within the surgery division varied between 22% and 89%.
- NHS Staff Survey data (2013) showed that the trust scored as expected in 15 out of 30 areas and better than expected in five areas. There were eight negative findings, for example, staff suffering from work related stress in the last 12 months, staff feeling pressure over the three months prior to the inspection to attend work when feeling unwell, and staff experiencing harassment, bullying or abuse from patients, relatives, the public, or abuse from staff over the 12 months prior to this inspection.
- One of the major criticisms from a number of staff was the failure of the management-level staff to engage with consultants. Some staff spoke of experiencing bullying to get results which compromised safety.

Innovation, improvement and sustainability

- There were systems in place to enable learning and to improve performance, which included the collection of national data, audit taking and learning from incidents, complaints and accidents.
- Evidence showed that staff were encouraged to focus on improvement and learning. We saw examples of innovation, such as the development of the use of robotics in surgery, the introduction of the 'green band' safety system and the use of tape-recorded handovers between nursing staff.

Critical care

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

Information about the service

The critical care service at Bradford Teaching Hospitals NHS Foundation Trust is located at the trust's main site, Bradford Royal Infirmary. The critical care service includes an intensive care unit (ICU) and a four-bed high dependency unit (HDU), situated away from the ICU.

The ICU has 16 mixed Level 2 and Level 3 beds and admits around 1,100 patients per year, placing it amongst the busiest 20 units in England and Wales. Around 40% of admissions are acute post-operative patients admitted directly from theatre and around 60% of admissions are elective.

During the inspection, we visited both the ICU and HDU, observed care, reviewed documentation, spoke with patients, families and also staff, including doctors, nurses and allied healthcare professionals.

Summary of findings

We found that caring was good but all other domains required improvement. The environment within the critical unit was inadequate to meet the needs of the service in terms of layout and facilities. There were concerns over the medical staffing skill mix as experience level varied amongst clinicians. There were some delays in the discharge of patients, which impacted on the patient experience and bed occupancy rates were high.

Outcome data showing the effectiveness of the care provided was positive. The staff provided compassionate care and were respectful towards patients and/or their family and friends. There was a strong team approach to ensuring the best outcomes for patients.

There had been recent leadership changes, including clinical leadership, and some newly introduced systems and processes had yet to become fully embedded. Some changes to the service had recently been proposed, but some staff reported that change wasn't effectively managed and there was limited consultation between senior managers / clinicians and the medical and nursing team.

Critical care

Are critical care services safe?

Requires improvement

The unit had an open incident reporting culture and staff were clear about their role in reporting incidents. There were examples of changes to practice as a result of feedback from incidents. A range of patient safety information was recorded and displayed for the public to see. This included information around falls and infection control.

The environment of the ICU was recognised as a key concern and working space was restricted. There was poor access to hand washing facilities and isolation facilities were not adequate. Equipment was well managed and there was a rolling equipment replacement programme. Two ventilators were comparatively old, but were due for replacement.

Nurse staffing levels were suitable and there was evidence of active recruitment. The use of agency nurses was low. Medical cover was provided by a range of doctors with varying critical medicine expertise. There was a medical on-call rota for out-of-hours cover and patients were reviewed at weekends in line with national guidance. The consultant on-call rota meant that at least one anaesthetist spent one day in every fourteen week days on ICU/HDU. This meant that some consultants were not carrying out intensive care medicine on a frequent enough basis to maintain and/or enhance their critical care medicine expertise.

Incidents

- Between 1 July 2014 and 9 October 2014, there were 53 recorded patient incidents from the intensive care unit (ICU). These figures were taken from the trust's computer-based incident reporting system, known as 'Datix'.
- Of the 53 incidents, three were moderate, seven were graded as low, 41 were 'no harm, impact not prevented' and two were classified as 'no harm, impact prevented'. Matrons were involved in assessing the levels of risk attributed to reported incidents.
- Of the 53 incidents, we noted that 43 had been reported to the National Reporting and Learning System (NRLS). Hospital trusts are required to report all patient safety incidents to the NRLS.
- The vast majority of incidents reported from the ICU were not classed as serious.
- All three moderate incidents related to pressure sores. One on a patient's nostril, another on the back of patient's head and another around a patient's tracheostomy site. All of the incidents were closely reviewed, lessons were learned and positive changes to practice were implemented.
- There were specific examples where changes to practice had occurred from incident analysis, including changes to drug charts and recording of allergies, nasogastric tube management and pressure area prevention.
- For the period between 1 April 2013 and 1 October 2014, there were 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 requiring investigation for the ICU.
- Nursing and medical staff we spoke with on the ICU described how there was an open reporting culture and lessons learned from incidents were appropriately shared between staff on the unit.
- Nursing and medical staff accurately described how they would report incidents and were clear about their accountabilities and who to escalate concerns to.
- Feedback to staff from reported incidents occurred in a number ways. Incidents were discussed at monthly unit staff meetings, which included nursing and medical staff. Incidents were also discussed at monthly clinical governance meetings. There was a designated consultant doctor who reported back on all serious incidents at departmental meetings and the unit education lead also discussed incidents at educational sessions.
- Formal mortality and morbidity meetings were not regularly held. This was discussed with the unit matron and a consultant intensivist. Such meetings were seen as desirable and an important part of the process. However, conflicting priorities and existing workload meant that such meetings were not imminently manageable.

Safety Thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. We observed that the unit's Safety Thermometer was on display in the main corridor of the unit. This meant it was clearly visible. Included in the display was data on infection prevention and control and patient safety.
- No patients had fallen during the month of September 2014 and no patients had developed pressure sores.
- Compliance with key policies were monitored on the ICU/HDU, including, but not limited to, hand hygiene, dress code, MRSA screening, the use of VTE risk assessments and health records.
- Hand hygiene and dress code compliance for September 2014 was 100% and, of 144 patients admitted to the ICU from 1 August 2014 to the end of September 2014, 141 were screened for MRSA.
- Compliance with the use of VTE risk assessments for the vast majority of 2014 was 100% and safe health records compliance for 2013 was 98.8%.

Cleanliness, infection control and hygiene

- The general environment of the ICU was visibly clean, including horizontal surfaces and high-contact surfaces/ equipment touched by staff and patients. For example, bedrails.
- Each bed space had a chair that staff used when completing documentation and charts at the end of each bed. We observed six chairs and all had visible stains on the fabric covering.
- We noted the chair coverings felt like cloth and, according to a cleaner we spoke with, they were not easy to wipe clean. The top of the chairs were frequently touched by staff, often when moving the chairs to one side, and there was potential for hand contamination. This posed a risk of cross infection.
- Hand wash basins were situated near to every bed space, but were all positioned at the back of the beds against the wall. Access to the hand wash basins was restricted, particularly because of amount of equipment around the beds.
- On the HDU, there were four beds and only one hand wash basin. Access to hand washing facilities was restricted, which could affect hand hygiene compliance and increase the risk of infection.
- We observed staff hand hygiene practice. The application of alcohol hand sanitising rub was the main way in which staff cleaned their hands. The use of the sinks for hand washing with soap and running water was disproportionately low. This was a potential risk because alcohol hand sanitising rub is not the ideal product to use with certain hand contaminants, especially spores.
- In the main, staff used alcohol hand sanitising rub before direct patient contact. The use of hand sanitising rub after patient contact and/or after coming into contact with the patient's immediate environment was not as consistent. The trust policy recommended good hand hygiene practice before and after patient contact and/or after contact with patient's immediate environment.
- During our observations of eight members of staff, we saw that the least compliant staff group, when it came to hand hygiene at patients' bedsides, were visiting medical staff/teams who were not based on ICU.
- Staff described how cleaning the environment was a challenge because there was limited space in which to freely move between pieces of equipment and they had to move equipment to one side during cleaning.
- Staff were encouraged to use a chlorine-based solution for most of the environmental cleaning, which helped to actively destroy certain environmental organisms. For example, Clostridium difficile (C. difficile). Detergent wipes were used on monitors, cables and mattresses.
- From the start of January 2014 to the end of October 2014, five patients were confirmed to have a C. difficile infection on the ICU. Three of the cases were deemed not attributable to the unit and the remaining two were under investigation. There were no cases on the HDU.
- The ICU/HDU had no confirmed cases of Methicillin-resistant Staphylococcus Aureus (MRSA) bloodstream infections between 1 April 2014 to the end of October 2014. There was one case of Methicillin-sensitive Staphylococcus Aureus (MSSA) on the ICU for the same period.
- We reviewed Intensive Care National Audit & Research Centre (ICNARC) data for the ICU and HDU from 1 April 2014 to 30 June 2014. Infection control data showed that C. difficile on admission was consistently below the average for other similar units but MRSA on admission figures were consistently above the average compared to other similar units; the reasons for this were not clear.
- Overall trends for unit-acquired infections per 100 and per 1000 admissions did not show areas for concern and figures were, for the majority, below the average for other similar units.

- Infection control data for ventilated admissions showed that unit mortality was consistently just above the average for other similar units but it was not by a significant percentage.
- For admissions with severe sepsis, there was a peak at the beginning of 2013 where unit mortality was higher than that of other similar units. However, since that point, there has been a downward trend and percentage figures are back in-line with the national average.
- The use of isolation facilities was also monitored. This was a challenge for the ICU, as the availability of isolation rooms was limited.
- The number of Datix incidents reported relating to the ICU and failure to isolate patients, in line with trust policy, was 52 for the previous 12 months. This worked out as one incident per week.
- Some patients who should have been cared for in a side room, as per infection prevention and control guidelines, had to be barrier nursed on the main unit. These occurrences were reported via Datix.
- Information gathering and auditing of ventilator associated pneumonia (VAP) had been put on hold, partly because of data management issues and also because of lack of audit support. This meant that there was no comparable data over time to assess outcomes for ventilated patients.

Environment and equipment

- The ICU and HDU had a variety of technical equipment, including syringe drivers, ventilators and monitors. The amount of equipment, and the space available, made the working environment cramped and space around patient beds was restrictive.
- Equipment maintenance and service was managed by the medical engineering department. The medical engineering department had an electronic database that held information for all equipment across the trust.
- For the ICU, there were 456 items of equipment, which included 18 ventilators. We looked at the maintenance checks and ongoing management of the ventilators and found all necessary service records were accurate and up to date.
- A majority of the ventilators were purchased in 2008 or 2009. The newest ones were purchased in 2013, of which there were two.
- Three ventilators were purchased in 2003 and three were purchased in 1997. Those from 1997 were next in line for replacement as part of the planned preventative maintenance programme and they were being appropriately maintained until that time.
- The head of clinical engineering discussed the capital equipment procurement group (CEPG) and its role in managing equipment.
- The aim of the CEPG was to centralise the process for decision-making in terms of the types and amount of equipment purchased across the trust. CEPG allocated money for equipment as part of a rolling replacement programme and it had appropriate oversight of how money was used.
- Another key item of equipment on the ITU and HDU were the resuscitation trolleys. We checked the trolleys and all necessary equipment was in place and had been checked according to the schedules. Staff commented that the resuscitation equipment was easily accessible.
- Storage space on the ICU was limited, but the dedicated equipment storage room was suitably tidy and organised.
- The sluice room was adjacent to the clean storage room and access to the sluice was via a 'clean' area. We discussed this with the unit matron and were told the infection control team had assessed the risks. Staff were clear to keep the sluice room door closed as often as possible and follow infection control guidelines. For example, use of aprons and gloves and meticulous hand hygiene.

Medicines

- Paper drug cards were used for medicine prescribing.
- We reviewed five drug prescription charts. There were no errors noted.
- There were two types of drug charts. One for patients with no known allergies or adverse drug reactions and one for patients with a known allergy or known previous adverse drug reaction.
- The two-chart system was introduced as part of changes implemented from incidents involving patients with a penicillin allergy.
- The pharmacy department provided direct clinical support to the Level 3 intensive care beds and the Level 2 HDU beds. Support was overseen by a band 8c pharmacist, who provided clinical leadership and expertise with additional support provided by band 8a and band 7 clinical pharmacists.

- Pharmacy ward visits were scheduled from Monday to Friday, with the direct ward input of at least one hour to the Level 3 beds and 30 minutes to the Level 2 beds.
- A senior pharmacist also visited the Level 2 and Level 3 beds as part of the nutrition ward round to provide specialist advice on Total Parenteral Nutrition Requirements (all nutrition requirements that are provided intravenously).

Records

- The records on ICU and HDU were a mix of paper and electronic records. The electronic system had been in place for two years.
- We reviewed five sets of patient records, including the paper-based and electronic elements. The electronic records were mainly clinical records. All records were correctly and adequately completed, including core care plans and risk assessments. For example, VTE, moving and handling, pressure area care and nutrition.

Safeguarding

- There was a trust-wide safeguarding policy and this was accessible on the computer via intranet. Staff we spoke with were able to describe how to access the policy and escalate any welfare and or safety concerns to the appropriate person.
- Staff told us they were also able to highlight signs of different types of abuse. For example, physical abuse and signs of bruising.
- The matron described how the unit had positive links with the safeguarding lead and the subject was actively discussed at matron's meetings.
- Safeguarding training was part of staff induction for nursing and medical staff and it was a trust requirement for all staff to be updated on a yearly basis.
- 94 critical care staff were required to complete Level 1 safeguarding training and 91 staff had achieved this; a percentage compliance of 97%.
- 86 critical care staff were required to complete Level 2 safeguarding training and 51 staff had achieved this; a percentage compliance of 59%; this figure was comparatively low.
- No staff on critical care were required to complete Level 3 safeguarding training.

Mandatory training

- The education lead we spoke with told us about mandatory training and we also reviewed the unit's training figures.
- On an annual basis, all staff were expected to update their knowledge on key subjects, such as moving and handling, infection prevention and control, safeguarding, health and safety and fire safety.
- Staff attendance at mandatory training was managed via a trust-wide database, which automatically flagged if a staff member was overdue an educational update. We were told that the process wasn't without its challenges and, apparently, there had been problems with data inputting, which affected the reliability of the information produced.
- To complement the process of sending staff to trust-wide mandatory training sessions, the unit set up periodic 'sweeper days' that enabled staff to complete their required updates in one day.
- 'Sweeper days' included four hours of e-learning and some face-to-face sessions, for example, intermediate life support training. Other non-mandatory training was also regularly factored in. For example, tracheostomy training.
- When it came to mandatory training, the level of compliance for unit staff was around 84%.
- We spoke with non-consultant grade medical staff and they described how much of their mandatory training was via e-learning. They also described the 'sweeper days', where much of their mandatory training requirements could be delivered in one day.

Assessing and responding to patient risk

- The trust used an early warning score system which supported the process for early recognition of those patients who were deteriorating and who required prompt medical assessment/intervention.
- All patients on the ICU and HDU were monitored closely and no concerns were raised in terms of the responsiveness of staff in reacting to the deteriorating patient. This included gaining prompt access to medical intervention.
- Management of the deteriorating patient, on the wards, was supported by a critical care outreach team. The team worked from 8am to 5pm seven days a week.

- We spoke with the outreach team nurse lead. The critical care outreach team followed up patients discharged from ITU/HDU to the ward – no significant concerns were raised in how outreach functioned, or regarding risks to patients.
- Prompt follow-up of some patients was not always possible if they had been discharged in the early evening or out of hours.
- An ITU consultant doctor we spoke with stated there was no medical input into the outreach team and it was a nurse-led service. They stated that the deteriorating patient was a key issue and a trial was starting in September 2014, whereby the unit's second consultant will review outreach patients on the ward. There was a desire to be more proactive in how outreach was run.
- After 5pm, when outreach was no longer available, care of the deteriorating patient was the responsibility of hospital ward staff, who relied on the advice and support available via the critical care team. There was no dedicated Hospital at Night team.
- Members of the medical team acknowledged that not all patients were consistently reviewed by a consultant, in person, within 12 hours of admission. This meant that staff were not adhering to the best practice standard.This reflected that the service did not have a resident Consultant rota. However, all patients accepted onto the unit were discussed with the Consultant on-call by the registrar. Through discussion, the acuity of patients were reviewed and, if required, a Consultant immediately attended the department to review patients in person.

Nursing staffing

- The unit matron provided insight into nurse staffing levels and their skills mix. ICU/HDU had a relatively low turnover of staff and this, it was felt, was because of the positive working culture and good morale.
- In determining appropriate nurse staffing levels, the national ICU core standard guidelines were followed. This included the requirement to have a ratio of 2:1 care for Level 2 patients and 1:1 care for Level 3 patients.
- Staff shared their time between working on the ICU and HDU and there was some flexibility depending on the needs of the patients.
- Nursing shift patterns were mixed, including 12-hour shifts and the more regular 7.5/8-hour shift.
- We found that, on the whole, rotas were managed well and staff worked effectively between themselves to fill any gaps in the rota.
- Over the previous three years, three band 7 senior nurses had retired. The hours of service delivery from these three posts were reviewed and replaced with band 5 qualified nurses as required to maintain the overall workforce requirements.
- There were four band 7 nurses and one band 7 nurse vacancy. Four years previously there were more band 7 posts, but these had been reduced.
- The unit was just under the recommended staffing complement for band 6 nurses and there was a 0.8 whole time equivalent (WTE) vacancy for a healthcare assistant.
- The main vacancies were at band 5 staff nurse level. The funded complement was 67.4 WTE and there were 63.4 WTE, indicating 5.9% vacancy in this staff group One band 5 nurse had very recently started work in the ICU/HDU and a further four band 5 nurses had been employed within the previous 12 months. The appointment in the past year of the five band 5 recruits to the ICU / HDU had helped relieve some of the staffing pressures.
- With the new band 5 nurses, the skills mix was suitable and senior nurse support was sufficient to meet the needs of patients.
- A mobile phone text message system was used as a way of communicating with the nursing team about available extra shifts and the process worked well, according to the matron and nurses we spoke with.
- Nursing staff were able to get time back for extra shifts worked, but this sometimes meant they needed to be on standby at home in case they were called upon to return to work at short notice.
- Staff were not routinely paid if they returned to work from being at home on standby, but would build up additional time owed.
- We received some concerns that ITU nurses were being used on occasion to fill short staffing on wards. The Trust confirmed that only when there was legitimate ITU/HDU nursing capacity available above that required to meet the needs of patients within ITU/HDU would consideration be given to moving a nurse to a non ITU/HDU environment.

- Due to the text messaging process, and teamwork, the use of agency staff to fill gaps in the rota was minimal. There was a nurse bank and the nurses used were always familiar with the ICU/HDU, which reduced the risks associated with using external agency staff.
- We observed a nursing shift handover. Basic clinical information about each patient was discussed and patients were allocated to incoming staff prior to their shift commencing.
- The handover was purely verbal and there was no printed hand out, staff made their own notes. The majority of information handed over was about admissions, discharges and transfers.
- The handovers were conducted in the shared staff coffee room/patient kitchen. It was noisy and disruptive.

Medical staffing

- Medical management on the ICU/HDU was directed by consultants in anaesthesia and intensive care.
- The consultants were a mix of accredited intensivists who covered the unit for a week at a time, and consultants in anaesthesia and intensive care, who covered on a sessional and on-call basis.
- In addition to managing patients on the ICU/HDU, consultants were actively involved in bed management and were responsible for ward patient assessment, ward patient resuscitation, accident and emergency (A&E) department patient assessment, A&E patient resuscitation, paediatric resuscitation and patient transfers.
- We were informed that there had been some discussion regarding the intensity of workload in the critical care unit and the requirement for the presence of a second consultant in the afternoon. An informal scoping exercise had been undertaken to identify any opportunities to modernise the critical care service to enable best use of resources. No conclusion had been drawn from the initial exercise and the newly appointed Directorate Clinical Lead was leading a review of all clinical practice in light of the proposed D16 requirements and the wider critical services including outreach.
- Five consultant intensivists worked from Monday to Friday daytime for a five-day block, this ensured appropriate continuity of care and followed best practice guidance.
- There was usually a second consultant intensivist working the whole day, sometimes half a day, before they went on-call. The on-call rota was shared between the six intensivists and eight anaesthetic consultants.
- The consultant on-call rota was one in 14; one consultant to 14 patients. Critical care national guidance stipulates that the best current evidence is a consultant / patient ratio not in excess of 1:14.
- The consultant on-call rota meant that at least one anaesthetist spent one day in every fourteen week days on ICU/HDU. This meant that some consultants were not carrying out intensive care medicine on a frequent enough basis to maintain and/or enhance their critical care medicine expertise.
- Other on-call commitments for consultants included obstetrics. Every other shift the consultant for critical care covered obstetrics. According to best practice guidance, consultants should not have other on-call commitments other than critical care. The out-of-hours on call anaesthetic service was provided by two consultants during week days and three consultants at weekends. There was one consultant for critical care and one consultant for acute theatres supported by a senior trainee and three junior doctors (Core Trainee or Specialist Trainee level) and, at weekends, one additional consultant covered Trauma Theatres. The obstetric service was provided by a dedicated trainee doctor with appropriate competencies, supported by the on-call consultant team. The critical care consultant was identified as the nominated cover on alternate evenings as activity within obstetrics was often very low at that time. On the infrequent occasion that a consultant was required to attend maternity then the critical care consultant provided the cover.
- In terms of trainees, there was one middle-grade ST4, plus three further more junior trainees to cover critical care, theatres and obstetrics. There were no significant issues raised in terms of non-consultant grade cover for the ICU/HDU.
- The consultant-to-patient ratio was adequate and there were no locum consultants being used.
- A medical consultant was available out-of-hours for advice and nursing staff we spoke did not express any concern in terms of accessing on-call medical staff and asking them to come in, if required.
- During the inspection, we were informed that anaesthetic theatre cover was an issue. Proposals had recently been put forward from the divisional clinical

director and divisional general manager, to permanently remove the weekday daytime second consultant. This resource would then be used to support anaesthetic cover in theatres.
- There was not a second daytime consultant at weekends and it was suggested by the clinical director that this could also be implemented during the week. The view of two consultant intensivists we spoke with did not support this; they stated that weekends were different to weekdays in terms of workload and that this was partly due to the planning and interventions performed on patients during the week to prepare for the weekend. The needs of some patients were therefore less at the weekend because of the plans put in place just before the start of the weekend.
- We observed medical handovers and ward rounds. Handover occurred in the ICU office between 8am to 9am, followed by a ward round between 9am to 11:30am. All patients were reviewed in detail and, occasionally, the medical staff would split into two teams to complete the round. There were also ward rounds at lunch and at 5pm.
- Consultants conducted twice daily ward rounds at weekends.

Major incident awareness and training

- We spoke with the matron and education lead about major incident awareness and training. The trust employed a resilience officer and part of their role was in relation to major incident planning and business continuity.
- Training was provided to staff on an annual basis on major incident awareness and business continuity. Each year, senior staff from the ICU took part in Emergo Train System (ETS), which is a one day exercise designed in real time to educate staff about responding to major incidents.
- We observed the major incident folder, which was located at the nurse's station. This included major incident guidance, contact numbers and action cards.

Are critical care services effective?

Requires improvement

Nursing and medical practice was in line with national guidance and best practice recommendations. There were variations in the standard of the clinical policies and many had not been reviewed within the stated timescales. Compliance with key policies was monitored and results showed good levels of compliance. For example, with venous thromboembolism (VTE) assessments and MRSA screening.

There were some concerns in relation to some quality indicators, as not all patients were reviewed by a consultant in intensive care medicine within 12 hours of admission. Other challenges included compliance with NICE 83 guidance for rehabilitation, mainly in relation to post-discharge follow-up, and consultants not being freed from all other clinical commitments when covering intensive care, including all other duties.

Evidence-based care and treatment

- During our inspection of ICU, we reviewed a selection of policies on the trust's intranet site. We found all paper copies had been removed as it was difficult to manage the correct versions of each policy.
- We found the policies were based on clinical evidence, including guidance from the National Institute for Health and Care Excellence (NICE), relevant Royal Colleges and core standards for ICUs.
- The policies we reviewed, in relation to critical care, did not appear to conform to a particular trust standard in terms of layout and content. We found that policies were dated correctly, but none had a review date, for example, the policy on ventilator management was written in November 2013 and the policy for the management of sepsis was written in 2010, but there were no review dates.
- Some policies had not been reviewed within the necessary timescales and the process that ensured policies were reviewed was not effective.
- There were a number of examples where practice was supported by evidence-based guidance. This included the management of patients who had been, or were, at high risk of ventilator associated pneumonia and a number of assessments, including venous thromboembolism (VTE), pressure area care and delirium scoring.
- In monitoring adherence to local policies and procedures we saw evidence of audit activity, including audits for pressure sores, use of oxygen, pressure ulcer care and MRSA screening.

- There were examples of changes to practice because of audit activity, including pressure sore prevention procedures and nasogastric tube management.
- Of the patient charts and care plans we reviewed there was evidence of decisions being made in line with national standards, for example, nutrition, pain, nasogastric tube placement and fluid management, or hydration.
- The process for managing the organ donation process was effective and every patient who should have been referred was.

Pain relief

- There was an acute pain team that worked across the trust, including on the ICU/HDU. Visits to the ICU/ITU were not on a daily basis and depended on the type of pain control interventions patients were receiving. Where necessary, daily visits were undertaken.
- The acute pain team would review patients who were using patient controlled analgesia (PCA) and patients with epidurals and paravertebral blocks (PVBs). We reviewed a selection of patient charts and noted that pain scores were appropriately recorded.
- The matron described how there was a productive working relationship with the acute pain team and the specialist nurses and/or consultant doctors were accessible for advice and support if required.
- Unit staff were involved in managing patients' pain and were familiar with pain score assessments and how to liaise with the acute pain team where necessary.
- We also witnessed that pain scores were being discussed during ward rounds and staff handovers.

Nutrition and hydration

- A dietician visited ICU/HDU on a daily basis to review patients in order to ensure patients were receiving optimum levels of nutrition and fluid.
- All patients had a malnutrition universal screening tool (MUST) assessment on admission to ICU/HDU. The MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese.
- The MUST also include management guidelines, which could be used by staff to develop care plans.

Patient outcomes

- The Care Quality Commission (CQC) mortality outliers programme looks at patterns of death rates within NHS trusts. We found there were no mortality outliers in relation to ICU/HDU.
- We reviewed Intensive Care National Audit & Research Centre (ICNARC) data for the ICU and HDU from 1 April 2014 to 30 June 2014. In relation to patient outcome data, there were no issues of concern. Unit mortality percentages for ventilated admissions were marginally, and consistently, over the average for other similar units. Unit mortality percentages for elective surgical admissions had risen slightly during the first quarter of 2014.
- In relation to trends in crude mortality and morbidity ratios there were no areas for concern and figures were within expected limits.
- Hospital deaths following discharge from the unit were below the average for other similar units and early readmissions were marginally above the average for other similar units.
- The critical care service was an active member of the West Yorkshire Critical Care Network and its members conducted a quality key indicator (QKI) assessment in 2013. This included a close assessment of ICNARC data from January 2012 to December 2013.
- ICU/HDU achieved 16 of the 18 quality indicators, which was an improvement on the previous year where 15 were achieved.
- The 2013 QKI report confirmed that some of our findings and areas of non-compliance were identified as delayed discharge and dedicated funded outreach service. This related to the outreach not being a 24-hour service, seven days a week.
- There was a business case being reviewed for the increase in hours for the outreach services.
- The 2013 QKI report also made reference to the NHS England D16 NHS Standard for Adult Critical Care. In relation to the D16 standard, the critical care service, as we noted from our observations, fell short in several areas:

- Patients reviewed by a consultant in intensive care medicine within 12 hours of admission.
- Compliance with NICE 83 guidance for rehabilitation, mainly in relation to post-discharge follow-up.
- Consultants being freed from all other clinical commitments when covering intensive care, including all other duties.

Critical care

Competent staff

- We spoke with the nurse education lead about staff training, including induction, mentorship, mandatory training, supervision and appraisal. The education lead had good oversight of nurse education and appraisal and closely monitored staff compliance with educational updates and appraisal.
- The critical care service had 97 nursing staff, of which 27 were overdue in providing their up-to-date appraisal. Compliance for critical care staff with appraisal was around 75%.
- New starters went through a 12-week induction programme and were supernumerary for eight weeks before becoming part of the actual staffing numbers on shift. Training was mixed and included competency-based assessments, specific training on equipment and case studies.
- For three to 12 months staff worked towards specific critical care training standards, which were also competency-based. Staff also worked towards gaining an assessing and mentoring qualification.
- The nursing staff group were 70% compliant in terms of critical care competency.
- Over 50% of registered nursing staff had a post-registration certificate in critical care nursing, which met the national standard.
- For medical staff, specialist critical care competence was variable and the exposure to critical medicine for the eight non-intensivist consultant anaesthetists was limited. This was affecting on-call rotas and ward rounds, in terms of patient safety and expertise.
- They also said there was very little formal training on the ICU/HDU, but training was accessible on a monthly basis through the anaesthetic department.
- There was a policy for the revalidation of consultants and guidelines for newly appointed consultants. The consultants we spoke with confirmed they were up to date with appraisal and revalidation requirements.

Multidisciplinary team working

- From speaking with consultants, junior medical staff, allied healthcare professionals and nurses, there was a sense of positive multidisciplinary team working and a desire to provide safe care to patients.
- Ward rounds we observed were effective and included input, where necessary, from dietetics, physiotherapy, the acute pain team and pharmacy.
- The critical care service had an outreach team who played a key role, especially in terms of the follow-up of patients on the ward, supporting unwell patients outside of ICU/HDU and managing the deteriorating patient.

Seven-day services

- In terms of the 2013 QKI report, the outreach service did follow-up all discharges from the ICU and all patients referred to outreach were assessed. The main negative was that outreach was not available as a 24-hour service, seven days a week. The trust informed us they had started a review of outreach services.
- Staff we spoke with about a range of services did not raise concerns about the lack of access to services and risks to patient safety.
- X-ray and computerised tomography (CT) facilities were available as a 24-hour service, seven days a week. Magnetic resonance imaging (MRI) was accessible for the Critical Care service at weekends
- Occupational therapy, in the main, provided a service during usual working hours from Monday to Friday.
- Physiotherapy services were provided mainly during the working week, but also on Saturday and Sunday mornings. Physiotherapy had an on-call service for urgent matters.
- Consultants were accessible out-of-hours, via an on-call rota and the challenges faced with the existing system had been discussed earlier in the report.

Consent and Mental Capacity Act 2005

- We reviewed a selection of patient records. In one record there was evidence of consent for a tracheostomy and notes of discussions held with a patient's family.
- Nursing staff we spoke with described how working closely with families was instrumental in providing optimum care and reaching best interest decisions for patients.
- Most often, the majority of patients on the ICU were intubated and not able to communicate effectively. The unit matron described how medical staff also worked closely with family members in discussing critical care invasive medical interventions. This was supported through conversations we had with families.

Critical care

- The unit matron stated that the service had an active safeguarding lead and they engaged well with staff and matrons across different services.
- The safeguarding lead had collaboratively designed a best interest decision-making form that guided staff through the appropriate processes for making best interest decisions.
- ICU/HDU used a standard mental capacity assessment form, if required, which included a specific assessment tool and scoring system.

Are critical care services caring?

Good

In the main, staff we observed were polite, respectful and professional in their approach to patients, relatives and colleagues. Patients we spoke were complimentary about their care and the support provided by staff.

There were some good examples of patient involvement and there was a range of support services available to patients and/or their relatives. The critical care service itself did not hold its own patient clinics, but was able to use information from the West Yorkshire Critical Care Network meetings.

Compassionate care

- During our visit to the ICU and HDU, we observed a number of interactions between staff and patients and relatives. We observed that staff were always polite, respectful and professional in their approach.
- Due to the cramped conditions on ICU, there wasn't much free space between patients. This meant that noise levels were relatively high, which was not ideal for some of the more alert patients.
- We observed some occasions where staff shouted across the unit to communicate with colleagues – this added to the existing noise. For example, we observed a nurse ask their colleague from across the unit who was next going for a break and if anyone was 'in the box', by which they meant to ask if anybody was with patients in the isolation room area.
- We spoke with three patients across the critical care service, two patients on the HDU and one patient on the ICU.
- The patients we spoke with on the HDU were both "happy" with the care they received and they felt staff were caring and attentive.
- The patient we spoke with in the ICU was also complimentary about their care and found staff to be understanding and supportive.
- We also spoke with the relatives of two patients on the ICU. One relative we spoke with was full of praise for the hospital and did not have anything negative to say. The other relative told us they felt staff were friendly and they were kept well informed about their mother's care.
- We observed staff supporting patients with personal care; privacy and dignity was maintained, including closing bedside curtains and speaking with the patient in a respectful way. This practice extended to unconscious/sedated patients.

Patient understanding and involvement

- The nursing staff described how they supported patients, where possible, to be involved in making decisions about their care but this was often not possible with the majority of ICU patients.
- Family members and/or friends and relatives were more often included in making decisions about their relative's or friend's care.
- In some instances, patients were aware of their medical treatment and we observed staff explaining and supporting patients to understand their plan of care.
- We observed evidence in patient records where decisions had been documented after consultation with a patient's family members. This was in relation to the insertion of a tracheostomy.

Emotional support

- There was good access to, and choice of, chaplaincy services to support varying cultural beliefs. Information about the chaplaincy service was clearly displayed on the communication board in the main corridor of the ICU.
- The chaplaincy service consisted of six people, three from the Muslim faith, one Christian, one Roman Catholic, one Sikh and one Hindu.
- Clinical psychology services were also displayed and patients could access psychology and related services such as counselling.
- There was one 'on-unit' overnight stay room, which had en-suite facilities. If necessary, accommodation could

be arranged at the doctor's mess in certain circumstances. There was also a visitors and relative's room where people could wait in relatively comfortable surroundings.
- There wasn't a dedicated relative interview room. The overnight stay room or doctor's office was sometimes used for that purpose.
- In relation to bereavement and end of life care, there was a band 7 nurse responsible for these areas and they provided specialised support, when needed.

Are critical care services responsive?

Requires improvement

There were aspects of the service that presented significant challenges, including: high bed occupancy rates, an inappropriate ICU working and patient care environment, delayed discharge and medical staffing skills mix. For example, bed occupancy had been at 95% for the previous three years and just over 50% of all patients had a delayed discharge. There were also issues with patient discharge from critical care to a ward not being within four hours of the decision to discharge being made.

There were plans for a new ICU and the design had been fully developed. The final business case for the new unit was approved by the Board of Directors in October 2014; a full draft was provided to the September 2014 closed meeting. The other challenges mentioned above had been known about for a comparatively long period and there had been limited action taken to improve.

Service planning and delivery to meet the needs of local people

- We spoke with the divisional general manager about aspects of service planning. There were plans to relocate the ICU to a newly built part of the hospital across the corridor from the existing unit.
- The aim was to have a more integrated critical care unit with more flexibility to alter between Level 2 and Level 3 care.
- From what staff said, discussions around the new unit had been happening for several years and it was not clear if, or when, the unit would be relocating to newer premises.
- We observed the plans for the new unit and it contained the same number of beds (16). The design of the unit would solve the existing environmental challenges, including lack of space, poor isolation facilities and difficult access to hand washing facilities. With the bed occupancy rate at 95%, it was unclear if the same number of beds would be sufficient for the future.

Access and flow

- According to a report written in September 2013 by a consultant intensivist, bed occupancy for the ICU had been consistently at 95% for the previous three years. This was a high occupancy rate and an optimum figure, according to national guidance, is around 85%.
- We spoke with senior medical staff and they described how the remit for the need for ICU had expanded, particularly over the past five years. This meant that more patients required critical care interventions.
- According to the same report, since the last revision of the critical care bed base in 2009, there had been year-on-year increases in all admissions, totalling around 15%.
- Also, over the three years up until October 2012, there had been a 44% increase in the elective demand, and an inability to deliver the increased demand in around one third of the time. During busy periods in particular, there were challenges because, even with usual levels of activity, there were consistent and ongoing issues with delayed discharges. This meant the trust were not responding to the changing needs and demands of the ICU.
- The NHS England D16 NHS Standard for Adult Critical Care was not being met in relation to discharge from critical care to a ward within four hours of the decision to discharge.
- Just over 50% of all patients had a delayed discharge and there were several reasons for this. The main issue was that there were, on many occasions, simply not enough free beds across the trust. This was likely due to delayed or complicated out of hospital discharges elsewhere in the hospital.
- However, even with such a high percentage of delayed discharges, the service was still on par with other similar units. This reflects the national picture in terms of bed pressures and patient flow.
- A further issue was that some ward teams lacked confidence in being able to manage certain patients

who no longer needed an intensive care bed, but who needed closer monitoring. For example, we were informed that some wards resisted accepting patients with an epidural.
- An audit was conducted in June 2009 of the 'unmet need' and this was the latest information we had available on that subject. The audit specifically focused on the unmet need of patients and identified a large cohort of acutely ill patients in the ward setting who required Level 2 (HDU) care.
- From discussions with medical staff it was felt that critical care facilities were not appropriately used and there had been, over recent years, a significant increase in the percentage of patients who could be managed in a non ICU/HDU setting.
- In December 2010, a retrospective audit demonstrated that 81% of elective surgical admissions to HDU could have been safely managed in a Level 1 (non HDU) environment. Only 45% of the elective admissions had been referred for anaesthetic preassessment for risk stratification.
- Out-of-hours discharges (out of hospital), up until the end of 2013, were in line with other, similar units, but during quarter one of 2014 there had been a slight upward trend, this was also true for non-clinical transfers out.
- Out-of-hours discharges to the ward were under the average figure for other, similar units.
- In the week prior to the inspection there had been six cancelled elective cases, due to lack of critical care beds.
- A number of the delayed discharges were due to the lack of a side room availability on the accepting wards.

Meeting people's individual needs

- We spoke with nursing staff, including the matron, about how staff met the needs of people with complex needs.
- Nurses commented that they had experienced supporting patients with complex needs, including dementia and learning disabilities, and how they liaised closely with patients' carers in such cases.
- The care and support offered by patients' carers was valued and was a key part of providing suitable care.
- The nurses described how the unit was flexible, in many cases, with visiting times, especially in cases where a patient needed a significant amount of extra support.
- The unit provided facilities for patients' families and/or friends and people could sleep on the ward overnight, if required.
- Translation services were easily accessible and staff were able to accurately describe the process for accessing such services.
- Patient follow-up clinics were no longer done and this was partly due to staff levels. Follow-up clinics can have real benefits to patients, particularly patients who have been on intensive care, because extra support is sometimes required. For example, patients can suffer from post-traumatic stress disorder and such issues can be assessed at follow-up clinics.
- Due to the issues with delayed discharges, this had a negative impact in terms of dignity because it increased the number of breaches in terms of mixed sex accommodation. The guidelines state that when patients no longer need Level 2 or 3 care then the breaches to the mixed sex accommodation criteria should be applied.
- The West Yorkshire Critical Care Network conducted 'coffee and chat' sessions periodically throughout the year to gather information about people's experiences and share learning and ideas.
- The critical care service itself did not hold its own patient clinics, but was able to use information from the West Yorkshire Critical Care Network meetings.
- In the visitors room, there was a 'You said, we did' notice and there were examples provided of changes that had been implemented from patient feedback. For example, visiting times were changed.
- In the visitor's room, there was an array of leaflets and information about hospital services and more general healthcare information.
- The service regularly provided visitors to ICU with a questionnaire which asked their views. For example, regarding facilities and nursing care.

Learning from complaints and concerns

- During the 12 months prior to the inspection, there hadn't been any formal complaints about the ICU, the last complaint was in June 2013, which, in the end, was referred to the Parliamentary and Health service Ombudsman (PHSO). The complaint was not upheld in relation to the care and treatment provided on the ICU.

Critical care

- There had been one complaint about the HDU in the previous 12 months and this was around a patient's diabetes management, communication and nutrition. The complaint was responded to and discussed with staff in order to allow staff to learn and improve.
- There were processes in place for learning from complaints and/or raised concerns. Such issues were discussed at matrons meetings and fed back to unit-based staff at team meetings.
- Complaints were also discussed at governance meetings and these were also attended by senior medical staff.

Are critical care services well-led?

Requires improvement

It was evident that the critical care team worked well together and there was a good sense of collaborative working and team effort. However, there was a distinct tension between senior clinical staff, particularly medical consultants, and senior directorate level staff. It was clear from discussions that management of change was not always conducted in an open and collaborative way.

At an operational level, the culture was encouraging and there was a strong sense of teamwork and openness, with a focus on patient safety and positive patient outcomes. There was some evident tension between the clinicians we interviewed and the Divisional Management team. The Trust confirmed there had been recent discussions regarding the intensity of work load for Critical care cover and options were being explored at the time of the visit. No outcome had yet been determined but the management team continue to work with the clinical team, through the newly appointed Clinical lead to reach a safe and sustainable solution.

There were feedback mechanisms within the service covering a range of items, including incidents, complaints, patient and relative feedback and there were examples where changes to practice had occurred as a result.

Vision and strategy for this service

- A key vision and strategic aim for the critical care service was to develop the consultant team in terms of critical care medicine. The clinical lead envisaged that, within five years, there would be a stable complement of 14 accredited intensivists, which would mean a specialised consultant in intensive care medicine would be available on-call at all times.
- Other visions and strategic objectives expressed by the consultant group included a strategic review of the critical care services, developing the operational policy further, particularly when it came to including more on referral processes, introducing robust strategies to improve patient flow out of ICU/HDU, strongly considering a post-anaesthetic care unit, or overnight intensive recovery (OIR) unit, and reviewing the utilisation of Level 1 facilities, such as on Ward 21 and Ward 18.
- The divisional general manager described the plans for the new Critical Care unit and was aware that the business case was approved at Trust Board with a 2016 completion date but as yet was not aware of the start date.
- The divisional general manger was able to provide some details about the potential use of the existing ITU space after its move in to the new unit.
- The Trust confirmed following the inspection, that discussions had been held with the ward team about future plans including using the existing ITU space as a dedicated HDU. Such plans were included in both the Clinical and Estate Strategy which were developed with staff on the unit.
- In a broader sense, the trust was focusing attention on developing its vascular services and head and neck cancer services. This would undoubtedly impact on the number of elective cases requiring intensive care support.

Governance, risk management and quality measurement

- The divisional general manager described the relevant governance processes in relation to critical care and theatres directorate. There had been recent changes to governance structures and this was the same for the trust as a whole. The changes were implemented from 1 October 2014 and new processes had not yet become embedded.
- We reviewed the unit's risk register and the top four risks included use of the side rooms, particularly in relation to infection control concerns, delayed discharges, checking of equipment before use and pressure ulcers.

- We discussed these risks with the ITU/HDU nurse educator and found that proactive steps had been taken, where possible, to reduce the infection control and pressure ulcer risks. For example, increased auditing of side room use, use of equipment and pressure area care. Additional teaching had also been provided to staff in these areas.
- From other discussions with a range of staff on ICU/HDU, as well as within the directorate, we found risks were recognised effectively, but the actions in responding to more complex risk issues and laying down firm plans for action were not as effective. For example, the concerns around bed occupancy rates, delayed discharge, patient flow and outreach services were not new issues. Interventions to address these issues were limited.
- There were feedback mechanisms within the service covering a range of items, including incidents, complaints and patient/relative feedback and there were examples in which changes to practice had occurred as a result.
- Information flow between frontline staff and the critical care management team was effective. However, information flow between senior critical care management and directorate leads was not as open and transparent.

Leadership of service

- From our observations, and from speaking with frontline staff, it was evident that the critical care-based team worked well together and there was a good sense of collaborative working and team effort.
- It was also evident, at senior directorate level, that managers faced operational challenges, especially in terms of finance and resource and difficult issues needed to be addressed.
- There was a distinct tension between senior clinical staff, particularly medical consultants and senior directorate level staff. It was clear from discussions that management of change was not always conducted in an open and collaborative way.
- There was uncertainty around specific aspects of the service, especially in relation to consultant staffing and the proposed new unit and the way in which decisions were made and translated to others was not always constructively managed.
- There has been a recent hospital-wide change of the areas of responsibility for the matrons. A matron we interviewed had only been in post for four weeks. It was reported by a number of staff that it was a particularly unsettling time for all of the teams.

Culture within the service

- At operational level, the culture, was encouraging and there was a strong sense of teamwork, openness and a focus on patient safety and positive patient outcomes.
- The matron stated that a lot of time was invested in staff and, comparatively, staff retention was good and sickness rates were low.
- The culture of the directorate as a whole had altered, particularly in light of the recent governance structure changes, but there was an 'us and them' tension between some consultant grade staff and senior management, which was negatively impacting on change management processes and morale.

Public and staff engagement

- Patients were invited, via the West Yorkshire Critical Network, to provide feedback about their experiences on the ICU/ITU. This information was relayed back to the senior nurse team.
- The senior management team had a number of effective ways of engaging with staff, including formal staff meetings, team briefs, and discussions at handover and via clinical governance update meetings.
- Any changes implemented as a result of patient feedback were displayed publically on the ICU in the form of a 'You said, we did' statement on a notice board document.

Innovation, improvement and sustainability

- There was focus on improving the service and there were clear examples of this, including the designs for the proposed new unit, the business case for improved outreach services, the review of consultant staffing and efforts to improve the swiftness of patient discharge.
- However, the responsiveness of the leadership team, decision-making processes and change implementation had not, in some cases, been adequate.
- In terms of sustainability, there were concerns about delayed discharge and the potential increased demand for intensive care beds if vascular and head and neck surgery cases increased.

Critical care

- We spoke with medical staff about examples of innovative practice and the main example discussed was the use of regional citrate anticoagulation (RCA), during continuous renal replacement therapy (CRRT). This wasn't a commonly used approach, and had benefits over other anticoagulants with certain patients.
- Echo cardiology was soon to be available on the ICU because the two new consultants starting employment in December 2014 would be able to perform the procedure.

Maternity and gynaecology

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

Information about the service

The maternity service at Bradford Teaching Hospitals NHS Foundation Trust delivered approximately 6,000 babies per annum.

The trust offered a full range of maternity services for women and families based in the Bradford Royal Infirmary and community settings, ranging from specialist care for women who needed closer monitoring, to a home birth service for women with healthy pregnancies. There were six teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics and general practitioner locations across the city. An integrated women's health unit also provided a range of treatments for gynaecological problems.

We visited the antenatal clinics, antenatal day unit, labour ward, obstetric theatres, birth centre, women's health unit, early pregnancy assessment unit, transitional care and postnatal wards. We spoke with 16 women and 41 staff, including: midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at seven care records. We also reviewed the trust's performance data.

Summary of findings

Overall, maternity and gynaecology services were good in all domains with the exception of safety, which required improvement. Midwifery and consultant numbers did not always meet the RCOG' Towards Safer Childbirth' recommendations during the day and at night. In the absence of a defined national tool, the Trust commissioned the application of Birthrate Plus to review current midwifery staffing. At the time of the inspection the findings of this review were being worked through in line with the principles utilised by the Board when considering all nurse staffing reviews that are presented six monthly to the Board of Directors. A business case had been approved by the Board to increase consultant cover on the labour ward which would bring the trust in line with the national average. The completion of mandatory training was between 60-78%, which meant staff may not have accessed up-to-date knowledge and skills. The arrangements for handovers were not always effectively managed, which, at times, resulted in overlap between teams and some delays.

Women were treated with kindness, dignity and respect while they received care and treatment. Services were planned to meet women's needs, including those in vulnerable circumstances. The service took complaints and concerns into account and took action to improve the quality of services.

Maternity ward areas were visibly clean and equipment was in date and in working order. However, the

Maternity and gynaecology

recording of equipment checks was not consistent in all areas. Medicines were managed appropriately, although issues were found with the safe storage of some medicines. Arrangements were in place to safeguard adults and children from abuse. Serious incidents were monitored and action taken when things went wrong. There were effective governance and risk management systems to support the delivery of good quality care. The leadership and culture encouraged openness and transparency.

Are maternity and gynaecology services safe?

Requires improvement

Staffing establishments and the skills mix did not always meet national recommendations. Completion of mandatory training was between 60%-78% and staff had training had been postponed or cancelled during periods of peak activity. The arrangements for handovers were not always effectively managed, which resulted in overlap between teams and some delays.

Maternity ward areas were visibly clean and equipment was in date and in working order. However, the recording of equipment checks was not consistent in all areas. Medicines were managed appropriately, although there were issues found with the safe storage of some medicines. Arrangements were in place to safeguard adults and children from abuse and reflected relevant legislation and local requirements. Serious incidents were monitored and action taken when things went wrong. Appropriate plans were in place to respond to emergencies and major incidents. Staff were aware of their roles and responsibilities in urgent and emergency situations.

Incidents

- There had been one Never Event during 2013/2014, which involved a retained vaginal pack following a clinical procedure. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. The case had been investigated and appropriate action taken. This included the development of a checklist, which was signed by the doctor and midwife following a swab count and improved communication and documentation between teams. Most staff told us they were aware of the recommendations made following the Never Event. However, we found some staff did not know what changes had been implemented.
- Three serious incidents had been reported for 2013/2014, which related to neonatal deaths. We looked at the investigation reports for two of the incidents. A comprehensive investigation was undertaken which

reviewed the root causes and contributory factors. We saw completed action plans, dated April and May 2014, with evidence of implementation, including improved documentation, revision of guidelines and training.
- The unit used a national trigger tool to identify and report incidents specific to maternity care.
- Staff stated they were encouraged to report incidents and were aware of the process to use. Most said they received feedback, although some staff said feedback was limited. We saw there was a comprehensive monthly newsletter and staff briefings for maternity services, which included lessons learned from incidents, complaints and claims. This was actively disseminated to all staff. Clinical practice issues were also referred to the midwifery supervisors who played an active role in managing maternity risks.
- Monthly perinatal mortality and morbidity meetings were held and minutes showed these were well attended by a multidisciplinary team. All serious cases, including stillbirths and neonatal deaths, were reviewed and presented at a peer group. Minutes from these meetings August-October 2014 showed recommendations to improve practice. These included a review of guidelines and changes to clinical practice.

Safety Thermometer

- The service used a maternity dashboard to monitor safety and risk. This included clinical indicators, incidents, and performance. Risks were monitored on a monthly basis and breaches were escalated to the maternity risk and governance group. Documentation from the group showed there were measures in place to monitor areas of risks against the clinical indicators.
- The performance report for obstetrics and gynaecology showed that between April-July 2014, 98% of women had received a venous thromboembolism (VTE) assessment against a trust target of 95%. The sample of records we looked at showed that risk assessments for VTE had been completed correctly.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and well maintained. However, the CQC's survey of women's experiences of maternity services 2013 showed that cleanliness of the hospital room or ward scored worse than other trusts. We found that records of cleaning schedules were not being consistently completed in all clinical areas.
- We saw that staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons. Hand sanitising gel dispensers were available at entrances to clinical areas. However, on Ward M3 there were no hand gels outside rooms. Staff informed us that this was being addressed.
- An audit for April-August 2014 showed the directorate was above the 95% target for compliance against the hand hygiene code, with the exception of August which was, at 93%, slightly below the 95% threshold.
- No cases of Methicillin-resistant Staphylococcus Aureus (MRSA) bacterial infection were reported in the last six months for maternity. Two cases of Clostridium difficile (C. difficile) infections were detected between April-July 2014. Investigations showed that there were no avoidable factors found in both cases. However, feedback regarding documentation was given to doctors completing discharge letters that C. difficile infections should be added to both the diagnosis box and infection risk sections.
- Women were screened for MRSA before undergoing elective caesarean sections.
- Failsafe systems were also in place to identify women for Hepatitis B and HIV at booking to ensure they were managed on the correct care pathways.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care, specifically cardiotocography (CTG) which records the foetal heartbeat and resuscitation equipment. Staff confirmed they had sufficient equipment to meet patients' needs.
- The emergency and resuscitation equipment we saw during our inspection was in date and in working order. However, some equipment that needed to be checked on every shift did not have a complete record to indicate that this had been done. For example, on the labour ward, birth centre and antenatal wards we found between three to 15 day gaps in recording during October 2014 for equipment used for new-born and adult resuscitation. Healthcare support workers told us this was usually seen as their role and if they were not on duty the records did not get completed.
- There were three birthing pools. One pool had a hoist and all pools had an evacuation sling. However, we

found there were variations in the preferred methods used for evacuation. The service had identified this as a risk and plans were in place to ensure the safest method for evacuation and for all staff to receive training.

Medicines

- Records showed the administration of controlled drugs (CD) were subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- We found epidural wastage was being disposed of correctly, although the amount was not being recorded in the CD book on the labour ward.
- We observed that not all areas were storing drugs securely. For example, on the labour ward we found Oxytocin (a drug used to induce labour or strengthen contractions during childbirth) had been left on a trolley situated on the corridor. We brought this to the attention of staff who immediately removed it.
- Fridge temperatures were checked daily in some areas. However, we found checks were not being consistently carried out on the day assessment unit, birth centre and postnatal wards. There were gaps in records of between five and eight days during September and October 2014. This meant staff would not know if the medication had been stored within the correct temperature range in between the checks and, therefore, if the medication remained safe to use.

Records

- Clinical records were completed to a good standard. Each record we looked at contained a clear pathway of care which described what women should expect at each stage of their labour. When not in use records were kept safe in line with the data protection policy.
- Risk assessments had been conducted and we saw that they identified any potential or actual risks.
- Audits of record-keeping formed part of each midwife's annual supervisory review.
- The personal child health record (also known as the PCHR or 'red' book) was given to parents before discharge and completed correctly.

Safeguarding

- There was an effective system for safeguarding mothers and babies. The service had a lead midwife for safeguarding, responsible for managing child protection and domestic violence issues.
- Risk assessments and clear pathways of care were in place to identify women and children at risk.
- Staff had a good understanding of the need to ensure that vulnerable people were safeguarded and understood their responsibilities for identifying and reporting any concerns.
- Safeguarding training was a mandatory subject for staff and we saw from training records that 95% of midwifery staff had received Level 1, 72% Level 2, 42% had received Level 3 and five midwives had received specialised training at Level 4 for children's safeguarding as at October 2014.
- There was a baby abduction procedure in place which included a lockdown system. Staff underwent training exercises with hospital security. Further training for lower grade staff were being planned.

Mandatory training

- Staff received a combination of face-to-face training and electronic learning. Figures for mandatory training in the last six months were between 60-78%. Staff said they had training postponed or cancelled on more than a few occasions during periods of peak activity so they could work clinically. Figures from the maternity dashboard showed an update for skills day attendance for medical and midwifery staff was below the 100% target for April-September 2014.
- Access to mandatory training was identified by the service as a risk and was being monitored by the professional development midwife. The risk register indicated that 'did not attend' rates were being addressed by line managers. The head of midwifery told us figures for mandatory training should improve once staffing levels were fully established.
- Midwives, who were newly qualified, undertook a period of preceptorship. During this time, they had access to extra support and training.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment

tool enabled staff to identify and respond with additional medical support if required. The records we reviewed contained completed MEOWS tools for women who had been identified as being 'at risk'.

- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's (WHO) 'Five Steps to Safer Surgery guidelines – a surgical safety checklist in operating theatres. We reviewed two checklists and found that all five stages were documented correctly.
- An audit of the WHO checklist for theatres trust-wide undertaken in July-October 2014 showed the team briefing at the beginning of the list was completed 100% of the time and led by the consultant surgeon or anaesthetist. The time out was also fully completed and results for the sign-out processes were 72%. Actions to address this included the raising of staff awareness through staff briefings and newsletters and re-auditing of the sign-out processes.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers post-natally to another unit.
- High dependency care was provided in room five on the labour ward. If a woman required this care the consultants and registrars in obstetrics and anaesthetics were involved in the decision-making process.
- The unit used the 'fresh eyes approach', a system that required two members of staff to review foetal heart tracings. This reduced the risk of misinterpretation.

Midwifery staffing

- Births to midwife ratio was 1:31 against the nationally recommended Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007) ratio of 1:28.
- From our discussions with staff and a review of rotas, we found that staffing levels may not always be satisfactory to adequately cover shifts. For example, on Ward M4 (mixed antenatal and postnatal ward with 20 beds), staff informed us that one midwife was regularly moved to the labour ward during the night shift, leaving one midwife to cover the ward. We reviewed two weeks duty rotas from September 2014, which confirmed there was only one midwife working at night along with a support worker on the 7, 12, 16, 18 and 21 September.
- During the week of our inspection, rota's showed that only one midwife and one support worker were on night duty on Sunday 19 and Monday 20 October 2014. We spoke with several midwives, who told us this was a regular occurrence. We were told that bed numbers were temporarily reduced from 20 to 16 beds when a midwife was moved. However, this still left one midwife responsible for up to 16 women (and their babies when postnatal).
- On ward M3 (a mixed antenatal and postnatal ward composed of 29 beds) when the staffing levels were two midwives plus one support worker the trust informed us that they reduced from 29 to 16 beds. This level gave a maximum ratio of one midwife per 8 women. Discussion with midwives, the ward manager and a review of the duty rotas showed that the ward struggled to maintain expected staffing and as a consequence the action of reducing beds as decribed happened. Despite this we were told by staff that expected staffing on the late shift and night duty meant midwives struggled at times to ensure women's acute needs were met.
- On Ward M3, we reviewed the duty rota for August. It showed staffing levels on a late shift fell below the expected minimum of three midwives on more than one occasion. For example, for the week 10-16 August 2014, there were only two midwives on late duty on the Sunday, Monday, Tuesday and Thursday. The duty rota showed that the ward manager had to maintain midwifery support worker staffing via the utilisation of the trust's bank system. For example, during the weeks 5-11 October and 19-25 October 2014, four out of seven nights were covered via bank on each respective week.
- The service aspired to provide 100% 1:1 care in labour. However, staff told us this was not always achieved. Data showed that the percentage of women receiving 1:1 care was below the trust internal target of 75% for the last five months, with 83% being achieved in April 2014. However, during the inspection, we did not receive any concerns from women who had received treatment. All of the women we spoke to confirmed they had received 1:1 care throughout their labour.
- We discussed staffing levels with the head of midwifery. She informed us the Chief Nurse had commissioned a review of midwifery staffing utilising the Birthrate+ tool. The findings of this review were being worked through in line with the principles utilised by the Board when considering nurse staffing reviews that were all presented six monthly to the Board of Directors. The

failure of meeting the Safer Childbirth recommendations of 1:28 was escalated on the maternity risk register and a review of staffing numbers showed a requirement for 22 whole time equivalent (WTE) midwives and 2.6 WTE midwifery support workers. The trust confirmed the maternity service had been supported to over recruit by 5 wte. This was in reflection of the challenges posed traditionally with an annual out turn of newly qualified midwives from university and the trust's positive stance of holding vacant posts in the lead up to this to enable recruitment of local midwives upon completion of training.

- In the interim, processes were in place to manage midwifery staffing through the daily hot desk midwife who liaised with managers (out of hours this was the Band 7 on Labour Ward and SOM on call), an overall view of the situation was taken over a 24 hour period and changes were made on an hour to hour basis as required and staff were moved to the pressure points and bed numbers reduced to maintain safety as a priority
- There was a rota to provide a theatre team for obstetrics 24 hours a day. Staffing for obstetric theatres was separate from the labour ward roster for elective cases during the week. However, for all emergency cases and out of hours, the theatre scrub role was provided by midwives from the labour ward. Staff told us that, if the unit was busy, this impacted on staffing numbers.
- We observed a morning handover on the labour ward. The unit used a recognised communication tool: Situation, Background, Assessment and Recommendation (SBAR). However, we found there were four different handovers taking place, followed by a ward round. Due to the time taken for handovers to take place, we found night staff were having to wait until 9am before going off shift. Staff on the day shift told us they came in earlier to try and reduce the time night staff were waiting.

Medical staffing

- In 2007 the RCOG report 'Towards Safer Childbirth' set a gold standard for resident labour ward cover at 168 hours per week. At the time of the CQC inspection, in the Trust there was cover on the labour ward for 60 hours per week. In July 2014, a business case was approved by the Board of Directors to employ four extra consultant obstetricians. This would allow presence on the labour ward of 98 hours per week with resident cover from 8am-10pm each day. In addition at the weekends, a second consultant would undertake ward rounds on the post natal wards and support the labour ward in the morning.
- The unit was not overly reliant on locum medical staff and only used locums who had previously worked in the unit.
- Junior doctor rotas were compliant with working time directives. Out-of-hours cover was available, including one resident middle grade and two senior house officers who covered maternity and gynaecology. Daily antenatal and postnatal ward rounds were carried out by consultants who could be contacted out of hours, if required.
- We observed a medical handover, which took place before the ward round and was attended by the consultant, registrar, anaesthetist and labour ward coordinator. We were told by staff that handovers were not always protected and there was overlap and a delay in handover, due to doctors having to cover both obstetrics and gynaecology.
- There was 24 hour anaesthetic cover.

Major incident awareness and training

- Business continuity plans for maternity were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incident, such as shortfalls in staffing levels or beds shortages.
- The trust had major incident action cards to support the emergency planning and preparedness policy, which staff in maternity were aware of. Staff understood their roles and responsibilities.

Are maternity and gynaecology services effective?

Good

The maternity service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Information about patient outcomes was routinely monitored and action taken to make improvements.

Maternity and gynaecology

There was a multidisciplinary approach to care and treatment, which involved a range of providers across healthcare systems in order to enable services to respond to the needs of women. Staff had the skills, knowledge and experience to do their job. Consent was appropriately obtained and women were supported to make decisions about their care and treatment.

Evidence-based care and treatment

- The delivery of care and treatment was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). Maternity used a combination of NICE and Royal College of Obstetrics and Gynaecology Safer Childbirth (RCOG) guidelines (for example QS22, 32 and

37 and the RCOG minimum standards for the organisation and delivery of care in labour) to determine the treatment they provided.

- There were processes in place to ensure guidelines were modified in line with best practice. The service had a virtual guidelines group consisting of a cross section of staff. Guidelines were reviewed, discussed and ratified by the Labour Ward Forum whose membership included a service user, GP and other women's services staff.
- The service participated in national and local clinical audits. There was an annual audit programme. Audits were monitored and actions taken to improve clinical practice. For example, changes had been made to swab counts, documentation and guidelines as the result of a Never Event.

Pain relief

- Information was given to women to make them aware of the pain relief options available to them.
- Various types of pain relief were available for women giving birth, which included drug-free methods. For example, use of the birthing pools.
- There was a 24-hour anaesthetic and epidural service.

Nutrition and hydration

- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. For example, menus included halal options.
- There was a specialist infant feeding coordinator who worked closely with the public health team and provided advice and support for women who chose to breastfeed. The service had achieved UNICEF Baby Friendly accreditation. This was a worldwide programme that encouraged maternity hospitals to support women with breastfeeding. Figures showed breastfeeding within the first 48 hours after birth was above the trust target of 67% – being between 67.5 and 71% in the last six months.

Patient outcomes

- In the 12 months prior to our inspection, there were 5,663 deliveries at this hospital.
- Normal delivery rates were lower than those reported nationally.
- The trust had higher rates of caesarean sections compared with national figures.
- No risks were identified for the number of maternal readmission rates, neonatal readmissions, puerperal sepsis, emergency caesarean sections and elective caesarean sections.
- Home birth rates were lower than the trust target. The maternity dashboard 2014/2015 showed figures for home births ranged between 0.4% and 1%. The service was carrying out a choice of place of birth audit to improve communication with women about the birth options available.
- There were no women waiting for a diagnostic test over six weeks.
- During 2013/14 there was one intrapartum death, one intrauterine death and one unexpected death (general).The number of at term admissions to the neonatal unit was within trust targets.

Competent staff

- We found staff had the correct skills, knowledge and experience to do their job**.**
- The Local Supervising Authority (LSA) annual report to the Nursing and Midwifery Council (NMC) for 2013/2014 indicated that the range of caseloads held by supervisors of midwives was 1:0 –1:20, which was above the recommended ratio of 15 midwives for each supervisor. This was largely historical and all supervisors of midwives had been offered the opportunity to reduce caseloads. Succession plans were in place for new supervisors of midwives to have 1:15 caseloads. However the average caseload was 1:13. Supervision was positively evaluated by midwives who said they

were able to contact supervisors at any time for guidance and support. Student midwives also told us they received good support and had the opportunity to become involved in the care of women to develop their skills while under the supervision of a midwife.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had good, ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- All staff we spoke with had appraisals and regular continuing professional development.
- Revalidation and appraisal for doctors showed 100% had been completed in maternity.
- The result for the General Medical Council (GMC) national training scheme survey 2014 showed educational and clinical supervision for junior doctors was 'within expectations' for this trust.

Multidisciplinary working

- There was good multidisciplinary working amongst all necessary staff, including those in different teams and services, when it came to the assessing, planning and delivery of women's care and treatment.
- There was access to medical care for women who had other clinical conditions. Joint clinics were held for diabetes, cardiology and mental health.
- Midwives worked closely with GPs and social care services while dealing with safeguarding concerns, or risks for child protection.
- There was a transitional care unit (TCU) consisting of nine beds for babies from the neonatal unit, who were being transferred to postnatal care. Typical admissions included mother and baby who may have feeding problems and required support to establish and maintain feeding. The unit was staffed by neonatal nurses and supported by a midwife during the day. A consultant neonatologist performed a daily ward round on the TCU every day of the week. Medical staff from the neonatal unit attended when required.

Seven-day services

- Consultants were present five days of the week from 8:30am to 5:30pm, and were on call out of hours. Ward rounds took place on the labour ward and the gynaecology ward during the weekends.
- Junior and middle grade doctors were present 24 hours a day and seven days a week.
- Twenty-four hour anaesthetic cover was available.
- Maternity services were supported by physiotherapists, occupational therapists and pharmacists.

Access to information

- During the transfer of women, there were processes in place to ensure all appropriate documentation and case notes travelled with the woman, and the results of the appropriate investigations carried out. Communication between teams was verbal, written or an electronic print out was available, when required, using the SBAR tool.
- There were effective processes in place to ensure that the results of the antenatal screening tests were followed up and actioned in a timely way and in line with protocols. The screening coordinator worked closely with the laboratory to ensure investigations were actioned. Results were checked and all high-risk women were given an appointment to be seen in clinic.
- The service was in the process of rolling out an electronic patient record. There had been a number of risks identified during implementation, which included: connectivity, integration with other systems and training of staff. Action had been taken to improve access and there was regular assistance from the IT support team. We saw a 'lessons learnt' newsletter for October 2014, which included guidance in terms of configuration and functionality.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Women were consented appropriately and correctly. Records showed they were given choices about their care and the risks, benefits and alternative options were discussed. The consent process was supported by written information.
- There was a system in place to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at the completion of five certificates and found these were correct, with two practitioners certifying their opinion in line with legislation. Consent forms included the risks and benefits of the procedure and were signed by the woman. Regular audits of records were also undertaken to ensure which showed the service was working within legal requirements.

Maternity and gynaecology

- There was a clear maternity care pathway for women with a learning disability. Where a woman lacked capacity to give consent, best interest decision meetings were held that included a multidisciplinary team and access to an independent advocate, where required.
- Training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was mandatory. Records showed the majority of staff had completed training in these areas.

Are maternity and gynaecology services caring?

Good

Maternity and gynaecology services were caring. Women spoke positively about their treatment by clinical staff and the standard of care they had received. Staff interacted with women in a respectful way and provided compassionate care. Women were involved in their birth plans and had a named midwife.

Compassionate care

- In the CQC Maternity Services Survey 2013, the results showed that the majority of questions relating to antenatal care, labour, birth and postnatal care were rated 'about the same as' other trusts with the exception of cleanliness, which was rated 'worse than other trusts'.
- Antenatal, birth and postnatal friends and family response rates were below the England average. The NHS Friends and Family Test results for September 2014 (NHS Choices) showed the majority of women were 'extremely likely' or 'likely to recommend' the service to their family or friends.
- All women spoke positively about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- We observed staff interact with women and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure privacy and dignity. However, we observed one episode in the antenatal clinic where this was not maintained, in which a staff member shouted over to a patient to see if they required an interpreter.

Understanding and involvement of patients and those close to them

- Most women told us they were involved in developing their birth plans and had received sufficient information to enable them to make choices about their care and treatment during labour.
- There were a range of information leaflets in clinical areas, including tests and screening, breastfeeding and other sources of support. However, we saw little evidence of signage or information in a language other than English. A few women confirmed the information they had received was not provided in a way which they were able to understand. For example, one woman told us she was unable to understand how to take the medication she had been prescribed and, therefore, had stopped taking it. To help staff improve communication, the service had implemented a team dynamics programme to promote listening to women using the service.

Emotional support

- Staff held debriefing and resolution meetings with women to discuss any concerns relating to their care and treatment and referrals were made to counselling or other specialist services, where required.
- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death. This was facilitated by a dedicated bereavement midwife who worked closely with the chaplaincy service offering support to families following bereavement. The service also held a weekly 'tender loving care clinic', which women could attend following a pregnancy loss.
- There were close links between the bereavement midwife and the Bradford Stillbirth and Neonatal Death (SANDS) Group (SANDS stands for stillbirth and neonatal death and is a charity which supported families following the death of a baby). Midwives followed the SANDS audit tool for maternity services to benchmark good practice and evidence-based care.
- There were effective and confidential processes in place for women attending the Lilac Clinic for medical terminations of pregnancy.

Are maternity and gynaecology services responsive?

Maternity and gynaecology

Good

Managers were aware of the risks associated with the increasing demands of the local and wider community and ensured that services were planned and delivered to meet these. However, there were occasions when capacity and the configuration of clinics interrupted the provision of services in antenatal care. This meant that women experienced longer waiting times.

The service responded to the needs of vulnerable patients. There were specialist midwives who provided support. The services offered a holistic approach by developing an enhanced care pathway based on individual needs and in partnership with community midwives and other agencies.

Complaints were handled in line with trust policy. There was learning from complaints and concerns and action and improvement to services was taken where required.

Service planning and delivery to meet the needs of local people

- Managers were aware of the risks associated with the increasing demands of the local and wider community and ensured that services were planned and delivered to meet these.
- Maternity and gynaecology services worked with the local commissioners of services, the local authority, other providers, GPs and service users to coordinate and integrate pathways of care. For example, in response to increased demand for uro-gynaecology services, steps had been taken to expand services, including the appointment of a consultant and nurse specialists and the introduction of telephone follow-up clinics.

Access and flow

- Bed occupancy rates in maternity services for the last two quarters in 2013/2014 and 2014/2015 were lower, at 47%, than the England average of 58.6%.
- We visited the antenatal clinic, which was used for all obstetrics and gynaecology patients, including women undergoing fertility treatments. The configuration of the clinical area meant that capacity and demand sometimes interrupted the access and flow for women attending the unit. We noted that there were two reception areas for booking patients, which women told us was confusing. One woman told us she had waited at the wrong reception desk and had missed her appointment. Another woman said they had been waiting between 40 minutes and an hour to be seen. We discussed this with the antenatal manager, who told us a bid had been submitted for Department of Health funding to redesign the clinical areas, which had not been successful. As an interim measure, a pilot scheme was put in place to help reduce waiting times in clinic. This provided a number of improvements that the team was looking at, such as one booking area, better signage and a new IT system.
- There were appropriate triage facilities in the midwifery-led antenatal day unit, which provided an ambulatory care facility. The unit accepted all referrals for any labour type. Patients were seen for up to four hours and either discharged or escalated to the labour ward. Access to medical input was available if required.
- The service had an integrated women's health unit providing gynaecological procedures. For example, hysteroscopy clinics were held five days per week and run by a consultant and nurse. Patients could access these by GP referral or from another medical specialty. Capacity was adequate and the service could respond to an increase in demand with additional clinic slots.
- There were two fast-track slots in every clinic for gynaecology cancer referrals with direct access to scanning, urology and colorectal teams. Referral to treatment times were performing better than the trust targets.
- Admission processes for women requesting medical terminations were flexible and included direct referrals from GPs, or the community sexual health service. All women choosing to proceed with a termination of pregnancy were offered an appointment for the procedure within five working days after the decision to proceed.
- The service was developing the enhanced recovery programme, which enabled low-risk women to go home 24 hours after delivery. The effectiveness of the programme was being audited.
- Women who presented in time were booked by 12 weeks and six days and received their health and social care assessment within 12 weeks and six days of pregnancy.
- The percentage of women presenting after 12 weeks and six days of pregnancy were seen by a midwife or a maternity healthcare professional for a full health and social care assessment within two weeks of referral.

Maternity and gynaecology

- The maternity unit had to close once to admissions in the last 12 months, due to capacity issues. We saw there was a clear escalation guideline to follow to manage capacity and flow, including risk assessment checklists that monitored bed occupancy, activity, dependency and staffing.

Meeting people's individual needs

- The service responded to the needs of vulnerable women. There were a number of specialist midwives who provided support in areas such as teenage pregnancy substance misuse and domestic violence. The services offered a holistic approach by developing an enhanced care pathway based on individual needs and that worked in partnership with community midwives and other agencies.
- Parent education was available for women and incorporated other agencies involved in the women's care, such as family nurse partnership, health facilitation nurses and the safeguarding and learning disabilities team.
- There was a clear care pathway for women with learning disabilities. Care was tailored to the needs of the woman and included more frequent and longer appointment times, home visits and orientation visits to the unit.
- A designated room was provided for the care and support of women during and after the loss of their baby. This was away from the main ward area to reduce distress and enable more direct support.
- The Lilac Clinic provided an integrated one-stop service for women requesting a medical termination. Women were provided with contraception advice and offered Chlamydia screening. Data showed the trust was achieving better than its targets for these areas.
- The service worked in partnership with the English for Speakers of Other Languages (ESOL) 'Mother's Tongue' programme, which enabled women accessing maternity services to improve on their limited English skills.
- We found the service was proactive in safeguarding women at risk of female genital mutilation (FGM). There were clear referral pathways in place and a consultant obstetric lead for FGM. Processes were in place to record if a patient had had FGM, if there was a family history of FGM, or if a FGM-related procedure had been carried out.
- Access was available to translation and interpreter services. Staff told us that, due to a high demand for the service, bookings had to be made a few days in advance. They told us they were able to obtain interpreters at short notice most of the time.
- The service had made appropriate adjustments to ensure women with a disability had appropriate access to facilities. This included adaptations to bathroom and toilet areas.
- There was equipment for women who were obese and required bariatric care. Bariatric is a branch of medicine that deals with the causes, prevention and treatment of obesity.
- A few women commented about the quality of appointment letters. One woman told us the letter was sent to the wrong address so she missed her appointment. Another woman said the letter had insufficient information regarding booking procedures for clinic, which meant she had waited in the wrong queue and was late for her appointment.

Learning from complaints and concerns

- Complaints and concerns were reported to the head of midwifery and were included on the performance dashboard for monitoring at the governance meetings. When complaints were received, staff offered to meet the complainant, and any meeting was followed up in writing, along with the outcome.
- Nine complaints were ongoing within maternity services. Two complaints were outside the response time of 25 days, which was due to the complexity of the complaint. The top themes related to unsatisfactory outcome, length of wait for an appointment, communication and appropriateness of treatment
- Learning from complaints was shared with staff through newsletters and staff briefings. Actions taken following complaints included improvements in communication and staff attitude, documentation and additional training.
- A patient story following a complaint was presented to the Trust Board and a podcast for staff learning was being developed.

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Good

The service had a strategy to improve governance, safety and capacity. There were good governance and risk management arrangements in place to monitor the quality of care and action was taken to improve performance.

There were supportive relationships between the leadership and staff. Strong team working was evident, with medical staff and midwives working cooperatively and with respect for each other's roles. The staff culture was centred on the needs and experiences of women who used the service. A culture that encouraged candour, openness and honesty was visible. Public engagement and support for women was good and the department was innovative and had made improvements in various areas. Further strengthening of staff engagement in some areas was required.

Vision and strategy for this service

- The women's services' strategy was aligned with the trust's clinical service strategy 2014-2019. The strategy included a programme to provide personalised midwifery care, planning objectives to ensure that services and patient activities were physically organised in a way to promote optimal operational efficiency and patient experience and improving consultant cover so that it reflected the times of most activity and medical need. The senior management team told us the Board was supportive of this vision and its business priorities.

Governance, risk management and quality measurement

- The risk management strategy set out clear guidance for the reporting and management of risk. It detailed the roles and responsibilities of staff at all levels to ensure poor quality of care was reported and improved.
- A maternity risk register was in use and monitored on a monthly basis. There were processes in place for escalating risks to the Trust Board where required.
- The service used a quality dashboard that was reviewed on a monthly basis by the governance groups. This used a red/amber/green flagging system to highlight areas of concern.
- The service had clear processes in place for the duty of candour following an incident or complaint. This included notifying the patient of the incident within specific timescales, providing an apology, offering a step-by-step explanation of the events and circumstances and providing a copy of the report and action plan to the patient or their family. We reviewed two serious incidents that showed the consultant obstetrician, bereavement midwife and risk manager had met with the patient and a full explanation of the investigation had been given.
- To ensure staff learned from incidents, a newsletter was circulated by email to each member of staff. We looked at the newsletters for July and August 2014, which showed lessons learnt in areas such as medication, documentation and checking procedures. For example, double checking blood bottles were flagged up, in order to avoid labelling errors and promote the discussion of clinical practice.
- The service had a dedicated risk management midwife who held regular clinical incident panel meetings and reviewed all adverse outcome incidents. The midwife worked proactively with supervisors of midwives and fed into the governance processes to recognise and raise concerns and ensure safe practice.

Leadership of service

- **The service ran as a triumvirate management structure consisting of the clinical director, head of midwifery, matrons and divisional manager. The clinical director was accountable for the service.**
- **During discussions with the senior management team, we found they were aware of the challenges for the service and had identified the action needed to address these at a local level.**
- **Staff told us there was a supportive management structure and senior managers, particularly the head of midwifery and matrons, who were visible and approachable.**
- **All midwives had a named supervisor of midwives with whom they had an annual review.**

Culture within the service

- We observed strong team working with medical staff and midwives working cooperatively and with respect for each other's roles. They told us the unit was a 'good place to work'.

- Staff reported that managers operated an 'open door policy' for staff to raise any issues or concerns. Most staff felt confident their concerns would be acted on.
- Debriefing meetings were held to provide staff with support following an adverse event. Junior doctors were also encouraged to seek support from their allocated educational supervisor.
- Staff sickness levels were slightly above the trust target of 4%.
- We saw a strong commitment by staff to patient care and treatment.

Public and staff engagement

- The service took account of the views of women and their families through the Maternity Liaison Services Committee (MSLC), a multidisciplinary forum where comments and experiences from women were used to improve standards of maternity care.
- There was evidence of engagement with various groups from different backgrounds and ethnicity. Focus groups were held between October and December 2013, across the Bradford and Airedale district, about women's experiences of community midwifery. The main recommendations from discussions included improvements to information about early booking procedures, antenatal education and cultural awareness and sensitivities. The MSLC was working with midwives to get their views of the service and how to improve.
- There was user engagement on the maternity clinical guidelines group and gynaecology strategy group, where women acted as advocates for patients and were involved in decision making to shape and improve services.
- Most staff felt their views were listened to in the planning and delivery of services. However, we found staff on the transitional care unit felt they had not been consulted adequately about the reconfiguration of the service. We discussed this with the head of midwifery, who acknowledged the handling of the process could have been managed differently.
- There was a newly appointed matron for community midwifery services. Link midwife meetings were being held and the matron was attending the community midwifery forum and introducing regular drop-in sessions for staff. Meeting minutes for September 2014 showed that discussions were held on the top five maternity risks, staff workloads and information governance issues.

Innovation, improvement and sustainability

- There was evidence that the service considered and acted on the Centre for Maternal and Child Enquiries (CMACE) reports on maternal deaths and perinatal mortality. Stillbirths were discussed at the monthly perinatal mortality/morbidity meetings. The perinatal mortality clinical lead categorised all incidents using the perinatal death tool kit, which graded the standard of care given in each case. All stillbirths had a supervision decision toolkit completed to identify midwifery practice issues and actions to improve care were cascaded to staff.
- The service was innovative in emphasising normality in pregnancy. A new midwifery-led birth centre had been built, which included two birthing pools and birthing aids to encourage women to remain upright during birth in order that labour could progress quickly. iPod docking stations were also available in all the rooms.
- The Annual LSA audit showed that the supervisor of midwife's team had made significant progress against their action plan from the last audit visit in October 2013. 70% of domains had been met. This showed staff were focussed on continually improving the quality of care.
- The trust awarded maternity services the 'team of the year' award, in recognition for the responsive and effective care and treatment of a palliative patient using maternity services.

Services for children and young people

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

Information about the service

children's services at the Bradford Teaching Hospitals NHS Foundation Trust were managed by the women and children's directorate. Services included three inpatient children's wards based at the Bradford Royal Infirmary site. Ward 16 was a 10 bedded medical ward and included a two bed stabilisation room. Children were cared for in the room until the paediatric retrieval team transferred them to another hospital for paediatric intensive care. The paediatric retrieval team is a dedicated team of doctors, nurses and ambulance staff who transfer critically ill children from one hospital to another. There was no paediatric intensive care or children's high dependency beds within the hospital. The nearest beds were at the regional unit in West Yorkshire.

The children's assessment unit was also based on Ward 16, and provided three assessment cubicles and four short-stay observation beds in the assessment unit. and accepted medical referrals from the children's emergency department, direct GP referrals and children with direct access. Ward 17 was a 25 bed medical ward and Ward 2 was a 27 bed surgical ward. At night, the ward capacity was reduced to 16 beds.

The children's community nursing team, child development service and children's outpatients' clinics were based at St Luke's Hospital. The children's community nursing team provided home-based care for children with continuing care needs. For example, for those who required 24-hour care. The team also provided short-term interventions either at the patient's home, or in the clinic. The children's development service saw children with developmental delays and complex health or disability needs. The health transition nurses supported young people whose care was being transferred from children's services to adult services.

During our inspection, we visited all clinical areas where children were either admitted or where they attended on an outpatient basis, including the neonatal unit, Wards 2, 16 and 17, the child development service, the children's outpatients department, the children's community nursing team and the children's assessment unit. We also participated in two home visits.

We talked with 62 staff, including the head of nursing, the clinical lead, the general manager, two matrons, medical and nursing staff and allied healthcare professionals. We examined 18 medical and nursing records and spoke with 21 children and parents.

Services for children and young people

Summary of findings

There were systems in place to report incidents, although staff did not always receive feedback from these. The children's ward environments were old and limited in meeting patient needs. The majority of side rooms did not have en suite facilities. We found on Ward 2 there were showers and basins for patients but the ward did not have a bath for patients to use. The actual number of staff on duty frequently did not meet that planned or best practice guidance. The dependency acuity tool for staffing was not embedded in practice.

We had serious concerns over the arrangements for the stabilisation room on Ward 16: staff did not have all the appropriate skills and experience to care for critically ill children; the equipment was not routinely checked on a daily basis or between patients and; an outcome from a serious incident related to the stabilisation room had not been acted upon.

There were no specific surgical lists for children and young people and no individual fasting times for children and young people. There were significant waiting times within the child development service (CDS). The Trust had concerns about the waiting times and capacity in the CDS service particularly autism assessment following national changes. Non recurrent funding had been provided which reduced the waiting times by 18 months but a recurrent solution was not yet in place. The Trust had been working with commissioners to resolve this through service development group with a formal proposal in September which had been escalated further.

Care and treatment was generally delivered in line with national and best practice guidance. The service participated in national audits, which monitored patient outcomes and service performance through the specialty dashboards. There was no pain assessment tools used, this meant that it was not clear how staff assessed and monitored a patient's pain.

We saw that patients and relatives were treated with dignity, respect and compassion. Patients and relatives felt involved and supported by staff within the services.

The trust's strategy and vision were not well-embedded across children's services. There was uncertainty about the changes to the paediatric wards if they moved into the new build. Staff were unclear as to whether or not the changes were 'rumours', or actually planned changes. Staff felt well supported by the ward managers and the senior management team within the directorate.

Services for children and young people

Are services for children and young people safe?

Inadequate

We rated children's and young people's services as 'inadequate' for safety. There were systems in place to report incidents. Staff told us they knew how to report incidents, but did not always receive individual feedback from these.

There were policies and procedures for infection prevention and control. Staff reported that they had received infection control training. Ward areas and clinics we visited were visibly clean. However, we noted that, in some of the clinical areas, the hand sanitising gel dispensers were broken and had not been replaced.

The ward environments on Wards 2, 16 and 17 were old and, as such, there were limitations in meeting patients' needs. We found that the majority of side rooms on the wards did not have en suite bathroom facilities. On Ward 2, adequate bathing facilities were not available to meet the needs of children and young people on the ward.

We found that the planned number of staff on duty frequently did not meet the actual number of staff on duty. The trust told us staff were relocated around the wards to support patient care (based on patient acuity) and the bed base was reconfigured as required. This meant that the staffing levels did not meet the trust's target or best practice guidance.

We had serious concerns over the arrangements for the stabilisation room on Ward 16: staff did not have all the appropriate skills and experience to care for critically ill children; the equipment was not routinely checked on a daily basis or between patients and; an outcome from a serious incident related to the stabilisation room had not been acted upon.

Incidents

There were systems in place to report incidents. Staff told us they knew how to report incidents, but did not always receive individual feedback from these.

- We saw that, between 1 July 2014 and 9 October 2014, there had been 141 incidents reported for children's services. We saw that nineteen of the reported incidents related to patient care, which included delayed discharge, inadequate handover of care, failure to isolate a patient and failure to recognise the severity of the patient's condition. The remaining incidents consisted of medication errors including prescribing, dispensing and storage of medications, documentation issues, communication and verbal abuse/ threatening behaviour from visitors to the hospital.
- Managers told us that themes from incidents were reported in a bi-monthly briefing from the matron. We saw that copies of the briefing were available in staff areas within the wards visited.
- There were a total of 10 risks identified on the risk register, one moderate, eight high and one extreme. The extreme risk related to access and service delivery within the child development service. The high risk items related to the neonatal unit funded establishment did not meet the need of high dependency care, the ward layout on Ward 2 which could impact on privacy and dignity, and insufficient cubicle space for isolation on the children's assessment unit.
- We saw information on the corporate risk register that highlighted that there was a risk of crash calls not being responded to as a result of problems within the paging system. We asked senior managers if this was an ongoing issue. They told us that this had been resolved and, as an extra measure, tannoy announcements asking staff to attend a ward during a crash call were now being made.
- We found that in children's services there had been two serious incidents, one of which the trust had investigated, with the other being investigated by another provider, but the latter incident had involved staff from the trust. An outcome from the latter had not been acted upon by the trust at the time of the inspection.
- For both serious incidents we saw that a root cause analysis (RCA) had been undertaken, an RCA is a method of problem solving that tries to identify the root causes of incidents. The RCA of the incidents highlighted lessons to be learned and contributing factors.
- When incidents do happen, it is important that lessons are learned. For example, we saw that, for one of the incidents, it had been highlighted that there needed to be a specific pathway for children who posed a risk to themselves or others.

- During our visit to the children's ward, we found that there was a paediatric deliberate self-harm pathway (April 2014), which staff were able to use to support them in their assessment of children and young people who posed a risk of self-harming. This is an example of how the service had learned lessons and implemented a pathway to support staff in caring for children and young people who self-harm.

Cleanliness, infection control and hygiene

- There were policies and procedures for infection prevention and control, these were easily accessible via the trust's internet site.
- Staff reported that they had received infection control training on an annual basis as part of the mandatory training.
- The ward areas and clinics we visited were visibly clean. However, we noted that, in some of the clinical areas the hand sanitising gel dispensers were broken and had not been replaced. We asked one of the ward managers about this. They told us that replacement dispensers had been ordered, but had not arrived yet.
- We saw that the women's and children's directorate participated in hand hygiene audits. We saw from April 2014 the directorate had consistently achieved above their 95% target with the exception of the results in August 2014 when the results had fallen below the 95% target.
- For a 15 minute period, we observed staff and visitors entering one children's ward area. In this period, we saw that there were seven people who entered the ward, including six members of staff and one visitor. Of these seven people, we saw only one member of staff use the alcohol hand sanitising gel when entering the ward, despite signs and notices to encourage the use of alcohol gel when entering or leaving the ward.
- We observed that one member of staff undertook an aseptic technique procedure to set up a new medication infusion to a patient. Aseptic technique refers to a procedure that is performed under sterile conditions. We saw that the member of staff followed good infection control procedures while doing this.
- We saw information in the infection prevention and control report of June 2014, which detailed that there had been one case of Clostridium difficile (C. difficile) on Ward 2. The post-infection review report stated that the diarrhoea care plan had not been completed fully on the ward. It also stated that evidence of actions taken in response to the report were due to be submitted by the matron.
- At the time of our inspection, there had been no recorded instances of Methicillin-resistant Staphylococcus Aureus (MRSA) on the paediatrics wards.
- We saw that, in the children's outpatients department, there were posters specifically designed for children and young people, advising them of the importance of washing their hands. This was a good example of information that was tailored to children and young people.
- We saw that there were information leaflets available for patients on MRSA and C. difficile. The leaflets contained information on how the infections were treated, how they were spread and what could be different about patient care. For example, moving to a single room to reduce the risk of spreading infection to other patients.

Environment and equipment

- The ward environments on Wards 2, 16 and 17 were old and, as such, there were limitations in meeting patients' needs. For example, two nurses on Ward 17 told us that they had had difficulty in using a hoist to move a young person, due to the close proximity of the other beds in the bay.
- We found that the majority of side rooms on the wards did not have en suite bathroom facilities. There were only three side rooms in total, across the three children's wards, that had en suite toilets, but there were no bathing or showering facilities. This meant that patients who were isolated for infection control reasons had to use the main toilets on the ward, or a commode in their room. This potentially could lead to an increased risk of infection.
- The Department of Health (2013) in their Health Building Note 00-09, Infection control in the built environment, states that**,** "The key to effective isolation on general wards is the provision of sufficient en suite single-bed rooms to prevent patients known to be a risk for spreading infections being cared for in open ward areas." This meant that the trust was not following national guidance on isolating patients on the children's wards.
- The layout of Ward 2 was identified as being a concern on the service risk register, due to the poor sight of some

beds and the fact that dignity and privacy were being compromised as a result. However, it was not clear how the service was looking to mitigate these in the interim period while they waited for the outcome of a business case for the building of the new ward block at the hospital site.

- On Wards 16 and 17, due to the layout and position of the nurse's station, none of the beds could be observed from behind the station. The beds closest to the nurses' stations were side rooms and were being used for patients who were infection control risks. Staff told us that this caused some difficulty as it meant that, occasionally, the patients who were most ill could be at the other end of the ward.
- On Ward 17, we saw that, in the boy's toilet area, a bathroom had been converted to a store room, which contained artificial feeds and other equipment. During the unannounced visit, we found that the door to the store room was open and accessible from the toilet area. This was a safety concern as patients, particularly young children were using the toilets, and had access to feeds and other equipment, which could have easily been reached in an area that was not supervised.
- In addition, during the unannounced visit, we found that, on Ward 17 in the boy's toilet area, there were three beds stored in front of the sinks in the hand washing area. These beds were being used for parents who stayed with their child. This was an infection control risk, as these beds could be placed next to the patient on the ward and access to hand washing facilities would then be compromised.
- All the children's clinical areas we visited had suitable resuscitation equipment available. However, we found gaps in the daily records regarding checks of the resuscitation equipment in some areas. We found that routine checks of the equipment had been completed on a weekly basis on Ward 2 and 17 and every few days on Ward 16. Staff on Ward 16 told us that this did not always get done, due to staffing levels.
- We found that, in the stabilisation room on Ward 16, there was a list of checks to be completed weekly and staff signed to say when they had been completed. We found that the equipment was checked weekly. However, no month or year was recorded on the checklist. We spoke with one of the sisters, who told us that checks should be completed on a daily basis. This meant that if the stabilisation room had been used in-between checks, staff could not be sure that they had the appropriate equipment available to them.
- During the unannounced visit, we rechecked the stabilisation room and the equipment checks. We saw that there had been two patients admitted to the room on consecutive days (2 and 3 November 2014). When we looked at the equipment checklist, we saw that the equipment had been checked on the 31 October and 3 November 2014. There was no evidence that equipment and stock had been checked in-between the two patients to ensure appropriate equipment was available.
- We asked staff about checking the ventilator in the stabilisation room. One member of staff told us of, and showed us, a folder that detailed how to check the ventilator. However, when we asked staff, they said they were not confident on how to check the ventilator properly. This meant that the checks may not have been completed fully, as staff were not confident, or trained in how to do this.

Medicines

- We reviewed a sample of treatment records on the children's wards and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered within the ward areas where children received inpatient care.
- Through discussions with staff, they told us that some medications required checking by two registered nurses. This meant that, on Ward 2 and 16, when there were only two staff on duty there were periods of time when there were no staff available on the ward, while staff were checking medications.
- We saw evidence from reviewing drug charts that medicines had been administered at appropriate times.
- We saw that between 1 July 2014 and 9 October 2014 there had been 23 incidents relating to medicine management reported within children's services. We spoke with one of the matron's, who told us that each incident had been investigated, themes identified and individual issues discussed.
- The head of nursing told us that, as part of the recruitment process, drug calculations were used so that the service could assess the interviewee's

competence with drug calculations. Where staff may need additional support following recruitment, this was identified and incorporated into their preceptorship period.
- We saw that, in the stabilisation room, there was information available for staff on the dosage of medications for children and young people.

Records

- We found that most of the records we had reviewed had been completed appropriately which included entries being dated and signed and all the sections being completed fully.
- We saw that medical and nursing records were stored securely.
- In the inpatient areas, we found care records contained pre-printed core care plans. For example, we saw care plans for when a child had a lower respiratory infection and/or a urinary tract infection.
- We saw an excellent example of a personalised health record for a young person who was supported by the health transition nurses. We saw that, for this patient, there was information for staff on how best to communicate with the young person. The care record stated, "[The person's name] can be calmed if upset by stopping what you are doing and playing music before you start again."
- The record also stated that, "The best way to interpret [patient name's] needs is through his carers and parents, who know him best." These examples demonstrate that the patient was treated as an individual and their needs were recognised.
- However, we found that, both in inpatient areas and within the children's community nursing team, most of the records we reviewed had not been personalised to reflect the needs of the child/young person, or an assessment of the family. This meant that, particularly for children with long-term conditions, information on their individual needs was not available in the care records to support staff while caring for their patients.
- We saw that, between 1 July 2014 and 9 October 2014, 13.5% of the incidents reported related to documentation issues and missing records within children's services.

Safeguarding

- We saw information in the children's Safeguarding Steering Group minutes of 10 July 2014 that indicated that the group had discussed serious case reviews, learning and development. For example, we saw that a child sexual exploitation e-learning package was now available for staff. However, staff told us that they had difficulty accessing training while at work due to staffing levels and they were not always able to access training from home due to IT issues.
- We found that there was a named nurse and doctor in place within the trust for safeguarding. In addition, the trust also had a designated doctor for safeguarding.
- The Safeguarding children and young people: roles and competencies for healthcare staff: Intercollegiate document, March 2014 stated that all clinical staff working with children/young people and their parents and who contributed to assessing and planning to meet the child's needs, should undertake Level 3 safeguarding training.
- We saw that, for the women's and children's directorate 73% of staff had Level 2 training and 45% had Level 3 training. This meant that the department did not ensure staff were trained to the appropriate level for safeguarding children.
- We saw that up to 10 July 2014, 178 staff had received supervision. The trust had a safeguarding supervision policy and staff told us they knew how to access supervision.
- Staff were able to tell us how they would access support, or make referrals to the local authority if they were concerned about a child or young person.
- All of the wards we visited had a keypad entry system where visitors were required to identify themselves prior to gaining entry to the ward.

Mandatory training

- Staff told us that they had received mandatory training through a full day's study, which incorporated the required training such as resuscitation and infection control.
- We saw information in the specialty dashboards that, in June 2014, 61% of staff in the women's and children's directorate had received their mandatory training. The head of nursing told us that, at the time of the inspection, over 90% of staff had completed the training. We requested information to confirm this, but the trust did not supply this to us.

Assessing and responding to patient risk

- The children's service utilised an early warning score system to detect a sick child, or infant, who may have required urgent or critical care. The system, known as the 'paediatric advanced warning score' (PAWS), allowed the paediatrician and children's nursing team to promptly identify when a child's clinical observations could be lying outside the normal range. During our visit, we reviewed seven charts and found that these had been completed appropriately.
- Staff told us that, particularly on Ward 2, they were sometimes unable to undertake observations as frequently as was required, due to being short staffed.
- As part of our inspection, we reviewed seven records and found that the observations had been completed appropriately and within the required timescales.

Nursing staffing

- We spoke to the head of nursing, who told us that the trust had started to review staffing levels for paediatric wards using the Safer Nursing Care Tool, with specific paediatric parameters included. The tool needed to be used over consecutive periods to develop staffing levels per ward. The service was in the middle of this process.
- The head of nursing also told us that the trust was looking to purchase the Great Ormond Street Hospital (GOSH) Paediatric Acuity and Nurse Dependency Assessment (PANDA) tool. The PANDA tool had been developed by Great Ormond Street Hospital to objectively assess the nursing dependency of children and calculate safe nurse staffing requirements for paediatric wards.
- We saw that the staffing establishment and actual staffing levels were displayed on noticeboards in the corridor of each ward, with the exception of the children's assessment unit.
- The Royal College of Nursing (RCN 2013) developed guidance on defining staffing levels for children and young people's services. Within the guidance, it stated that, for children under two years, there should be one registered nurse for every three patients, day and night. For children over two years, there should be one registered nurse for every four patients, day and night.
- We asked the head of nursing what staffing levels the trust were working towards. They told us that the service should have been, within the current staffing establishment, able to work to one nurse to five patients. However there were times due to sickness, vacancy and leave staffing levels were not at the staffing to patient ratio.
- Following the inspection the trust told us they do not work to defined nurse to patient ratio's pending the development of NICE guidance in this area. The trust were utilising modified paediatric parameters in the adult safer nursing care tool.
- The trust told us staff were relocated around the wards to support patient care (based on patient acuity) and the bed base is reconfigured as required. However during the inspection we found this was not recorded to reflect the movement of staff.
- Ward 2 is a 27 bed children's surgical ward. The planned number of staff on an early shift was five qualified nurses, on a late shift four qualified nurses and on a night-time shift, when the beds were reduced to 16, two qualified nurses.
- We looked at the planned and actual number of staff between 14 and 22 October 2014. We saw that there were five occasions where the actual number of staff was one less than the planned number of qualified staff for the early shift.
- On one of these occasions, on the 18 October, there were two less qualified staff than planned and there had been 18 patients recorded on the ward's fire register. This meant that there was a nurse to patient ratio of one nurse to nine patients. This did not meet the trust's target or best practice guidance.
- In the same time period, we saw that there were two occasions where the actual number of staff on a late shift was less than the planned number of qualified staff for the shift. This meant that, if the ward was full, there was a nurse to patient ratio of one nurse to seven patients.
- On a night shift, there was a one nurse to eight patient ratio if the 16 beds were full. This meant that the staffing levels did not meet the trust's target for best practice guidance.
- Ward 16 was a 10 bed medical ward. The planned number of staff through the day was three qualified nurses and two qualified nurses on a night shift. We looked at the planned and actual number of staff between the 1 and 21 October 2014, for Ward 16. We found based on the planned and actual numbers at the inspection that on 18 out of the 21 days, the ward did

not have the planned number of qualified staff for some, or part, of the day. Through the day, there was one nurse to five patients, which met the trust's target, but did not match best practice guidance from the RCN.

- Following the inspection the trust reported the planned number of staff through the day had been documented wrongly and we were provided with the correct information which was three qualified nurses on an Early shift and two qualified nurses on a late and night shift. The information the trust provided between the 1 and 21 October 2014 showed that on 13 occasions the ward did not have the planned number of qualified staff for some, or part, of the day. During this period of time on weekdays the senior sister who has been working in a supernumerary capacity was available to provide clinical care on Ward 16. There was one nurse to five patients, which met the trust's target, but did not match best practice guidance from the RCN.
- The children's assessment unit, based on Ward 16, comprised four short stay observation beds-and three assessment cubicles The planned number of staff, we were told, was two qualified nurses on each shift. We looked at the number of staff on duty between the 19 and 24 October 2014. We found that there was only one qualified nurse on duty on two shifts for all, or part, of the day. At the time of the inspection, the unit was quiet. However, the number of patients on the unit was unpredictable, as admissions from accident and emergency (AED) or GP referrals were received 24 hours a day.
- We also saw that, for the period between 25 October 2014 to 1 November 2014, there were five days where for some, or part, of the day there was only one qualified nurse planned to be working on the children's assessment unit. Following the inspection the trust told us in this time period there were only two shifts where there was only one member of qualified staff.
- Critically ill children were ventilated in the stabilisation room on Ward 16. They were cared for by staff from the wards who were not fully trained in caring for a ventilated child. This affected the staffing raios on the wards. Staff who have not been trained or are experienced at caring for a ventilated child puts critically ill children at risk of harm. There was no process in place that gave assurance of how many staff across the children's wards were suitably qualified, trained, experienced and competent to care for the deteriorating child, including care of a child on ventilation.
- We spoke with the head of nursing and both matrons and asked what specific training staff had received. They told us that ten staff had, and were, currently undertaking a high dependency course. When we asked if this would provide staff with the skills and competencies to care for a ventilated child, we were told that the course would not cover this.
- We were told by the senior nursing team that some staff had developed skills through experience and would normally be the nurses that covered the stabilisation room. When we asked if the service ensured that staff with experience of caring for children in the stabilisation room were always on duty we were told that the service did not do this. Nor were they able to articulate how many staff across the children's wards were confident and competent to care for children who were critically ill. This meant that the service had no mechanism in place to ensure that suitably skilled practitioners were able to care for children in the stabilisation room.
- Ward 17 is a 25 bed unit. The planned number of staff through the day was five qualified nurses and four qualified nurses on a night shift. We saw that the ward was generally achieving this. However, staff told us that, if Ward 2 or 16 were short staffed, staff were moved from Ward 17 to cover.
- The nurse to patient ratio on Ward 17 through the day was one nurse to five patients, which met the trust's target, but did not match best practice guidance from the RCN. On a night-time shift, the nurse to patient ratio was one nurse to six patients, which did not meet the trust's target, or best practice guidance. This was further increased if staff were moved to different areas.
- The senior management team told us that there had been investment into the nursing service a few years ago to increase the number of band 6 staff (sister level) so that there was senior nursing cover 24 hours a day, seven days a week. However, when we spoke with staff on all the wards, they told us there was not always a band 6 on duty.
- The senior management team also told us they recognised that, on the neonatal unit, they did not meet national recommendations for nurses who were "neonatal nurse qualified in specialty" (QIS) with a recognised neonatal course.
- Along with commissioners, the service had developed an action plan to rectify this. The initial completion date

had been identified as April 2015. However, the general manager told us that there had been some "slippage" in starting the action plan, so they anticipated the completion date would be moved.

- The trust were actively recruiting staff for the neonatal unit and new staff were being recruited on the basis that they would undertake the neonatal course.
- An advanced nurse practitioner (ANP) is a nurse who has undertaken further training so they are able to diagnose and treat healthcare needs, or refer to an appropriate specialist, if needed.
- The service had two advanced nurse practitioners. One was on the neonatal unit and one worked in the child assessment unit. A further two staff were being supported to undertake the advanced nurse practitioner course.
- During the unannounced visit, we saw a notice displayed in the staff area on Ward 17 that said that an extra member of staff was to be booked to cover all the children's wards, particularly the stabilisation room. When we asked staff about this, they told us that this had been talked about and was not yet in place.
- The head of nursing told us that the service routinely booked an additional registered nurse to cover the wards over the winter period and this was rostered into the rotas from November.
- Patients and relatives we spoke with told us how busy staff were. One person told us, "Staff really struggle, they are on the go all the time, but they manage really well." We also spoke to student nurses on the wards. They told us that staff were very supportive towards them and their learning, but they did express concerns about staffing levels on the wards.

Medical staffing

- There was an appropriate consultant, as well as middle grade and junior doctor cover for paediatric services. There were 12 general consultants who worked on the children's wards and on the neonatal unit they had six consultant neonatologists. There were eight consultants who covered the child development service and community paediatric service.
- There was a named paediatrician working as 'consultant of the week' to cover the children's wards. We were told by the clinical lead that, between September and March each year, there was an additional consultant who also covered the wards. During this time, the consultants had no other commitments other than to provide this cover.
- For paediatric services, there were two middle-grade rotas. One covered general paediatrics and the other was for the neonatal unit.
- Medical staff we spoke with reported good communication and handover of patients between staff. We were told that, and observed, medical staff attending board rounds as part of the multidisciplinary team periodically through the day.
- The ANP's were not currently on the medical rota, but they did support out-of-hours cover, particularly when new doctors started in February and August.

Major incident awareness and training

- We saw that information on business critical activity (October 2013) was available for Wards 2 and 16, including the stabilisation room, as well as Ward 17 in the event of an emergency. These included information on how many staff were required to ensure continuity of the service provision. For example, we saw that, for Wards 2, 16 and 17, the document stated that the minimum requirement needed to deliver the service was five qualified nurses and one healthcare assistant. However, this did not meet the staffing levels on the wards.
- Staff we spoke with were aware of the trust's major incident plan.

Are services for children and young people effective?

Good

The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. We found that policies based on NICE and Royal College guidelines were available to staff and accessible on the trust intranet site.

We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance through the specialty dashboards. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. All staff we talked with told us that they undertook mandatory training and received an annual appraisal.

Evidence-based care and treatment

Services for children and young people

- The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. We found that policies based on NICE and Royal College guidelines were available to staff and accessible on the trust intranet site.
- Clinical care pathways had been developed to support staff in delivering evidence-based care to children and young people. We saw a clinical guideline for acute wheeze and asthma, which identified symptoms that would classify the attack as 'life threatening', 'severe', 'moderate' and 'mild'.
- There were specific symptoms and indicators identified on the guideline to support staff in identifying how severe the attack was. For example, we saw that, on the documentation, it stated observation ranges to help staff classify the severity.
- Initiatives, such as the UNICEF Baby Friendly Initiative were in operation. The UK Baby Friendly Initiative was based on a global accreditation programme developed by UNICEF and the World Health Organization. It was designed to support breastfeeding and parent/infant relationships, by working with public services to improve standards of care.

Pain relief

- Children and young people had access to a range of pain relief should it be required, including oral analgesics and patient-controlled analgesics.
- In the records we reviewed, there was no pain assessment tools used. Pain assessment tools enabled nurses to assess the level of pain the patient was reporting and the effectiveness of any analgesia given to relieve the pain. This meant that it was not clear how staff assessed and monitored a patient's pain.
- During our visit, staff told us that they used to have pain assessment tools in the care records, but they did not know when or why these had stopped being used.

Nutrition and hydration

- We saw that a child's or young person's nutrition and hydration were assessed and recorded in their records.
- Specialist dietician support was available when required. Staff told us that they would like to develop specialist clinics to support patients. For example, with weight management, allergies and coeliac clinics. However, they felt that they were unable to do this, due to capacity within the service.
- We found that there were no individual fasting times for children and young people. Staff on Ward 2 told us there had been occasions when children had been fasting all day waiting for theatre, which had then been cancelled. The patient then had to fast again the following day for theatre. The RCN 2003 guidance stipulated that, for preoperative fasting, a minimum fasting time was six hours for solid food and formula milk, breast milk for four hours and clear fluid (water) for two hours. This meant that the services were not following best practice guidance on fasting times for children and young people.
- When we visited Ward 2, we spoke to the parent of a two-year-old child who was visibly upset. The parent explained that their child was upset because they were hungry and did not understand why they had not had any food. They also told us that a much older child had been taken down to theatre for a procedure under local anaesthetic before their child. The parent expressed that they did not understand this and no explanation had been given to them.

Patient outcomes

- We reviewed information that showed that the service participated in national audits, which monitored patient outcomes. For example, we found that the service had participated in the British Thoracic Society Paediatric Wheeze/Asthma Audit Report 2012. We saw that the results showed that, at the trust, a written asthma plan was given to 90% of patients compared to 53% of patients nationally.
- We saw that information in the specialty dashboards showed that the service monitored performance and patient outcomes. For example, the women's and children's directorate monitored breastfeeding rates, retinopathy of prematurity screening and the asthma wheezy child pathway. Data showed that, from April 2014, the service had met the required targets.
- Hospital episode statistics (HES) 2013, showed that there was a higher than average emergency readmission rate following elective general surgery for patients aged between one and 17 years old. Following the inspection the trust told us the data for 2013-14 there had been one readmission against an expected 0.40 which gives a standardisation readmission ratio of 249.51.
- We saw that the service regularly held morbidity and mortality meetings. The purpose of these meetings was to review specific cases to identify any learning about

clinical care. Staff from the trust also attended the Safeguarding Board's child death overview panel (CDOP), which led, and completed, multiagency evaluations of all child deaths in the area.

Competent staff

- There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. All staff we talked with told us that they undertook mandatory training and received an annual appraisal.
- Appraisal rates for paediatric services in August 2014, averaged at 58%. This ranged from 0% of staff in the Paediatric specialist team who had been appraised to 83.33% on ward 17. The other children's services were between this range.
- Nursing staff told us that they had access to safeguarding supervision, but not regular clinical supervision.
- At the junior doctor's forum, staff told us that the children's wards had a range of diverse patients, which was great for experience and learning.

Multidisciplinary working

- Staff we spoke with gave positive examples of multidisciplinary working. We were told that the paediatricians and nursing teams, along with other allied healthcare professionals – such as dieticians, occupational therapists and physiotherapists – worked closely together.
- Within the health transition nursing team we saw positive examples of multiagency and multidisciplinary working to support children and young people. We spoke with one parent who told us the nurse was key in supporting them with different services and professionals.
- In the child development service, there were examples of how the medical team worked closely with other professionals. For example, the consultants had a joint epilepsy clinic with a consultant from the regional unit. These were examples of how the service worked with others to meet the needs of children and young people.

Seven-day services

- On the paediatric unit, there was consultant cover on site out of hours and at the weekend. The last ward round on the paediatric wards with a consultant was at 9pm through the week. There were 2-3 ward rounds on a weekend with a consultant. Staff told us that consultants would come in to review patients out of hours and there were two or three ward rounds at a weekend.
- The children's wards had access to diagnostic services, such as the x-ray department and laboratory during the weekend.
- Pharmacy services were available seven days a week, although there were limited operating hours on a weekend.
- However, staff on Ward 2 told us that there were sometimes delays in discharges and patient reviews from the surgical teams, particularly out of hours.

Access to information

- Staff reported that they had access to information for each patient, which included medical and nursing records and results from any investigations.

Consent

- Staff were aware of Gillick competencies used for deciding whether a child is mature enough to make decisions and give consent. These guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice, or treatment to young people and children under 16 years old without parental consent. Since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
- Patients and relatives told us that they felt they were aware of the risks of any planned procedures, or operations, and staff had explained these fully to them.

Are services for children and young people caring?

Good

As part of our inspection, we observed care on the children's wards, in patients' homes, clinic settings and we observed staff speaking to patients and relatives on the telephone.

Services for children and young people

Throughout our inspection, we saw that patients and relatives were treated with dignity, respect and compassion. Most of the patients and relatives we spoke with all indicated how involved and supported they were made to feel by staff within the services.

Compassionate care

- As part of our inspection, we observed care on the children's wards, in patients' homes, clinic settings and observed staff speaking to patients and relatives on the telephone.
- In order to gain an understanding of people's experiences of care, we talked to 21 patients and their relatives who used services in the children's and young people's services.
- Throughout our inspection, we saw that patients and relatives were treated with dignity, respect and compassion. One relative said, "The staff have been very supportive to me emotionally." Another person stated that the, "Nursing care is good. Staff listened to concerns and acted on them."
- A small number of people expressed some concerns about their care and treatment. Two relatives of one patient told us that they found "some staff were rude and insensitive".
- Children's services did not participate in the NHS Friends and Family Test as this was due to be rolled out to children's services in 2015.
- We saw that the service gained feedback from patients and relatives through the 'Tell us what you think' leaflet; Comments from these were displayed in the entrance to the wards. One comment stated, "I would just like to say what a wonderful team of staff, including doctors and nurses work on this ward. I have never experienced in any other ward such care, compassion, thought and consideration."
- Another comment had been written by a patient. It stated, "I like coming to the ward because the staff are very friendly and nice. They support me in getting my health better. Thank you."
- One patient, who was 11 years old, told us, "The nurses are really nice and explain everything to me."

Understanding and involvement of patients and those close to them

- Most of the patients and relatives we spoke with all indicated how involved and supported they felt by staff within the services. However, one family told us staff did not always communicate with them and they did not always feel fully involve in their child's care.
- We observed staff explaining care and offering support and guidance to parents.

Emotional support

- Generally patients and relatives we spoke with felt supported by the staff within the children's services.
- Within the neonatal unit, there was a bereavement support group, which included staff from the unit, parents, chaplaincy staff and other voluntary agencies to support parents who had been bereaved.
- The service had a range of specialist nurses to provide support to patients and relatives. One relative, who was supported by a specialist nurse, told us, when the nurse became involved in their child's care "they were a godsend" as they supported the family in working with other professionals and specialities to meet their child's needs.
- Staff told us that, if a child or young person needed specialist mental health input, they could refer the patient to child and adolescent mental health services, which were provided by another trust.

Are services for children and young people responsive?

Requires improvement

There were no specific surgical lists for children and young people. The senior management team told us that children were usually prioritised at the beginning of lists. However, staff on the ward told us that this was not always the case, particularly in some specialties.

We found that the dependency acuity tool was not embedded in practice and there was no written guidance or protocols to support staff while assessing a patient's acuity.

Service planning and delivery to meet the needs of local people

- We had been told by the Chief Executive that there were plans for the paediatric wards to move into the new

building when it had been completed. The senior management team in the women and children's directorate told us that this meant they could reconfigure the surgical ward particularly so there would be a separate day case unit.
- However, when we spoke with staff, they were aware of the new build and potential plans for paediatric services, but they were less certain of when, or if, this was going to take place.
- There were specialist services to support children and young people. This included a health transition nursing team, the child development service and community paediatric team to support children and young people with long-term conditions and a rheumatology specialist nurse.
- During the winter months, an additional nurse and a second consultant on call were rostered on duty to meet the additional capacity demands over this period.
- Bed meetings had been introduced across the hospital to monitor bed availability in the hospital, review planned discharge information and future bed availability.

Access and flow

- There were no specific surgical lists for children and young people. The senior management team told us that children were usually prioritised at the beginning of lists. However, staff on the ward told us that this was not always the case, particularly in some specialties for example, in plastics where children often fasted all day for theatre.
- We saw, information from September 2014 for paediatric services that the RTTs for admitted and non-admitted pathways were consistently above 90%, with the exception of paediatric ophthalmology, which had fallen to 62.5% for admitted pathways.
- Staff were able to refer to Child and Adolescent Mental Health services (CAMHS) if required.

Meeting people's individual needs

- The head of nursing told us that staff used a red, amber and green (RAG) system to identify the level of dependency and acuity of patients on the wards. During the announced inspection, no staff we spoke with told us of this system. When we visited the children's wards during the unannounced inspection, staff on the children's medical wards told us the categories for the children on the ward using the system. When we asked staff how they defined, for example, what a red patient was, they described it as being through experience, rather than guidance as to how they would allocate a category to patients.
- We found that there was no local written guidance on the different levels of dependency, this meant that the levels were open to interpretation by different staff and there was no guidance in place for less experienced staff. Staff on Ward 2 told us they did not use the categories, as there were no specific descriptions of the levels, so they did not find it beneficial.
- There was a health transition team in place to support children and young people with complex needs. However, we were told that the funding for the team was only available until March 2015 and the sustainability of the service was unclear.
- Within the health transition team there were excellent examples of individual care planning to meet the needs of young people with complex needs through the Health Passport. A Health passport is a unique individual health care record which is designed to be a record of the person's health, it also contains information which is important to the child or young person and supports professionals in caring for them the way in which they prefer.
- There was a range of information leaflets available about various treatments, as well as other care available within the hospital. We saw that the majority of leaflets available were written in English. Members of staff explained that they could get leaflets interpreted when this was required.
- Translation services were available; staff had access to a 24-hour language line to support people where English wasn't their first language. In the children's outpatients department, we saw that there was information for patients to point to and identify which language they spoke so staff were able to access the right interpreter.
- We saw that the children's wards did not have specific areas designated for adolescents. Staff told us that young people would be given a choice from ages 14 to 15 years as to whether they would prefer to be admitted onto an adult, or children's ward. We were unable to confirm this during the inspection, as there were no young people in this category to ask.
- On Ward 2, we had serious concerns that there was no bathing facility for patients on the ward. The one bathroom there was had been converted to a waiting room. There was one shower on the ward in the ladies

toilet area. Staff told us that, if a male patient or a male relative wanted a shower, they had to check the area to make sure there were no women in the toilet area. This meant that there was the potential that privacy and dignity could not always be maintained.

- On Ward 2, in the nursing care plans, we saw that, for the removal of a urinary catheter in a child or young person, this had to be done while the patient was in a bath. We asked staff how they managed this and they told us they had to take the patient to either Ward 16 or 17, which were on different floors. The bathing facilities on Ward 2 were not adequate to meet the needs of children and young people.
- We found that there was room to play on all the wards we visited. We found that, on the first day of our inspection, the play room on Ward 2 was locked. Staff told us that the room was locked when there was no play leader to supervise children. This meant that, in the evening and over the weekend, children could not access the play room and so there was a risk that their social and play needs were not being met.
- We saw, and staff told us, that they had a wide range of equipment to be able to assist them in providing care for children. We also saw that all equipment was tested and serviced by the hospital's medical physics department.
- In the children's outpatients department, we were told that there was a designated specific waiting area for young people. The senior nurse told us that iPads had been bought for young people to use while they were waiting to be seen.

Learning from complaints and concerns

- The children's services followed the trust's NHS complaints processes. There was complaints information available within the areas we visited**.** Staff told us that they knew how to manage complaints locally and how to escalate where appropriate.
- We found that, in some areas, staff were able to give examples of improvements that had been made as a result of complaints. However, in other areas, staff were unable to give examples of lessons learned.
- We asked the service to provide information on themes and trends of complaints within children's services, but the trust has not provided us with this information.

Are services for children and young people well-led?

Requires improvement

The trust's strategy and vision were not well-embedded across children's services. There was uncertainty about the changes to the paediatric wards if they moved into the new build. Staff were unclear as to whether or not the changes were 'rumours', or actually planned changes.

Staff felt well supported by the ward managers and the senior management team within the directorate. We found that there was a culture of openness among all the staff and teams we met.

Current staffing ratios were based on one nurse to five patients and this applied to all age ranges. However, these did not follow the RCN staffing standards which provided an indicative baseline ratio of registered nurses to children and young people, which took into account the distinct care requirements linked to age and development. When we asked for the rationale for the staffing levels on the children's wards, the senior managers were unable to give us a clear response to the rationale for the staffing levels other than to tell us that they would be able to deliver the one to five staff to patient ratio within the current budget.

We had serious concerns over the arrangements for the stabilisation room on Ward 16. We found that staff from the wards were left for periods of time caring for critically ill children while waiting for the paediatric retrieval team to transport them to the regional paediatric intensive care unit. From the serious incident that had occurred, we found that no learning, or changes had been made to the arrangements for caring for critically ill children in the stabilisation room.

Vision and strategy for this service

- The trust's strategy and vision was not well-embedded across children's services. There was uncertainty about the changes to the paediatric wards if they moved into the new build. Staff were unclear as to whether or not the changes were 'rumours', or actually planned changes.

- Staff told us they had been originally involved in discussions about the potential future changes, but they had not heard anything about these changes for the last 12 to 18 months.

Governance, risk management and quality measurement

- We reviewed the service risk register and found the concerns regarding the stabilisation room had not be identified as a risk on the register. We found the facilities on Ward 2 regarding the lack of a bathroom had been identified with mitigating actions in the long term which related to the business case. However, short and medium term actions had not been identified to address the lack of facilities.
- We had serious concerns over the arrangements for the stabilisation room on ward 16. We found staff from the wards were left for periods of time caring for critically ill children while waiting for the paediatric retrieval team to transport them to the regional paediatric intensive care unit. The majority of staff we spoke with told us they had not received specific training to care for such ill children. Staff also expressed concern that they had not received any specific training to check the equipment, for example, the ventilator.
- We found the service did not have systems in place to ensure staff with training or experience of the stabilisation room were always on duty. This meant if a child required intensive support there was not always staff who were confident or competent to care for them.
- The service had been involved in two serious incidents, both had been investigated, one had been investigated by the trust and another by the paediatric retrieval team's organisation. We reviewed both of these incidents. The one investigated by the external organisation related to the care of a child in the stabilisation room. We asked the head of nursing if any of the recommendations related to the children's services. They told us none of them did.
- However, when we reviewed the report, we found that there was one recommendation that related to the trust. The recommendation stated that, "The trust is to consider if there is to be a significant delay in the transfer [of a patient], are current arrangements for managing very sick children at the Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) adequate?"
- The action plan specified that BTHFT should review the arrangements for very sick children with a completion date of 1 October 2014. We found that, during the inspection, no changes had been made to the arrangements for caring for critically ill children in the stabilisation room. From the information reviewed, we saw that this incident had occurred in November 2013, which meant that the trust had not demonstrated they had learned from the incident or implemented any changes to prevent a similar occurrence from happening again.
- We saw that the service held monthly child and neonatal group meetings, where performance was reviewed and clinical governance and risk and reports were discussed.
- We saw that, in the meetings held on the 18 June 2014, there was information about ongoing work around clinic capacity and templates, with further work to be completed. The backlog of rescheduling from earlier in the year had now been resolved. Specific information about clinic backlogs was requested by the Care Quality Commission (CQC), but the trust did not supply this information. Therefore, we were unable to confirm whether or not there were any backlogs at the time of inspection.

Leadership of service

- Staff told us that there had been frequent changes in the management of the trust over the last two years. Staff said that they felt well supported by the ward managers and the senior management team within the directorate.
- Staff reported that the senior management team and the Trust Board were visible. Directors had made regular visits to clinical areas.
- The chief nurse was the executive board lead for safeguarding children, but we could not establish if children had a formal board level non-executive director to promote children's rights and views, as required by the National Service Framework for Children, Young People and Maternity Services' standard for hospital services.
- We saw that, in the annual NHS Staff Survey 2013, 21% of staff felt that there was good communication between senior managers and staff. This was compared to a trust score of 25% and a national average for acute trusts of 34%.

Culture within the service

- We found that there was a culture of openness among all the staff and teams we met. Staff spoke positively about the services they provided to children and young people.
- We observed staff working well together and there were positive relationships within the multidisciplinary team.

Public and staff engagement

- We saw that the trust had developed a patient and public experience strategy for 2015 to 2018. We saw that, within the children's outpatients department in July 2014, an audit had been undertaken of people's experiences while visiting the outpatients department. For example, we saw that 91% of people who responded were happy with the length of their clinic appointment.
- Within neonatal services, the lead clinician told us that parents' groups had been involved in the design and layout of the unit. For example, the parents' group had specified the colour schemes throughout the unit, which included feature walls.
- Within ward areas, patient and relative feedback was gained through the 'Tell us what you think' leaflet that we saw was displayed on the wall at the entrance to the wards. The comments we saw were all positive.
- We also saw that 100% of people who responded said they would recommend the outpatients department to family and friends.

Innovation, improvement and sustainability

- Within the neonatal unit, staff told us they used innovative care practices to improve outcomes for patients on the unit. For example, the use of probiotics to reduce mortality and brain cooling with neonates. Probiotics **are live bacteria and yeasts which are thought to have various health benefits, including preventing and treating a range of conditions.**
- Within the children's wards, the service was collecting information on children and young people and how intensive the clinical support was that they required. The service was using this to determine whether a high dependency unit was required.
- Within the children's outpatients department, they were looking at making improvements to the layout to improve wheelchair accessibility and a teenage zone with iPads for young people to use while they waited. One person who responded to the outpatient's service stated, "When you get here it doesn't feel like a hospital, that's the best thing."

End of life care

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

Information about the service

End of life care (EOL) services were provided across the hospital. The hospital specialist palliative care team (HSPCT) had a clinical and educational role within Bradford Teaching Hospitals NHS Foundation Trust. The service offered by the team was an advisory one, in which patients remained under the care of the referring medical team. There were also two community palliative care teams (from another NHS trust) and local hospices in the city with whom the team worked closely.

As part of this inspection, we visited medical and surgical wards, the oncology and the chemotherapy units. We looked specifically at end of life care and reviewed the medical and nursing records of 14 patients. We observed care being delivered on the wards and spoke with 10 patients. We also visited the bereavement service, chaplaincy and mortuary. We spoke with 25 staff, including the HSPCT, nurses, doctors, managers and we reviewed the trust's end of life performance data.

Summary of findings

Overall, the rating for end of life services was good. We found some areas of excellent practice in how the service responded to the patients' individual needs. However, we found that improvements were required with regard to ensuring facilities in cases of bereavement were effective, such as the chaplaincy and the mortuary services. The facilities were currently insufficient and limited to meeting the demands of each service. There was insufficient physical space in all areas and a lack of facilities to meet the spiritual and cultural needs of different faiths.

We found that patients received care in line with evidence-based guidelines, national standards, and protocols. Staff were caring and motivated. Evidence showed that patients approaching the end of life were identified appropriately and care was delivered according to their personal care plan, including effective pain relief and other symptoms, which were regularly reviewed.

There were effective governance and risk management systems to support the delivery of good quality care. The leadership and culture encouraged openness and transparency.

End of life care

Are end of life care services safe?

Good

There were processes in place to ensure action was taken as a result of incidents or when things went wrong. There were appropriate systems to protect patients against the risks associated with the unsafe use and management of medicines. Clinical records showed action plans were present to meet patient needs and that their choice of care had been discussed and their personal preferences recorded.

Standards for the care of patients in the last days and hours of life were in place. These took into account recommendations from national guidance and best practice. There was evidence of good care provided by nursing staff working across the trust, supported by high levels of specialist palliative care input from qualified and skilled nurses and doctors.

Incidents

- Staff were aware of the process for investigating when things had gone wrong. We found staff were familiar with the process for reporting incidents, near misses and accidents and were encouraged to do so.
- Members of the HSPCT said the team did not always receive feedback from incidents submitted concerning end of life care involving other specialties. For example, the palliative care consultant had submitted an incident that involved poor communication by ward staff, but had not received a response about the outcome.
- Meeting minutes showed action points from incidents were discussed in the palliative care team governance meetings and changes were implemented. For example, changes had been made to the do not attempt cardio-pulmonary resuscitation (DNA CPR) decision forms.
- We saw action plans and learning relating to end of life care following incidents in other areas. For example, action had been taken by staff on Ward 15 to improve monitoring of deteriorating patients and ensure timely reviews by medical staff before discharge.

Cleanliness, infection control and hygiene

- We saw good practice with hand hygiene from the HSPCT staff, when caring for patients. Staff followed the hospital policies on the prevention of infection and control.
- Infection control processes were followed within the mortuary. Records showed that weekly cleaning checks were completed and temperatures fridges checked daily. Arrangements were in place for dealing with the deceased, particularly where there was a known risk of infection.

Equipment

- We observed that the mortuary had a roof-mounted hoist fitted. However, this no longer worked and there was limited evidence as to the actions taken to provide equipment to minimise risks to employees. This did not comply with The Manual Handling Operations Regulations 1992, which required employers to eliminate manual handling operations wherever possible. We spoke with the pathology manager about these concerns, who said these would be acted upon promptly.

Facilities

- We found a room, that had previously been a post-mortem room, in a poor state of repair and not adequately clean. Part of the room was now utilised for the storage of a number of tissue samples kept within dedicated storage cabinets. These cabinets were stored in a room, which would be classified as a “dirty area” and should be stored in a “clean” area.
- The viewing room and entrance for relatives was old and tired in terms of appearance and décor. The viewing room had large windows with obscured glass but there were no blinds fitted. The technician told us bright sun shone directly onto the viewing table. The technician told us he had recently added some soft furnishings to improve the waiting area.

Medicines

- There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines.
- The medical team caring for the patient were responsible for prescribing any recommendations, or alternations to medication. Where medical staff were not available, the palliative care team prescribed medicines to improve symptom management.

End of life care

- The palliative clinical nurse specialists were all independent nurse prescribers. They had access to an independent prescriber's forum and regularly audited their practice in line with the trust's non-medical prescribing policy.
- Anticipatory end of life care medication was prescribed appropriately. We reviewed medication administration records in a number of areas we visited and saw appropriate prescribing.
- Syringe pumps were stored securely and there was consistent availability of pumps across the trust. All wards had their own universal key for the locked boxes. Pumps could be accessed 24 hours a day.

Records

- Clinical records showed action plans were present to meet patient needs and choice of care had been discussed and personal preferences recorded.
- Risk assessments relating to pressure care, mobility and nutrition were reviewed on a regular basis and completed accurately.
- The preferred place of death was clearly recorded and daily reviews of care were completed.

Safeguarding

- Staff had a good understanding of the need to ensure vulnerable people were safeguarded and understood their responsibilities for identifying and reporting any concerns.
- The HSPCT were working with the coroner and legal team to review the revised legislation relating to Deprivation of Liberty Safeguards and its application to end of life care, and were providing feedback and recommendations to the national end of life network.

Mandatory training

- The HSPCT had produced an education and training programme to deliver all aspects of palliative and end of life care training. End of life training was not seen as mandatory training by the trust.
- Ward staff said they received end of life care training and support, which was provided by the specialist palliative care team. Figures from January through to October 2014 showed the uptake for training was between 60% to 85%.
- Chaplaincy volunteers received three days of training, which included dementia awareness.
- The chaplains told us that the training they received was good. However, they did not receive continual professional development.

Assessing and responding to patient risk

- Standards for the care of patients in the last days and hours of life were in place. These took into account National Institute for Health and Care Excellence (NICE) quality standards and recommendations from the national Leadership Alliance for the Care of Dying People and its priorities for care.
- Clinical records showed patients at the end of life were assessed for problems relating to pain and symptom management, nutrition and hydration and pressure area care. The multidisciplinary teams referred to the HSPCT where appropriate. For example, when patients exhibited any uncontrolled symptoms or psychological needs that the normal caring team required support with.

Nursing staffing

- The HSPCT included four Macmillan palliative care nurse specialists, a care of the dying educator, an ethnic liaison worker (shared with the Marie Curie Hospice and Bradford District Care Trust) and a medical secretary.
- We observed a handover of palliative care patients. The handover was well structured, holistic and multidisciplinary. All aspects of care were discussed appropriately, with referrals made to fast-track discharge, psychological and spiritual care.

Medical staffing

- Consultants in palliative medicine rotated their posts across the hospital, hospice and the community every two to four years to promote integrated working.
- There was a consultant in palliative medicine who provided six sessions per week. There was also a specialist registrar.
- A 24-hour telephone advice service was available from the on-call palliative medicine consultant in the district who could be contacted through the two local hospices.
- Good teamwork was evident during the medical handover, with appropriate follow-up and coordination of patient care.

Major incident awareness and training

- There were escalation processes in place to activate plans during a major incident. The trust had major

incident action cards to support the emergency planning and preparedness policy. This included the provision of spiritual and pastoral care and the setting up of a temporary public mortuary to deal with any surges in demand.

Are end of life care services effective?

Good

The effectiveness of facilities in the mortuary were currently insufficient and limited to meet the demands of each service. There was insufficient space in all areas.

End of life services used national, evidence-based guidelines to determine the care and treatment they provided and the service participated in national and local clinical audits. Information about patient outcomes were routinely monitored and action taken to make improvements.

There was effective multidisciplinary working between teams and services involved in assessing, planning and delivering patient care and treatment. Patients and their carers were involved in decisions, which included discussions about nutrition and hydration, preferred place of death and do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions.

Evidence showed that patients approaching the end of life were identified appropriately and care was delivered according to their personal care plan, including effective pain relief and other symptoms, which were regularly reviewed.

Evidence-based care and treatment

- Individual roles and responsibilities were understood by staff in the delivery of evidence-based care. This included involvement in the development of policies and procedures, and in the assessment and monitoring of the quality of care provided to people requiring end of life care. For example, a policy containing the core standards for the last days of life was being developed in the trust.
- Care pathways demonstrated they had referred to NICE guidelines and the Gold Standards Framework (GSF) for end of life care to ensure patients were appropriately assessed and supported with their end of life needs.
- The service was actively involved in national and local audits. This included the preferred place of death audit, an iterative audit of current practice in the care of the dying patient and care of patients at the end of life in A&E. Records showed that recommendations and actions had been taken in areas such as symptom management, increased awareness of advance care planning and improved documentation.
- The trust had implemented the 'AMBER care bundle' system (Assessment Management Best practice Engagement Recovery uncertain) on medical wards. This is an alert system to identify patients who were not responding to current treatment., This system provided a systematic approach to managing the care of hospital patients who were facing an uncertain recovery and who were at risk of dying in the next one to two months. The care bundle was being rolled out to surgical wards.
- The trust had withdrawn the Liverpool Care Pathway in line with national guidance. As an interim measure, all adult wards had been advised to follow a 'Ten Key Elements of Care for the Dying Patient' and action plans were in place to ensure all decisions and care was clearly recorded in the care plans and medical notes.
- The HSPCT was in the process of developing individualised medical and nursing care plans for the last days and hours of life. A pilot of the new care plans had been completed in October 2014 on the elderly medical ward. The care plans were being evaluated and amendments made as required. Following a second phase pilot the launch of the documentation across the trust was anticipated in January 2015.
- A mnemonic had been devised as an aide memoire for clinical staff to embed the five priority areas at end of life care recommended by the national Leadership Alliance for the Care of Dying People, One Chance to get it Right policy document. This was being piloted alongside the revised care plans to achieve good care in the last days and hours of life.

Pain relief

- New symptom management guidance had been agreed across the locality groups, which covered key symptoms in the last days of life and key prescribing points, such as anticipatory or 'ahead of time', as required, medication. The guidance was available on all wards and electronically.

End of life care

- During our visit to the wards with the HSPCT, we observed patients at the end of life were receiving appropriate pain relief. Patients we spoke with confirmed their pain was well managed.
- A trust audit of prescribing practice in 2014 showed two out of 11 (18%) delays in patients receiving medication prescribed via a syringe driver within the recommended time of two hours from prescription. This had improved from 2010 when the figure was 38%.

Nutrition and hydration

- Patients were supported to eat and drink for as long as they were able to.
- Nutrition and hydration assessments were completed for all appropriate patients. These assessments were detailed and used nationally recognised nutritional screening tools.
- The National Care of the Dying Audit for Hospitals (NCDAH) 2013 showed the trust achieved a higher than average percentage for reviews of patients' nutrition and hydration (70% against 48% nationally). This included an assessment of the patient's ability to take oral hydration, and an assessment regarding a patient's need for clinically assisted (artificial) hydration.

Patient outcomes

- The NCDAH showed the trust had achieved four of the seven organisational key performance indicators. All clinical indicators were higher than the national average.
- There had been a significant reduction in the number of patents with non-cancer diagnosis who died in hospital.
- The average length of stay in hospital for patients at the end of life was between four to five days.
- The main reason for referral to the HSPCT related to pain and symptom control, general assessment and assessment for hospice admission.

Competent staff

- The palliative care clinical nurse specialists were all trained in specialist palliative care nursing and had obtained advanced qualifications in this area. There was a high level of expertise and good understanding of caring for patients at the end of life within the team.
- There was good access to continuous professional development and all staff in the palliative care team had received an appraisal. Revalidation for medical staff had also been completed.
- Ward staff shadowed the HSPCT. This involved 16 staff during 2013/2014, which included medical and nursing staff from the trust and across the region.
- Learning needs analysis was undertaken to identify any gaps in learning for end of life care. A half day end of life communication skills workshop series was delivered to senior clinicians (ST3 and above and band 6 and above). The sessions were undertaken in the simulation centre and included workshops about difficult conversations at the end of life with patients and their families. Staff feedback from the sessions was very positive.
- We observed a junior doctor using the end of life resource pack on the ward and informal teaching in symptom control provided by the palliative care specialist doctor.

Multidisciplinary working

- There was effective multidisciplinary team working between the HSPCT care team and other specialties. The HSPCT included a psychologist and ethnic liaison worker.
- The team aimed to attend weekly cancer site-specific multidisciplinary team meetings as well as oncology, haematology and medical ward rounds on a weekly basis. They also attended 'grand rounds' to facilitate education to a larger audience.
- As part of the specialist palliative care peer review the team worked with providers across the locality to develop "locality specialist palliative care multidisciplinary team meetings". The locality teams enabled patients and carers with complex needs to be discussed by a broader team. The multidisciplinary team consisted of all consultants in palliative care, nurse specialists from the community and hospital, day hospice and hospice inpatients, social work and rehabilitation services. The team also co-opted staff from the chaplaincy service and acute pain management team.

Seven-day services

- The HSPCT was available Monday to Friday between 8am and 4:30pm. However, the service was not meeting the national recommendation of providing face-to-face specialist palliative care seven days a week, which would require further investment. This had been recognised by the trust and work was ongoing in this area.

End of life care

- There was 24-hour telephone advice service available from the on-call palliative medicine consultant in the district who could be contacted through the two local hospices.

Access to information

- All specialist palliative care services, GP and district nursing services used an electronic tool, which formed an electronic palliative care coordination system (EPaCCS). This enabled service providers across care boundaries to share information about patients nearing the end of their life, helping to improve care delivery and co-ordination.
- The systems enabled all individual patients and carers' information and communication needs to be identified ensuring continuity of care when patients transferred between different settings.
- A system had recently been introduced to inform GPs of a patient's death within a timely way.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We observed effective communication by staff with patients, which was delivered in an honest and open manner. Patients and their carers were involved in decisions about their care and treatment. This included discussions about nutrition and hydration, preferred place of death and do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions.
- There was a joint DNA CPR policy in place, developed and agreed by a multiagency working group. The policy included a framework for making decisions around resuscitation and guidelines for conversations with patients and families. We reviewed a sample of DNA CPR decision forms on wards and in the community. We found decisions had been documented, which included the circumstances surrounding the decision together with who was involved in the decision-making process.

· We did not observe patients without capacity to consent during our inspection of ED. However, we saw that do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were available for use in the resuscitation area and staff demonstrated they were familiar with these.

- The NCDAH showed discussions held with the patient or their relative, friend or independent mental capacity advocate regarding DNA CPR decisions was higher than the national average.
- Patients were offered written summaries of their individual consultations.
- Where patients were unable to make decisions about their treatment, records showed assessments of the person's mental capacity and best interests had been taken, which followed the principles of the Mental Capacity Act 2005.
- The Human Tissue Authority (HTA) inspected Bradford Royal Infirmary in 2012. The report identified major concerns that consent was not being obtained for the retention of tissue in accordance with the requirement of the Human Tissue Act 2004 and as set out in the related code of practice. We reviewed the trust's actions plans and saw evidence that corrective actions had been taken and the shortfalls had been addressed. This included revised standard operating procedures (SOP), describing audit and inventory of retained wet tissues and blocks/slides and revised guidance regarding tissue disposal. The adult consent form for post-mortem examination had been revised to include tissues (blocks/slides) as well as whole organs and the adult post-mortem information booklet was amended to reflect this, with a section added describing the role of the HTA.

Are end of life care services caring?

Good

End of life care services were caring. Patients and relatives told us they were well supported by staff and received a good standard of care. We observed high levels of compassionate and holistic care being provided to patients by the HSPCT and ward staff. Staff were aware of the emotional aspects of care for people with end of life care needs and ensured specialist support was provided for patients, where needed.

Compassionate care

- We observed a high standard of empathy and holistic care being provided by the HSPCT and ward staff to patients at the end of life. Staff took time to interact with patients and showed a sensitive and supportive attitude.
- Patients told us they had received a good standard of care from clinical staff and that staff responded to their needs in a timely and appropriate way.

End of life care

- The trust did not participate in the bereaved relatives' survey, which was an optional part of the NCDAH 2013. The trust had developed a survey for this purpose and a six-month pilot had commenced in July 2014.
- Staff told us that side rooms were usually provided for people who were at the end of their lives. However, we observed two cases where patients were cared for in main ward areas because a side room was not available. Single rooms were available in the chemotherapy unit for patients who were immune suppressed (and therefore vulnerable to infection). There was also a dedicated viewing room in the A&E, which contained religious books and resources.
- Although most wards did not have dedicated family rooms, staff tried to use an office or other room to conduct sensitive conversations.

Understanding and involvement of patients and those close to them

- Patients and relatives indicated they were involved in care decisions. Staff appropriately identified patients approaching the end of life and patients were offered, and given, the opportunity for end of life care planning, including their preferred place of death. The NCDAH showed that communication regarding the patients plan for care for the dying phase was 82% compared to 57% nationally.
- Staff provided patients with information on how to contact the specialist palliative care team and where to obtain additional support and information. There was information available for patients from ethnic minorities. For example, there was an Islam and Chronic Pain information leaflet for Muslim patients.
- NCDAH results showed that 70% of relatives were given written information following the death of the patient compared to 45% nationally.
- Easy-to-read guides were available for patients and their families in areas such as What happens if my heart stops and Living with Dying.

Emotional support

- The trust bereavement policy provided clear guidance to ensure patients received appropriate care after death. Care after death forms were completed for all patients by ward staff. These included guidance for the timely transfer from hospital in order to meet patients' cultural and religious needs, both in and out of hours.
- The trust had a dedicated multifaith chaplaincy service, which was supported by 70 chaplaincy volunteers. A duty chaplain was available during working hours and Christian and Muslim chaplains were on call 24 hours a day. Other faith cover was subject to local availability. During January to September 2014 there had been 24,134 patient, relative and staff contacts made by the chaplaincy service.
- The HSPCT worked closely with the chaplaincy service, particularly in areas such as DNA CPR consenting and withdrawal of treatment decisions.
- A comprehensive Faith Requirements Resource Pack had been developed to provide guidance for staff on the spiritual and pastoral needs of patients practising different faiths. This included information on bereavement processes and care after death.
- Access was available to a psychologist and social worker, who provided pre- and post-bereavement support.

Are end of life care services responsive?

Requires Improvement 

End of life services were very responsive on a person to person level. The service effectively planned, designed and delivered services to meet the needs of a diverse population. There were systems in place to respond to changes in local and national guidance which ensured flexibility, choice and continuity of care.

The service took account of, and understood, the needs of people, including their individual preferences, spiritual, ethnic and cultural needs. There were excellent examples of staff ensuring the needs of patients with complex conditions , were understood and taken into account. Staff facilitated patient access to end of life care. There were processes in place to ensure patients had timely access to initial assessment, diagnosis and treatment.

Systems were in place to encourage patients and those close to them to provide feedback about their care. However, facilities were inadequate for the provision of spiritual support. The multi-faith facilities were too small to meet the needs of the patients, relatives, staff and visitors who used them. The chaplaincy service was severely challenged in meeting the needs of large numbers of people accessing their services.

End of life care

Service planning and delivery to meet the needs of local people

- The trust was using the framework The route to success in end of life care – achieving quality in acute hospitals (2010) to develop and pilot a Last Year of Life Project. Beginning the pilot in acute medical wards, the project aimed to improve the recognition and care of patients identified as being at their last year of life. Four work-streams with multidisciplinary team involvement had implemented and evaluated the identification of patients in their last year of life: the discharge pathways, recordings, accessing and sharing information, education and patient experience. Improvements were noted in the identification of patients from 38% to 57%. There was also a reduced total number of occupied bed days, significant improvement in recording the preferred place of death and identification of patients to be in their last year of life with a non-cancer diagnosis from 27% to 58%. The trust has received regional and national recognition for the work undertaken in the Last Year of Life Project.
- Patients on the Gold Standards Framework had access to The Gold Line. This was a dedicated service using tele health for patients and carers, which could be accessed as an alternative to phoning 111, when the GP surgery was closed, or if patients were finding it difficult to get help during the day and required advice. The Gold Line was staffed by a senior nurse and the service was available 24 hours a day, seven days a week, to take calls.
- Clinical review meetings were held each week where all newly referred patients were discussed, based on the initial holistic assessment. Patients who had been recently discharged or deceased were also reviewed at this meeting. The identified palliative care keyworker was responsible for presenting, implementing and communicating agreed action plans and these were recorded on the electronic patient record.
- Service planning was in place to ensure patients with complex needs were reviewed by a multidisciplinary team group of professionals to discuss care needs and agree future care plans. Aspects of care included complex symptom management, difficult family situations and ethical issues regarding treatment decisions.
- Data for January to February 2014 showed that 79% of patients achieved their preferred place of death.
- Data for April to March 2014 showed that 59% of patients were discharged to their preferred place of care within 24 hours and 69% were discharged within 48 hours.

Meeting people's individual needs

- There were systems in place to ensure that end of life care was delivered and coordinated to take account of patients' complex needs. For example, there was evidence of collaborative working with national networks to ensure palliative care needs for people with learning disabilities were met. The Bradford & Airedale Network for Palliative Care for People with Learning Disabilities had a team of nurses, doctors, psychologists and social workers who supported people, their families and carers. A ward sister described the care pathways used to care for a young patient with learning disabilities on the ward. This showed effective collaboration across teams to support the patient and their family, which ensured the patient died in their preferred place.
- The HSPCT included an ethnic liaison worker who accompanied South Asian patients and their carers through their end of life journey, providing emotional support and identifying a holistic and culturally appropriate care package, which included repatriation following death. The liaison worker attended all weekly multidisciplinary team meetings and worked with staff to ensure care and treatment was planned and delivered to reflect the patient's ethnic, spiritual and cultural needs. Evaluation of the service showed very positive patient experiences and improved access rates. The role had been shared across health and social care services in Bradford and across palliative care services in the UK.
- The service worked with a charity and introduced 'Bradford Comfort Bags', which included toiletries, a blanket and neck pillow to try and make relatives more comfortable when staying with patients at the end of life. Recliner chairs for overnight stays were available. Concessionary parking permits and dining in the canteen were also offered.
- Two clinical nurse specialists were trained in cognitive behavioural therapy, providing support to patients at the end of life.
- The bereavement office had procedures in place to ensure the timely issue of death certificates. In addition, the registrar also had a separate office on site located

close to the bereavement office. The registrar attended three days per week (Monday, Wednesday, and Friday), which allowed families to register deaths straight away, rather than having to go to the city's main office.

- The bereavement team arranged funerals for patients who died with no next of kin. The team explained how they investigated in an attempt to find the families of people with no next of kin. They were able to advertise to look for families in local newspapers.
- We found chaplaincy and prayer room facilities were not adequate. The multi-faith chapel and Muslim prayer room lacked sufficient space. Chaplaincy staff told us it was a struggle to meet the spiritual and cultural needs of a larger family or group of people. There was a lack of ablution facilities (Ablution is the term used for ritual washing). The current ablution facility was also used as a disabled toilet and had to be accessed by a radar key obtained from the hospital's main reception.
- The chaplaincy team were struggling to meet the needs of the large population of people needing to access their service particularly for congregational prayer activities. There was a small multifaith chapel and at times, particularly on a Friday this could have over 100 people attend for prayer. In addition, Muslim chaplains found that they were frequently taken away from their normal duties to assist with large numbers of visitors attending their relatives in hospital.
- The family room adjacent to the chapel was very small with no natural light. Staff told us that, as part of the trust's estates strategy, it was anticipated that these areas would be included in the proposed new build. There were operational procedures for the management of deceased patients' belongings. The trust used specially designed property bags rather than hospital bags, in order to allow families to take personal belongings home following bereavement.
- Arrangements had been made with the mortuary and local coroners to ensure that, where necessary, for religious and cultural reasons, bodies could be released promptly.
- The NCDAH showed the trust scored above the national average for the care of the patient and their nominated relative immediately after the patient's death.
- We visited the bereavement office and found this was small with limited office space for staff and doctors to complete death certificates.
- The NCDAH showed the trust had achieved four of the seven organisational key performance indicators. The three areas not achieved were access to specialist support for care in the last hours or days of life, Trust Board representation and formal feedback processes regarding bereaved relatives' views of care delivery. The service had taken action to address these areas and work was ongoing regarding the provision of seven day face-to-face working. There was now Trust Board representation.

Access and flow

- The HSPCT received 626 referrals during 2013 and 2014, 34% of which were for patients with non-malignant disease. The total number of contacts made by the team had risen by 25% over the past year.
- The team aimed to respond to urgent referrals on the same day, or within one working day and see routine referrals within two working days. Figures for the last 12 months showed the majority of patients were seen within one working day.
- There were escalation processes in place to ensure patients at the end of life who were admitted via A&E, or the medical assessment unit, were transferred to appropriate wards as quickly as possible.
- Processes were in place to facilitate rapid discharges at the end of life. The service had developed a rapid discharge at end of life integrated pathway, which was used alongside the fast-track tool and short nursing needs assessment. This included guidance on prescribing take home drugs, community prescriptions and out-of-hour's handover forms. The integrated pathway had improved the documentation, coordination of care and sharing of information between teams. The HSPCT, discharge team and fast-track team met quarterly to ensure that any issues were identified and action plans agreed.

Learning from complaints and concerns

- The trust participated in a national review alongside 15 other acute hospital trusts to capture themes and trends from complaints, which related to the Liverpool Care Pathway. The trust applied the following definition to identify complaints which may be related to end of life care: "Any complaint relating to an admission where a patient died, or where a patient died within three months of discharge." The national team have recommended this definition as good practice.
- The trust complaints team forwarded any complaints that fulfilled the criteria to the HSPCT to identify

common themes, or areas that needed addressing on a trust-wide basis relating to end of life. Learning from complaints was evident, with changes being made to documentation, guidelines and training of staff.
- The majority of complaints were resolved through a meeting with bereaved families and senior clinicians involved in their relatives' care.

Are end of life care services well-led?

Good

End of life services were well-led. The trust took an active part in influencing and implementing strategic developments in line with local and national palliative care networks to improve the quality of care and people's experiences.

There were effective governance and risk management arrangements to support the delivery of good quality care. Staff were encouraged to raise problems and concerns about patient care without the fear of being discriminated against. There was good staff engagement and awareness in embedding end of life care for patients.

Patient views were encouraged, heard and acted upon. Information on patient experience was reported and reviewed alongside other performance data. Where issues were identified, action plans were put in place to ensure improvements to patient care.

There was evidence of continuous learning, improvement and innovation.

Vision and strategy for this service

- The trust took an active part in influencing and implementing strategic developments in line with local clinical networks and national guidance and standards.
- The Bradford & Airedale Network for Palliative Care for People with Learning Disabilities managed clinical network (MCN) provided a structure for all specialist palliative care services to collaborate in education, clinical governance and strategic planning. The HSPCT took an active part in attending meetings and working groups to ensure end of life care was integrated across the district.
- The Trust Board were engaged in raising standards in end of life care. The chief nurse was the designated Board member and a non-executive director had recently been appointed as the non-executive lead with specific responsibility for care of the dying.
- The HSPCT had an annual 'time-out' to plan the service strategy, including relevant audits. An annual report of the HSPCT's work, which included the end of life strategy was presented to the executive team.
- The trust had acted on the national End of Life Care Strategy recommendations (published by the Department of Health in 2008) through the implementation of the Last Year of Life Project, which had been rolled out across the medical wards.

Governance, risk management and quality measurement

- The HSPCT were fully aware of their roles and responsibilities regarding ensuring that effective risk management and governance processes were in place. All patients receiving end of life care were discussed at a weekly clinical review meeting. Learning from incidents was used to inform the content of end of life education.
- The HSPCT collected and analysed activity data and reported annually to the trust and the National Council for Palliative Care. Data on the number of deaths by ward was collected and the team participated in a programme of audit activity and quality assurance measures.
- There were no corporate risks identified that related to end of life care.
- Minutes from the clinical governance meetings showed action had been taken to improve documentation, implementation of policy and guidelines and patient/carer information.

Leadership of service

- There was strong leadership within the palliative care department with clearly defined roles and responsibilities.
- The HSPCT regularly presented to the Trust Board and had quarterly meetings with the chief nurse to discuss areas of concern. We found there was good support from the executive team to ensure national standards and best practice was embedded throughout the hospital for end of life patients.

End of life care

- The HSPCT was fully funded by the trust and had clinical and educational roles at Bradford Royal Infirmary and St Luke's Hospital**.**

Culture within the service

- Staff on the wards and members of the HSPCT were focused on providing high quality care for patients at the end of life.
- The HSPCT said they were encouraged to report any concerns they had and felt confident that these would be acted on.
- Staff said the trust was a friendly place to work and working relationships with senior staff were good.

Public and staff engagement

- As part of the trust's dignity group a bereaved relative's survey was being piloted over a six-month period beginning in July 2014.
- There was good collaboration with local and national palliative care networks, including other providers, to improve the quality of care and people's experiences.
- We observed good staff engagement and awareness in embedding end of life care for patients. Staff felt engaged with the work of the HSPCT. A consultant told us the amber care bundles and multidisciplinary team ward rounds had changed his practice and he felt more confident in recognising when a patient was approaching end of life.
- Partnership working was evident in other specialties to ensure services met the needs of patients. For example, the HSPCT worked with critical care on withdrawing ventilation and rapid discharge home pathways.

Innovation, improvement and sustainability

- Working in collaboration with Macmillan Cancer Support, the HSPCT were awarded the International Journal of Palliative Nursing multidisciplinary teamwork award for the positive impact that their work had on the care they provided.
- The HSPCT were the first team in the country to link the AMBER care bundle to the Gold Standard Framework for end of life care register and the EPaCCS. Results from the pilot showed an increase of 38% to 57% in the identification of patients in their last year.
- The HSPCT were currently working within budget in a way that did not impact on the quality of care.
- The palliative care liaison service work with ethnic minorities had won a Department of Health and Social Care award under the category 'Improving Lives for People with Cancer' and was awarded with a commendation.

Outpatients and diagnostic imaging

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

Information about the service

Bradford Teaching Hospitals NHS Foundation Trust provided a wide range of outpatient clinics, predominantly at Bradford Royal Infirmary and St Luke's Hospital. Between 2013 and 2014, 577,619 patients attended outpatient clinics across the two sites, with 239,831 of these patients attending outpatient clinics at Bradford Royal Infirmary.

Outpatient services at the trust were to be managed by the new outpatient and booking services, diagnostic and therapies directorate. This had been part of a recent restructure from the end of September 2014. The trust was transitioning to a centralised patient booking service. This was due to be completed by December 2014. The patient booking service was located at St Luke's Hospital. Currently, some outpatient activity was managed by other clinical divisions, such as trauma and orthopaedics, ophthalmology and ear, nose and throat. Other specialties were managed within the outpatient department with their own staff rotating between Bradford Royal Infirmary and St Luke's Hospital. As part of the restructure responsibility for outpatient nursing and outpatient clinics would fall within the remit of the new directorate. Detail of the moves and phasing of this were currently being developed by the trust.

Outpatient services were delivered at Outpatients West and other locations within Bradford Royal Infirmary. This hospital also provided diagnostic imaging, including radiology (plain film), general and maternity ultrasound, clinical physics, fluoroscopy, angiography, computerised tomography (CT) and magnetic resonance imaging (MRI) scans.

Outpatient clinics were held in several areas on the site. Each clinic area had a reception and waiting area. We visited most outpatient areas as part of this inspection and observed clinics in vascular, ear, nose and throat and ophthalmology services. We also observed phlebotomy clinics.

During the inspection, we spoke with 22 patients, six relatives, and 17 staff, including consultants, divisional managers, radiologists, nurses, healthcare assistants and porters. We checked the outpatient environment, equipment and looked at patient information.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging services as 'inadequate' for safety, responsiveness and well-led.

We had serious concerns over the large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. This meant that some patients were waiting considerable amounts of time for follow-up appointments, which could have resulted in delays accessing treatment. These problems were not proactively brought to the attention of CQC before or during the inspection

There had been a serious failure of governance systems to identify, respond and address the significant backlog of patients waiting to have their care pathways reviewed. The trust had belatedly recognised this as a significant issue and had commenced plans on how to address this, but there had been little done to risk assess the impact on individual patients. The trust recognised the full extent of the problem in May 2014, but it was not until October 2014 that extra staff were recruited to address the backlog.

Outpatients and diagnostic imaging services were caring. Systems were in place to capture concerns and complaints raised within both departments, review these and take action to improve the experience of patients.

We saw that trust policies were based on and included nationally recognised good practice guidance. Staff in both departments were competent, and there was evidence of multidisciplinary working. Staff in diagnostic imaging stated that they were well supported by their managers. Staff and managers told us there was an open culture. However, most medical secretaries and some outpatients' staff did not feel empowered or listened to.

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated safety within outpatients and diagnostic imaging as being 'inadequate'. We had serious concerns over the large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed This meant that some patients were waiting considerable amounts of time for follow-up , which resulted in delays for patients. The trust had recognised this as an issue and had commenced plans on how to address this, but there had been little done to risk assess the impact on individual patients. In February 2015 the Trust were able to verify that the actual number of patients who were overdue a follow up appointment due to the non RTT issue was less than 5,500.

Cleanliness and hygiene in both outpatients and diagnostic imaging departments were within acceptable standards, with high levels of compliance in infection control audits. There was sufficient clean and well maintained equipment to ensure that patients received the treatment they needed in a safe way.

There were policies and procedures in place to respond to, and assess, patient risk.

There were sufficient well trained and competent nursing and medical staff within the department to ensure that patients were treated safely.

Incidents

- There have been six serious incidents recorded on the Strategic Executive Information System (STEIS) in 2013/2014 in relation to outpatients at this trust.
- At the time of the inspection there had been one patient identified where a delay in treatment had happened and another where a delay in a patient's follow-up had resulted in a potential delay in treatment. Both cases had been reported and identified as serious incidents. In December 2014, following an investigation, the trust confirmed that the incidents were not related to the non-RTT patients.
- The trust provided information on the 28 November 2014 about the incident reporting system and acknowledged that at that time the system did not

separate access and administration issues. A total of 509 access/appointment/ admission/discharge/transfer incidents have been reported, but the trust's system did not identify risk through delayed follow up.
- Between July and October 2014, there had been 29 incidents reported on Datix regarding outpatients at this hospital. The majority of these were low grade or 'no harm' and were in relation to medical records and cancelled appointments.
- Between July and October 2014, diagnostic imaging departments at this hospital had reported 50 incidents on Datix. The majority were low grade or no harm.
- Staff were aware of how to follow the trust's policies and procedures for reporting incidents.
- General incidents were reported and investigated in line with trust policies within diagnostic imaging. We looked at a copy of all reported trust incidents from 1 July 2014 to 9 October 2014 and saw incidents for the diagnostics division were categorised, described and included a record of any immediate and/or further actions taken to manage/minimise further similar events. The senior managers we spoke with told us they encouraged a culture of open incident reporting across all of the diagnostic modalities.
- The trust had reported radiation incidents to the CQC under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) during the past year.
- The Radiology Protection Adviser (RPA) report included reference to all of the radiation incidents reported in each modality and the report included confirmation of their involvement in the investigations of all radiation incidents.
- Managers within outpatients told us they provided staff with verbal feedback from incidents at team meetings. This was confirmed in the minutes of these meetings. Staff we spoke with confirmed the manager fed back the learning from incidents and discussed how they could do things differently to improve.

Cleanliness, infection control and hygiene

- Clinical and non-clinical areas in both outpatients and diagnostic imaging appeared to be clean and tidy, with equipment stored appropriately.
- We saw staff adhering to the trust's 'bare below the elbows' policy. We also saw that staff wore protective aprons and gloves when required and regularly used hand sanitising gel between patients.
- Hand washing signage was clearly displayed throughout the departments and there were sufficient supplies of hand sanitising gel available.
- Cleaning schedules were on display in all areas and completed correctly.
- The outpatient and diagnostic imaging departments completed infection control audits every month, which monitored compliance with key trust policies such as hand hygiene and dress code. Most areas within outpatients and diagnostic imaging demonstrated compliance of between 95% and 100% during 2014.
- Systems and processes were in place to manage patients with suspected communicable diseases and isolation facilities were available, along with access to the deep cleaning teams within the diagnostic imaging department.

Environment and equipment

- During the course of our inspection, we observed staff wearing specialised personal protective equipment, while working within radiation areas.
- In diagnostic imaging, the trust had maintained compliance with their annual programme of quality assurance testing of x-ray equipment throughout 2014 across all of the modalities and provided over 60 examples of the compliance testing being carried out throughout 2013 and 2014. The managers told us there were systems and processes in place to respond to national medical equipment alerts. The RPA report confirmed the trust's ongoing compliance with quality assurance testing of x-ray equipment and referred to appropriate actions taken in response to two applicable medical equipment safety alerts.
- We looked around the imaging departments at Bradford Royal Infirmary and saw radiological protection/hazard signage displayed throughout the departments. Illuminated treatment room 'no entry' signs were clearly visible and in use throughout the department at the time of the inspection visit.
- The general environments in the diagnostic imaging department appeared to be clean, uncluttered, well maintained and directional signage to the reception area and the various treatment areas were clearly displayed. Patient waiting areas were clean and tidy. We saw private changing areas for patient use along with single sex and disabled toilet facilities.

Outpatients and diagnostic imaging

- Appropriate containers for disposing of clinical waste were available and in use across the diagnostic imaging department. The RPA had assessed the trust as being fully compliant with the Environmental Permitting Regulations 2010 legislation.
- All of the outpatients' areas we visited appeared to have adequate seating.
- We looked at equipment and found it was appropriately checked and cleaned.
- Resuscitation equipment and defibrillation machines were checked daily in all areas that we visited in outpatients and diagnostic imaging.

Medicines

- Medicines were stored and managed safely, including in locked cupboards and fridges, where required.
- Medicine fridge temperatures were checked daily and medication room temperatures were set at 19°C.

Records

- All records were in paper format. Outpatient clinics also operated a paper patient record for each visit, called a 'clinic outcome form'. These records included the patients' personal data, referral to treatment status and an 'outcome' and 'future appointment' sections.
- Medical staff completed the consultation records along with the outcomes form, which was passed to the receptionist to arrange follow-up appointments and/or discharge, as determined by the medical staff.
- We found that nursing staff were responsible for checking and recording each patient's height, weight and basic physiological signs, such as blood pressure and pulse rates. We saw that these procedures were consistently completed before patient consultations.
- At the time of inspection, we saw that patients' personal information and medical records were managed safely and securely in the diagnostic imaging department.

Safeguarding

- The trust had safeguarding policies and guidance in place for both children and adults. All staff we spoke with were aware of these policies and guidance and could describe how to report and escalate a safeguarding issue.
- Overall, in outpatients, 94% of appropriate staff had adults and children safeguarding Level 1, 62% had Level 2 and 3 adults safeguarding and 78% had Level 2 and 3 children safeguarding training within the trust.
- In diagnostic imaging, 100% of appropriate staff had safeguarding training, at all levels, for both adults and children within the trust.

Mandatory training

- Staff reported that mandatory training was delivered via e-learning and face to face. They reported that reminders were received from their managers when updates were required and that they were up to date with their mandatory training.
- We looked at staff mandatory training records for both outpatients and diagnostic imaging.
- Overall, in outpatients staff had to complete 26 mandatory training courses. Mandatory training was at 81% completion to date for 2014, ranging from 12% in the safe administration of medicines to 100% in equality and diversity training for managers.
- In diagnostic imaging, staff had to complete 13 mandatory training courses. Mandatory training was at 80% completion to date for 2014, ranging from 0% at the safe administration of medicines, to 100% in moving and handling. There were plans in place to ensure relevant staff received safe administration of medicines training before the end of 2014.

Assessing and responding to patient risk

- In May 2014, the trust identified a very large back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. This was across all specialties. A briefing paper presented to the Quality and Safety Committee, dated 16 October 2014, stated that in September 2014, the trust had "had 205,257 patients on the patient tracking list with no active referral to treatment pathway" or who were not on a review waiting list. Of the 205,257 patients, "155,622 do not have a follow-up appointment".
- In February 2015 the trust informed us that following validation, the actual number of patients who were overdue a follow up appointment due to the non RTT issue would be less than 5,500.
- There was a significant risk that decisions about treatment or diagnostics were delayed for some patients. One patient's treatment had been identified as being delayed and another patient's follow-up had been delayed. This had resulted in a potential delay in treatment.

- We found that the issue had been escalated to the divisional general managers and divisional clinical directors, as well as the Quality and Safety Committee and Trust Board.
- On 26 November 2014, the CQC formally issued a statutory request for information using its powers under Section 64 of the Health and Social Care Act 2008 with regard to the back log of patients on a non-referral to treatment pathway who did not have a follow-up appointment.
- The trust provided information that stated, "the cohort of pathways being validated was 200,000, this is not a total follow up backlog number but the total volume of non-RTT pathways on the system classed as 'not applicable".
- The trust instructed staff in April 2014 to ensure that any patient, known to be past their 'see by' date, was clinically reviewed and an appointment given if required. However, progress was slow. Additional staff were recruited in October 2014 for the validation process (a validation process checks and confirms whether information/or process is correct), which was expected to be a six month piece of work to identify which patients required a follow up appointment, whether this was in the past or whether it would be required in the future. At the time of the trust response to the Section 64 formal request for information, 20,000 patients on the backlog had been validated. Of these 8000 had their referral closed down, with no further action required, 1000 had been added to the waiting list with an overdue review date. Of the patients whose due date had passed, 30 should have been seen before February 2014, 154 in March 2014 and the remaining between April and November 2014.
- The trust informed us that the validation team was fully recruited to at the end of October, which should increase the validation rate. The trust is expecting to complete the validation process by the end of March 2015.
- The validation process was commencing with an initial cohort of two specialities and at the time of the inspection the trust was not in a position to understand the level of potential harm to patients whose follow up care had been delayed or the numbers of patients affected. In February 2015 the trust told us "No harm had been identified from the clinical review of the patients to date"; that the majority of patients/pathways were being validated to either discharge or future appointment date and it was difficult to ascertain the final volume of follow up delay.
- Patients attending outpatients had baseline physiological signs, such as blood pressure and pulse rates taken before their consultation.
- Staff in both the outpatients and diagnostic imaging departments told us that urgent care and resuscitation could be provided in cases of emergency. Patients would then be transferred to the urgent and emergency care department for further assessment and treatment.
- In diagnostic imaging, the trust's radiation protection annual report summarised radiation protection during the year April 2013 to March 2014. The report provided an overview of the work carried out by the RPA and the Radiation Protection Service.
- The manager confirmed that the RPA was an employee of the trust and the RPA report confirmed that "regular contact was maintained between the RPAs, medical physics experts (MPEs), departmental managers and the radiation protection supervisors (RPS) throughout the year, in order to progress this work. This included visits to various departments as well as telephone and email contact".
- The report highlighted the trust's "continued commitment to ensuring the health and safety of staff, patients and members of the public and to complying with relevant legislation in relation to work activities involving radiation". They also stated that, "Staff appeared to be maintaining good standards of practice."
- All of the managers we spoke with in diagnostic imaging told us that all modalities had an appointed and trained RPS. The RPA had commented within their report that, "The trust was fortunate in having members of staff in all radiation-using departments who carry out the duties of RPS with great diligence."
- We were told that the trust had a range of policies and procedures in place in relation to radiation protection regulations. The changes in policies and procedures within the past year were referenced within the RPAs annual report: "The local rules for diagnostic x-ray were updated in March 2014. The local rules for diagnostic radiology were amended to incorporate trust-wide local rules in one document for all areas where x-rays are used. The magnetic resonance imaging local rules were also revised." The report also noted that a number of policies were reviewed and reissued in 2013, which

included, "Ionising Radiation Protection, Magnetic Resonance Imaging, Patient Identification, and Telephone (including mobile phones). IRMER procedures for Diagnostic Radiology had also been reviewed and reissued along with amendments to the pregnancy checking procedures."
- An audit completed in April 2013 for 'Computed Radiography' concluded that the trust was broadly compliant with the Institute of Physics and Engineering in Medicine (IPEM) Report 91: Recommended Standards for the Routine Performance Testing of Diagnostic X-ray Imaging Systems, 2005.
- An audit, completed in July 2014, confirmed that the radiology minor intervention safety checklist met the World Health Organisation (WHO) surgical safety checklist requirements specified by the National Patient Safety Agency (NPSA).

Nursing staffing

- There was a dedicated team of outpatient nurses, receptionists and administration staff. The nursing staff covered clinics across the two hospital sites. Nurse staffing at this hospital was also part of the surgical and orthopaedic divisions.
- The number of patients who attended clinics held each week was used to calculate the staffing needed for each clinic.
- Staff and patients confirmed that there were enough staff available to meet patients' needs during clinics.
- We reviewed staffing information for oncology and haematology outpatients at this hospital and found that required staffing levels met the actual staffing for the month of September 2014. During September 2014, in the ear, nose and throat and ophthalmology outpatients departments, the average actual qualified staffing numbers was nine against a planned provision of 10. The average actual unqualified staffing number was 15 against a planned provision of 18. Shortfalls were addressed by using bank staff.
- The overall staffing compliment for the imaging services was approximately 40 plain film members of staff. This number included staff at varying levels. One band 8, three band 7 members of staff, seven or eight band 6 staff members, four band 4 staff members. The rest of the staff were students. The CT scanning team was reported to have one band 8a staff members, three band 7 staff members, 2.5 band 6 staff members and one band 5 trainee. The radiological intervention team had two band 6 and two band 5 staff members. The MRI scanning team had three band 7 staff members, two band 6 staff members and two locums. The fluoroscopy team had one band 7, two band 6 and two band 5 staff members.
- There were systems and processes in place to request additional temporary staffing and the service used temporary nursing staff (bank) when shortages were identified.
- Induction and competence training for staff in different roles was carried out to facilitate staff moving between departments.
- We found that there were clear lines of management responsibility and accountability within the outpatients and diagnostic imaging services.

Medical staffing

- Medical staffing for outpatients clinics, along with clinic capacity and demand were agreed and reviewed with each clinical division, such as medicine and surgery. The divisions reviewed and managed mandatory training, appraisal and revalidation for medical staff.
- There were no reported medical staff vacancies.

Major incident awareness and training

- There was a trust major incident policy and business continuity plans, which staff were aware of and could refer to.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We saw that trust policies were based on, and developed to include nationally recognised guidance, such as NICE and the Royal Colleges' guidelines. Staff in both departments were competent, and there was evidence of multidisciplinary working.

The main outpatients' service operated a five day a week service. Radiology and imaging provided a 24-hour service, seven days a week.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- We saw that the NICE guidance was disseminated to both outpatients and diagnostic imaging departments, with a lead clinician taking responsibility for ensuring it was implemented. Staff were aware of the NICE and other guidance that affected their practice.
- We saw that the departments were adhering to local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care.
- The diagnostic imaging department undertook a range of audits, these included compliance with the radiation regulations. The trust radiation protection annual report summarised radiation protection, which included outcomes from surveys and audits. The report concluded that "in most respects" the trust "complied with the Ionising Radiations Regulations 1999 (IRR99), Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000), Artificial Optical Radiation Regulations 2010 (AOR) and fully complied with the Environmental Permitting Regulations 2010 (EPR)."

Patient outcomes

- "In May 2014 the trust identified a very high volume back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed This was across all specialties. The trust was validating all of these patients to determine the extent of the issue and the actual follow-up backlog.
- Staff had not been putting due dates onto the system. It was confirmed that the trust had invested in additional staff for nine months to validate whether appointments were required for patients in the backlog.
- When patients attended for their appointments, we saw that they were kept informed of any delays to their appointment times and sufficient time was allocated for each patient's appointment.
- Patient outcomes in outpatients were monitored by clinic outcome forms, as well as a clinic utilisation activity record. Both forms were completed by nursing and medical staff for every patient, to ensure that there was a follow-up treatment plan in place.
- The staff in the outpatient departments we visited told us that they took part in local and trust-wide audits. For example, infection control, environmental and documentation audits. All of these audits demonstrated high levels of compliance.
- The diagnostic department undertook a range of national statutory audits to demonstrate compliance with the radiation regulations.

Competent staff

- Some staff had extended their roles to meet patient needs. For example, in advanced practical otology skills, ear syringing and intravitreal drug delivery within the macula service. Training packages and competency-based assessments were completed prior to staff undertaking these roles.
- In diagnostic imaging, the manager told us that there were a number of advanced practitioners who were trained to undertake more specialised roles within each of the different modalities. For example: ultrasound sonographers were independent reporters, along with radiographers and mammographers.
- Managers in diagnostic imaging told us of the formal arrangements were in place for mentoring students and new staff and for continually assessing staff performance through supervisions and appraisals. Training alert updates for all staff were flagged to managers for action on the departmental training database.
- Staff confirmed that they had received appraisals in the last year.
- Information sent to us showed that all doctors were up to date with their revalidation.
- To date, appraisal rates for staff in outpatients ranged from 65% in orthopaedic outpatients to 97% in ear, nose and throat and ophthalmology for 2014.
- To date, appraisal rates for staff in diagnostic imaging specialties ranged from 80% to 100% for 2014.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team.
- There was access to multidisciplinary teams and clinical specialists within outpatient clinics. For example, staff gave us examples of how the learning disability specialists had assisted them to care for patients with learning disabilities.
- The trust provided nurse-led clinics and we spoke with one of the vascular nurse specialists, who told us they provided a direct service to the patients and they were supported by the medical team.

Outpatients and diagnostic imaging

Seven-day services

- The main outpatient service operated a five day a week service.
- Radiology and imaging provided a 24-hour service, seven days a week.
- Phlebotomy services were available from 9am to 5pm for people to have their blood samples taken. During our inspection, we saw that the phlebotomy clinics were very busy.
- We found that, sometimes, if clinics ran late, they did not have support from the phlebotomy service as it had closed. This meant patients could not have their blood samples taken at the time of their outpatient appointment and would have to return to the hospital for this.

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 the required patient information in a timely manner.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Senior staff reported that, within the outpatients department, implied consent (as opposed to written consent) was routinely obtained from patients before any care and treatment interventions – such as obtaining specimens, routine diagnostic tests and the checking of height, weight and basic physiological signs. The General Medical Council defined implied consent in their guidance Consent: patients and doctors making decisions together (2008) as, "Patients may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken."
- Staff reported that, if consent could not be safely obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding team for advice.
- We spoke with a number of staff members about their understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. On the whole, staff were able to explain to us what each involved.
- All staff designated as requiring Mental Capacity Act 2005 training Level 2 had completed it, and 95% of other staff had attended Mental Capacity Act 2005 training Level 1.

Are outpatient and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging services were caring. During our inspection, patients and relatives commented positively about the care provided from all of the outpatients and diagnostic imaging staff. Staff who worked in the departments treated patients courteously and with respect.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Compassionate care

- We spoke with one patient after a procedure in diagnostic imaging and they told us that they were very happy with the service provided. They had consented and been involved in their care and treatment and the staff had kept them informed throughout their procedure.
- Staff were courteous when caring for patients and staff were seen responding to patients' individual needs in a timely manner.
- In outpatients, we observed staff interacting and speaking with patients in a caring, courteous and friendly manner. Patients told us staff were "great" and "friendly".
- Since the beginning of October 2014, the outpatient department had commenced the NHS Friends and Family Test. Posters and collection boxes were on display and we observed staff asking patients to complete the appropriate cards. Results of this test had not yet been collated.
- We saw that staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Outpatients and diagnostic imaging

- The environment in outpatients and the diagnostic imaging department allowed for confidential conversations.
- There were two issues relating to patients' privacy and dignity that we bought to the manager's attention in diagnostic imaging. There was one patient who had been sitting in a shared treatment waiting area without a dressing gown. As well as this, the curtain had not been drawn across the main recovery area and patients within this area were open to public view. The manager agreed to deal with these matters immediately.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated they felt involved in decision-making about their care and treatment.
- A range of information leaflets were available, which provided patients with details about their outpatient appointment and clinical supporting literature to assist them in their understanding of their medical condition. We saw that staff used these leaflets as supportive literature to explain to patients about their health problem.
- The outpatient departments completed patient surveys. The survey completed in February 2014 confirmed that between 85% and 96% of patients were treated with dignity and respect and that their privacy was respected. The survey detailed areas for improvement, including waiting times, efficiency of services and the provision of written information. An action plan was in place to address these areas and the survey was to be repeated in March 2015.

Emotional support

- We saw that staff were always nearby and/or in the consulting rooms to support the patients emotionally in the event of receiving difficult news. Staff spent time talking to patients.
- Clinical nurse specialists in areas such as pain management, neurology and vascular services were available to give support to patients.
- Patients were able to access counselling services.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated responsiveness within outpatients and diagnostic imaging as being 'inadequate'. "In May 2014 the trust identified a very high volume back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed: specifically patients who were not on the formal referral to treatment (RTT) pathway. Some patients were waiting considerable amounts of time for follow-up , which could have meant there were delays in treatment.

All other referral to treatment (RTT) pathways for admitted and non-admitted patients were similar or better than the England average. Cancer waits and diagnostic waiting times were the same as, or better than, the England average. Did not attend (DNA) rates for this hospital were worse than the England average.

Mechanisms were in place to ensure that the care within clinics was able to meet the individual needs of people, such as those living with dementia or those with a learning disability, and for people whose first language was not English. Departments had systems in place to capture concerns and complaints, to review these complaints and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- The trust was transitioning to a centralised patient booking service. By December 2014, all outpatient booking will have transitioned into the centralised model.
- Outpatient nursing staff rotated between Bradford Royal Infirmary and St Luke's Hospital, which helped ensure the needs of local people were met.
- Staff told us that when clinics were expected to be busy, extra staff routinely worked to try to ease the pressure.
- When clinics were running late, some clinics offered patients alternative appointments.
- Additional outpatient capacity was arranged, when required, to ensure patients were seen according to an appropriate timescale.

Access and flow

- "In May 2014 the trust identified a very high volume back log of patients waiting for a review of their outpatient

care pathway. There were over 205,000 patient pathways to be reviewed This was across all specialties. A briefing paper presented to the Quality and Safety Committee, dated 16 October 2014, stated that in September 2014, the trust "had 205,257 patients on the patient tracking list with no active referral to treatment pathway" or who were not on a review waiting list. Of the 205,257 patients, "155,622 do not have a follow-up appointment".

- Following the formal request for information under Section 64 of the Health and Social Care Act 2008, the trust provided further details on the patients affected and the progress on the validation process they had commenced in October 2014. The trust informed us that of the 20,000 validated by 23 November 2014 - 8,000 referrals had been closed, 10,000 had been added to the waiting list with a review date in the future and 1,000 patients required a case note review as there was insufficient information in the clinic letter available to determine what was required.
- The trust also informed us that as part of the 205,000 there were 25,000 obstetric referrals that were being sampled by the consultant group to confirm all referrals could be closed. The work was expected to be completed by January 2015 due to the need for a software upgrade.
- Did not attend (DNA) rates for this hospital were worse than the England average, at 11%. The hospital had started to use an SMS text messaging system to help improve this.
- Referral to treatment (RTT) pathways being implemented within 18 weeks for admitted pathways was 90% for this trust, RTT for non-admitted pathways was 97% and for incomplete pathways was 97%. This was similar, or better, than the England average.
- The RTTs for non-admitted patients starting their treatment within 18 weeks of referral were not met within oral surgery. At the time of the inspection the figure was 92.3%. The reasons for these shortfalls had been identified and additional recruitment to consultant posts undertaken, as well as locum cover arranged to reduce the backlog of patients.
- The trust was meeting the referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral, 95% of non-admitted patients starting their treatment within 18 weeks of referral
- At this trust, for all cancers, the percentage of patients seen by a specialist within two weeks following an urgent GP referral was 94%, for less than 31 days from diagnosis to first definitive treatment was 96%, and for less than 62 days from urgent GP referral to first definitive treatment was 87%, which is better than the England average.
- At this trust, diagnostic waiting times of six weeks or more were less than 1%.
- In 2014, 70% of patients were seen on time for their appointments at this hospital, 23% were seen within 15 minutes of their allocated time, and 2% and 3% were seen within 30 and 60 minutes respectively.
- The managers told us that the majority of outpatient diagnostic imaging procedures were managed through planned appointments times. Inpatients were booked into time slots within the departments, as required, and based upon the acuity of the referral.
- The manager also told us that the hospital provided a weekly fast-track, one-stop lung biopsy service.
- A drop-in plain film x-ray service was provided during normal opening times from Monday to Friday. Imaging out-of-hours services were provided at this hospital only.
- Referrals for imaging, particularly CT, MRI and ultrasound, were triaged and vetted by each modality and booked according to acuity.

Meeting people's individual needs

- Information signage was adequate within outpatients and diagnostic imaging and patients appeared to be able to make their way around both departments easily.
- Translation services were available for patients. The staff explained the systems and processes in place for arranging translation services.
- The outpatient and diagnostic departments had information leaflets for patients. Leaflets were not always available in different languages if needed.
- We observed staff spending time explaining to patients about procedures they were to have as part of their outpatient and diagnostic imaging appointment.
- Staff told us that, when patients with learning disabilities attended the departments, they tried to give the patient priority to be seen. They were aware of additional support that was available within the trust, and also allowed carers to remain with the patient if this was what the patient wanted.

Outpatients and diagnostic imaging

- Some staff told us they had attended training about dementia within the trust and were aware of how to support people at different stages of dementia. One of the sisters we spoke with told us that most patients living with dementia were accompanied by carers or relatives, and provisions were made to ensure that patients were seen quickly.
- One of the main themes that patients and public raised about the Trust at the CQC Listening event prior to the inspection was the issue of not getting appointments or delays in appointments.
- Local Healthwatch also reported that one of the main themes from their engagement with local people about the trust's services was the long waiting times for appointments.

Learning from complaints and concerns

- The outpatients and diagnostic imaging services had a process in place for managing informal complaints. Both formal and informal complaints and concerns were recorded through the trust's Patient Advice and Liaison Service (PALS), as well as informally by the department.
- Between August 2013 and July 2014, the outpatient department received 55 complaints, 26 related to aspects of clinical treatment, five related to communication and 19 related to appointment delays and cancellation.
- Between August 2013 and July 2014, diagnostic imaging received three complaints relating to delayed or cancelled appointments and clinical treatment.
- Staff in both outpatients and diagnostic imaging were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the PALS or make a complaint was available within waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at team meetings and any learning was shared.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated the service as inadequate in terms of being 'well-led', The main concern was regarding poor management systems, which did not identify the significant back log of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed.. It was not clear what monitoring and governance took place prior to this backlog of outpatient care pathways occurring. The backlog was identified following a recommendation from an external review of waiting times. The trust recognised the full extent of the problem in May 2014, but it was not until October 2014 that the majority of extra staff were recruited to address the backlog. These problems were not proactively brought to the attention of CQC before or during the inspection.

Staff in diagnostic imaging stated that they were well supported by their managers.

However, there were significant concerns raised by administration and outpatients staff who did not feel empowered or listened to.

They said managers were visible and provided clear leadership. Staff and managers told us there was an open culture.

Vision and strategy for this service

- The staff we spoke with were aware of the trust vision and strategy. They reported that the Chief Executive was visible and they were aware of the recent listening events undertaken by the Chief Executive. Other members of the executive team and trust were reported to be less visible.
- Staff were aware of the decisions and actions taken to centralise the booking service for outpatients.

Governance, risk management and quality measurement

- In May 2014, the trust identified a very high volume backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. This was across all specialties.
- This represented a significant failing in governance and reporting arrangements. It was not clear what monitoring and governance took place prior to this issue occurring, as the briefing paper stated that it had been the expectation of the trust that everyone needing

an appointment received one. This was presented to Clinical Executive in August 2014, Quality & Safety Committee in October and subsequently escalated to the Board of Directors and Monitor.

- On 26 November 2014 and the 3 December 2014, the CQC formally issued a statutory request for information using its powers under Section 64 of the Health and Social Care Act 2008 with regard to the back log of patients on a non-referral to treatment pathway who did not have a follow-up appointment.
- The trust provided information detailing that in 2012 the trust had identified issues with RTT management and reporting. A turnaround team had been appointed and support from the Interim Management and Support service (IMAS) to validate pathways to deliver RTT performance. This entailed separating RTT and non RTT pathways, with a focus on RTT delivery. The initial focus was RTT delivery with IMAS signing off the Trust in March 2014. Additionally a recommendation had been made to invest in a formal Data Quality tool to support assurance mechanisms, with a second recommendation to review non RTT waiting times. Folloiwng a procurement process the trust put in place the Data Quality tool in September 2014.
- In May 2014, following recommendation in March a review was undertaken, which highlighted concerns about the volume of non-RTT pathways. This led to a recommendation for investment in validation, which was presented to the Clinical Executive in August 2014, the Quality and Safety Committee in October and then escalated to the Board of Directors and Monitor. There had been a considerable time lag between the identification of the backlog problem and it being presented to the Board.
- It was five months before additional staff were in place to validate the backlog which added significant delay in delivering appropriate follow up appointments for patients."
- Information provided to CQC on the 5 December 2014 included a non-RTT clearance graph which indicated that the backlog extended to pre 2007 for 20-30,000 of the care pathways. Validation of these was completed by 10 November 2014. This indicated that there had been system failure in identifying patients who needed follow up for a number of years. We were informed by the trust that deciding priority for booking appointments would be through the validation process involving the clinical lead and the relevant consultant. The process would be rolled out to each speciality.
- The trust provided information on the incident reporting system and acknowledged that at the present time the system does not separate access and administration issues. A total of 509 access/appointment/admission/discharge/transfer incidents have been reported but the system does not identify risk through delayed follow up. Of the 509 incidents, two incidents were rated as moderate, one related to administration and one to access. The two serious incidents reported identified potential harm. These were being investigated (28 November 2014 Trust Response Letter).
- The trust had put in place a number of changes including Global newsletters reminding staff of the processes, additional system training, refresher training sessions on the patient pathway to divisional teams and central booking teams. In addition, the trust has changed the clinic booking process.
- Outpatients and diagnostic imaging departments held monthly clinical governance meetings. The outpatient and booking services, diagnostic and therapies division also held monthly divisional meetings with attendance from all the relevant departments. Both meetings escalated issues to the trust's Quality and Safety Committee.
- Complaints, incidents, audits and quality improvement were discussed.
- Feedback from these meetings was given at department weekly meetings.
- Risk registers were in place for both outpatients and diagnostic imaging. These had controls and assurance in place to mitigate risk. They were regularly reviewed.

Leadership of the service

- Currently, some outpatient activity was managed by other clinical divisions, such as trauma and orthopaedics, ophthalmology and ear, nose and throat. Other service specialties were managed within the outpatient department with their own staff rotating between Bradford Royal Infirmary and St Luke's Hospital.
- Staff in diagnostic imaging stated that they were well supported by their managers.
- However, there were significant concerns raised by some medical secretaries/administration staff and

outpatients staff who did not feel empowered or listened to.Most staff felt that their local managers communicated well with them and kept them informed about the running of the department.

Culture within the service

- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well supported by the organisation.
- Staff told us that the Chief Executive was visible, although members of the executive team were less so.
- All of the staff we spoke with were proud to work for the trust.

Public and staff engagement

- The outpatient department completed patient surveys. The survey completed in February 2014 confirmed that between 85% and 96% of patients were treated with dignity and respect and that their privacy was respected. The survey did detail areas for improvement, including waiting times, efficiency of services and the provision of written information. An action plan was in place to address these areas and the survey was to be repeated in March 2015.
- Since the beginning of October 2014, the outpatient department had commenced the NHS Friends and Family Test. Posters and collection boxes were on display and we observed staff asking patients to complete the appropriate cards. Results of this test had not yet been collated.
- Overall, the trust was rated better than expected for staff engagement in the NHS staff survey key findings for 2013.

Innovation, improvement and sustainability

- Managers and staff in both outpatients and diagnostic imaging told us that they were supported to try new ways of working to improve the effectiveness and efficiency of their departments.
- In diagnostic imaging, all ultrasound sonographers were independent reporters. There was a high proportion of advanced practitioners, which had helped reduce waiting times.

Outstanding practice and areas for improvement

Outstanding practice

Good practice:

- The surgical services had introduced a complementary system of 'green bands' worn by patients on their wrists displaying personal and procedure information. This was an effective additional safety measure to the World Health Organization (WHO) checklist.
- Working in collaboration with Macmillan Cancer Support, the hospital specialist palliative care team (HSPCT) were awarded the International Journal of Palliative Nursing multidisciplinary teamwork award for the positive impact that their work had on the care they provided.
- The HSPCT were the first team in the country to link the AMBER care bundle to the Gold Standard Framework for end of life care register which showed an increase of 38% to 57% in the identification of patients in their last year.
- The palliative care liaison service work with ethnic minorities had won a Department of Health and Social Care award under the category 'Improving Lives for People with Cancer' and was awarded with a commendation.
- The elderly care wards, particularly Ward 29 and Ward 30, had made improvements to the care of older people, including those living with dementia. The environment had been adapted and was an exemplar for dementia-friendly environments.

Areas for improvement

Action the hospital MUST take to improve

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Action the hospital MUST take to improve:

- Ensure that there are appropriate arrangements for the prevention and control of infection including the isolation of patients throughout the hospital, including the urgent and emergency care department; that infection prevention and control practices are adhered to, particularly on Ward 9 and in critical care. Ensure that there is suitable access to hand wash sinks, particularly on the critical care unit and high dependency unit. Review the number of side rooms available with ensuite bathroom facilities for the management of patients with infections. Ensure the procedures for cleaning and disinfecting endoscopes are consistent with accepted practice.
- Ensure that proper steps are taken to protect patients against receiving care and treatment that is inappropriate or unsafe by planning and delivering care in ward environments that meet individual needs and ensures the welfare and safety needs of patients on wards, particularly on Wards 2, 16 and 17.
- Ensure that on Ward 2 there are the appropriate bathing facilities for the removal of a urinary catheter in a child 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, on medical wards, including the provision of staff out of hours, on bank holidays and at weekends; that staffing levels meet planned staffing levels in the children and young people's services including the children's stabilisation room and; in critical care and in the recovery areas of operating theatres and maternity services. Ensure that there are sufficient numbers of suitably qualified, skilled and experienced staff assessing patients within the urgent and emergency care department to ensure the safe initial streaming of patients attending the reception area.
- Ensure that a nationally recognised acuity tool is used and ensure that written guidance is developed to support staff whilst assessing a patient's acuity.

Outstanding practice and areas for improvement

- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring non-invasive ventilation to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with good practice guidance.,
- Ensure that resuscitation equipment is checked according to best practice guidance and trust policy. Ensure that all checks are appropriately recorded.
- Ensure that patient records are maintained up to date, are patient centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.
- Ensure formal arrangements are developed for the receipt, recording and storage of surgical instruments.
- Ensure that there are suitable arrangements in place to provide effective bereavement, chaplaincy and mortuary facilities that treat patients and their visitors with consideration and respect and takes into account their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.
- Ensure that safe manual handling procedures are in place in the mortuary through the use of suitable equipment. Review the care pathway for children undergoing surgical procedures including individual fasting times and timings for theatre.
- Review the access to and capacity of the child development service, especially in relation to access to autism services.
- Review the processes for ensuring patients on critical care are reviewed by a consultant with 12 hours of admission.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve:

- Review the queuing arrangements for patients in the ED reception area.
- Review the provision of ED facilities for patients living with dementia.
- Ensure paediatric nurse staffing in the ED is increased to enable the children's emergency area to be open in the morning each day.
- Provide patients in the ED waiting area with information about waiting times.
- Improve lighting and access to the ED at night.
- Review the use of the public address system used to address patients in the ED.
- Review the provision of side rooms in the ED.
- Record the cleaning of children's toys in the paediatric emergency area.
- Review information available about the emergency services for patients whose first language is not English.
- Consult with, and involve, reception and administrative staff in the redesign and improvement of the ED.
- Ensure staff receive feedback on incidents and that shared learning occurs.
- Review public and staff access to results of the Safety Thermometer.
- Ensure the referral system is fit for practice and maintains an audit trail.
- Ensure staff receive information regarding audits and reviews of practice so that trends and good practice can be identified.
- Review the trust's approach and uptake of clinical supervision.
- Review access to patient information in languages other than English.
- Review dedicated management time allocated to ward managers.
- Review the adequacy of facilities for staff and waiting patients within the endoscopy unit.
- Ensure that the chair seats in the bed spaces in ICU meet the required standards to prevent cross-infection.
- Ensure that clinical policies have review dates and are reviewed within the required timescales.
- Ensure that critical care delayed discharges are reduced and that patients are discharged from critical care to a ward within four hours of the decision to discharge being made.
- Ensure the audits of Ventilator Associated Pneumonia (VAP) to assess outcomes for ventilated patients are re-commenced.
- Review and ensure that NICE 83 guidelines for rehabilitation, mainly in relation to post-discharge follow-up, are followed.
- Review the handover arrangements to improve their effectiveness.
- Make the phlebotomy service available for patients if clinics are not running to time.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good governance. We found that the Trust had not protected service users from the risks of inappropriate or unsafe care and treatment as the provider's systems designed to regularly assess and monitor the quality of the services and identify, assess and manage risks were not always effective. This was in breach of regulation 10(1)(a) and (b) and (2)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1) and (2)(a), (b) & (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must: Ensure that there is in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified, assessed and managed including incident reporting and lessons learnt from these. Ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed. Ensure there is in operation an effective system for regularly seeking the views of staff on the standard of care and treatment provided including service development to inform decision making about the identification and assessment of risks and how these should be managed.

This section is primarily information for the provider

Compliance actions

Ensure that there is in operation an effective system for reviewing and updating policies and procedures to ensure that the patients are protected from receiving inappropriate or unsafe care and treatment.

Ensure that there are effective systems in operation that give assurance that the resuscitation equipment is checked according to best practice guidance and trust policy, including appropriate recorded.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17(2)(c): Good governance – records. We found that the trust did not always protect patients against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of records. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust should ensure that an accurate record is maintained in respect of each patient, which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training and had an appraisal. This was in breach of regulation 23 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. The trust must ensure there are suitable arrangements in place for staff to receive appropriate training, supervision and appraisal including the completion of mandatory training, particularly the relevant level of safeguarding
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 17 (1) (a) 2(a) (h) Respecting and involving service users Service users needs were not always met with regard to the provision of bereavement and chaplaincy services. Ensure that there are suitable arrangements in place to provide effective bereavement, chaplaincy and mortuary facilities that treat services users and their visitors with consideration and respect and takes into account their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(f) & (g): Medicines We found that the trust did not always have arrangements in place to protect service users from the risks associated with the unsafe use and management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must: Ensure medicines are stored safely on all wards and fridge temperatures are checked in line with national guidance. Ensure there are suitable arrangements in place for the oversight and reconciliation of patients' medicines by a pharmacist.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9: Person centred care. We found that the Trust was not ensuring that all patients received appropriate person-centred care and treatment that was based on an assessment of their needs. This was in breach of regulation 9(1)(a) and (b)(i) & (ii) of the Health and Social Care Act 2008 (Regulated

This section is primarily information for the provider

Compliance actions

Activities) Regulations 2010, which corresponds to regulation 9(1)(b) and (3)(a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The trust must:

Ensure that pain scores are consistently completed in the urgent and emergency care department and children and young people's services, as these could have led to a delay in patients receiving adequate pain relief.

Ensure that proper steps are taken to protect patients against receiving care and treatment that is inappropriate or unsafe by planning and delivering care in ward environments that meet the individual needs of patients on wards, particularly on Wards 2, 16 and 17.

Review and improve the environment on Ward 7, Ward 9, and Ward 24 and in the Diabetes Centre.

Ensure that there are adequate bathroom facilities on Ward 2 to meet the needs of the children on that ward.

Ensure that a nationally recognised acuity tool is used and ensure that written guidance is developed to support staff whilst assessing a patient's acuity.

Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring non-invasive ventilation to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with good practice guidance.

Review the care pathway for children undergoing surgical procedures including individual fasting times and timings for theatre.

This section is primarily information for the provider

Compliance actions

Review the access to and capacity of the child development service, especially in relation to access to autism services.

Review the processes for ensuring patients on critical care are reviewed by a consultant with 12 hours of admission.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(h): Assessing the risk of, and preventing, detecting and controlling the spread of infections. We found that the trust did not always have the facilities, systems and arrangements in place to protect service users from the risk of exposure to a health care associated infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must: Ensure that there are appropriate arrangements for the prevention and control of infection including the isolation of patients throughout Bradford Royal Infirmary, including the urgent and emergency care department. Ensure that infection prevention and control practices are adhered to, particularly on Ward 9 and in critical care at Bradford Royal Infirmary. Ensure that there is suitable access to hand wash facilities, particularly on the critical care unit and high dependency unit at Bradford Royal Infirmary.

This section is primarily information for the provider

Compliance actions

Review the number of side rooms available with ensuite bathroom facilities for the management of patients with infections at Bradford Royal Infirmary.

Ensure the procedures for cleaning and disinfecting endoscopes are compliant with HTM 0106 at Bradford Royal Infirmary.

Ensure formal arrangements are developed for the receipt, recording and storage of surgical instruments to ensure that there are appropriate levels of sterile equipment at all times at Bradford Royal Infirmary.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 15: Premises and equipment. We found that the trust did not have suitable arrangements in place within the Bradford Royal Infirmary mortuary to protect staff from the risk of using unsafe equipment. This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must ensure that safe manual handling procedures are in place in the mortuary through the use of suitable equipment.