York Teaching Hospital NHS Foundation Trust

The York Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The York Hospital was one of three main hospitals forming York Teaching Hospital NHS Foundation Trust. The trust provided acute hospital services to the local population. The trust also provided a range of other acute services from Scarborough and Bridlington hospitals to people in the wider York area, the north-eastern part of North Yorkshire and parts of the East Riding of Yorkshire. In total, the trust had approximately 1170 beds, over 8700 staff and a turnover of approximately £442,612m in 2013/14. The York Hospital had over 700 beds.

The York Hospital provided urgent and emergency services, medical care, surgery, maternity and gynaecology services, paediatrics services, outpatients and diagnostics and end of life care for people primarily to the York and surrounding area, but also served the people in the Scarborough, Whitby and Ryedale areas of North Yorkshire for some services.

We inspected the York Hospital as part of the comprehensive inspection of York Teaching Hospital NHS Foundation Trust, which includes this hospital, Scarborough and Bridlington hospitals and community services. We inspected York hospital on 17 – 20, 30 – 31 March 2015.

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

We rated urgent and emergency service and critical care as 'requires improvement', with medical care, surgery, maternity and gynaecological service, children & young people, outpatient and diagnostic services and, end of life care as 'good'.

Our key findings were as follows:

- Care and treatment was delivered with compassion and patients reported that they felt they were treated with dignity and respect.
- Patients were able to access suitable nutrition and hydration, including special diets. Patients were satisfied with their meals and said that they had a good choice of food and sufficient drinks throughout the day.
- We found the hospital was visibly clean, hand-washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. The last episode of MRSA septicaemia was more than 500 days prior to the inspection.
- There were concerns that patients arriving in the A & E department did not receive a timely clinical assessment of their condition.
- At the time of the inspection, in the majority of services the Trust was below its own target of 75% for mandatory training including safeguarding training. The Trust's target was to achieve 75% minimum compliance for the year ending August 2015. We have since been informed by the Trust that the figures provided to the CQC only included the training provided for the period of six months prior to the inspection as this was the time the Trust implemented a new system to capture and record training carried out. We were told the compliance levels did not include any training staff may have had prior to the 1 September 2014 and we were not provided with evidence to reflect this in the overall training levels.
- There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. However, we found that some maternity services policies and guidelines were out of date.
- The trust had no mortality outliers and mortality rates were as expected when compared with other trusts. The Summary Hospital-level Mortality Indicator (SHMI) of 98 was lower than both the Trust overall (102) the England average (100) in June 2014. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Summary of findings

- Some areas had staff shortages: nursing staff on medical and surgical wards; consultant cover within A & E; registered children's nurses on ward 17 and other appropriate clinical areas; and radiologists. The trust was actively recruiting to the majority of these roles.
- Patients were not always protected from the risks of delayed treatment and care as the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets were not being achieved.
- The trust was half way through its five year plan to integrate services following the acquisition of Scarborough & North East Yorkshire NHS Trust in 2013.Services within all three of the acute hospitals were at differing stages of integration.
- Seven of the eight core services we inspected had good local leadership within the service.

We saw several areas of outstanding practice including:

- The appointment of a senior paediatric specialty trainee 'quality improvement fellow' for one year has led to improvements such as the use of technology in handover sessions, with further plans for development of electronic recording of clinical observations and the PAWS assessment.
- We saw positive partnership working with and support from CAMHS in York, which ensured that the acute inpatient wards had seven-day support. The community nursing team also had a CAMHS nurse specialist allocated to the team who provided psychological support for families and staff.
- The innovative way in which central lines were monitored, which included a central line clinical pathway. The critical care unit were finalists for an Institute for Healthcare Improvement (IHI) safety award.
- The medical service had an innovative facilitating rapid elderly discharge again (FREDA) team, which provided multidisciplinary support and rehabilitation to elderly outlying patients.
- Ward 25, an integrated orthopaedic and geriatric ward, worked closely with the A&E department, and actively identified elderly patients with a fractured neck of femur, to speed up flow to the ward and on to theatre, had demonstrated positive outcomes of speedier rehabilitation and reduced length of stay, with the majority of patients returning to their usual place of residence.
- Phlebotomy outreach clinics in the local community, which have led to improved access to the service.
- Availability of pathology services in the oncology outpatient department, meaning that up-to-date blood results are available for patients when they see the consultant in clinic. Treatment changes are based on up-to-date information.

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

Importantly, the trust must:

- Ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.
- 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; nursing staff on medical and surgical wards; consultant cover within A & E; registered children's nurses on ward 17 and other appropriate clinical area; and radiologists.
- Ensure there are suitable arrangements in place for staff within the medicine and surgery, outpatient and diagnostic services to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.
- The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.

Summary of findings

- The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16.
- The provider must ensure effective plans are in place and implemented to eliminate the non-clinical delayed discharges and delayed admissions on the critical care unit.

In addition there were areas where the trust should take action and these are reported at the end of the report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The environment did not always enhance patient safety, particularly for young children. At the time of the inspection patients were seldom clinically assessed as soon as they arrived in the department. Some patients waited up to two hours for a clinical assessment and some did not receive an initial clinical assessment at all. It was therefore possible for their condition to deteriorate while they were waiting to be seen. There were not enough senior doctors or nurses. The majority of care and treatment was effective and delivered in line with current evidence-based guidance and standards. There was participation in national clinical audits. Feedback from people who used the service was very positive regarding the way they were treated by staff. They thought that staff went the extra mile and the care they received exceeded their expectations. The A&E department needed to improve its responsiveness to the needs of people using the service. In the year leading up to our inspection, the department had been unable to meet the national target of admitting or discharging 95% of patients within four hours. There was little evidence of a hospital-wide approach to improving patient flow through A&E. The department itself was well led. The leadership actively shaped the culture through effective engagement with staff and patients. They demonstrated the skills, knowledge and experience needed for their roles.
Medical care	Good 	Overall, we judged this service as good, with safety requiring improvement. In the main, patients were protected from avoidable harm and abuse. However, the provider was unable to consistently provide safe staffing levels. There was poor compliance with mandatory training requirements. Policies and pathways were based on national good practice and were accessible to staff. National audits were completed and acted upon. Patients were happy with the care they received, and found the service to be caring and

Summary of findings

compassionate. Most patients, and their friends and families, spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. Staff worked to meet the needs of individual patients.
Managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service. Staff told us that they were well supported by their ward managers and clinical matrons, and were encouraged to develop to improve their practice. However, staff did not always feel that their views or ideas were listened to or acted upon. There were a number of examples of innovation and service improvements.

Surgery

Good

Services were responsive to patients' individual needs, but there were concerns over waiting times, such as the 18-week referral-to-treatment time (RTT) targets, the achievement of cancer waiting time targets, and the high number of non-surgical patients being cared for on surgical wards, which was having an impact on access and flow.
Optimum staffing levels and skill mix across surgical services were not being sustained at all times of the day and night. However, the trust was mitigating some of this risk by the use of bank/agency staff and the redeployment of other staff. Pressures on the wards had an impact on staff being able to attend statutory and mandatory training.
The service provided effective and evidence-based care and treatment. Staff were seen to be caring and compassionate while delivering care. Patients' privacy and dignity were maintained, although some concerns were raised from patients about being cared for in mixed-sex accommodation on the nursing enhanced unit on ward 16.
Work was continuing to integrate surgical services and deliver common standards of care across the three hospital sites (York, Scarborough and Bridlington). Directorate-level governance arrangements were in place but protocols, guidelines and pathways of care in all three hospital sites were variable and not yet fully established.

Critical care

Requires improvement

Overall critical care services required improvement. Safeguarding training figures for the unit, across all

Summary of findings

levels of training, were under the target of 75%. Mandatory training figures for the directorate presented a mixed picture and, overall, compliance levels were well below the Trust's target of 75%. There were suitable processes in place in relation to incidents, safeguarding and assessing and responding to patient risk. Medical and nurse staffing levels were adequate. Staff worked to best practice guidance and overall, safety outcome data was good. The support provided from other services, such as the pain team, dietetics and physiotherapy was adequate, but in terms of dedicated hours for the unit some services fell short of best practice guidelines. Access to training was an issue and the lack of a clinical nurse educator was having a negative impact on educational progress. Staff were caring and professional, patients, relatives and friends spoke highly of the care provided on the unit.
Service and strategic planning was at an early stage and there was a lack of certainty in terms of the future design of the service and the immediate mitigating actions in terms of delayed discharge, delayed admissions and high capacity. There were positive comments from staff regarding culture and team work. However, it was felt by some staff that issues could be discussed in a more collaborative way and service planning could be more inclusive of others.

Maternity and gynaecology — **Good**

Staff were caring and treated women with respect. The services were responsive and delivered in a way that met the needs of the women accessing them. The service was well led.
There were policies and guidelines on the intranet. However, there were some guidelines in maternity services, relating separately to Scarborough Hospital and York Hospital, which were out of date and did not adhere to national guidance. Monitoring of performance was difficult to review.

Services for children and young people — **Good**

Overall the service was good. However, there were not always adequate numbers of registered children's nurses available to meet the needs of children, young people and parents within the inpatient areas. Children's services did not have all the necessary individual risk assessment tools in place so that members of staff could conduct a

robust, individualised risk assessment if required.
We found that all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Training records submitted by the trust prior to the inspection showed varying levels of training uptake by members of staff, but not all were achieving the 75% compliance set by the Trust.
Children's services had made improvements to care and treatment where a need had been identified using assessment programmes or in response to national guidelines.
Children, young people and parents told us that they received compassionate care with good emotional support. Parents felt informed and involved in decisions relating to their child's treatment and care.
The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy and was led by a positive leadership team.

End of life care

Good

We saw that end of life care services were safe, effective, caring and responsive, with elements of outstanding practice in terms of being well led. Staff were caring and compassionate and we saw the service was responsive to patients' needs.
There was good use of auditing to identify and improve patient outcomes and we saw measures in place to monitor key areas that had been identified.
The trust had a clear vision and strategy for end of life care services and participated in regional and locality groups in relation to strategic planning and implementation. There was consistent leadership relating to end of life care and a number of positive developments had been implemented, for example, non-cancer end of life care and the development of training to improve advance care planning discussions, including those relating to DNA CPR.

Outpatients and diagnostic imaging

Good

Overall the care and treatment received by patients in York Hospital outpatients and diagnostic imaging departments was effective, caring, responsive and well led. However the safe domain required improvement.
The managers told us that they continued to report any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical

Summary of findings

Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from York Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action had been taken by the unit to promote safety. The trust did not provide at the inspection evidence that it was consulting and receiving regular advice and reporting from its radiation protection adviser (RPA) to comply with the Ionising Radiations Regulations 1999 (IRR99). Post inspection the trust informed us they had an RPA and issues were discussed.
The information on staff training especially on mandatory training was kept as departmental records. This meant outpatients staff training records were with theatres, anaesthetics and critical care unit training records. Therefore we were unable to separate out and report on the compliance within the outpatients department. Data indicated that the diagnostic imaging services staff training were not compliant with training.
There was a 14% vacancy rate for consultant and registrar radiologists in York. Some of the vacancies were covered by locumsThe trust informed us that there were 3.5 WTE specialist registrar vacancies. There was no formal tool or mechanism used to decide on staffing levels.
Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because staff were aware of the policies and how to follow them.
Patients told us that staff working in the outpatients and radiology departments were caring and compassionate at every stage of their journey. People were treated respectfully and their dignity and privacy was maintained at all times by staff. We found the services were well led and care and treatment was delivered in response to patients' needs and to ensure that the departments ran effectively and efficiently.

The York Hospital

Detailed findings

Services we looked at

Urgent & 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 & Diagnostic Imaging

Detailed findings

Contents

Background to The York Hospital

York Hospital is the York Teaching Hospitals NHS Foundation Trust's largest hospital. It has over 700 beds and offers a range of inpatient services, including critical care medicine. The trust covers a large geographical footprint of 3,400 square miles and in the region of 800,000 people.

The Indices of Multiple Deprivation indicates that York is the third least deprived city (out of the 64 largest cities in the UK) and is the 87th least deprived borough out of the 326 boroughs in the UK. North Yorkshire is a relatively prosperous county compared to the rest of England, although there are pockets of deprivation. Eighteen Lower Super Output Areas (LSOAs) within North Yorkshire are amongst the 20% most deprived in England. Fourteen of these LSOAs are in the Scarborough district (around Scarborough and Whitby), two in the Craven district (around Skipton), one in the Selby district and one in the Harrogate district.

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

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Adam Brown, Care Quality Commission

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

Detailed findings

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at the York hospital:

- Urgent and emergency
- 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 trust. These included the clinical commissioning

groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

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

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

We carried out the announced inspection visit between 17 and 20 March 2015 and undertook an unannounced inspection in the evening on 30 March and the 31 March 2015 at York and Scarborough hospitals

Facts and data about The York Hospital

The York Hospital is the Trust's largest hospital. It has over 700 beds and offers a range of inpatient and outpatient services. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma, intensive care and cardiothoracic services to the population and visitors to York and North Yorkshire.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Information about the service

The accident and emergency (A&E) department at York Hospital is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment, such as lacerations and suspected broken bones. The A&E department is a recognised trauma unit although major trauma cases go directly to Leeds. The department sees approximately 84,000 patients each year.

The department has a three-bay resuscitation area with one bay designated for children. There is a major treatment area with 12 cubicles and an adjacent observation ward for four patients. Patients with minor injuries or illnesses are seen in an urgent care centre that has 12 cubicles. A newly built ambulance receiving area has room for seven patients. There are separate rooms for patients with mental health problems and for relatives of patients who require resuscitation.

We visited on 17, 18 and 20 March 2015. We observed care and treatment and looked at 40 treatment records. During our inspection, we spoke with approximately 30 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We talked with 15 patients and four relatives. We received comments from patients and the public at our listening events, and we reviewed performance information about the department.

Summary of findings

The environment did not always enhance patient safety, particularly for young children. At the time of the inspection patients were seldom clinically assessed as soon as they arrived in the department. Some patients waited up to two hours for a clinical assessment and some did not receive an initial clinical assessment at all. It was therefore possible for their condition to deteriorate while they were waiting to be seen. There were not enough senior doctors or nurses.

The majority of care and treatment was effective and delivered in line with current evidence-based guidance and standards. There was participation in national clinical audits. Feedback from people who used the service was very positive regarding the way they were treated by staff. They thought that staff went the extra mile and the care they received exceeded their expectations.

The A&E department needed to improve its responsiveness to the needs of people using the service. In the year leading up to our inspection, the department had been unable to meet the national target of admitting or discharging 95% of patients within four hours. There was little evidence of a co-ordinated hospital-wide approach to improving patient flow through A&E.

Urgent and emergency services

The department itself was well led. The leadership actively shaped the culture through effective engagement with staff and patients. They demonstrated the skills, knowledge and experience needed for their roles.

Are urgent and emergency services safe?

Requires improvement

The environment in the A&E department did not always enhance patient safety. There was no separate treatment area for children and people in the waiting room could not be observed by reception staff. Risks to patients were not always assessed or managed on a day-to-day basis. The majority of patients were not clinically assessed when they first arrived in the department. Some patients waited up to two hours for a clinical assessment and some did not receive an initial clinical assessment at all. Specific assessments of patients who were at risk of abuse were not carried out in a systematic fashion and some staff had not received recent training in safeguarding processes.

The department was visibly clean and infection control precautions were adhered to. Medicines were stored and administered correctly. Incidents were reported in a methodical and timely fashion and action was taken when necessary. There were not enough senior doctors or nurses.

Incidents

- Staff in the A&E department reported incidents using the trust-wide reporting system (Datix). We saw that the majority of incidents (85%) that had been reported between April and December 2014 resulted in no harm or minor harm, such as a short delay in treatment.
- Senior staff had addressed the incident reports promptly and had taken action when necessary.
- The incident database that was sent to us lacked detail and so it was not possible to establish whether safety issues such as long delays for treatment or aggression towards staff had been reported.
- Learning from incidents and 'near misses' was displayed on a noticeboard in the staff room.
- We saw copies of three incidents that had occurred in the department and the root cause analysis that took place subsequently.
- Several staff told us about, and we were shown, the Patient Safety Casebook. This gave up-to-date information on the department's safety record as well as on governance and quality topics.

Duty of Candour

- The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and to any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred.
- Doctors and nurses we spoke with understood the responsibilities associated with the Duty of Candour.
- Senior staff demonstrated detailed knowledge of the practical application of this new responsibility.

Cleanliness, infection control and hygiene

- The department was visibly clean and tidy and there were cleaning checklists in all clinical areas. We observed support staff cleaning the department throughout the day in a methodical and unobtrusive manner.
- Hand-washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by all staff. This helped to prevent the spread of infection.
- We were told that infection control audits were being redesigned in order to reflect new guidance from the World Health Organization. Because of this, there were no recent audit results available.
- Staff were aware of the actions necessary to look after someone with Ebola or who may have been involved in the recent outbreak. There were notices at the entrance to A&E asking people to inform the receptionists if they had recently travelled to the affected countries. Receptionists knew how to isolate people before asking for help from clinical staff.
- We observed staff treating a patient in isolation in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.

Environment and equipment

- The department was well laid out and generally well equipped. However, there were some aspects of the available facilities that did not enhance patient safety which are outlined below.
- Cubicles in the major treatment area did not have a call bell for patients to use if they needed help. Although the cubicles were visible from the staff base, when the department was busy, staff were not always available to observe patients. We saw a patient who had been immobilised due to a neck injury who was alone in a cubicle without any means of calling for help.
- The A&E department did not have a separate children's treatment area and therefore did not comply with guidance set out in the Intercollegiate Committee's Standards for Children and Young People in Emergency Care Settings.
- Although one or two cubicles in each treatment area had been made 'child friendly', they were surrounded by adult treatment facilities. This meant that children were sometimes exposed to disturbing experiences such as serious injuries, loud noises and, occasionally, aggression.
- There was a small corner in the waiting room designated for children. Although it contained a number of toys, it was cold and unwelcoming and was rarely used during our inspection.
- The waiting room was shared with the neighbouring orthopaedic clinic. This caused confusion and anxiety to A&E patients who often had to wait for lengthy periods to be seen. However, they were aware of patients who had only just arrived at the same reception being called in before them. (These patients were orthopaedic patients attending the clinic although this was not clear at the time). One patient described the waiting room as "confusing and chaotic".
- The waiting room was not in the line of sight of the reception desk or the clinical areas. This meant that patients were isolated and their condition could deteriorate without them being observed by a member of staff.
- There was a small x-ray department within A&E. It was well equipped and easily accessible from all areas.
- There was a separate quiet room for people suffering with mental health problems.
- There was sufficient resuscitation, monitoring and decontamination equipment. This was clean, well maintained, regularly checked and ready for use.
- We spoke with staff from the medical physics department who maintained clinical equipment. They had responded quickly when nurses reported that a monitor was working incorrectly. They showed us comprehensive maintenance records for the clinical equipment in the department.

Urgent and emergency services

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs were checked regularly and recorded accurately in a register.
- Unused drugs were disposed of in accordance with hospital policy.
- We observed staff administer intravenous fluids safely and correctly. They methodically completed details on the medication chart.

Records

- The department had a new computer system that showed how long people had been waiting and what investigations they had received.
- The system produced a patient record in a format that consisted of one sheet of A4 paper. This was often not big enough to record all of the information necessary. Doctors and nurses sometimes had to write in the margins and this made the information difficult to read. There were no body map diagrams to accurately record injuries and no sections for risk assessments.
- If further pages or documents were needed, they were filed loosely in a plastic folder. Although this meant that patient details remained confidential, there was a risk that vital documents could fall out of the file and be lost.
- Paper records for patients who were discharged were stored for two weeks. They were then scanned into the computer system and the paper record destroyed.
- When a patient was admitted to a ward, their A&E records would go with them and would be included in the main medical record file. Copies of the documents were placed on the A&E computer system via a scanner.
- However, the quality of the scanned copies was poor and we found that important information was sometimes missing. This meant that, if a patient returned to the department at a future date, important information about their health and treatment might not be available to clinical staff.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Most understood the safeguarding procedures that were in place for children and how to report concerns. There was limited awareness of adult safeguarding procedures.
- We were told that safeguarding was included in annual mandatory training sessions and during induction training. Trust-wide records indicated that compliance with the planned 75% was very variable for the emergency department directorate, but mostly not met. For administrative and clerical staff 19% had received the training; medical staff level 1 adult training was at 56%; safeguarding adults level 1 for nursing was 44%.
- For level 2 adult safeguarding training was at 8% for nursing staff.
- For safeguarding children training the figures were: administrative and clerical staff level one 25%; for level 2 nursing it was 89% and for medical staff 15%.
- Level 3 figures were nursing 37%: additional clinical service staff 15%; and medical staff 15%.
- We were told that no staff had been able to attend mandatory training in the last year and so their knowledge may not have been up to date.
- There was no clearly defined system for identifying children who might be at risk of abuse. The standard children's A&E record contained the question: "Do you have any concerns that this presentation may be the result of non-accidental injury?" However, there was no risk assessment or checklist incorporated into the patient record for staff to follow. Staff told us that they would use their professional judgement but this varied depending on the experience of the member of staff involved.
- The sister who led on children's safeguarding issues had recognised the weakness in the A&E documents and had devised a prompt card to help staff assess whether children were at risk of abuse. All the staff we spoke with had a copy of the card in their pocket so that it was easily available when needed.
- In order to improve the safety of vulnerable children, the hospital safeguarding lead reviewed all children's records once a week. In addition, copies were sent to school nurses.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control and safeguarding.
- Data supplied by the Trust indicated that in most staff groups statutory and mandatory training for the York hospital emergency department directorate were not achieving the 75% compliance levels required by the

Trust. For example, the statutory fire safety awareness was at 67% for nursing staff and 24% for medical staff. Conflict resolution training was at 7% for nursing staff and 11% for medical staff.
- Senior staff told us that no mandatory training had taken place in the previous year because of staff shortages.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.
- We were told that ambulance patients were assessed in the ambulance assessment area by an experienced nurse. They would then be transferred to an appropriate treatment area. However, on the second afternoon of our inspection, we observed that there was no nurse in the assessment area when an elderly patient was brought in by ambulance. A member of the ambulance crew left to find a nurse but came back without one. He said that a decision had been made to take the patient to the minor treatment area even though the nurse had not seen the patient. There was a risk that the patient could have been taken to the wrong treatment area because a clinical assessment had not taken place in A&E.
- The hospital was failing to meet the target for all ambulance patients to be handed over to the care of A&E staff within 15 minutes. Figures from the ambulance service showed that, during the last year, between 8% and 22% of ambulance patients had waited more than 15 minutes. Some waited over an hour. Figures for February 2015 showed that 20% of ambulance patients waited more than 15 minutes and eight patients waited more than two hours.
- When there were long waits to hand over to a nurse, ambulance crews were encouraged to bypass the clinical assessment process and take patients to the waiting room instead. We saw a large poster in the ambulance waiting area entitled 'Ambulance self-handover'. This advised ambulance crews to take patients to the waiting room if they were considered to have a minor injury or illness. This included children over one year old if accompanied by an adult. Patients, or their parents, were asked to sign a disclaimer to say that the decision had been explained to them and that they were happy with it.
- Patients who walked into the department, or who were brought by friends or family, were directed to a receptionist. Once initial details had been recorded, patients were asked to sit in the waiting room while they waited to be assessed by a nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their ongoing care. This is often known as triage. We observed the initial assessment of a patient (with their consent) and found it to be thorough and effective. The nurse had completed special training in triage and had been assessed as competent before undertaking the role. Guidance from the Royal College of Nursing (RCN) and Royal College of Emergency Medicine (RCEM) states that: "Triage is a face-to-face encounter which should occur within 15 minutes of arrival." The A&E department at York Hospital was not meeting this standard.
- During our inspection we observed that sometimes there was no triage nurse available. This was because the major treatment area was busy and the triage nurse had been asked to help. Although nurse practitioners from the urgent care centre shared the triage role, they were not always available. Figures supplied by the trust showed that only 44% of patients were clinically assessed within 15 minutes. These delays meant that patients with serious conditions could deteriorate while they were waiting.
- Attendance figures from the week before our inspection showed that some patients waited between two and three hours before being clinically assessed.
- Some patients were not triaged by a nurse at all. If the receptionist thought that their injury or ailment was a minor one, they would wait to see an emergency nurse practitioner. Before the inspection we were told that a list was available giving details of which conditions did not require triage. However, receptionists we spoke with said that they did not have a list to refer to so they used their common sense. Some of the reception staff we spoke with expressed concerns about deciding whether injuries were minor or not, particularly where small children were concerned. We raised this with the Trust at the time of the inspection.
- There were often long waits to see an emergency nurse practitioner. Data from the previous week showed that

some patients waited one or two hours before seeing an emergency nurse practitioner. This meant that their condition could deteriorate because no one had identified the risks that could be associated with it.

- A position statement issued by the RCN and RCEM states that: "Staff undertaking this role [triage] should be registered healthcare professionals experienced in emergency/urgent care who have received specific training and can demonstrate developed interpersonal skills so that they are able to communicate effectively with patients and their families in what is often a stressful situation." This means that triage should not be carried out by a receptionist or members of the ambulance service, however experienced they may be.
- Staff had recognised that the current arrangements for the initial assessment of patients needed to improve. There had been a discussion of the difficulties at the clinical governance meeting in February 2015. One solution that was proposed was for a nurse to briefly assess all patients as they entered the reception area.
- At the unannounced inspection on the 30 and 31 March we checked to see if the streaming of patients by receptionists had changed. There had been some minor changes to the list of symptoms that required an automatic referral to a clinician but no substantive changes.
- The trust indicated in a letter dated 27 March 2015 that a revised Standard Operating Policy would be developed and that discussions within the directorate have begun already around this. The review would consider and develop a proposal to ensure that the department had enhanced 24 hour cover of nursing staff, appropriately skilled in the assessment and triage of children. The review would also assess the respective skills of those undertaking triage in both the ED and urgent care centre and would consider if further training and development would deliver improved flexibility and more efficient use of these highly skilled staff. This review was to be completed by the end of April 2015.
- The National Early Warning Score (NEWS) was used throughout the department once initial assessment had been completed. This is a quick and systematic way of identifying patients who are at risk of deteriorating. Once a certain score is reached, a clear escalation of treatment should be commenced.

Nursing staffing

- Nurse staffing levels were based on historical establishments that had been reviewed over time to take account of changing demand. A specific staffing acuity tool was not used. Senior staff told us that an independent workforce review had taken place in 2012. This had recommended an increase in the nursing establishment but the recommendations had not been implemented. A senior nurse told us that the resulting staffing levels would have been similar to those recently recommended by the National Institute for Health and Clinical Excellence (NICE).
- We looked at the duty rota for the fortnight beginning 16 March 2015 and compared it with the A&E staffing recommendations issued by NICE. Most treatment areas had sufficient nurses except for the ambulance assessment area. This had seven cubicles and should have had a minimum of two experienced nurses. Instead, only one nurse was allocated to this area and it was usually a less experienced band 5 nurse.
- There were insufficient experienced band 6 nurses to ensure that the resuscitation and triage areas had sufficiently competent and knowledgeable nurses available at all times to look after the sickest patients.
- There were not enough band 7 sisters to take charge of the department on every shift.
- There were only three registered sick children's nurses employed by the department so it was not possible to have one on duty at all times.
- The lead nurse for A&E told us that there was rarely any difficulty in recruiting new nurses and she rarely had to use temporary nurses to fill vacancies. However, the budget that was allocated did not allow for sufficient nurses in the department to comply with the NICE recommendations.

Medical staffing

- There were insufficient consultants to comply with RCEM guidelines for consultant staffing. These state that there should be a consultant in the department for 16 hours a day. The rota showed that consultants worked from 9am to 11pm during the week and from 9am to 10pm at weekends. They were on call at night.
- The RCEM guidelines also state that there should be a senior doctor (at least a ST4 grade) in the department at all times. The rota showed that this was rarely achieved at night.

Urgent and emergency services

- We saw a consultant working clinically in the department. They led the treatment of the sickest patients, advised junior doctors and ensured a safe clinical handover of patients' treatment when shifts changed.

Major incident awareness and training

- The hospital had an up-to-date major incident plan (MIP). This provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering from a range of injuries, including those caused by burns or blasts and chemical contamination.
- Staff in the department were well briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (hazardous material or HAZMAT).
- However, it was not possible to rapidly access the special equipment needed to deal with a major incident. This was kept in a Portakabin outside the A&E department and the key was held by a manager who did not work in the department. It took 20 minutes for the door to be opened and this delay would have had an adverse impact on the department's ability to respond to a major incident.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

By effective, we mean that people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence.

Patients' care and treatment were planned and delivered in line with current evidence-based guidance, standards and best practice. There was participation in national clinical audits. Information about effectiveness was shared with, and understood by, staff working in the department.

Evidence-based care and treatment

- The A&E department used a combination of clinical guidance including NICE and RCEM guidelines to determine the treatment that was provided. Guidance was discussed at governance meetings, disseminated and acted upon as appropriate.
- A range of clinical care pathways and proformas had been developed to guide best practice. These included severe asthma, feverish children and major trauma. At monthly governance meetings, any changes to guidance and the impact that this would have on practice were discussed.
- The department did not comply with the national Intercollegiate Committee's Standards for Children and Young People in Emergency Care Settings. It did not have separate facilities for children and did not have enough staff who were trained to look after sick children.

Pain relief

- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department. However, patients sometimes waited for over two hours to be assessed, which delayed effective pain relief.
- Patients we spoke with who had arrived by ambulance told us that their pain had been controlled effectively.
- Initial pain scores had been recorded when patients were first assessed but had not always been reassessed

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed and administered and recorded when clinically indicated.
- Patients we spoke with told us that they had been offered drinks and snacks where appropriate.

Patient outcomes

- The A&E department participated in a number of national audits, including those carried out on behalf of the RCEM. Results from the 2013 RCEM clinical audit relating to consultant sign-off were compared with those of the same audit in 2011 to determine whether the A&E had made any improvements. The consultant sign-off audit measures a number of outcomes, including: whether a patient has been seen by an A&E consultant or other senior doctor in emergency medicine prior to being discharged from the A&E when they have presented with non-traumatic chest pain (17

years of age or older), management of children under one year of age presenting with a high temperature; and patients who present back to the A&E within 72 hours of previously being discharged from A&E.
- Results from the 2013 audit were not quite as good as those for 2011, but they were significantly better than most other A&E departments in the rest of the country.
- We looked at other national audits in which the department had been involved. These included audits of the treatment of feverish children and identification and treatment of patients with severe sepsis. The audit of feverish children showed that the department had improved since the last audit and was as effective as most hospitals in the country. The sepsis audit showed that the department was less effective than other hospitals, particularly in the speed with which oxygen and intravenous fluids and antibiotics were administered.
- The RCEM audit of fractured necks of femur (broken hips) showed that pain relief was poor but that patients were sent to x-ray and were admitted more quickly than in most other departments. Since the audit, a specialist nurse had been appointed to lead the care of patients with fractured necks of femur. We were told that pain control had improved in recent months although the new audit results were not available at the time of the inspection.

Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process. For the period July 2014 – November 2014 there was 65.3% of registered nurses who had a current appraisal; 53.3% of staff in additional clinical services and 90% of administrative and clerical staff.
- We observed staff being encouraged to develop new skills at every opportunity throughout our inspection. This ranged from healthcare assistants being taught to set up equipment for sterile procedures to doctors being trained in advanced resuscitation skills.
- We observed high levels of competency in triage, the treatment of minor injuries and the treatment of seriously ill patients.
- Junior doctors spoke positively about working in A&E. They told us that the consultants were supportive and always accessible. In-house teaching was well organised and comprehensive, although sometimes it had to be cancelled if the department was very busy.
- We spoke with the nurse training facilitator who explained that the role was a new one and that they had been seconded for a year to set up a training and development structure for A&E nurses.
- New nurses underwent a two-week orientation programme that involved working with an experienced nurse. This was supported by an induction programme that set out the skills nurses needed to learn.
- A competency framework had been developed for band 5 nurses so that they could develop the skills required to be a competent A&E nurse. This also prepared them for more senior roles.
- A training tracker had recently been developed to monitor the specialist training and qualifications achieved by nursing staff. This showed that qualifications such as advanced and intermediate life support, paediatric life support and trauma nursing were out of date. The training facilitator explained that it had not always been possible for staff to attend training in the last year because there would not have been enough staff left to look after patients.
- The department was taking part in an 'Emerging Leaders' programme. This develops the skills of band 6 and band 7 nurses in areas such as staff management and development and service improvement. The programme had been nominated for an award by the NHS 'Develop the Champions' project.

Multidisciplinary working

- There was effective multidisciplinary working within the A&E department. This included effective working relations with specialty doctors and nurses, mental health teams, social workers, therapists and GPs.
- Medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

Seven-day services

- The department had access to emergency medicine consultants 24 hours a day, seven days a week. When the consultants were not in the department they were on call from home.
- The department had access to x-ray facilities 24 hours a day. However, there had been occasions in the last year when computerised tomography (CT) scanning was not always available. An audit carried out by the national trauma audit and research network (TARN) in March

2015 showed that this had resulted in average delays of one and a half hours for CT scans relating to trauma. This is contrary to NICE guidelines. There was 24-hour access to adult mental health services but out-of-hours mental health support for children was difficult to obtain.

Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer-based and we observed staff referring to them when necessary.
- The computer systems provided up-to-date information about patients' condition and progress within the A&E department. However, previous information about patients who had been admitted was difficult to find.

Consent, Mental Capacity Act 2005 and deprivation of liberty safeguards

- We observed that consent was obtained for any procedures undertaken by staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Senior staff displayed a commitment to the use of new mental capacity assessment forms although they were not able to show us any examples during the inspection.

Are urgent and emergency services caring?

Good

Feedback from people who used the service was very positive regarding the way they were treated by staff. They thought that staff went the extra mile and the care that they received exceeded their expectations.

There was a strong, visible people-centred culture which resulted in patients and those close to them being treated with dignity, respect and kindness. The well-being of people being treated was of great importance to staff and was promoted by the leaders of the department.

Compassionate care

- People we spoke with praised the staff for their kindness and compassion and told us that the care they had received exceeded their expectations. One relative said: "We have been overwhelmed by the kindness that we have received today."
- A patient told us: "Nothing is too much trouble. They keep coming back to see if I am alright."
- We observed doctors and nurses introducing themselves when they met patients and their families for the first time.
- Care was delivered with appropriate information and checking of understanding. Staff took time to listen to people's concerns and were observed to act in a respectful, considerate and supportive manner. Nurse practitioners would often walk with patients to the x-ray department rather than letting them find their own way.
- We spoke with an elderly patient who had been brought to the department in the early hours of the morning. They had been ready to go home at about 5am but a relative had to drive to the hospital in order to take them home. Rather than calling the relative at an early hour, staff found the patient a bed in the observation ward and the patient was collected at 9.30am instead.
- A patient who had been to A&E several times before was greeted warmly by one of the doctors. The doctor allayed the patient's concerns and spent a considerable amount of time explaining the results of blood tests that had been carried out.
- Results from the Friends and Family Test and the CQC A&E survey were similar to those for most other A&E departments in England.

Understanding and involvement of patients and those close to them

- People's individual needs and preferences were reflected in how care was delivered. We observed a very sick infant being brought to the resuscitation area by ambulance. Throughout the treatment the infant was allowed to stay on their mother's lap. This reassured both mother and baby. Doctors and nurses remained calm and informative throughout the treatment process, which visibly reduced the mother's anxiety.
- Once the infant's condition had stabilised, a nurse drew up a chair, sat down next to the mother and said: "Now that we have made X better, it is time to look after you." A full explanation of the infant's illness was given followed by information about what would happen next.

Urgent and emergency services

- Patients and their families told us that they were kept informed of all care and treatment due to be carried out. Medical staff were praised for the quality of their communication to families so that families understood the sequence of events and the likely timings.

Emotional support

- We saw one family being supported while their relative was being treated and cared for in the resuscitation area. They were given clear information and their understanding was checked. They were given the opportunity to talk within a private area. One nurse had been given the responsibility of looking after them so that they received consistent information and support.
- Special attention was paid to the families of people who had died suddenly in the department. They were told that they could spend as long as they liked with their deceased relative in a quiet room away from the activity of the main department. There was a nurse available to support them and they were encouraged to take a lock of hair away with them to help them remember their loved one.
- Nurses had sourced strong, smart-looking bags to contain the clothes and belongings of the deceased. Before this, plastic carrier bags labelled 'NHS property bag' had been used and it was thought this lacked dignity when given to relatives.
- Nurses were particularly concerned about the parents of babies who had died in the department. New babygrows were available so that babies could be dressed in a dignified way after death. Staff had knitted appropriate clothes to dress larger babies.
- We heard the reception staff respond to an anxious family. This was done in a calm and reassuring manner, and the receptionist promised to obtain more detail and pass it on to the family. When we asked later, this had been done.
- There were chaplaincy services available for those who might require them for psychological and emotional support during periods of emotional distress.

There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people.

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

(for example, to feedback?)

Requires improvement

The A&E department needed to improve its responsiveness to the needs of people using the service.

Once patients were within the clinical treatment areas of A&E, their initial needs were responded to in a timely manner. However, there were delays of over an hour in nurse assessment for ambulance patients. At times there was crowding in the A&E department, mainly due to difficulty admitting patients to wards. There was little evidence of an effective or co-ordinated hospital-wide approach to improving patient flow through the department. In the year leading up to our inspection, the department had been unable to meet the national target of admitting or discharging 95% of patients within four hours.

Staff responded well to patients with complex needs. They responded well to any complaints or concerns and used learning from these to improve future care and treatment.

Service planning and delivery to meet the needs of local people

- We were told that the department had an escalation plan which described how it prepared in advance to deal with circumstances when there was an unusually high demand for services. We looked at the plan and saw that A&E staff followed the actions that were required.
- Senior staff told us that some progress had been made in response to the RCEM report How to Achieve Safe, Sustainable Care in our Emergency Departments. However, service planning had been difficult during the last six months because the department had not had a permanent directorate manager.

Meeting people's individual needs

- Staff we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There was an assessment tool that helped identify immediate treatment needs.

Urgent and emergency services

- The majority of staff had undertaken training in the specific needs of people with dementia. Patients over the age of 65 were assessed for signs of dementia. If they were found to be vulnerable, they were referred to a specialist team before being discharged.
- People with learning disabilities attended a listening event organised by CQC before the inspection. We were told that they had been treated with respect and consideration but their special needs were not fully understood. Their difficulties in describing symptoms had occasionally led to delayed diagnosis.
- Staff told us that, in the past, there had been no training in the needs of people with learning difficulties. The appointment of a trust-wide learning disabilities nurse had improved awareness and staff felt able to contact the nurse for advice.
- Staff were able to describe the translation services that were available to the department. They were familiar with their use.

Access and flow

- All A&E departments in England are expected to receive and assess ambulance patients within 15 minutes of arrival. York Hospital had failed to meet this target over the last year. In January 2015, 52 ambulance patients had waited between 30 and 59 minutes to be handed over to A&E staff, while 92 patients had waited an hour or more.
- The A&E department at York Hospital had not achieved the national emergency access target to admit, transfer or discharge 95% of patients within four hours of arrival. This target had not been met since April 2014. Some 10% of patients had waited between four and 12 hours to be admitted to a ward. In January 2014, seven patients had spent more than 12 hours in the department. Staff told us that in recent weeks the situation had improved; there were no 12-hour waits during our inspection.
- There was an obvious awareness of the importance of the four-hour target among admitting teams of clinicians and ward staff and there was evidence that they were committed to achieving it. We heard a number of conversations between admitting teams regarding how they could best admit a patient to a ward within four hours of their arrival in the A&E department.
- During our inspection, there were few delays in admitting patients to wards in the hospital but we were told that this was unusual. Several staff told us that it was common to wait three or four hours for a bed to become available on a ward. Patient data from the previous week confirmed this. We looked at information from 10 and 11 March 2015 and found that in excess of 20 patients each day waited more than an hour to be admitted to a ward following the decision to admit. On 10 March 2015, five patients waited more than six hours to be admitted. These delays had led to excessive crowding in the A&E department.
- Staff told us that this was because there were delays in other parts of the hospital and community care system that meant patients were not being discharged promptly when medically fit.
- We were told that there had been a number of meetings with senior trust staff with a view to solving the problem of flow into the hospital. However, the issue involved several directorates and was complex, and therefore it was difficult to resolve.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern could not be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), which would formally log their complaint and would attempt to resolve their issue within a set period of time. PALS information was available within the main department.
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant within an agreed timeframe. Learning points from complaints were discussed at A&E governance meetings and at nursing staff meetings.

Are urgent and emergency services well-led?

Requires improvement

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture.

Urgent and emergency services

Staff reported incidents however the escalation of concerns, any response and action was slow. Staff were concerned about the difficulties escalating severe risks to senior staff within the trust. Concerns were not been acted upon expediently. There was no evidence provided of an assessment of the staffing in the department in relation to the recently developed NICE guidance.

Staff knew and understood the vision, values and strategic goals of the A&E department. However, senior staff told us that the strategy had proved difficult to implement. Structures, processes and systems of accountability were set out and understood by staff. The local leadership actively shaped the culture through effective engagement with staff and patients. Staff demonstrated the skills, knowledge and experience needed for their roles.

Vision and strategy for this service

- The A&E department had a written strategy and staff we spoke with understood the vision for the department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. They were clear about what the department did well and where it could improve.
- Senior staff told us that the strategy had proved difficult to implement. To some extent this was due to a lack of consultant medical staff but also because of difficulties in admitting patients to wards. This led to slow patient flow and a crowded department.

Governance, risk management and quality measurement

- There were processes in place to identify, monitor and address current and future challenges to care and treatment.
- The department maintained a risk register that defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce risks. We saw that the highest risk scores were for delays in admitting patients to wards and the fact that this resulted in the department being crowded.
- We asked how departmental risks were included in the hospital risk register. The procedure was described to us but we were told that it did not always work in practice. This meant that there were difficulties escalating severe risks to senior staff within the trust.
- Monthly governance meetings were held and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed.
- Concerns about the arrangements for “streaming” of patients when they entered the department was raised by CQC. In response the Trust informed us that this had been identified within the Trust as being associated with potential risk. Notes of a clinical governance session highlighted the need to review the process however CQC was concerned this had not been acted upon expediently.
- At the time of the inspection we raised concerns regarding a possible theme for some of the headache/ head injury incidents reported. The executive were aware of the incidents. However, a themed review had not been completed to ascertain whether there were systematic failures in the streaming and clinical assessment of these patients.
- Following the inspection the trust, in a letter dated 27 March 2015 informed us that the reports for the specific incidents had been completed and have been reviewed by the Serious incident group. Some actions have already been implemented and we were told that none of the cases related to the process for streaming and clinical assessment.
- There was no evidence provided of an assessment of the staffing in the ED in relation to the recently developed NICE guidance.
- Staff told us that they felt fully supported by their clinical leads and senior managers and they were confident that they would address any concerns reported to them.

Leadership of service

- Leadership and management of A&E were shared between a clinical lead, lead nurse and directorate manager.
- Departmental leaders, both clinical and non-clinical, were said by staff to be “visible and approachable”. They were knowledgeable about the quality issues and priorities, understood what the challenges were and took action on a departmental level to address them.
- Nursing and medical staff told us that the senior clinical and managerial staff had the knowledge, skills and personal integrity to effectively lead their department.
- Debrief sessions were held by senior clinicians after difficult clinical situations.

Urgent and emergency services

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the A&E.
- There was a strong sense of teamwork, which encouraged candour, openness and honesty.
- We were told that concerns were investigated in a sensitive and confidential manner and that lessons were shared and acted upon.
- The culture within the department was centred on the needs and experiences of people who used the service.

Public and staff engagement

- Staff felt actively engaged by the A&E leadership in the planning and delivery of services.
- The Friends and Family test indicated that the percentage of people who would recommend the department to others was variable. It ranged from 80% in December 2013 up to about 92% in July 2014. The trust had been actively encouraging patients to respond to the survey.

Innovation, improvement and sustainability

- A rapid discharge team had recently been set up within the department to facilitate the timely and safe discharge of elderly or frail patients.
- The team consisted of an occupational therapist, physiotherapist and social worker and operated seven days a week. Nursing staff told us that the team was very proactive and identified many patients who might need help even before they were formally referred.
- The department was undertaking a six-week pilot project to investigate the effectiveness of an ambulatory care unit. This was aimed at rapidly diagnosing and treating patients presenting with conditions such as non-cardiac chest pain, deep venous thrombosis and infections requiring intravenous antibiotics. It was hoped that, by treating them in the unit, an admission to a hospital ward could be avoided.

Medical care (including older people's care)

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

Information about the service

The York Hospital forms part of the York Teaching Hospital NHS Foundation Trust. Medical care at the York Hospital comprises 15 medical wards, an acute medical unit (AMU) and ambulatory care provision, and also a discharge lounge. The medical directorate includes a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, stroke, gastroenterology, endocrinology and haematology.

During the inspection we looked at the care records of 30 patients. We spoke with 20 patients and relatives, and over 50 members of staff, including doctors, nursing staff, therapists, volunteers, non-clinical staff and managers. We visited all medical wards, including the AMU, ambulatory care area and the discharge lounge. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall, we judged this service as good, with safety requiring improvement. In the main, patients were protected from avoidable harm and abuse. However, the provider was unable to consistently provide safe staffing levels. There was poor compliance with mandatory training requirements. Policies and pathways were based on national good practice and were accessible to staff. National audits were completed and acted upon.

Patients were happy with the care they received, and found the service to be caring and compassionate. Most patients, and their friends and families, spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. Staff worked to meet the needs of individual patients.

Managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service. Staff told us that they were well supported by their ward managers and clinical matrons, and were encouraged to develop to improve their practice. However, staff did not always feel that their views or ideas were listened to or acted upon. There were a number of examples of innovation and service improvements.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Medical services provided at York Hospital were rated as requires improvement for safety. In the main, patients were protected from avoidable harm and abuse. However, the provider was unable to consistently provide safe staffing levels. There were additional concerns regarding the operation of ward 24, the winter pressures ward which was often reliant on a majority of hospital bank and agency workers to staff it.

There was poor compliance with mandatory training requirements. Incidents were reported and learning was fed back to staff. The trust was aware of areas in which it needed to improve (such as falls), and there was an established falls panel which evaluated the investigation, findings and learning from falls incidents. The wards were clean and tidy, and there were regular cleaning schedules in place. The trust used the National Early Warning Score (NEWS), and staff could easily escalate deteriorating patients to medical staff.

Although staff we spoke with at York indicated that they were up to date with mandatory training and that this was easily accessible, data indicated that compliance rates for some elements of training were low. For some of the staff groups in the medical or elderly directorates, completion rates of basic life support and adult safeguarding were 43% and 52% respectively.

Incidents

- There had been 829 incidents reported at York, during the period from October to December 2014, in the medical care service. Seventeen of these were classified as resulting in moderate harm or above. The largest category of incidents were those relating to slips, trips and falls.
- All incidents graded as moderate or above were investigated using root cause analysis (RCA) methodology.
- Incidents were reported using 'Datix', the trust's electronic incident reporting system. The senior sister told us that they encouraged staff to report incidents.
- Incidents were investigated in line with trust incident management policies and procedures using RCA methodology, and the senior sister aimed to have responses for patients and families ready within a two week time frame.
- A ward manager in one area showed us the ward communication folder kept at the nurses' station for all staff to access and read. The communication file held quality and safety information, which included compliance against a number of key quality indicators, including information regarding incidents. The incident summary report for January 2014 to February 2015 showed all of the incidents reported across the medicines directorate by type, and gave the detail of the actions taken as a result of each incident. The outcome of the RCA investigation of serious incidents (SIs), together with their associated action plans, were also held in this file to be shared with staff.
- In addition to the communication file, safety briefings occurred each morning, at handover. Incidents were discussed there to identify whether an incident could have been avoided and what actions were needed to reduce the likelihood of future incidents occurring.
- Staff were aware that the number of falls was an issue for the trust, and the investigation of falls incidents were reviewed by a falls panel to ensure robustness of investigation, and that key messages were shared and improvements made in all relevant areas of the trust.
- Falls training was regularly available and could be accessed by any staff; this was a short 20 minute session and was attended by all members of the multidisciplinary team (MDT). The training looked at causes of falls and advances in management.
- Actions taken by the trust to reduce the number of falls included the use of red non-slip socks to highlight patients at risk of falling; movement sensors were also used, and patients were nursed in cohorts when one-to-one nursing levels were unavailable.
- Staff we spoke with were very familiar with the incident reporting system and knew how to report.
- We were told that regular safety incident bulletins were made available to staff, and incidents were reviewed and discussed at shift handovers. Staff told us that they regularly reported incidents and near misses.
- Staff were able to tell us about a serious incident which had happened in their area and the changes to practice that had been made as a result of the investigation.

Medical care (including older people's care)

- We saw that the Duty of Candour information was publicly displayed, and the duty was included as a mandatory field for completion within the incident reporting and management system.
- Staff understood the principles of Duty of Candour and when this should be implemented.
- Consultant mortality reviews were undertaken on every death, and there was a monthly summary discussion of all cases.

Safety Thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- We were shown the Safety Thermometer information which was held electronically on the 'signal system', the trust's electronic safety report system.
- We saw that the system included a range of safety information, recorded monthly for the past 12 months. Safety incidence information included falls, pressure ulcers, catheter-associated urinary tract infections (UTIs), deteriorating patient, venous thromboembolisms (VTE), hand hygiene and infections.
- The information held on the 'signal system' was used to populate the ward governance and assurance chart on display for staff to review.
- Over the previous year, the medical directorate had maintained a consistently low rate for pressure ulcers, except for one peak in May 2014. Falls and catheter-associated urinary tract infections (CAUTIs) remained low throughout the year.
- Safety Thermometer information for York Teaching Hospital NHS Foundation Trust showed that between July 2013 and July 2014 there had been 67 pressure ulcers with a consistent prevalence rate over the period; there had been 120 falls over the 13 months, which saw spikes in the Winter period, and there had been 59 catheter-associated urinary tract infections, which were consistent over the time period.
- Information regarding the results of the Safety Thermometer was routinely displayed on all of the wards.

Cleanliness, infection control and hygiene

- The wards were visibly clean and mostly tidy; some wards had limited storage space and appeared cluttered.
- Single sex accommodation was maintained, and bathroom and toilets clearly labelled male and/or female.
- All of the patients appeared comfortable and well cared for.
- Posters giving information about hand-washing techniques were clearly displayed. Gels and soaps were in sufficient supply around the ward.
- Personal protective equipment (PPE) was available throughout the ward, and on most occasions, we saw staff washing their hands and using PPE appropriately during the delivery of care and treatment.
- One patient on ward 34 told us that he had developed diarrhoea while in hospital, but there was no single room available to nurse him in.
- Staff told us that on occasions, bed management pressures had overridden infection control guidance.
- We observed that a patient with C. difficile was appropriately isolated, with infection prevention and control precautions in place.

Environment and equipment

- The environment in the ward areas appeared clean and well maintained. Daily cleaning checks were displayed and up to date.
- Staff said that equipment was available to meet patient needs.
- Resuscitation trolleys were available along with portable oxygen and suction. On most wards, daily and weekly checks of this equipment were up to date. Emergency drug boxes were sealed with an expiry date visible and in date. The trolley on ward 21 was found to have gaps in the checking record, and equipment was disorganised. The system of ABC drawers was not being used, which meant that equipment would be difficult to find in an emergency. Ward 24 did not have their own resuscitation trolley and used one from either ward 21 or 23. Ward 24 did have an emergency drug box on the ward which was readily accessible.
- On ward 34 we saw that equipment items, such as linen skips, were being stored outside of the bed bays on the main corridor. The environment overall appeared cluttered and overcrowded, but clean.

- Shared bedded areas were single sex. Shared bathrooms and toilets were clearly identified for either male or female. Single sex bathrooms and toilets were also clearly identified.
- Servicing of bathroom hoists and weigh scale equipment within the assisted bathroom was up to date.
- We looked at other equipment and refrigeration, and found they were appropriately checked, cleaned and maintained. All electrical equipment had been portable appliance tested (PAT) within the last 12 months, and all equipment was cleaned regularly and labelled as such.
- We saw there was one empty side room where clean stickers had not been attached. This issue was discussed with the sister, who told us that the room had just been fully deep cleaned. Clean stickers were applied immediately following discussion.
- Ward 37 had a large seating area for elderly patients with mental health needs, which allowed for good visibility for monitoring of patients at risk. The ward environment was dementia-friendly, with brightly painted doors, and pictures were used to identify shower rooms and toilets. The clinical room was cluttered, but everything was labelled and had tags to indicate the cost of items to promote reduction in waste. Environmental issues were raised by medical staff regarding access to outlying patients: "patient outliers on other wards are often a long way away"; "'can be dangerous. If got to go a distance to a ward, for example to do a warfarin or an antibiotic review, you tend to wait until there are a few things to deal with before you go".

Medicines

- On the wards we found that medicines were stored, prescribed and administered safely.
- We reviewed a sample of medication administration records, and we saw that most of the medication had been administered as prescribed and medicines had been administered at appropriate times. We noted that on two venous thromboembolism (VTE) assessments, rationale for not prescribing anticoagulants was not given.
- Pharmacy staff carried out a full clinical check of all prescription and administration records daily, Monday to Friday.
- Omissions of critical medicines were monitored monthly, and the results were shared with ward staff to identify areas for improvement.
- Nursing staff told us that they had easy access to medicines information, and that a pharmacist would discuss medicines with individual patients if this was requested.
- Medicines were stored safely, and pharmacy staff audited medicines security and the management of controlled drugs on a regular basis.
- Fridge temperatures were monitored daily and recorded appropriately.
- A satellite pharmacy had recently been opened on the acute medical unit (AMU), and nursing staff told us that this had enabled more timely pharmacy staff intervention into managing medicines and discharge prescriptions.
- We observed nurses checking controlled drugs into the store cupboard, and this was done safely and correctly.
- The pharmacy team undertook analysis of medication errors, but ward staff were not aware of feedback.

Records

- Patient's records were a combination of both electronic and paper records.
- A range of risk assessments were included within the electronic records; for example, falls, manual handling, Waterlow scores, nutrition and body mass index (BMI), bed rails, early warning scores, and neurological observations to manage the deteriorating patient.
- On the acute medical unit (AMU) we looked at two patients MDT records, electronic risk assessment records, and bedside charts.
- We saw a number of gaps in the completion of the AMU records; for example, the sections for the identity wrist band application, sleep patterns and emotional needs were not completed. The MRSA risk assessment screening section within the record was also not completed. When this omission was pointed out to the sister a check was made, and the MRSA screening was carried out immediately. As it was trust policy that all patients were MRSA screened on admission, or shortly following admission, an incident report was completed.
- The bedside records were completed and up to date for blood glucose level monitoring, fluid intake and food intake, and for the patients overall comfort observations.

- The electronic risk assessment records were completed and up to date, and included the use of bed rails, falls, nutrition, daily blood sugar levels, manual handling and early warning score (EWS) observations.
- From our review of the second set of patient records, we saw a stroke pathway of care and treatment was completed, and that the pathway of care and treatment, along with identified risks and bedside charts, were all completed and up to date.
- Medical notes were completed legibly in all of the five sets of medical notes reviewed on ward 24.

Safeguarding

- Staff we spoke with were aware of their roles and responsibilities in safeguarding adults. They were able to explain safeguarding referral processes, and told us that they were up to date with their safeguarding training.
- Staff told us that there was a safeguarding team who were accessible for advice and guidance when needed.
- There was a safeguarding e-learning programme available.
- We saw a range of safeguarding information displayed on notice boards for staff reference.
- Despite staff indicating that they were up to date with safeguarding training, uptake against the trust's targets was poor for nursing staff in the elderly care directorate, and poor for both nursing and medical staff in the medical directorate.
- Trust-wide data for the elderly medical care wards showed 59% compliance with adult safeguarding training for nursing staff, and 79% compliance for medical staff against a target of 75%.
- Level 2 children's safeguarding compliance trust-wide for elderly medical wards was 35% for nursing staff and 79% for medical staff against a target of 75%.
- Trust-wide data for the medical care wards showed 67% compliance with adult safeguarding training for nursing staff and 52% compliance for medical staff against a target of 75%.
- Level 2 children's safeguarding compliance trust-wide for medical wards was 50% for nursing staff and 39% for medical staff against a target of 75%.

Mandatory training

- Most of the staff we spoke with told us that they were up to date with their mandatory training and appraisals; however, trust data indicated poor compliance in a number of areas.
- Ward 26 told us of an initiative for staff to have a 'time out' day, where they would receive relevant clinical updates, as well as having the opportunity to undertake some of their mandatory training. The day would cover topics such as nutrition, continence, manual handling and infection prevention and control.
- At the time of the inspection the trust target for compliance with mandatory training was 75% for all categories. Compliance rates with mandatory training at the York Hospital for the acute and elderly medical directorates varied. From the data provided acute medical staff had not achieved the 75% for any of the categories whereas four of the training categories were above 75% in elderly medicine. All other medical staff training was non-compliant with the 75% target. For example, dementia awareness was 55% for elderly medicine doctors and 43% for acute medicine, infection prevention and control was 50% acute medicine doctors (and 82% for acute medicine doctors) and person with a learning disability awareness training was at 74% for elderly medicine and 40% for acute medicine doctors.
- For nursing staff in elderly medicine there were only six of 19 areas of mandatory training that were above 75%. Areas below included: Moving & Handling Training (practical) 23%; dementia awareness 59%; learning disability awareness 43%; nutrition 43% and; conflict resolution 31%. For nursing staff in acute medicine eight of the 19 areas of mandatory training that were above 75%. Areas below included: Moving & Handling Training (practical) 29%; learning disability awareness 37% and nutrition 44%.

Assessing and responding to patient risk

- All wards used the National Early Warning Score (NEWS) system to identify patients' whose condition was deteriorating. Patient observations were recorded appropriately and concerns were escalated in accordance with the guidance.
- Basic observations, such as blood pressure, pulse, and respirations, were recorded electronically, and these were up to date. We saw that there were standard

operating procedures and escalation procedures displayed for managing the deteriorating patient. The staff we spoke with were able to explain the procedures for managing the deteriorating patient.
- Frequency of observations was set by the RNs based on the NEWS score and clinical judgement.
- Risk assessments were also recorded electronically and a risk scoring system was in use.
- Risk assessments were carried out on admission, and re-assessed weekly or when conditions changed.
- Training was being rolled out to aid the recognition of the deteriorating patient and sepsis.
- Risks associated with falls, pressure ulcers, VTE, catheter and urinary infections were assessed on a monthly basis using the NHS Safety Thermometer assessment tool.
- The ward manager on ward 33 told us of an initiative on the ward, 'Safety Sunday', which ensured the weekly re-assessment of all patients' risks, such as pressure ulcers and falls.
- Multidisciplinary meetings occurred daily to discuss patient's progress, goals and any patient safety issues.
- Medical staff told us that GP referrals to the acute medical unit were triaged by the bed managers, which meant that the specialist registrar (SpR) on duty did not always know how ill the patient was, or the patients' medical diagnosis, until they arrived on the unit. We were told that sometimes the bed manager would contact the SpR with information, but this did not always happen. We were given an example of a diabetic patient with ketoacidosis waiting in a chair for several hours without treatment as the SpR was unaware of their diagnosis.

Nursing staffing

- Information on planned and actual staffing numbers were reported to the trust board monthly, and submitted nationally in accordance with requirements.
- In January 2015, only two out of fifteen wards within the medical directorate filled over 90% of the required shifts for both registered nurses (RNs) and support staff for day duty. Night shifts on all wards, except wards 24, the Winter pressure ward, and 36, the stroke unit, achieved a 90% or better fill rate.
- Where low numbers of RNs were evident, the hospital tried to provide greater numbers of healthcare assistants (HCAs), although this was not always possible.
- Nurse staffing issues were most acute during the day, with some wards falling below an 80% fill rate for RNs.
- The elderly wards 23, 26 and 35 had RN fill rates of 79.3%, 75.1% and 73.2 % respectively, with 97.6%, 111.9% and 117.2% fill for HCAs. At the time of inspection, ward 23 had two RN vacancies, but had managed to recruit to the HCA posts.
- The speciality wards, 31 oncology, 32 cardiology, 33 gastroenterology and 34 respiratory had RN fill rates of 88.4%, 72.5%, 73.1% and 79.5 % respectively, with 91.7%, 94%, 81.6% and 82.8% fill for HCAs. Staff told us that recent acuity audits showed that wards 32, 33 and 34 needed an increased number of RNs.
- Staff on ward 34 told us that the ward had recently recruited two RNs, who were due to start in the near future, but that left three RN vacancies and two HCA vacancies. We were told that bank or agency staff were used almost every day, and planned staffing levels are not always met. The hospital also moved staff from other areas to cover if senior or more experienced staff were needed. We were told that patients requiring non-invasive ventilation require additional staff, and these were not always available.
- The AMU (21) and short stay (22) wards had RN fill rates of 82.7% and 72.6 % respectively, with 72.6% and 115.4% fill for HCAs.
- Ward 24, the Winter escalation ward, published fill rates were in excess of 100% during January 2015. However, the ward manager told us that her budgeted establishment was 17.6 whole time equivalent (WTE) RNs, and there were only 9.6 WTE RNs in post. This meant that there was a huge reliance on agency, bank staff and staff from other wards being used to fill shifts. We were told that there had been occasions when all nursing staff on the ward had been agency, bank or staff from other areas. This had been raised with nursing managers, who understood the issues, but the hospital had been unable to recruit to all posts.
- At the unannounced inspection we noted that one of the agency staff had been working on the ward since it opened and had provided some continuity of staff.
- Information supplied by the hospital corroborated that there were three night shifts during March 2015 that were entirely staffed by agency staff. There were a further three nights where the only regular member of staff was an HCA, and a total of 15 night shifts when there was only one regular member of staff on duty.

Medical care (including older people's care)

- Planned and actual staffing information for the six week period from 16 February 2015 to 31 March 2015 showed that on average, the ward was short of one member of qualified staff on both early and late shifts. There was an extra HCA on duty on late shifts, but not on early shifts.
- Nursing staff on the wards told us that they felt they could not always deliver the standard of care they would like to due to insufficient numbers. There were processes in place to escalate staffing concerns should they arise, but there were not always extra staff to be found.
- Staff reported mixed feelings regarding moving to other wards to help; while some did not mind, and felt it was good to offer support and could be good for personal development, others felt moves were so frequent that it had an adverse effect on staff morale, and some staff would come to work not knowing where they would be working that day.
- A number of patients commented that they felt there were not enough staff on the wards and that care was delayed. One comment was specifically about buzzers and the length of time for staff to answer them. The person also commented that they felt they were queuing for the toilet. Another patient commented about non urgent tasks such as washing being delayed or put off.
- Ward 37, an elderly mental health assessment ward, was staffed with a mix of RNs and registered mental health nurses (RMNs), and the ward rosters were set up to ensure that there was always at least one RMN on duty for each shift. Staff levels on ward 37 were reported to be less of an issue than on other wards. One-to-one nursing was often required for patients on this ward when behaviour was challenging. There were three patients requiring one-to-one nursing at the time of inspection. The average fill rate for ward 37 during January 2015 was 81% for RNs, and 90.1 % for HCAs for day shifts.

Medical staffing

- Medical staffing was made up of a higher proportion of consultants than the England average; the proportion of middle career doctors was the same as the England average, and for registrars it was lower than the England average. The proportion of junior doctors was slightly higher than the England average.
- There was 24 hour, seven day a week consultant cover, and junior doctor availability. Out-of-hours cover was provided at nights and weekends.
- The 'hospital at night' consisted of two senior house officers (SHO) and one specialist registrar (SpR) to cover AMU and the wards. Medical staff felt that this was inadequate, and commented that "it is not unusual for consultants to be here until 1am or 2am".
- Foundation year 1 (FY1) doctors did not do night time on-call duties, but covered normal working hours, and, when on-call, covered weekdays 5pm until 10pm, and weekends 9am until 10pm.
- Junior doctors reported good supervision and support from senior doctors and consultants, and that they could easily escalate patient concerns to a SpR out of hours, and also that they had access to a critical care outreach team.
- Medical staff reported good communication and handover of patients, and attended daily board rounds as part of their multidisciplinary teamwork activities.
- Junior medical staff had some concerns regarding staffing and junior medical cover. For respiratory medicine we were told that there were five consultants, all with their own patients, who could be on any medical ward or potentially outlying on a non-medical ward. This meant that it was difficult to keep track of all patients needing to be seen, and it also took longer to review patients who were spread over a number of wards. We were told that there was an inconsistent approach to allocating patients to consultants which made providing safe, effective care more difficult.
- AMU workload peaked in the late afternoon and evening, but numbers of doctors were the same throughout the day. When possible, extra locum doctors worked evening shifts to address the increased demand. We were told that it was difficult to fill extra shifts during the night.
- Medical staff told us that the AMU team covered cardiac arrests elsewhere in the hospital, and this took resource away from the clerking of patients for up to an hour at a time.
- Medical staff did report that they also received good support from the advanced care practitioners.
- There was a SpR who worked as part of the dedicated Facilitating Rapid Elderly Discharge Again (FREDA) team that provided care to elderly medical outlying patients, but at the time of inspection they were also needed to provide cover to ward 24, the Winter pressure ward.

Medical care (including older people's care)

- There were a number of consultant vacancies which had been difficult to recruit to and remained unfilled. Vacancies were apparent in A&E, respiratory medicine, cardiology, neurology and gastroenterology.
- The trust was supporting the development of 16 advanced care practitioners (ACPs) to help address some of the shortfalls in medical staffing.
- Doctors at all levels told us that medical shift patterns, ways of working, on-call and cover arrangements, including consultant cover, were too varied to be efficient, and impacted upon patient safety, effectiveness, and access and flow of patients throughout the hospital. For example, staggered working shifts made it difficult to provide a handover each time someone came on duty. There was no formal handover at 5pm, and jobs were allocated via the bleep system, which did not lend itself to any form of prioritisation. Some areas worked a 'consultant of the week' system, whilst others a 'consultant of the day'. Consultants were not always ward-based and had patients on many wards throughout the hospital. Two elderly care consultants had their own caseload of patients who may be on a number of wards and who they reviewed twice a week. Junior staff were ward-based and felt that having a number of consultants reviewing patients at different times and from different specialities made work disjointed. Doctors felt that this meant limited access to senior medical decision-making for some patients, and potentially increased length of stay. Staffing patterns did not necessarily complement workload patterns. Gastro and renal consultants worked a 'consultant of the week' system, and junior staff reported that this worked well, and provided the ward and team with significant consultant support.

Allied Health Professional Staffing

- Staffing was a key concern across all therapy services. One member of staff told us that they were working 12 days on and two days off to cover shifts.

Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions to be taken.
- There was a business continuity plan for the trust, and site-specific plans were also available.

Are medical care services effective?

Good

Medical services at York were rated as good for delivering effective care. Policies and pathways were based on NICE and Royal College of Physicians guidelines, and were available to staff and accessible on the trust's intranet site. York results for the Myocardial Ischaemia (heart attack) National Audit Project (MINAP) for 2013/14 were better than national averages for most indicators, and had improved on the previous year. Other national audits were contributed to as expected, and we were given evidence of changes made by specialities in response to their outcomes. Nurse appraisal rates varied from 88% in the Admissions unit and 44% in acute medicine.

We witnessed strong and respectful multidisciplinary team (MDT) working during our inspection, and this was corroborated by feedback from all disciplines spoken with. Overall, the York Hospital had a shorter length of stay than the England average for both elective and non-elective admissions, and overall, medical re-admission rates were better than England averages.

Evidence-based care and treatment

- Policies and pathways were based on NICE and Royal College of Physicians guidelines, and were available to staff and accessible on the trust's intranet site.
- Wards were audited against compliance with a number of key quality indicators, such as staffing, sickness, appraisals, capacity, Friends and Family Test (FFT), patient harm, and MDT effectiveness.
- We saw that this information was held in staff communication files, so that staff could access their results and progress, and any issues were easily visible. Ward managers would address any issues highlighted by these reports with their staff, and implement action plans as appropriate.
- On ward 36, the stroke unit, there were dedicated stroke nurses employed at band 6 and 7 as part of the ward establishment, who were available to provide specialist support to the emergency department.
- Ward 25 participated in a hip fracture audit, which included evaluation of length of time from admission to surgery, length of stay, and discharge to usual place of

residence. Outcomes from the audit were good, with most patients having surgery in less than or equal to 36 hours, and most patients being discharged to their usual place of residence.

- The stroke pathway and supporting documentation in use were developed in line with national and NICE guidance. The pathway was a multidisciplinary record of the patients care and treatment. The stroke pathway for the York Teaching Hospital NHS Foundation Trust was under review to improve effectiveness of treatment across the trust. The on-call stroke consultant also provided support to Scarborough Hospital through the use of telemedicine outside of normal working hours, to ensure thrombolysis was given appropriately and within the critical time window, before patients were transferred to York for further treatment.
- Cardiac outreach nursing (CON) services were provided 24 hours a day, seven days a week by a dedicated team of eight staff. The priorities were mainly to see, assess and divert all cardiac patients admitted via A&E to either the coronary care unit (CCU) or AMU, according to the patients' acuity. The CON team were all trained to advanced life support (ALS) standards, and updated their skills six monthly.
- CON staffing was part of the daily CCU staffing numbers, which meant that staffing on CCU could be compromised, on occasions, when staff were called to support other services within the hospital. Cardiac treatment pathways were developed in association with national and NICE guidelines.
- Ward managers told us that they have an audit day every month (called QUEST) to monitor compliance with guidance and quality indicators.
- We looked at the QUEST report on ward 34, which was available for staff to read in the communications folder at the nursing station. The report included compliance against a number of key quality indicators, for staffing, sickness, appraisals, capacity, Friends and Family Test, and MDT effectiveness.
- We saw that in March 2015 the QUEST report demonstrated overall improvement from a total score in December 2014 of 11, to 15 in March 2015.
- We saw that Sepsis Six cards were in use, and there were posters on display to alert staff, and remind them of the actions they need to take.
- York Teaching Hospital NHS Foundation Trust had its own service improvement team, which assisted clinicians with work to improve pathways. Senior clinicians told us that there were ongoing projects around developing a mobile chemotherapy service, fast track dermatology services, and improved neurology support.

Pain relief

- We saw that a 0 – 10 pain assessment score was available on the trust's electronic system. There was not an alternative pain assessment tool in use that prompted staff to make a full assessment of a patient's pain incorporating the assessment of body language or facial expressions when patients were unable to score their pain. We did not see clearly documented evaluations of pain in relation to the effectiveness of medication given.
- Regular comfort rounds were carried out, and these included asking patients regularly about their level of comfort or pain.
- The ward staff had access to an acute pain team for specialist advice and support five days a week, when they were finding it difficult to manage a patient's pain. The palliative care and end of life team had on-call staff that were available to provide support outside of office hours.
- One patient reported that due to the busy nature of the ward, at times, they had waited for pain relief. Patients reported that pain relief was effective.

Nutrition and hydration

- A nutritional screening and assessment tool was incorporated into the patient admission record to assess patients on admission.
- Nutrition and hydration risks were assessed and monitored via the electronic records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside.
- We looked at patient menus and saw a range of food choices were available to the patient. The menus also highlighted choices such as healthy, gluten free, diabetic and soft consistency options.
- Four hourly comfort rounds included offering the patient oral fluids and nutrition as appropriate.
- We observed elderly patients on ward 37, and saw that they had access to drinks when sitting in the communal area, as well as when at the bedside.
- Ward 23 were piloting a beverage service which operated from 7am until 7pm. This meant that there was a dedicated member of the housekeeping team

whose role was to ensure patients always had a plentiful supply of drinks and food. The role also ensured food and fluid charts were accurately maintained. The feedback from the pilot was very positive and other wards wanted to adopt this initiative.
- Most patients told us that food was of a good quality, and they were offered plenty of food and drinks throughout their stay.
- Meal times were displayed as protected times.

Patient outcomes

- During 2013/14 York Teaching Hospital NHS Foundation Trust participated in national clinical audits and national confidential enquiries, as well as undertaking a programme of local clinical and quality audits.
- Coronary care staff participated in 'failure to rescue' audits with hospital medical staff and ambulance services, which looked at deaths from cardiac arrests.
- In the Sentinel Stroke National Audit Programme (SSNAP) 2014, the York Hospital was within band C. York has consistently maintained a combined indicator level of C rating since October 2013. The scale used is A – E, with E being the worst.
- Results from the National Diabetes Inpatient Audit (NaDIA) in September 2013 indicated that York was performing worse than the national average in eight of the 19 measures of the Audit. Of the indicators that performed below the national average, these predominantly related to staff knowledge, visit by specialist diabetes team, medication errors, meals and foot risk assessment. No data was available for whether or not patients were involved in their treatment plans. The hospital did not have a dedicated ward or a specialist diabetic foot service.
- In the heart failure audit, York was worse than the England and Wales averages for clinical practice in five out of seven England discharge measures (2012/13 audit). In hospital care, indicators were all worse than the England averages. Since the audit was published. York has appointed a heart failure specialist nurse to facilitate improvements in these indicators.
- The York Myocardial Ischaemia (heart attack) National Audit Project (MINAP) for 2013/14 showed that patients with non-ST segment elevation myocardial infarctions (NSTEMIs) – a heart attack – were seen by a cardiologist or their team in 97.9% of cases, against an England average of 94%. Patients were admitted to a cardiac unit or ward in 25.5% of cases, against an England average of 53%. Numbers of patients that were referred for angiography stood at 100%, against an England average of 73%. There was no data for thrombolytic treatment being received within 30 or 60 minutes of the patients' arrival at hospital. All indicators showed an improvement on the 2012/13 audit results.
- Consultant mortality reviews are undertaken on every death, and there is a monthly summary discussion of all cases.
- Overall, the York Hospital had a shorter length of stay than the England average for both elective and non-elective admissions. Geriatric medicine had a longer length of stay for non-elective admissions, with an average stay of 11 days against a national average of 9.8 days, and haematology and gastroenterology had longer stays than the England averages for elective admissions, with gastroenterology having an average stay of 5.2 days against a national figure of 3.3, and haematology 7 days against a national average of 6.3. Overall, the trust had a shorter length of stay than the England average for both elective and non-elective admissions. Geriatric medicine had a longer length of stay for non-elective admissions, and haematology and gastroenterology had longer stays than the England averages.
- Emergency re-admissions to the York Hospital within 28 days of discharge from medical wards was better than the England average for all of the top three categories of non-elective admissions. The re-admission rate for elective admissions to haematology and respiratory medicine was worse than the England average. Overall, elective re-admission rates were better than the England average.

Competent staff

- Nursing annual appraisal rates for the York medical departments for the period July to November 2014 varied from 44% (acute medicine) to 88% (The admissions unit) In addition to mandatory training, training was facilitated by a number of staff groups and specialist nurses, such as the cardiac outreach nurses and the critical care outreach team, who provided training in the clinical areas.
- Training records could be accessed by the ward manager online, and the IT hub within the training and development department alerted managers when training updates were needed.

Medical care (including older people's care)

- Induction and preceptorship processes were in place for new staff. A new RN on ward 24 told us she had been given a six week supernumerary period and had a one year preceptorship programme in place. During this time, the RN would complete a number of skills and competency assessments. Mentors were provided for student nurses, although students reported that RNs did not always have time to spend with them to complete project work.
- Staff on the oncology ward had seen an improvement in the number of nurses trained in chemotherapy over the last year, and an agency staff member told us that she worked regularly on oncology, and that she received support and training to be effective in her role. Oncology staff also told us that cross-site working had improved, and good practice was shared between Scarborough and York staff.
- CCU staff reported that they received training for extended roles and were all advanced life support trained (ALS).
- During the inspection, the critical care outreach team were observed providing simulation training, regarding a deteriorating patient, to nurses and junior doctors. The training was very thorough, and staff were able to recognise the signs of deterioration and escalate care appropriately.
- Ward 33 had set up a learning room for staff on the ward to access up-to-date information and resources.
- FY1 doctors told us that an hour of teaching was provided for them every week, and that it was usually possible to get to the sessions. The quality of the sessions was usually very good, and a variety of topics were covered, but sometimes sessions were cancelled without notice and people were left waiting.
- Training for advanced care practitioners (ACPs) was a two year university training course, to enable them to take on some duties that have been traditionally undertaken by doctors. We spoke to a practitioner who confirmed that the trust was fully supporting and sponsoring this training. As part of the course, practitioners were assigned to support and undertake weekly clinical practice with named clinicians.

Multidisciplinary working

- All medical wards, except the acute medical unit (AMU), held a multidisciplinary team (MDT) morning board round meeting, which included ward nursing staff, physiotherapist, occupational therapist, consultant and junior medical staff.
- During the inspection, we observed a number of board rounds, and they were seen to include reviews on all of the inpatients care, treatment and daily progress. Key agreed outcomes, goals or tasks were logged onto a white board located within the staffroom for all staff to refer to.
- Some of the key events included medication reviews, referral for assessments by social services, mental health services, clinical diagnostic tests and review of any results. Moving and occupational therapy progress assessments, family involvement and discharge planning were also discussed.
- We spoke with staff from all professional groups, and they told us that the ward MDT board rounds worked well and promoted effective MDT working.
- The board rounds were a positive way of capturing and communicating a holistic, clinical and social progression of the patients care and treatment.
- On the stroke unit, the MDT met weekly to discuss patients' care and treatment progress, in addition to the daily board rounds.
- The AMU operated a morning medical handover from the night team to the consultant, who worked through the patient list. Any actions or immediate plans from the medical ward round were passed on to the nurses at the end of the round. A multidisciplinary team meeting was held at lunchtime to discuss patients' progress and plans.
- The ward manager on ward 37 explained how the service provided was a joint provision by consultant geriatricians and a consultant psychiatrist, who visited the ward four to five times a week. There was good input and support from the mental health liaison team.

Seven-day services

- Physiotherapy and occupational therapy were provided mainly within normal working hours, Monday to Friday, 8.30am to 5pm. If patients needed ongoing support at the weekend they could be referred to be seen by the on-duty respiratory physiotherapy team.
- Therapy staff were aware of the trust undertaking a review of seven day services.

Medical care (including older people's care)

- The oncology triage team and the cardiac outreach nursing team provided services 24 hours a day, seven days a week.
- Pharmacy inpatient patient services were available Monday to Friday, 8am to 5pm. There was also a pharmacist and technician on duty on a Saturday morning, and a pharmacy technician on duty on a Sunday morning for dispensing. Night times and weekend afternoons were covered by an on-call pharmacist. Pharmacy staff told us that they would be recruiting additional staff to provide weekend cover from April 2015.
- The facilitating rapid elderly discharge again (FREDA) team in elderly medicine were available seven days a week
- The trust was actively moving towards a seven day working scheme, and were developing a number of business cases across a number of services.

Access to information

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

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff demonstrated a good understanding of consent, mental capacity and best interest decisions, and accessed training through an e-learning platform.
- Staff had readily accessible guidance and information, and knew who to contact for advice and support if needed.
- Ward 37, the elderly mental health assessment ward, regularly had significant numbers of patients with limited mental capacity, confusion and often challenging behaviour. Ward 37 was a locked ward, and all patients were assessed for mental capacity on admission to seek consent to remain on a locked ward.
- Deprivation of liberty safeguards (DoLS) were in place for patients who lacked capacity to consent.
- Thirteen of the 22 patients on ward 37 had a DoLS in place. DoLS were reviewed by the consultant psychiatrist at least once following admission.
- On occasions, patients were transferred to the ward with a DoLS already in place.
- We saw that two patients on the ward had an Independent Mental Capacity Advocate (IMCA).

Are medical care services caring?

Good

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

Friends and Family Test (FFT) information for the trust showed a slightly lower response rate (38.35%) than the England average (39.8%). Percentage of patients who would recommend the services was the same as the national average, at 95% in February 2015.

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

Compassionate care

- Throughout our visit we saw staff speaking to patients in a caring and kind manner. We saw staff drawing curtains around patients' beds and closing side room doors to maintain patients' dignity and privacy.
- We saw elderly patients with mental health needs using communal areas and sharing laughter with staff.

Medical care (including older people's care)

- We saw that regular comfort rounds were in place, and records indicated these were adhered to in a timely manner.
- We saw that staff on the wards actively encouraged patients to leave feedback on their experience. During February 2015, most wards achieved a response rate of over 30%. Most of the wards had over 90% of patients who would recommend their ward to others.
- We spoke with 20 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 caring and responsive to needs.
- One patient told us of one occasion when staff attitude had been uncaring, but most staff were good.
- Patients told us they felt safe, cared for, and their privacy and dignity were respected. Patients overall were happy with the hospital and care given, and would recommend to others.
- The trust performed around the same as other trusts in relevant questions in the national inpatient survey for 2014.

Understanding and involvement of patients and those close to them

- Patients we spoke with in the discharge lounge told us they had been happy with their care, and explanations had been given to them in a way they could understand.
- Patients told us staff had introduced themselves and they had been treated as an individual.
- One patient felt that her care pathway had not been fully explained.
- We saw that the ward staff actively encouraged patient and family feedback through the Friends and Family Test, and results and actions from surveys, such as the Friends and Family Test were displayed for patients and visitors to see.
- Staff on the oncology ward told us how written information was being altered following feedback from patients and relatives.
- Posters were visible advising patients and relatives what to do if they had any concerns or complaints.
- We observed staff discussing care issues with patients and relatives, and these were generally clearly documented in patient's notes.
- We saw in a set of records that 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) information was recorded as being discussed with a patient's wife; however, it was unclear if the patient was aware, or if there was any rationale for not discussing this with the patient.
- A patient told us that she was involved in her care from admission to discharge.

Emotional support

- We saw staff providing emotional assistance to patients when appropriate.
- A patient told us that the Macmillan Cancer Support team gave excellent support.
- There was a range of material around the hospital offering information, advice and signposting to people with mental health problems.

Are medical care services responsive?

Good

Medical services provided at the York Hospital were responsive to patient's needs. The York Hospital struggled with the management of flow through the hospital due to the significant rise in emergency attendances and subsequent admissions. Work had been undertaken to reduce the number of unnecessary admissions in terms of developing and piloting ambulatory care. Work had also been undertaken to improve discharge planning by the development of a discharge liaison team and the Facilitating Rapid Elderly Discharge Again (FREDA) team in elderly medicine.

Referral-to-treatment (RTT) times for medical inpatients had exceeded standards for all speciality groupings, with the exception of rheumatology. The trust was on a par with the England average for national cancer waiting times. Between July and October 2014 there were 253 medical outliers at the York Hospital. The top specialities at York are geriatric medicine (86), gastroenterology (60) and respiratory medicine (42). Overall, the York Hospital had a shorter length of stay than the England average for both elective and non-elective admissions. Geriatric medicine had a longer length of stay for non-elective admissions, with an average stay of 11 days against a national average of 9.8 days, and haematology and gastroenterology had longer stays than the England averages for elective admissions (HES 2013/14).

Medical care (including older people's care)

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.

Service planning and delivery to meet the needs of local people

- The services provided by York Teaching Hospital NHS Foundation Trust were predominantly commissioned by the clinical commissioning groups of East Riding, Vale of York and Scarborough and Ryedale) to meet the needs of the local people.
- The major challenge for the trust was to provide medical care services for an increasing elderly population, which was expected to increase significantly over the next five years. There was also expected to be a significant service requirement for the management of dementia and other long-term conditions.
- The trust had identified that reconfiguration, particularly of the acute medical beds, was required to meet patient needs. The reconfiguration was in progress, and some changes had already been implemented.
- Work was also ongoing to improve integration with community services to help maintain people with long-term conditions at home, and to develop community hubs where patients could access care closer to home.
- Ambulatory care services were being developed at the York Hospital to help alleviate patient flow pressures by working closely with the acute medical unit and A&E. Staff reported that 16 to 18 patients could be treated daily through ambulatory care, saving unnecessary inconvenience for patients and unnecessary admissions to the medical wards.

Access and flow

- Routine / elective admissions and outpatients were admitted directly to the relevant base ward.
- Non-elective / emergency patients were predominantly admitted from A&E to the AMU.
- The York Hospital was trialling an ambulatory care area, and patients were triaged for admission by the bed managers, using protocols for different conditions, such as chest pain or suspected deep vein thrombosis (DVT).
- The AMU operated a telephone triage system to establish whether a patient needed to attend the unit, or if patient needs could be met by diverting elsewhere, such as to community services, or to the palliative care team.
- The AMU and ambulatory care area also took direct referrals from GPs where criteria were met, or where a clinician-to-clinician discussion had taken place.
- AMU admitted patients 24 hours a day, and the average length of stay was around 12 hours. When patients could not be discharged home they were transferred to the short stay ward or a medical inpatient ward.
- The ward manager told us that the throughput of patients on the AMU was between 1,000 and 1,300 patients a month.
- It was reported that the demand for beds often exceeded the capacity, and some patients were waiting in A&E until there was a bed available. Patients who had been referred by GPs sometimes had to use a ward waiting room, which regularly overflowed into the corridor. Ward records showed that there had been up to five patients waiting, at any one time, in the corridor in the two weeks prior to the inspection. This had been exacerbated by the need to change the use of 10 beds on the adjacent ward, which had been used by AMU for frail elderly patients, into winter pressure beds.
- It was hoped that the frailty beds would be re-introduced, as this unit had provided rapid access to physiotherapy, occupational therapy and a consultant geriatrician. The unit had facilitated rapid transfer to rehabilitation and community services, helping to keep elderly patients in their own homes and avoiding prolonged admission in many cases.
- Initial feedback regarding the pilot of ambulatory care was that this had reduced the pressure for beds to some extent on the AMU.
- Bed occupancy for quarters one and two 2014/15 was just under 90% for general and acute beds.
- Generally, patients on the AMU were seen by a junior doctor within four hours and by a consultant within 12 hours. We observed in the records of five patients that four had been seen by a consultant within 12 hours, the fifth patient had been seen in 14 hours.
- We observed three elderly patients waiting on trolleys in the AMU corridor for bed spaces to become available; the longest wait was two hours for one patient. While waiting, the patients were cared for by six members of

the ambulance service. Paramedics and ward managers told us that patients' waiting in the corridor was a common occurrence, with ambulance crews tied up for three to four hours every day.

- Generally, the other medical wards did not take non-elective admissions; however, staff on ward 26 told us that this was known to happen on occasions, especially if a patient needed admitting directly to a single room.
- Handover from the AMU to ward 26 was carried out using a situation, background, assessment and recommendations (SBAR) approach, which staff evaluated as being effective and thorough.
- Ward 25, an integrated orthopaedic and geriatric ward, worked closely with the A&E department, and actively identified elderly patients with a fractured neck of femur, to speed up flow to the ward and on to theatre. The ward had dedicated therapy support, and post-operative care was provided by the geriatric team. This meant that patients had speedier rehabilitation and reduced length of stay, with the majority of patients returning to their usual place of residence.
- Discharge and transfer from York was facilitated by a discharge liaison service, which consisted of six full time members of staff working 8am until 4pm, Monday to Friday. The service covered all inpatient areas, and assisted ward staff with planning and co-ordinating of complex discharges.
- Overall, the York Hospital had a shorter length of stay than the England average for both elective and non-elective admissions. Geriatric medicine had a longer length of stay for non-elective admissions, with an average stay of 11 days against a national average of 9.8 days, and haematology and gastroenterology had longer stays than the England averages for elective admissions, with gastroenterology having an average stay of 5.2 days against a national figure of 3.3, and haematology 7 days against a national average of 6.3. Overall, the trust had a shorter length of stay than the England average for both elective and non-elective admissions. Geriatric medicine had a longer length of stay for non-elective admissions, and haematology and gastroenterology had longer stays than the England averages.
- Feedback from staff was that effectiveness and timeliness of discharge had improved, and workload pressures for other members of staff had also been alleviated to some extent by the discharge team's assistance.
- There were good links between medical staff and managers if they needed to discuss risks to patients that may be caused by delayed discharge. One doctor told us that they believed delayed discharge was, in itself, a risk to patient safety, and could have significant detriment to morbidity and mortality due to hospital-acquired infections.
- The trust had a much lower proportion of delayed discharges caused by either completion of assessment or from waiting further NHS non-acute care compared to the national average. There was a high proportion of delayed transfer of care due to patients awaiting care packages in their own home (37%) or waiting for nursing home placement or availability (22.1%) and the trust needs to consider how this could be improved.
- Between July and October 2014, there were 253 medical outliers at the York Hospital which was much lower than Scarborough hospital. The top specialities at York are geriatric medicine (86), gastroenterology (60), and respiratory medicine (42). Medical outliers have led to cancellations of elective surgical procedures for some patients.
- The medical management of patients who were outliers was covered by the patients' named consultant's team.
- Data regarding inpatient moves for April – November 2014 showed that 26% of patients were not moved to another ward during their hospital stay. Fifty-six percent of patients had one ward move, while the remaining 18% had two or more ward moves during their stay.
- Ward staff told us that due to the demand for beds, it was sometimes necessary to board patients out onto non-medical wards. We were told that this usually affected patients who were medically fit for discharge, but were awaiting social care input at home, or a nursing home placement.
- When we visited the stroke unit, it was observed that there were five patients who were outliers from other medical specialities.
- All of the elderly care outlying patients were reviewed by the facilitating rapid elderly discharge again (FREDA) team, which operated a seven day service and consisted of one SpR, one nurse, one physiotherapist, one occupational therapist and two healthcare assistants.

The FREDA team ensured that elderly care patients did not get missed, and that they received daily access to therapies and senior medical decision-making. The medical staff felt that the FREDA team made the admission and discharge of the patients under their care much smoother and more effective.

- The SpR also covered the Winter ward, 24, and reviewed patients daily. Medical tasks were performed as part of the ward round, if at all possible, which facilitated discharge as early in the day as possible.
- Patients on the elderly wards had good access to therapy services, Monday to Friday. Physiotherapy and occupational therapy staff were allocated to certain wards, and covered these on an ongoing basis.
- A patient told us that admission, procedure and transfer to the ward had been well organised.
- We spoke with eight patients in the discharge lounge, two told us that they had been waiting for over an hour and had not been informed how long it would take to receive discharge, medicines or a letter, or how long they would have to wait for transport.
- A patient on ward 24 told us that they had thought the ward was a discharge ward, and had been a little upset when they needed to stay.
- Referral-to-treatment (RTT) within medicine had been consistently better than the England average since June 2013. RTT times for medical inpatients had exceeded standards for all speciality groupings, with the exception of rheumatology, which had achieved 83.3% of patients meeting the 18 week wait standard against a target of 90%. General medicine, gastroenterology, geriatric medicine and neurology all achieved 100% against the 18-week RTT target.
- The trust was on a par with the England average for national cancer waiting times.
- Access to neurology services was limited due to consultant vacancies.
- Coronary patients for primary angioplasty accessed services mainly provided by the Leeds Teaching Hospitals NHS Trust, with some patients going to Hull and East Yorkshire Hospitals NHS Trust. Ambulance paramedic crews were requested for transferring patients to both trusts, and relatives were provided with information regarding these transfer services.
- There was a 'board round - out before lunch' approach to improve patient flow, as the majority of admissions and GP referrals were during the afternoon and evening. This aimed to ensure that patients were identified early for discharge, and letters and prescriptions were made ready in a timely manner.
- Doctors told us that the trust's referral system is an old-fashioned paper-based system, which varies between specialities, which can cause confusion and delays, as they need to be handed to the relevant secretary or administrator.

Meeting people's individual needs

- We saw a wide range of information publicly displayed, to provide patients and families with information relating to different services and aspects of care.
- Laminated information and advice sheets were on display regarding patient discharge.
- Ward 37 used the 'This is me' approach to caring for dementia patients; however, not all patients had this document fully completed.
- Patients on ward 37 were seen using communal dining and living areas, and also had access to a private room for discussions if needed.
- Patients felt that visiting times were appropriate to the wards they were on, and staff were flexible regarding relatives' requests to visit outside of usual visiting times if they needed to, or if a patient was extremely unwell, or needed additional support.
- Patients we spoke with told us that their care was individualised, and we observed discussions around care and treatment, and documentation that demonstrated this.
- Staff had access to information about different cultural, religious and spiritual needs and beliefs, and interpreting services were available for patients who did not speak English, or who had other communication difficulties. Staff were aware of how to arrange these services. One staff member had used the language line with Polish and Asian patients, and said that the system had worked well.
- Telephones had a long-line hearing loop for patients who were hard of hearing, and other communication aids were available through occupational therapy.
- One patient told us that they felt the ward they had stayed on was understaffed, and this led to long waits at times for "mundane things such as waiting for a towel

for 20 minutes as urgent things took precedence". Patients had to wait for pain relief and toileting due to the busy nature of the ward, but staff were caring and worked hard.

- Another patient told us that her discharge had been well organised; she had the information she needed about her care, everything was arranged and someone was waiting at home.
- Patients told us that care was explained to them in a way that they could understand.
- Staff told us that they liked working at the York Hospital, and team work was good, but they were sometimes frustrated by the level of care they could provide due to staff shortages.
- Staff on ward 24 told us that when staff numbers were low, they had to prioritise food, drink and medications over other aspects of care. This meant that patients experienced delays with personal care. Staff told us that medical cover on this ward was very good, and poorly patients and new patients were seen immediately.
- One relative of an oncology patient felt that there was not enough choice regarding treatment options for immune-compromised patients. Support from ward staff was good, and response following a request to see a dietician was accommodated.
- We saw that requests for help, and patients calling out on the elderly mental health ward, were quickly answered and assistance given.

Learning from complaints and concerns

- The trust had a Patient Advice and Liaison Service (PALS), which was available to all patients. PALS information, on how people can raise concerns and/or complain was publicly displayed and available.
- Responses to formal complaints received by the medical directorate were shared by the matron with ward staff, and action plans were developed and implemented with ward staff, where appropriate.
- Safety briefings were carried out each day, and we were told that these included learning and action points from complaints and incidents. The information from complaints was held in ward communication files, which were accessible to all staff.
- Staff we spoke with told us that they would try and resolve concerns and complaints at ward level wherever possible; on occasions, they would escalate the complaint to the ward manager or matron, who would resolve it if possible, and refer on to PALS when necessary.
- The ward manager on ward 33 told us of a patient who did not want to make a formal complaint, but who came in to the ward informally to talk about his experience of being restrained during a detoxification episode, and the bruising he had suffered. As a result of this, improvements were made to the assessment of detoxing patients, and awareness raising with staff was undertaken.

Are medical care services well-led?

Good

We rated medical services as good for well led. There were some areas needing improvement. Managers and senior clinicians had a vision for the future of their services, and were aware of the risks and challenges faced by the service. There were a number of business plans with the trust board for strategic development of services. Long-term strategies were in place for the medical and elderly medical departments. Most staff were clear about the vision and strategy for the service.

Staff told us that they were well supported by their ward managers and clinical matrons, and were encouraged to develop to improve their practice. There was a good culture of improvement, and staff were supported to undertake additional training, be innovative and to try out new ideas. Risks (and potential risks) were identified and discussed openly, and there was a governance structure in place that allowed formal escalation where appropriate.

Staff shortages impacted upon ward managers' ability to effectively lead their teams. Staff did not feel that the executive team were visible at ward level. There were a number of examples of innovation and service improvements.

Vision and strategy for this service

- Ward managers and sisters were aware of the trusts vision and strategy, and that key messages were on the intranet and emailed out periodically to senior staff to share with their teams.

Medical care (including older people's care)

- Staff we spoke with were aware of the trusts vision, and knew how to access trust-wide information from the intranet.
- There were a number of business plans with the trust board for strategic development of services, such as a proposal to merge the AMU and short stay ward, to create a 64-bedded admissions unit, with a target length of stay of under 72 hours. This would also allow for eight beds to be dedicated as a medical high dependency unit.
- There were longer-term plans to develop and increase the number of medical trainees coming through the trust, to promote York as a place to work for their future career. Emphasis was being given to training, retention and talent management of junior medical staff.
- Plans for addressing staffing and recruitment problems included the development of a local staff bank, development of a career structure for nursing, sponsorship for HCAs wanting to undertake nurse training, and development of new roles for non-registered practitioners.
- There was an information technology strategy in place, which would improve cross-site working and integration with primary care systems, to facilitate more effective communication and patient care.
- There was a five year strategy in place for the directorate of elderly medicine.

Governance, risk management and quality measurement

- Clear governance structures were in place to facilitate analysis of information from incidents and complaints, identify themes, and ensure communication from ward to board. Key messages from incidents and complaints were communicated across the trust, via staff meetings, training and newsletters.
- Risk registers were in place for the medical and elderly medical directorates.
- Leaders and managers were aware of the risks and challenges faced by the wards, such as staffing and shift patterns, and had a number of plans to address these, such as working closely with the University of York, taking part in recruitment fairs, and holding one-stop-shops for the recruitment of nurses and healthcare assistants.
- There were internal quality assurance systems and processes in place to investigate and review any clinical concerns or issues, and to make recommendations and improvements. For example, weekly mortality reviews were carried out, involving the chief executive, the director of nursing and the medical director.

Leadership of service

- At ward level, there was clear leadership of the services. Ward managers told us that they had one day a week allocated to management time. However, staffing pressures sometimes limited ward managers dedicated management time, and impacted upon their ability to lead and manage their ward.
- Ward staff stated that local leadership was supportive; ward managers and matrons were visible, and provided clear leadership.
- Staff were recognised where patient feedback had named staff in a positive light. Ward 26 staff were recognised through a monthly award. Compliments and concerns were held in a ward folder accessible to all staff.
- Sisters and ward managers appreciated that they were able to access the matrons easily if needed, and that they were very supportive.
- Matrons worked on a ward for one day of each month, which increased both their visibility and their credibility with staff.
- Ward managers and other senior nurses could access a professional leadership forum for learning and support, and ward managers were encouraged to undertake a leadership programme, which was also to be rolled out to junior sisters.
- The staff did not feel that the executive team were visible at ward level, but were aware that the chief executive held surgeries for staff to drop in on. The dates of these were advertised in the staff bulletin, Staff matters.
- In the main, staff were proud to work at the York Hospital, and felt ward and multidisciplinary team work was very good.
- Staff we spoke with were aware of 'Operation Fresh Start', a trust-wide initiative to improve patient flow.
- The percentage of staff able to contribute towards improvements at work had been a negative finding in the trust staff survey (2013).
- Staff told us that they had not received feedback regarding staffing requirements from patient acuity and dependency studies.

- Support and training for medical staff was reported as being very good. with particularly high praise given to the renal consultants and ward.

Culture within the service

- The service clearly had a culture of improvement, and staff were willing to try new ways of working to improve services for patients.
- Trust-wide data from the 2013 staff survey reported a negative finding regarding fairness and effectiveness of procedures for reporting errors, near misses and incidents.
- There was a good ethos of multidisciplinary working, and respect and value for multiprofessional skills and knowledge. There were a number of examples of training and support offered across disciplines.
- Staff told us that they had felt better supported by managers over the past 12 months, and that the culture was improving in terms of openness and honesty.
- Staff mentioned that there had been difficulties working across sites with Scarborough Hospital, but that relationships had now developed, and there was a sharing of ideas and good practice.
- Staff told us that they regularly raised concerns, although there was mixed feedback regarding the impact or any changes made as a result of concerns raised. This was particularly in relation to medical shift patterns / ways of working, and the need for improved cross-site working.
- Staff told us that they regularly reported incidents and near misses, and received feedback.

Public and staff engagement

- The trust had a well subscribed foundation trust membership, and actively sought their views on various topics regarding the hospital, such as changes to the trust visiting times.
- The public were encouraged to nominate staff for annual awards, and the trust and its staff proactively sought feedback through the Friends and Family Test (FFT), and other patient surveys.
- The wards displayed the FFT results on 'You said, we did' boards, so patients and the public could see changes made as a result of their feedback.
- Staff were not always engaged with service changes, or felt that their views had been heard or acted upon. For example, staff told us that the AMU lost its frailty beds to the Winter pressures ward over a weekend, with no forewarning or planning evident.

Innovation, improvement and sustainability

- There were a large number of examples of innovation, improvement and sustainability, such as the FREDA team facilitating rapid discharge for elderly patients; the creation of a dispensing pharmacy within AMU to improve patient flow; the development of a fractured neck of femur pathway including the orthopaedic /elderly integrated ward developed to care for patients to improve rehabilitation, minimise length of stay and improve the number of discharges back to usual place of residence and 'Perfect week'. Perfect week was a week when all staff and stakeholders strived to ensure all systems operated perfectly and then used the learning to develop 'Operation Fresh Start': This included the development of an early warning trigger tool to identify wards where problems were occurring and the development of a discharge liaison team.
- Senior clinicians and managers told us that there was work to be done to improve cross-site working at consultant level, to improve the clinical sustainability of some services.

Surgery

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

Information about the service

Surgical services at York hospital included general surgery, orthopaedic surgery, ear nose and throat (ENT) services, ophthalmology, maxillofacial surgery, theatres and endoscopy. There were 172 surgical inpatient beds across six ward areas. There were 12 operating theatres in the main theatre suite and six operating theatres in the day unit. Of those, three were clean air theatres used for orthopaedics and trauma procedures.

We visited pre-assessment, the day surgery units, operating theatres, acute surgical admissions unit (SAU), ophthalmology unit, discharge lounge and the post-anaesthetic care unit (PACU). All surgical wards were visited, including general surgery (wards 11, 14 and 16, including the nursing enhanced unit), head and neck (ward 15), and trauma and orthopaedics (wards 28 and 29).

We spoke with 33 patients and 32 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified), medical staff (senior and junior grades) and managers. We observed care and treatment and looked at care records for 10 patients. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Summary of findings

Services were responsive to patients' individual needs, but there were concerns over waiting times, such as the 18-week referral-to-treatment time (RTT) targets, the achievement of cancer waiting time targets, and the high number of non-surgical patients being cared for on surgical wards, which was having an impact on access and flow.

Optimum staffing levels and skill mix across surgical services were not being sustained at all times of the day and night. However, the trust was mitigating some of this risk by the use of bank/agency staff and the redeployment of other staff. Pressures on the wards had an impact on staff being able to attend statutory and mandatory training.

The service provided effective and evidence-based care and treatment. Staff were seen to be caring and compassionate while delivering care. Patients' privacy and dignity were maintained, although some concerns were raised from patients about being cared for in mixed-sex accommodation on the nursing enhanced unit on ward 16.

Work was continuing to integrate surgical services and deliver common standards of care across the three hospital sites (York, Scarborough and Bridlington). Directorate-level governance arrangements were in place but protocols, guidelines and pathways of care in all three hospital sites were variable and not yet fully established.

Surgery

Are surgery services safe?

Good

Safety was rated as good.

Staffing establishments and skill mix were reviewed regularly. Optimum staffing levels and skill mix across surgical services were not being sustained at all times of the day and night. However, the trust was mitigating some of this risk by the use of bank/agency staff and the redeployment of other staff. Pressures on the wards had an impact on staff being able to attend statutory and mandatory training.

Effective handovers took place between shifts; these included daily safety briefings to ensure continuity and safety of care.

There were effective arrangements to minimise the risk of infection to patients and staff. Medicines were managed appropriately; however, where omissions were noted, the results were not always shared with ward staff to identify areas for improvement.

Staff were encouraged to report incidents and most received feedback on what had happened as a result.

There were processes in place for staff to recognise and respond to changing risks for patients, including responding to warning signs of the rapid deterioration of a patient's health. Appropriate plans were in place to respond to emergencies and major incidents.

Incidents

- Staff were aware of the processes for reporting incidents and were confident in their explanations of the reporting mechanisms and the categories of incidents that they needed to report. Most staff told us that they received feedback and learning from incidents to improve patient care.
- In surgery, there had been 30 serious incidents reported between January and December 2014 that required investigation. These included 11 falls and 11 pressure ulcers. The directorate recognised the concerns around harm occurring from patient falls and pressure ulcers and improvements included a revision of risk assessments and intervention processes. Fall reduction plans showed that the prevalence of harm resulting from falls had decreased.
- A monthly safety publication, 'Nevermore', included key learning from serious incidents, complaints and claims. All serious incidents were reviewed and learning discussed at clinical governance meetings each month.
- We observed the weekly mortality and morbidity meeting. Clinical staff discussed all patients whose length of stay was longer than seven days, patient readmissions within 14 days, returns to theatre and deaths. A comprehensive case summary was presented identifying themes and trends and any required actions.
- There was good awareness from staff about the principles of the Duty of Candour and the specific requirements of the new regulations that had come into force in November 2014. The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. We saw that the regulations were displayed in ward areas.

Safety thermometer

- The trust used the NHS Safety Thermometer, which is a local implementation tool for measuring, monitoring and analysing harm to patients and 'harm-free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters and venous thromboembolism (VTE or blood clots).
- Twenty-two pressure ulcers had been reported between July 2013 and July 2014. The prevalence rates were spread consistently across a 12-month period. Fifty-three falls had been reported for the same period, with a downward trend between March and July 2014. There were 13 urinary tract infections for people with catheters.
- Trust data showed that 94.2% of patients admitted to York hospital had received care 'free from harm' in January 2015.
- Trust data showed 97% compliance with VTE risk assessments on admission in January 2015 against a trust target of 95%.

Cleanliness, infection control and hygiene

Surgery

- Ward areas appeared clean and we saw that staff regularly washed their hands between patient appointments and interventions. Staff were 'bare below the elbows', in line with trust policy and national guidelines for best hygiene practice.
- There had been no methicillin-resistant Staphylococcus aureus (MRSA) infections within surgery over the last 12 months. There had been five reported cases of Clostridium difficile (C. difficile) for the surgical directorate between April and November 2014.
- Elective patients undergoing orthopaedic surgery were screened at pre-assessment for MRSA and patients with MRSA were isolated in accordance with infection control policies.
- We observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps).
- Schedules for ward and equipment cleaning frequency were in place and in accordance with NHS national cleaning standards.
- The unit participated in ongoing surgical site infection audits run by Public Health England. The last published results for April 2013 to March 2014 showed that there were no surgical site infections for the trust relating to total knee replacements.
- Infection control information was visible in all ward areas. This information included how many days a ward had been free from C. difficile.
- Infection control and environmental audits were regularly carried out in clinical areas. Overall results were compliant with trust targets in most surgical areas and action plans were in place where improvements were required.

Environment and equipment

- Ward-based staff reported having sufficient equipment to enable them to carry out their duties. They reported being able to request replacement items or new equipment, if required, with relative ease.
- There were effective systems to ensure that resuscitation equipment, including emergency drugs, was readily available in all surgical areas, including theatres. Records showed that daily checks of this equipment had been carried out.
- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.
- Theatre equipment preference books were completed for each surgeon to assist staff in obtaining the correct equipment for surgical procedures.
- Technical equipment used for monitoring patients had been safety tested and labels indicated the next date for checks to be made.
- Full tracking and traceability of surgical instrumentation was provided. This offered a full audit trail to ensure that each decontamination process was followed correctly and according to international standards.
- There was equipment available on wards and theatres for patients with a high body mass index (BMI).
- Staff told us that one set of doors was locked on the SAU as an infection prevention measure. This had been introduced in February 2014 and meant that patients had a longer distance to travel to get to theatres. Staff told us that, in an emergency, they would break the lock on the door. Junior doctors told us the locked doors were not efficient and caused problems when they were on call, especially at weekends, because of the distances travelled between wards. The ward manager told us that the design of the SAU would be changing once the current bed pressures subsided so the entire ward could be decanted to an empty ward area.

Medicines

- Pharmacy staff carried out a full clinical check of all prescription and medicine administration records daily, Monday to Friday.
- New patients had medicines written up immediately and all medicines were signed for and patient allergies recorded.
- Nursing staff said that they had easy access to information on medicines and a pharmacist discussed medicines with individual patients if this was requested.
- We saw that a number of patients were receiving oxygen but sometimes a prescription had not been written to authorise this.
- Omissions of critical medicines were monitored monthly but the results were not always shared with ward staff to identify areas for improvement.
- Medicines were stored securely and pharmacy staff audited medicine security and the management of controlled drugs on a regular basis. However, medicine fridges on some wards were not fully monitored in line with trust policy.
- Wards kept supplies of commonly used pre-labelled medicines to facilitate faster discharge of patients. A full

audit trail was maintained to account for all medicines supplied. However, nursing staff told us that patients were sometimes discharged without their medicines because doctors did not always write up electronic discharge notes in a timely manner. This meant that discharge prescriptions for some medicines were not available when the patient left the hospital, which resulted in medicines being sent by taxi to a patient's home or the patient or relative returning to the hospital to collect them.

- We observed that the preparation and administration of controlled drugs 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.

Records

- Care pathways were used for patients undergoing elective surgery. The pathway incorporated the patient journey from pre-assessment to admission, surgery, recovery and discharge. The records we looked at were completed accurately.
- There was access to electronic patient records on the wards, and these listed the essential patient care requirements. This included completion of the National Early Warning Score (NEWS) and risk assessments for falls, VTE, pressure ulcers and malnutrition.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Dementia screening tools were completed for patients over the age of 65. Records showed that where a diagnosis of dementia was made, patients received further investigations.
- An electronic information system was used in theatres and included the nursing care plan, theatre times for the patient, the surgery undertaken and the type of surgical implants used.
- A register was completed in the PACU detailing reasons for any patient who stayed for over two hours in the recovery areas. The register documented post-operative complications that required the patient to be transferred to high dependency care and details of patients who were waiting for beds to become available on the wards.

Safeguarding

- There were safeguarding policies and guidelines for the protection of vulnerable adults and children. The trust had a designated safeguarding lead who provided advice and training for staff and linked into the multi-agency safeguarding networks.
- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and they were aware of the hospital's safeguarding systems and processes.
- Figures showed that 57% of staff had completed training in safeguarding adults and children at levels 1 and 2 against a trust target of 75%.

Mandatory training

- Overall completion of statutory and mandatory training for surgery and theatres was 62% and 67% respectively for orthopaedics against the trust target of 75%.
- Data for surgery and theatres showed that staff had completed training in areas such as infection control (78%), medicines management (72%), health and safety (85%) and manual handling (46%).
- Staff told us that it was difficult to attend training due workload pressures. Theatres were implementing dedicated time for staff to attend two sessions a year in order to complete the required training.
- The trust had launched a learning hub that enabled staff to understand their training requirements and how these could be delivered. Management teams could also see which staff had not refreshed their training.

Assessing and responding to patient risk

- The surgical wards used NEWS, a recognised early warning tool for the management of deteriorating patients.
- Escalation processes were in place to obtain a medical review or response within 30 minutes. Staff confirmed that there was good access to the patient's consultant or the on-call consultant out of hours when urgent medical input was required.
- Protocols were in place for the marking of surgical sites. All checklists were completed before the patient was transferred to theatre.
- We saw guidance to theatre staff with regard to following the 'Five steps to safer surgery' (part of the World Health Organization (WHO) surgical safety

checklist). This included team brief, sign-in, time out, sign-out and debrief. An audit conducted between April 2014 and February 2015 showed good compliance of between 98% and 100% across surgical specialties.
- Surgical staff used a sepsis screening tool as part of the assessment under the early warning score. This enabled them to alert medical staff to patients with clinical indicators of possible infection.
- There was a nursing enhanced unit for patients who needed more intensive observation, treatment and nursing care from experienced, trained staff and good input from the ortho-geriatrician.
- In the PACU, there was a dedicated area for patient stabilisation; this included post-operative patients and patients who had been intubated in A&E and were waiting for an intensive care bed or transfer to a specialist unit. Patients were cared for by skilled operating department practitioners with anaesthetist input.

Nursing staffing

- There was a recently implemented trust-wide patient acuity tool to help calculate the number of nurses required on the wards and the trust was in the process of increasing them, including starting the process to recruit staff from abroad. An acuity and dependency audit had commenced in January 2015 using the Safer Nursing Care Tool; this was ongoing. Recruitment was ongoing in most surgical areas and a number of vacancies had been filled or interviews were scheduled during the coming months. This was to ensure that staffing establishments reflected the acuity and dependency of patients.
- As of the 6 March 2015 there were 97.4 actual RN vacancies within York hospital with 20 of these pending a start date. The surgical directorate had a number of nursing vacancies on most wards while facing demands due to an increase in inpatient activity. For example, wards 11, 14, 15, 16 and 28 (general surgery, ENT and trauma and orthopaedics) were understaffed by 13.52 whole-time equivalent (WTE) staff compared with the budgeted establishment. Similarly, the anaesthetic day unit was understaffed by 5.46 WTE and theatres by 5.34 WTE.
- The average daytime fill rate in February 2015 for York hospital as stated in the March Board report was 84% for RNs and 86% for HCAs. Fill rates at night were over 100%.
- Vacancies, Sickness and the Trust's ability to fill shifts did reduce the average percentage staffing levels each month. In the March 2015 Board report it stated that the surgical wards 11, 14, 15 and 16 had less than 80% due to vacancies and sickness.
- The RN fill rate for six surgical wards at York hospital in February 2015 ranged from 75.3% on ward 14 to 87.8% on ward29. Four of the six wards were below 79%. In January 2015 the RN fill rates for the same six wards ranged from 76% to 92.7% and in March 2015 from 75% to 92% with all but one ward being above 81%. The fill rate for care staff ranged from 78 to 88% during the day
- The fill rate on nights was better than days on the surgical wards ranging from 86 – 109% for RNs and for care staff 85 – 120%.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed numbers. Daily staffing meetings took place to discuss high-risk areas. Where there was low activity on wards, staff were moved to other wards in order to improve staffing levels. There was evidence of skilled surgical nurses having to care for medical patients (who were outliers on the surgical wards).
- During periods of high patient activity, matrons and assistant directors of nursing met twice daily to ensure the safe deployment of staff.
- Wards and departments had expected and actual staff numbers on display. We noted on most wards that the number of staff meant to be on duty was not always achieved.
- Staff reported good cross-department working to support patient care. Deficits in nursing staff numbers were offered to bank and agency staff to fill. Staff could also work extra hours.
- At the time of the inspection the trust used an agency (NHSP) to fill some of the gaps in the rotas. March 2015 Board papers indicated that 53.9% of hours requested through NHSP were filled which was a decrease of just over 3% in fill rate from the previous month. The fill rate for qualified hours was 46.1% and the fill rate for unqualified hours was 60%. The fill rate for the internal back was much better and was above 80%.
- There was a high percentage of agency staff used in the main theatres: data from between December 2013 and November 2014 showed an average usage of 15.22%. There was a system for planning theatre activity in order to allocate staff efficiently and to respond safely and flexibly to changes in routine.

- An in-house nursing bank had been recently developed to cover York hospital which used the Trust's own staff and therefore reduced the risk of staff being unfamiliar with services, polices and protocols as bank staff received the Trusts induction and training arrangements.
- PACU staffing levels were in line with recommendations from the Association of Anaesthetists of Great Britain and Ireland. Staffing numbers allowed for no fewer than two registered nurses to be present when there was a patient in the PACU who did not fulfil the criteria for discharge to the ward.
- Nursing handovers occurred three times a day, using patient information from the ward's electronic system that identified any risks regarding patient care. Daily safety briefings took place.
- When a patient became acutely unwell and required escalation to medical staff or to critical care outreach, the registered nurse and medical staff communicated using the Situation, Background, Assessment Recommendation (SBAR) tool to ensure that all information was handed over.

Surgical staffing

- Surgical services were overseen and led by consultants for each 24-hour period.
- Arrangements were in place to ensure that the surgical directorate had access to support from consultant surgeons and anaesthetists during normal working hours and out of hours, with on-call access if needed.
- We spoke with senior grade doctors regarding the surgical on-call procedures. The on-call registrar was paired with the consultant for the duration of the on-call week; this improved continuity of patient care. There were two senior doctors on call at the same time; this meant that if one doctor was in theatre, the second was available for immediate patient care.
- The SAU was staffed by doctors of appropriate grades who were free from other clinical commitments.
- There was a resident junior doctor on the trauma ward with access to the on-call consultant, who could be available within 15 minutes. Staff said that consultants attended the trauma ward regularly and carried out ward rounds at weekends.
- We observed a comprehensive surgical handover; handovers occurred each morning at 8am. The night on-call team prepared a list of patients for the handover. This was available electronically and included patient details, main complaint, investigations, provisional diagnosis and management. The medical team had access to x-ray and laboratory test results. Ward patients in non-surgical areas were also discussed and seen by the appropriate medical team.
- The directorate was expanding nursing roles and had two advanced nurse practitioners in post on the trauma ward.
- The directorate's locum usage was 5%.
- Medical staff shift lengths were in line with the European Working Time Directive. The General Medical Council National Training Survey 2014 identified no risks with regard to doctor workloads.

Major incident awareness and training

- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who could be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency. Staff were familiar with their role in an emergency response.
- There was a business continuity management plan that provided a clearly defined framework to ensure the resilience and continuation of the trust's critical activities.

Are surgery services effective?

Good

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

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

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

Evidence-based care and treatment

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.
- The directorate took part in all the national clinical audits for which they were eligible. It also had a formal clinical audit programme in which national guidance was audited and local priorities for audit were identified. For example, results from the National Bowel Cancer Audit Programme (NBCAP) 2014 identified no cause for concern against the key indicators. The 90-day mortality rate was slightly higher than average, but this was still within acceptable limits.
- A fractured neck of femur audit assessing the level at which the targets for best practice were being met for patients at discharge showed 100% compliance. This was better than the standards set by the British Geriatrics Society.
- Patients receiving post-surgical care were nursed in accordance with NICE guideline CG50: 'Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital'.
- The directorate followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). There was protected time in theatres for emergency cases and dedicated NCEPOD lists each weekday that covered the surgical sub-specialties.
- Patients followed an enhanced recovery programme for hip replacement surgery. This was an evidence-based approach that allowed patients to play an active role in their care and helped them to recover more quickly following major surgery and return to a normal life as soon as possible.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and these were recorded using a pain scoring tool. We reviewed a number of care pathway records and saw that pain relief for patients undergoing a variety of procedures was documented.
- The trust had a dedicated pain team that provided daily advice and support to the wards. Out of hours, ward staff could access the on-call anaesthetist.
- The majority of patients who spoke with us said that they had their pain assessed by nurses and, when required, they had been given pain relief promptly. For example, patients on the orthopaedic enhanced recovery pathway received pre-operative, peri-operative and post-operative analgesia, which facilitated early patient mobilisation and independence and earlier hospital discharge.
- Patients recovering from surgery were provided with patient-controlled analgesia to enable them to control their own pain.

Nutrition and hydration

- Fluid input and output records were used appropriately to monitor patients' hydration. We looked at a sample of records on the surgical wards and saw that they were completed to a good standard.
- A nutritional screening tool for inpatients was completed within the first 24 hours of admission and repeated weekly; action was taken where required. Dietary boards were used on the orthopaedic wards to identify those patients who were diabetic or required special diets.
- Patients requiring specialist dietary advice were referred to the dietician and offered the most appropriate menu: for example, textured, low-fibre or gluten-free diets.
- Staff followed guidance from the Royal College of Anaesthetists regarding pre-operative fasting. A post-operative nausea and vomiting protocol was also completed.
- Mealtimes were protected on wards and we observed staff giving positive encouragement and assistance where possible, with involvement from family and carers when required.
- Patients were satisfied with their meals and said that they had a good choice of food and sufficient drinks throughout the day.

Patient outcomes

- There were no current CQC mortality outliers relevant to surgery at York hospital. This indicated that there had been no more deaths than expected for patients undergoing surgery at the hospital.
- York hospital was performing better than the England average in nine out of 10 measures of the National Hip Fracture Audit 2014. The trust was slightly worse than the England average for patients being admitted for surgery on the day of, or day after, admission. For example, 71.9% of fractured necks of femur were seen within 48 hours compared with the England average of 73.8%.

- The relative risk of readmissions was better than the national average for both elective and non-elective procedures.
- The hospital outcomes for the Patient Reported Outcome Measures (PROM) for April 2013 to December 2014 for hips, knees and groin hernia repair showed that the percentage of patients who had improved after each procedure was in line with percentages reported nationally.
- The average length of stay was slightly shorter than the national average for elective procedures and slightly longer for non-elective procedures.
- Patient outcomes for emergency laparotomies were unclear: the National Emergency Laparotomy Audit 2014 showed that 12 out of the 31 indicators that were audited were rated as 'not available'.

Competent staff

- Staff had the right qualifications, skills and knowledge to do their job. Nursing staff undertook competency-based assessments to show that they met the requirements of their role.
- Staff had opportunities in an annual appraisal to discuss their performance and identify learning and development needs. However, data for four out of six staff groups in surgery showed that only 67% of staff reported they had had a staff appraisal against the trust target of 95%. This was due to sickness and staffing shortfalls on the wards.
- There was a comprehensive PACU competency induction programme available for all new staff. Staff were assigned a mentor who was responsible for delivering the competency programme. Staff had a personal learning log and reflective diary that acted as a focus for discussions with mentors or peers.
- Most junior doctors in surgery told us that they attended teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were well supported by the ward team, and could approach more senior staff if they had concerns. However, some junior doctors, for example those working in orthopaedics, said that they had limited opportunities to observe clinics and theatre sessions because the wards were too busy. The General Medical Council National Training Survey 2014 identified no risks in these areas.
- Operating department practitioners and PACU staff had all completed paediatric intermediate life support training.
- Student nurses we spoke with gave positive feedback about their surgical ward placements and the support they had received.
- Theatre staff underwent a three-day trust induction programme and a two-day theatre induction. All new staff were provided with a surgical-specific competency assessment document to complete.
- Theatres had a well-equipped resource room with computer terminals for staff to complete their e-learning and access protocols and guidelines.
- Newly appointed staff from the PACU spent four weeks working in the high-dependency and critical care units as part of their induction programme.

Multidisciplinary working

- There was effective multidisciplinary team working on the wards. Daily ward rounds were carried out during which the clinical care of every patient was reviewed by members of the multidisciplinary team, led by the consultant managing the patients' care.
- Staff told us that there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits, or to discuss any changes to the care of patients.
- Effective team working between ward and theatre staff was observed; interactions, interventions and treatment were recorded.
- A discharge letter was sent to the patient's GP and a copy of the letter provided to the patient.
- There was evidence of effective team working for patients on the enhanced recovery programme with input from dieticians, occupational therapists and physiotherapists.

Seven-day services

- Consultants were available on call out of hours and would attend when required to see patients at weekends.
- There was a consultant ward round each day; this ensured that all patients were reviewed within 12 hours.
- During the week, there were two radiographers available for theatres. Out of hours and at weekends, there was one radiographer allocated to theatres.

- Pharmacy support was available between designated hours on a Saturday and via on-call arrangements out of hours.
- Referrals for computerised tomography (CT) scans could be made 24 hours a day, seven days a week.

Access to information

- Laboratory requests were mostly electronic and made through the electronic patient record system. Routine haematology, biochemistry and microbiological investigations were available 24 hours a day. Blood samples were sent to the laboratory using a chute system with high-risk and urgent specimens taken by porters.
- All local policies and guidelines could be accessed electronically on the trust's systems. Local policies were written in line with national guidelines: for example, there were local guidelines for pre-operative assessments and these were in line with best practice.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- The elective surgery care pathway incorporated formal consent forms and supporting information for both staff and patients. These consent forms were in line with current Department of Health guidance.
- Consent forms identified the procedure to be undertaken, its associated risks and the healthcare professional responsible for consulting the patient. They also recorded signatures from patients, indicating that they were providing consent to undergo the proposed procedure.
- All patients we spoke with told us that they had been asked for their consent before surgery. They said the risks and benefits had been explained to them and they had received sufficient information about what to expect from their surgery.
- Staff were aware of their responsibilities relating to the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DOLS).

Are surgery services caring?

Good

We observed positive, kind and caring interactions on the wards and between staff and patients. The majority of patients spoke positively about the standard of care they had received. Some patients raised concerns about the levels of noise on the wards at night.

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

Compassionate care

- We observed positive, kind and caring interactions on the wards between staff and patients. Staff introduced themselves appropriately and drew curtains to maintain patient dignity. There were facilities on the wards where staff and relatives could have more sensitive conversations if required.
- Call bells on the wards were mostly answered promptly and were in reach of patients who needed them. A few patients told us that they "felt guilty" if they had to use their call bell because staff were "very busy".
- Some patients reported that they were unable to sleep because of noise at night from staff and other patients and because of environmental noise.
- Patients in pre-assessment said the service had been "excellent" and they had not waited too long to be seen.
- Patient-led assessments of the care environment (known as PLACE) for 2014 showed that the trust was better than the England average for cleanliness, privacy, dignity and wellbeing and slightly below average for food and facilities.
- Hourly comfort rounds (checks to make sure that patients were comfortable and had what they needed) took place to ensure that staff were aware of any emerging needs patients might have.
- The response rate for the NHS Adult Inpatient Friends and Family Test was 38.35% for February 2015. Data showed that 95% of patients receiving care at the trust were either 'highly likely' or 'likely' to recommend services to their family or friends.

Surgery

- The CQC Adult Inpatient Survey 2014 did not identify any evidence of risk and the trust was rated 'about the same' as other trusts.

Understanding and involvement of patients and those close to them

- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given the contact numbers of specialist nurses to ensure they had adequate support on discharge.
- We observed that staff made every effort to ensure that patients who were unable to communicate were fully involved in their care and treatment.
- Patients on the colorectal enhanced recovery programme completed a patient diary. This gave them the opportunity to comment on how they were feeling and whether they were able to achieve their goals while recovering from surgery.

Emotional support

- There was information in care plans to identify whether patients had emotional or mental health problems. Assessments for anxiety and depression were conducted at the pre-assessment stage. Nursing staff provided extra emotional support for patients both pre-operatively and post-operatively where required.
- Clinical nurse specialists in areas such as colorectal, stoma care, breast care and head and neck services were available to give support to patients.
- The mental health team provided a service during working hours and was on call out of hours for patients with psychiatric problems or following episodes of self-harm.

Are surgery services responsive?

Requires improvement

Staff were responsive to patients' individual needs, but there were concerns over issues such as the 18-week RTT targets, achievement of cancer waiting time targets and the high number of non-surgical patients being cared for on surgical wards, which had an impact on access and flow.

Surgery had systems in place to plan and deliver services to meet the needs of local people. Services were available to support patients living with learning disabilities and dementia. Some patients raised concerns about being nursed in mixed-sex accommodation on the nursing enhanced unit.

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

Service planning and delivery to meet the needs of local people

- Surgical services were available 24 hours a day, seven days a week, with emergency access to operating theatres outside normal working hours.
- Further areas were being reviewed for collaborative working with other NHS and private providers in order to improve care outcomes. This included the tendering of orthopaedic services with private providers, sub-specialisation with other NHS hospitals, and the expansion of elective services within Bridlington.
- The trust had an escalation policy and procedure to deal with busy times. This gave guidance to staff on how to proceed when bed availability was an issue.

Access and flow

- The directorate was not meeting its targets for the 18-week RTT pathway in five of the eight surgical specialties. National operational standards are that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. The trust recognised that it required joint working between the Trust and commissioners to ensure that the Trust could move to a sustainable backlog. The trust were working with commissioners but at the the time of inspection were unable to undertake additional sessions to reduce the backlog, due to funding. . The directorate was continuing to work to meet the 18-week target.
- In January 2015, 234 elective procedures were cancelled at a time of national demand on NHS acute services. The organisation responded to this by moving some elective orthopaedic activity to the Bridlington site and by organising additional lists when pressures eased and some patients were offered surgery at other NHS providers..
- Minutes of the February 2015 finance and performance committee meeting showed that delivery of the 62-day waiting time target was not assured during the following

three months due to internal and tertiary centre elective cancellations. The Trust continued to monitor and escalate patients on a daily basis. It was also likely that the trust would not be able to deliver the required standard for the 14-day fast-track cancers for this period.

- The Trust had failed to deliver the 14 day breast symptomatic target. These were patient choice breaches which were the main reason for not achieving target, with patients being offered dates but declining them. The organisation surveyed patients to understand the reason for non-acceptance of appointments and was looking at how this service may be organised to meet patient needs..
- Average theatre usage across all theatres at York was reported to be 86.91% for November 2014 (the national average in England was 86%).
- There were 334 elective operations cancelled at last minute for non clinical reasons (bed unavailability and staff sickness) between April –December 2014. A a robust clinical decision making process was undertaken to determine those patients who could have their surgery safely postponed. All but two patients were re-booked within 28 days as per the national standard.
- Surgical patients who were nursed on non-surgical wards received reviews regardless of their location. An electronic list of all outliers was managed by either the registrar or the consultant and was updated on an ongoing basis.
- The directorate had outlier guidelines that included criteria for whether patients were suitable for transfer. Staff reported that it was common for medical patients to be cared for on surgical wards. Trust data showed that between July and October 2014 there were 253 medical outliers at York hospital. Staff said that patients were reviewed by the medical teams; however, due to the length of stay of some medical patients, this was having an impact on surgical patient admissions and access and flow.
- Outlying patients were tracked by the patient flow teams and the number in each outlying specialty was known (see medicine report) and discussed at the trust's daily operational meetings.
- Theatre lists were discussed six weeks in advance and patients were allocated to lists. If lists had vacancies, these were offered to other surgical specialties; however, this depended on whether lists could be staffed and if an anaesthetist was available. There was also a weekly meeting to discuss operating lists.
- Patients were assessed by the multidisciplinary team, including an anaesthetist, before admission. This allowed staff to identify patients' care needs before their operation and have plans in place for their recovery.
- Discharge planning began at pre-operative assessment stage for elective patients and on admission to the unit for trauma or emergency patients. Staff reported that, if community services were required, these were arranged by referral to social services.

Meeting people's individual needs

- We observed that male and female patients were being cared for in the same bay in the nursing enhanced unit based on ward 16. The unit consisted of two six-bedded bays, which allowed closer observation of level one dependency patients. Three female patients raised concerns with us about being nursed in mixed-sex bays. One patient told us that when she came round from her operation she was in a bay with three male patients without the curtains drawn around her. The patient was moved to a female bay the following day and was informed that this had occurred because "there was a shortage of beds". Following inspection, the trust told us they were not aware of any patients being placed on the Nurse Enhanced Unit because of bed shortages.
- Support was available for patients with learning disabilities. A learning disability specialist nurse was available in the trust and would visit the patient to offer support and advice. A 'This is me' form was completed so staff were aware of the patient's likes and dislikes.
- Staff were able to access and refer patients living with dementia to the specialist dementia nurse. This nurse was supported by two mental health liaison nurses. The trust had introduced 'forget-me-not' stickers on case notes to remind staff that patients with dementia may have memory problems.
- At York, ophthalmic services were sited within a self-contained unit in the department. The department had two dedicated eye theatres. The unit met the needs of patients who were visually impaired. For example, there was low-level background lighting and signage that followed RNIB guidelines.
- Patients using colorectal services were allocated a key worker, usually a clinical nurse specialist, who took a role in the coordination and continuity of the patient's care, including providing information, advice and access to other specialists when required.

Surgery

- As part of the enhanced recovery programme in orthopaedics, patients were active in any preparation and planning before admission, pre-operative assessment, recovery and early mobilisation.
- A physiotherapist was based on the elective orthopaedic ward to provide patients with support and advice for early mobilisation. The ward had a dedicated area and equipment for exercises and rehabilitation.
- Input from an ortho-geriatrician was available for elderly patients who had been admitted with orthopaedic conditions.
- Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission with specialists such as physiotherapists and occupational therapists identified and arranged while the patient was in the hospital. Delays to discharges were mainly related to external factors, such as community-based care needs and referrals for a social services assessment.
- A translation telephone service was available for patients who did not speak English as their first language. There were multiple information leaflets available for different conditions and procedures, and these could be made available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes for dealing with complaints at ward level and through the trust's patient experience department.
- 'Your Experience Matters' booklets informed patients how to complain and the trust asked for feedback from patients, relatives and carers.
- Between April and November 2014, there were 88 complaints relating to surgery, which was the second highest number in the trust. The top three areas where complaints had been raised were surgery and urology (45 complaints), head and neck services (17 complaints), and trauma and orthopaedics (16 complaints). Of these, 11 complaints remained open and six complaints had been re-opened.
- The main themes for complaints related to aspects of clinical care, staff attitude, admission, and discharge and transfer arrangements.
- Complaint officers met regularly with the management team to review current complaints, identify any problems and offer support and advice.

Staff from surgery attended the patient experience steering group on a quarterly basis. The group's key focus was to consider complaints referred to the Health Service Ombudsman, NHS Friends and Family Test feedback, national patient surveys, complaints and Patient Advice and Liaison Service feedback.

Are surgery services well-led?

Good

There was a vision for the service, and senior leaders understood their roles and responsibilities to oversee the standards of service provision in all surgical areas. Work was continuing to integrate surgical services and deliver common standards of care across the three hospital sites.

There were governance systems and process in place and staff were aware of their roles. Reporting took place, and staff reported an open and supportive culture. The staff survey was positive and patient feedback was sought and in the main positive.

Vision and strategy for this service

- A five-year strategic plan was in place for orthopaedics, head and neck services and ophthalmology. The general surgery strategic plan was being developed. The plans were aligned with the trust's vision and values. There was evidence of staff being consulted about and asked to comment on the development of the strategy and any future surgical reviews.
- In July 2012, York acquired Scarborough and North East Yorkshire Healthcare NHS Trust, bringing Scarborough and Bridlington hospitals into the organisation. Work was ongoing to integrate surgical services. The directorate was working towards the delivery of common standards of care.

Governance, risk management and quality measurement

- Clinical quality in the directorate was managed through the performance management process. Performance improvement, quality and safety meetings were held in the directorate and were used to monitor and improve clinical practice.

- The directorate was in the process of developing standardised protocols, guidelines and pathways of care for the three hospital sites. However, these developments were variable and not yet fully established.
- Some staff told us that there was limited collaboration and sharing of best practice between staff working in York, Scarborough and Bridlington hospitals. For example, theatre staff in York did not know about the 'never event' (Serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented) at Scarborough and the learning from this.
- We saw that risk registers were in place for orthopaedics, ophthalmology, theatres and head and neck services. The level of risk was identified, along with actions needed to manage gaps in the controls and assurance, and associated review dates and executive leads.
- Directorate risk registers were discussed at the performance management meetings and locally in the directorate. Significant risks identified from the directorate risk registers were added to the corporate risk register and considered by the board of directors.
- The directorate held monthly governance meetings and joint governance meetings were held across hospital sites every quarter. The meeting minutes showed that patient experience, complaints, incidents, audits and quality improvement projects were discussed, and that action was taken where required, including providing feedback to staff about their individual practice.
- Staff told us that the trust was open and honest with patients following incidents and complaints in accordance with the trust's 'Being Open' policy and Duty of Candour regulations.

Leadership of service

- Each surgical specialty was led by a clinical director, director of nursing and general manager.
- The senior leadership team had a good understanding of their roles and were aware of the risks and developments required to improve the quality of patient care. A number of developments were being implemented across the three hospital sites, although it was too early to say whether these would be effective and sustainable. The senior management team told us that the process was 'evolutionary' and that it would take time to ensure full surgical integration.
- Matrons and ward managers were in post within the directorate to oversee operational issues and assist with daily workforce planning to ensure that staff were distributed according to clinical needs. Staff reported that matrons and ward managers were visible and accessible.
- As part of the nursing quality assurance framework, the chief nurse team planned to introduce nursing performance management meetings across the trust. Representatives from the chief nurse team and directorates met to discuss nursing issues, monitor action plans and support clinical areas.
- At present there was no permanent matron for theatres. The service had advertised the post and was waiting for interview dates.

Culture within the service

- Most staff reported that there was an open and transparent culture on the surgical wards. They reported good engagement at ward level and felt that they were able to raise concerns and that these would be acted on.
- Staff told us that the senior management team for the service and senior medical staff were visible and approachable on the unit.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Staff in most surgical areas said that they had staff meetings; however, some staff said they had not had a staff meeting for a few months.
- Ward sisters said that they were not able to have their protected management time because of pressures on the wards. This meant that areas such as staff training and personal development reviews were not being kept up to date.
- Most junior doctors said they liked working in the hospital and that they had been well supported by the trust and their colleagues. A few said that the workload could be overwhelming because of the high number of patients and wards they had to cover and that support from consultants was variable.
- Staff told us that they wanted to work more collaboratively with Scarborough and Bridlington hospitals and felt that this area was improving. For

example, ward managers told us they occasionally used conferencing facilities for meetings with staff at Scarborough and there was some evidence of cross-site working in areas such as ophthalmology.

Public and staff engagement

- The NHS Staff Survey for 2013 showed that the trust scored as expected in 23 out of 29 areas. There were negative findings in areas such as job satisfaction, training, staff being able to contribute to improvements at work, and the fairness and effectiveness of procedures for reporting incidents.
- The wards were starting to receive quarterly laminated patient experience information that was displayed at ward level. This informed patients, relatives and staff about the NHS Family and Friends Test results. The trust's patient experience team worked closely with ward sisters to ensure that information reflected the actions wards had taken when improvements were required.
- Staff worked with Breast Cancer Care and Breakthrough Breast Cancer to obtain feedback from patients with a diagnosis of metastatic breast cancer. A breast cancer pledge document was developed with details and actions planned and was sent to all patients.
- The head and neck service provided support for patients following a laryngectomy (surgical removal of the voice box). Patients discharged from hospital were buddied with other patients attending the service who provided support and advice.

Innovation, improvement and sustainability

- The directorate had a dedicated clinical simulation theatre used for simulating anaesthetic, paediatric and obstetric emergencies. This allowed teams to rehearse events.
- Staff told us that IT systems at York were not always compatible with the systems in place at Scarborough. The Scarborough system could link to SystmOne in GP surgeries, which made it much easier for consultants to get information.

Critical care

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

Information about the service

The unit had in the region of 1,200 admissions per year; 50% of which are medical, the other 50% being surgical.

The York Hospital has a combined intensive care unit (ICU) and high dependency unit (HDU) and the move to combine the two occurred around four years ago. The ICU/HDU has a total of 17 beds and the unit flexes between certain numbers of level 2 and level 3 patients. Due to staffing the maximum number of level 3 patients that can be cared for is nine with four level 2 patients.,

We inspected the unit over the course of a day and a half and spoke with a range staff, patients and relatives. We also assessed the environment and spoke with the senior management team about the ICU/HDU service, including the following staff from both York Hospital and Scarborough Hospital: the director of theatres, anaesthetics and critical care, the deputy director of theatres, anaesthetics and critical care, the directorate manager for theatres, anaesthetics and critical care, the lead clinician for critical care and matrons for theatres, anaesthetics and critical care.

Summary of findings

Overall the critical care services provided required improvement.

There were suitable processes in place in relation to incidents, safeguarding and assessing and responding to patient risk. Medical and nurse staffing levels were adequate. Staff worked to best practice guidance and overall, safety outcome data was good. The support provided from other services, such as the pain team, dietetics and physiotherapy was adequate, but in terms of dedicated hours for the unit some services fell short of best practice guidelines. Access to training was an issue and the lack of a clinical nurse educator was having a negative impact on educational progress. Staff were caring and professional, patients, relatives and friends spoke highly of the care provided on the unit.

Service and strategic planning was at an early stage and there was a lack of certainty in terms of the future design of the service and the immediate mitigating actions in terms of delayed discharge, delayed admissions and high capacity. The Trust was engaged with its Clinical Commissioning Groups (CCGs) to identify the model of critical care to be delivered and how this was to be financed. There were positive comments from staff regarding culture and team work. However, it was felt by some staff that issues could be discussed in a more collaborative way and service planning could be more inclusive of others.

Critical care

Are critical care services safe?

Good

Safety was rated as good. There was an open incident reporting culture and incidents of concern, particularly serious incidents, were investigated and lessons learnt were implemented, where necessary. Safety data was collected and the way in which some of the data was displayed for the public was under review.

The environment of the ICU/HDU was clean and there was suitable working space, but storage space for some equipment was limited. Infection control data was within expected ranges and infection control practices were, on the whole, good. Medicines were suitably managed and there was appropriate pharmacy input. However, the hours of pharmacy support provided were less than recommended by national guidance.

There were suitable processes in place for assessing patient risk and escalating concerns and there was a clear escalation policy. Nurse staffing levels were suitable for the levels of nursing care required and bank/agency staff usage was relatively low.

Mandatory training figures for the directorate presented a mixed picture and, overall, compliance levels were well below the Trust's target of 75. Safeguarding training figures for the unit, across all levels of training, were under the target of 75%. Safeguarding processes were in place and staff were aware of how to raise concerns. %. Staffing was 12% below expected in November 2014. The ongoing lack of a clinical nurse educator was a concern, but we were told steps were being taken to address the issue.

Medical staffing, including out-of-hours support, was managed well and the majority of medical staff were specialists in intensive care medicine. Some on-call services were covered by non-intensivist consultant anaesthetists who did not meet best practice guidelines.

Incidents

- 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 untoward incidents (SUIs) requiring investigation from January 2014 to December 2014 in relation to ICU/HDU.
- For ICU/HDU there were two SUIs between January 2015 and March 2015 and both related to pressure area care and pressure ulcers. Root cause analysis (RCA) was conducted for both incidents and was reviewed at the pressure ulcer panel. Learning led to changes to practice as a result, including the introduction of a pressure ulcer skin care bundle.
- There was one SUI 18 months prior to the inspection for which there was a coroner's investigation. The SUI involved problems experienced by a patient with their tracheostomy tube (a tube inserted into a surgically created opening in to a patient's windpipe). Lessons were learnt from the SUI and actions included revision of the tracheostomy competency pack, revision of the tracheostomy policy and inclusion of scenarios involving tracheostomy tubes to scenario-based training sessions.
- Nursing staff we spoke with were able to describe how they reported incidents and this was via a computer system known as Datix. Nursing staff described how there was feedback from incidents and, in the main, this was provided via monthly team meetings.
- We spoke to several doctors in relation to medical staff and incident reporting and they were aware of Datix and how to report incidents. However, the threshold at which something should be reported was unclear.
- The senior nursing sister reviewed all Datix incidents and discussed them at the monthly ICU/HDU multidisciplinary team meetings, which were attended by: a medical consultant, a band 7 critical care nurse, the relevant matron and representatives from allied health profession services, including: physiotherapy, dietetics and pharmacy. Incident trends and necessary actions were discussed at these meetings.
- In addition, there was also a senior nurse meeting every other month and incidents, required learning and changes to practice were discussed.
- We reviewed incident data provided by the trust and this related to theatres, anaesthetics and critical care, including the ICU/HDU at York Hospital. The data was not specific to critical care only.
- For theatres, anaesthetics and critical care as a whole, there were a total of 661 recorded incidents between April 2014 and December 2014. The vast majority of

recorded incidents (396) were 'no harm'. There were 150 'minor' or 'low harm' incidents, 11 'moderate harm' incidents and one 'severe harm' incident. The data showed that 99 incidents were not classified- the forms had not been fully completed. We were not able to establish if these figures were comparable to other, similar sized directorates at other hospital trusts.

- Of the 661 recorded incidents, there were 24 falls (12 no harm, 12 minor or low harm), 77 medication errors (10 involving controlled drugs) and 118 pressure ulcer incidents, 21 of which were regarding newly-developed sores. The number of falls appeared to be comparatively high, as did the pressure ulcer data.
- We asked the lead sister if there were any formal meetings where mortality and morbidity was discussed. At the time of the inspection, there were no mortality and morbidity meetings, but these were soon to start. The consultants on the unit had 'time out' sessions every three months where mortality and morbidity was sometimes discussed, but the meetings were not solely focused on mortality and morbidity reviews.

Safety Thermometer

- The Safety Thermometer is an improvement tool for measuring, monitoring, and analysing patient harms and 'harm free' care. The Safety Thermometer records the presence or absence of four harms: pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter and new venous thromboembolisms (VTEs).
- While on the unit, we observed that some displayed patient safety data was displayed, including ventilator-associated pneumonia (VAP) infections, central line infection rates and MRSA bacteraemia rates.
- The displayed data was not specifically in relation to the Safety Thermometer tool, but it did highlight some key safety measures. The unit sister stated that, historically, Safety Thermometer information was displayed and it was currently under review.
- However, the unit did provide Safety Thermometer data to the Health and Social Care Information Centre (HSCIC) on a monthly basis.
- The Safety Thermometer data for the 12 months prior to the inspection showed three 'harms'. These included two VTEs; one in May 2014 and one in October 2014. There was also one pressure ulcer in January 2015. No falls or urinary tract infections (UTIs) were recorded.

Cleanliness, infection control and hygiene

- Some infection control data formed part of the quality indicator and outcome data presented within the Intensive Care National Audit & Research Centre (ICNARC) report for 1 July 2014 to September 2014. Trends in unit acquired infections for MRSA and Clostridium difficile (C. difficile) for the period stated above were within expected limits and not above the figures of other, similar units. This included the MRSA bloodstream infection.
- For the 12 months prior to the inspection, the unit had no MRSA bacteraemia. The last recorded instance of the bacteraemia appearing was December 2010. There were three confirmed methicillin-sensitive staphylococcus aureus (MSSA) bloodstream infections on record.
- In addition, there were three confirmed cases of C. difficile and two ventilator-associated pneumonia (VAP) infections. It was felt the VAP infections were because the patients affected were not able to be nursed at a 30**°** angle, which is an important preventative measure. The last VAP was October 2014.
- There were no central venous pressure line infections and the last one recorded was June 2013.
- The unit sister described how there were no concerns regarding the standards in place for managing patients who were ventilated. She acknowledged, however, that monitoring VAP patients was challenging and that the VAP care bundle was relatively complex.
- We observed the physical environment of the unit and found surfaces, particularly commonly touched surfaces, to be visibly clean and there were suitable cleaning schedules in place.
- Equipment was also visible clean and nursing staff we spoke with understood their role in ensuring the environment and equipment was clean.
- We noted that there were designated hand-washing basins within every bed bay area and these were easily accessible.
- Alcohol hand-sanitising rub was also available for staff and visitors to use, although the majority of the alcohol rub dispensers were situated next to the hand soap dispensers at the hand wash basins. It is not uncommon in such situations for people to mistake the alcohol rub for liquid soap.
- In addition, having an alcohol hand rub dispenser at a hand wash basin does not increase the number of points where people can clean their hands. Alcohol

hand rub dispensers are commonly positioned away from hand wash basins as this then increases the number of areas within a ward setting where people can clean their hands.

- We did observe smaller alcohol hand rub dispensers on trolleys close to patients' beds and these did provide more opportunities for staff to ensure their hands were clean before coming into contact with patients if they had not washed their hands at a sink.
- We spoke with the unit's infection control link worker and they told us they conducted monthly hand hygiene audits. They also said that these audits could occur more frequently, if there was a drop in hand hygiene compliance. The results of recent audits showed that hand hygiene compliance was between 95% to 100%.
- We observed staff, both nursing and medical, providing care and support to patients and, in the majority of cases, staff used alcohol hand rub before patient contact.
- Personal protective equipment (PPE), including gloves and aprons, were easily accessible and we observed staff using PPE, when required.
- The use of PPE was also audited and the infection control link worker stated that PPE was over-used. Staff, mainly nursing staff, tended to wear gloves and aprons when universal precaution guidelines did not indicate a need, for example, such as when not dealing with blood and/or other body fluids. The link worker also stated that the over-use of gloves may have been causing staff to have sore hands. The use of alcohol rub may also have been contributing to this.
- We were informed that not being able to isolate a patient was rare but, if there was a concern, escalation processes were in place and consideration would be given to cohorting certain patients together if appropriate.

Environment and equipment

- The environment of the unit was suitably set out and had been rebuilt eight years previously. The unit was in a good state of repair.
- The unit was an adequate size and, according to the lead sister, was compliant with Health Building Note (HBN) 57 (2003). However, storage space was a challenge and this was partly because of the relatively large amounts of equipment used on the unit.
- There were a total of five side rooms, three of which had separate gowning areas. These were situated on the intensive care side of the unit. The other two side rooms were situated on the high dependency side.
- There was adequate working space both within corridor areas and around patient's beds.
- In relation to equipment, there was an eight-year, rolling equipment replacement programme. Ventilators had recently been replaced with new models and so had non-invasive ventilators. Monitors were also new and syringe driver pumps were due for replacement.
- Beds were also part of a replacement rolling programme and weren't due for replacement in the near future. All the mattresses were a particular make and model and were, according to the lead sister, in good working order.
- The unit had a blood gas machine, which was constantly in use. There was technical support provided remotely for the machine during weekday office hours. We were told that the machine regularly required technical support and the service was not available out-of-hours. This was causing difficulties for staff, who were often required to use blood gas machines in other departments, for example, in accident and emergency (A&E).
- Resuscitation equipment was easily accessible and there were separate trolleys used in emergency situations. The resuscitation equipment was checked daily.
- Within the resuscitation trolley on the high dependency side of the unit, we noted that four of the six endotracheal blades were out of their original packaging. According to a nurse we spoke with, this was so the bulb within the blade could be tested using the handle. Ideally, equipment in sealed packaging should be opened at the point of use.

Medicines

- We spoke with a pharmacist who regularly worked on the unit about medicines and the pharmacy support provided, as well as compliance with best practice recommendations as set out in the Intensive Care Society core standards for intensive care units (2013).
- Ideally, the unit should have had just over one whole time equivalent (WTE) pharmacist. The pharmacy support provided was around 0.7 WTE. This was mainly

because the pharmacist for the unit had other commitments as part of their workload, including both cardiology and theatres. These commitments absorbed around one third of their available time.
- The pharmacist we spoke with described how their role was manageable, but time restraints meant they did not get adequate non-clinical time. This affected aspects of the role, for example, audit and research. The pharmacist was conducting a research project, which had taken about one year to complete. They stated it should have been completed in about one month.
- We reviewed four drug charts and found they were accurately completed and clearly set out.
- The clinical competencies of pharmacy staff working on the unit were to a good standard and the pharmacist we spoke with was a non-medical prescriber. This complemented the role of medical prescribers well and improved the efficiency of the service.
- Pharmacists working on the unit closely monitored the standards of prescribing via their day-to-day activities and the unit was part of the annual, trust-wide pharmacy audit.
- The unit was trialling an automated drug storage and dispensing system. Staff were positive about the system and described how it was easy to use, secure, auditable and allowed them to manage drug stock levels efficiently.
- We observed both drugs fridges. The doors were appropriately locked, temperature checks were recorded daily and the temperatures, on the day of the inspection, were within the correct ranges.

Records

- We reviewed both medical and nursing records. A key document used by the nursing team was the observation chart. We observed four charts and saw that the nursing observations and interventions had been accurately documented.
- There were separate medical and nursing files and the contents were standardised and information was easy to locate.
- Many of the interventions and risk assessments were managed using specific care bundles. We closely reviewed the use of some care bundles. For example, the care bundle for skin integrity, and found them to be accurately completed.
- We reviewed two sets of medical notes and saw that medical documentation was to a good standard, including: admission details/assessments, daily reviews and multidisciplinary input. There were specific examples of good documentation, including blood transfusion and central venous pressure line charts.

Safeguarding

- There was a designated safeguarding team working within, and for, the trust. The lead sister said the team were supportive and easily accessible.
- Safeguarding incidents were often managed by using a multidisciplinary team approach involving medical staff, senior nursing staff, including the matron, and members of the safeguarding team.
- During the inspection, there were circumstances around a specific patient that required safeguarding processes to be instigated. We reviewed the approach taken and saw that referral arrangements were effective. There was good multidisciplinary team working and safeguarding processes were effective in enabling a positive outcome for the patient.
- Nursing staff we spoke with were clear about how to escalate safeguarding concerns and what might be seen as a safeguarding issue. Staff were also clear about how to access to trust's safeguarding policy and the safeguarding team.
- Safeguarding training was recorded for the York hospital site within the group of theatre, anaesthetics and critical care staff. Safeguarding adults level 1 training for nursing was 59% compliant and for medical staff it was 68% compliant from a trust requirement of 75%. Safeguarding adults level 2 for nursing was 45% and for medical staff 55% compliant. Safeguarding children level 2 for nursing was 59% and for medical staff 55% compliant. Safeguarding children level 3 training data were not provided for theatres, anaesthetics and critical care. However, for York Hospital as a whole, the compliance was 45%.

Mandatory training

- The training information provided centrally from the trust was for the York hospital site but not specific to critical care. It included staff from for theatres, anaesthetics and critical care.
- Some aspects of the training data provided was for statutory training, which included fire safety awareness and health and safety.

- The Trust target for all mandatory and statutory training was 75%. Training was split into staff groups, including: medical and dental, nursing and midwifery, additional professional staff and additional clerical staff.
- The training data we reviewed covered 26 different topics, which included the two different levels of training for infection prevention and control and safeguarding for adults and children. There were 93 separate staff groups/training modules on the list provided, each should have been at 75% (green) or above. Twenty-six of the 93 were green and the remainder were red (less than 75% compliant).
- Further training data was provided at unit level after the inspection. This stipulated that there were 25 training topics, with eight of these having met the 75% target in terms of staff completion. Only two topics were under 50% compliance, the rest were between 50% and 74%.
- Four areas had 0% achievement. This was for 'nursing and midwifery' with infection prevention and control at level 1; 'medical and dental' with manual handling practical and 'additional clinical services' with safeguarding adults level 1 and 2.
- There appeared to be a discrepancy between the trust collated figures and the locally collected data which did not provide an accurate record of training.
- The post of clinical educator had been vacant for four years which may have impacted on training (see Effective section below for more detail).
- The Trust's target was to achieve 75% compliance within a 12 month period. The Trust was six months into this period at the time of the inspection.
- The figures provided to us included the training provided for the period of six months prior to the inspection as this was the time the Trust implemented a new system to capture and record training carried out.

Assessing and responding to patient risk

- We spoke with the critical care outreach lead. The outreach service had a pivotal role in supporting the unit, and other wards and departments, in assessing and responding to patient risk.
- The outreach service provided services 24 hours a day, seven days a week.
- York Hospital had implemented the use of an early warning score (EWS) system, which is a way of standardising the assessment of acute illness severity in the NHS. The system was used to support staff in determining the urgency of a clinical response. A low score prompted an assessment, a medium score prompted an urgent review and a high score prompted an emergency assessment.
- There was an escalation policy and this involved paging the outreach team and following a Situation, Background, Assessment, Recommendation (SBAR) referral process. SBAR is a way of ensuring information is communicated clearly and in a standardised way.
- To complement the assessments used to assess patients' vital signs and wellbeing, the trust developed a sepsis screening tool and set up a sepsis operational group. The sepsis tool was another way in which patients could be assessed using specific criteria in order to help determine the clinical input required and urgency of response needed.
- There were clear escalation processes in place, written in the escalation policy, for managing patients of increasing concern/risk.
- Previous concerns had been raised about the layout of the unit and the line of sight staff had on patients. It wasn't always easy to observe patients all of the time. Remote monitoring was installed, which improved safety and ensured closer monitoring of patients all of the time.

Nursing staffing

- The unit had two band 7 senior nurses (including the lead sister) and was funded for 10.62 whole time equivalent (WTE) band 6 senior nurses. One of funded band 6 posts was for a clinical educator. There were 9.08 WTE band 6 nurses in post and the clinical educator post was vacant. The unit was down by 0.5 WTE band 6.
- The clinical educator nursing post had been vacant for around four years, prior to that, the role was fulfilled by a band 7 senior nurse.
- The unit was funded for 58.5 WTE band 5 junior grade nursing posts and was down by around five band 5 posts. In addition, five band 5 nurses were on maternity leave at the time of the inspection. Recruitment processes were due to start for the vacant band 5 positions. Figures indicated that staffing was 12% below expected levels in November 2014.
- In order to fill some of the gaps in the nursing rota, the hospital's staff bank were used and any staff used were

the unit's existing staff. This was ideal, as it maintained continuity of care and was less burdensome on other staff. Bank staff had also been through the necessary ward induction processes.

- As an example of bank nurse usage, for the week following the inspection, four nursing shifts were required to be covered with bank nurses. Occasionally, some band 2 healthcare assistant shifts were also covered using bank staff.
- Agency nursing staff were infrequently used and if they were required, nurses who had gained previous experience on the unit were requested. Having two agency staff during the same shift was avoided.
- All agency nurses were required to undergo a short induction process on the unit before starting their shift and were overseen by a permanent member of staff during their shift.
- In terms of nursing numbers and grades of nurses, there was an appropriate balance and suitable skills mix.
- A staffing acuity tool has been applied to the unit, mainly regarding level 2 beds, in order to assess the ideal number of nurses to be able to manage the flexing between level 2 and level 3 beds. Linked to this was a clear escalation process. If any member of the nursing team were concerned about staffing numbers and/or skills mix, there were clear processes to follow in order to escalate any concerns.
- Nursing handovers were at 7.15am and 12.15pm and lasted about 30 minutes. We observed a nurse handover and information was shared in clear and structured way. As part of every handover there was a safety briefing element that provided staff with a short update on any key safety issues.
- Nursing staff we spoke with felt the nurse handover process worked well and all necessary information was included.
- In terms of sickness levels, the trust aimed for a level of around 3.1%. For March 2015, the unit had a level of 4.5% and this was partly due to a staff member being off work on a long-term basis. For the year, the unit was running at sickness leave levels of between 3.1% and 3.5%.

Medical staffing

- Part of the merger of Scarborough Hospital and York Hospital involved considering staffing arrangements, especially in terms of medical clinical leadership.
- There was a clinical director of theatres, anaesthetics and critical care covering the two sites. Under the director, there were two clinical leads, one based at York Hospital and the second (deputy clinical lead) was based at Scarborough Hospital.
- At York hospital for critical care, there were 13 consultants, all of whom were intensivists, and three anaesthetists. Two consultants worked on the unit each day from Monday to Friday, from 8am to 9pm and at weekends 8am to 9pm.
- During the week, if necessary, one of the consultants on duty supported outreach and A&E, if necessary.
- All consultants did one week block shifts, which matched best practice guidance. This supported continuity of care and patient safety.
- In the main, the on-call rota was covered by intensivists and one day in 13 was covered by an anaesthetist. This wasn't ideal, as best practice guidelines describe how a consultant intensivist must be available at all times to offer consultant level care as necessary.
- Consultants were only on-call for critical care.
- Medical staff confirmed that patients were seen by a consultant within 12 hours of admission and in the vast majority of cases, they were seen by an intensivist consultant.
- The consultant/patient ratio did not exceed the range of 1:8 or 1:15, which was in line with best practice guidance.
- After midnight, there was appropriate consultant on-call cover and two on-site consultant trainees covering intensive care, obstetrics and acute admissions.
- We observed a medical handover and these were decisive and proactive. There were no concerns.
- A consultant informed us that the use of medical locums on the unit was infrequent.

Major incident awareness and training

- The lead sister and several consultants on the unit had attended "Emergo" training, which is a disaster simulation exercise and training system.
- The lead sister stated that there were plans in place for major incidents. For example, if an outbreak of influenza or Ebola were to occur.
- Business continuity plans were also in place. For example, if there was a power shortage. All ventilators had back-up power supplies and there was back-up generator, which was tested regularly.

Critical care

- All major incident and business continuity plans were available on the intranet.

Are critical care services effective?

Good

Overall, we found that the critical care service was effective. Medical and nursing practice was, from what we assessed, based on up-to-date evidence and followed best practice guidance. There was suitable input from specialist teams, including the hospital-wide pain team and dietetics service. However, the time spent on the unit by the dietician only just met the minimum standard recommended.

There were no concerns regarding data quality indicators and outcome data presented within the latest ICNARC report. Being part of the ICNARC Case Mix Programme was a positive, but there was limited evidence of other measures being taken to assess effectiveness.

There were effective processes in place that ensured new members of staff were supported, including: induction, competency-based training, peer support, supervision and appraisal. In-house training was varied and accessible. The training simulations were particularly useful and the scenarios were interactive and realistic. Staff felt well supported in their role, but were restricted in some instances from developing their skills and knowledge because of staffing pressures. Staff could not be released for training frequently enough. The lack of a clinical educator also had a negative impact on the development of staff and steps were being taken to address the issue.

Staff, both nursing and medical, had a good understanding of consent and best interest decisions and, in the majority of cases, discussions with patients, friends and family were well documented.

Evidence-based care and treatment

- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of the nursing care provided were based on the use of care bundles. For example, the ventilator care bundle or the skin care bundle. Such bundles were all evidence-based and aligned to best practice guidance.
- In terms of medical interventions, from our observations and discussions with medical staff, the approaches taken followed up-to-date medical practice.
- Policies we reviewed were based on best practice guidelines and were up-to-date and easily accessible via the intranet.
- There was limited evidence in terms of local assurance of staff adherence to local policies and procedures for both nursing and medical practice. This included audit activity. We were aware of some audits and these included hand hygiene and environmental cleanliness.
- We spoke with a consultant trainee and they were uncertain of who the audit lead was or what the medical audit activity underway was. They had conducted an audit on perioperative hyperthermia, but how the results were fed back to influence practice was unclear.
- In relation to nursing, we requested a list of audit activity and the impact these had made on clinical practice, but no information was provided. From speaking with nursing staff, audit activity and results were not clearly understood.
- When it came to national audits, the unit took part in the ICNARC Case Mix Programme and non-invasive ventilation (NIV) audits managed by the British Thoracic Society.
- There were processes in place for the management of delirium.

Pain relief

- There was a hospital-wide pain team and they provided advice and support for the unit when necessary and/or when requested. All surgical patients on the unit were reviewed daily by the pain team.
- The pain team also helped manage all patients with epidurals and patient-controlled analgesia (PCA) pumps.
- The unit had a pain link nurse who was able to support staff on the unit and provide advice and education.
- We reviewed patient records and observed the appropriate use of pain scores and support for patients requiring pain relief.
- All pain relief medication was stored and managed via the electronic drug storage and dispensing system.

Nutrition and hydration

- We spoke with the dietician for the unit, who worked at the hospital from Monday to Friday.

- They worked as part of the multidisciplinary team and attended the multidisciplinary team ward round on Wednesdays. They reviewed all patients every other day during the week, as and when required.
- They were usually on the unit Mondays, Wednesdays and Fridays.
- Best practice guidance recommends 0.05 to 0.1 dietician WTE per bed. The dietician said provision was 0.05, which is the lower end of the recommended number. The dietician felt that the staff and patients did receive an adequate amount of support from the dietetics service.
- In terms of initiating nutritional support out of hours, there was a protocol in place for this and nursing staff were able, with the support of medical staff, to initiate this.

Patient outcomes

- We reviewed the ICNARC data for 1 July 2014 to 30 September 2014. Unit mortality data for ventilated admissions were within normal ranges. Unit mortality for admissions with severe sepsis was more variable, but numbers were not excessive and followed the trends of other similar units.
- The other unit mortality outcome measures, including: admissions with pneumonia, elective surgical admissions, emergency surgical admissions and admissions with trauma, perforation or rupture were all within normal ranges, as compared with other similar sized units.
- For other quality and patient outcome data, including early deaths, late deaths, early readmissions, late readmissions, post-unit hospital deaths, transfers out and non-clinical transfers out, these were all within expected ranges as compared to other similar sized units.
- Early readmissions and late readmissions to the unit were within expected ranges as compared to other similar units.
- Mortality ratios and trends in mortality were within range as compared with other units and other similar units.
- There were no reported Care Quality Commission (CQC) outliers.
- We were unable to establish the extent to which the unit participated in other audits, including national audits. We requested information and a list of clinical audits and any critical care network peer audits, but no information was received.

Competent staff

- There were specific processes in place for managing appraisal and supervision. The lead sister for the unit described how staff were split into teams, all of whom had a designated band 6 nurse overseeing them. This helped supervision and appraisal to be more manageable and structured.
- We reviewed appraisal documents and records and found that support provided to the team was effective and well managed.
- We were informed that the appraisal rate for the unit, for nursing staff, was around 95%. The data provided by the trust for critical care, dated July to November 2014, was 100% completion for nursing and midwifery staff, for additional clinical services staff it was 46% and for administrative and clerical staff, 50%. The latter two staff groups had previously been above 96% for the period April to June 2014.
- From speaking with medical staff, suitable processes were in place for managing revalidation and all consultants were up to date.
- We asked about guidelines for newly appointed consultants. There were no guidelines specific to critical care, but there was a hospital-wide policy, which provided suitable information in relation to the processes that should be followed.
- All medical staff were required to attend corporate induction and follow local induction protocols.
- In relation to nursing staff, a key recommendation is for a minimum of 50% of registered nurses to have been awarded a post registration award in critical care nursing. At the York Hospital unit, 37% of nurses had completed the award.
- We spoke with the deputy unit sister and a band 6 senior nurse about training and competency development for nurses. All new band 5 nurses worked through a specific induction package and six to eight week preceptorship programme.
- Induction, as a whole, included three days of corporate induction and two to three days of local induction on

the unit. This included critical care specific subjects including clinical pathways, ventilated patients, pressure area care and the general environment of the unit.
- It was felt that in-house training on the unit was good and there were a variety of sessions delivered on, for example, continence and diabetes.
- Simulation training was also provided using a training manikin and video conferencing facilities.
- A fundamental issue, as described by many of the senior nurse team, was the lack of a dedicated clinical nurse educator. Best practice guidance states that each critical care unit should have a dedicated clinical nurse educator and the role should be supernumerary. The post had been vacant for four years.
- The nurse educator role was originally a dual role delivered by a band 7 nurse. The other element to their role was patient safety. The role became almost entirely focused on patient safety and clinical education on the unit was negatively affected.
- The educator role was advertised in July 2014 at band 6 level and there were three applicants, none of whom were appointed. In March 2015, the role was advertised again, at band 6, and there was one applicant. Again, the candidate was not appointed. Such a role is seen as pivotal in supporting nurse education and is commonly a band 7 role. It was felt by staff that the role was not being applied for, and appointed to, because of its grading.
- The two band 7 nurses on the unit had taken on the role of clinical nurse educators, but time did not allow for them to fulfil all aspects of the position. However, efforts were being made to support nurses with the resources available and the new national critical care core competencies were in the process of being introduced to the unit. In addition, nurses on the unit were supported to complete both basic and advanced critical care core competencies.
- We spoke with nurses on the unit and they all felt well supported, but acknowledged that being released for training was an issue.
- Senior nursing staff described how the funding was available for staff to attend courses and develop their competencies, but there wasn't always the time available to release staff to attend such training.
- The lack of a designated clinical nurse educator and the difficulty the staff had in finding the time to release nursing staff to attend specialised training was having a negative impact on the educational development of staff and meeting of best practice recommendations.
- Shortly after the inspection, we were informed that an existing band 6 nurse had been appointed to the clinical educator role and a second band 6 nurse was to be appointed to support them. Back-fill money had been provided to do this.
- In addition, approval had been granted for the longer-term clinical educator role to be advertised at band 7.

Multidisciplinary working

- We attended ward rounds and medical and nursing handovers. The care provided was a cohesive multidisciplinary team approach and we found different staff teams worked constructively together.
- The multidisciplinary team approach enabled care to be delivered in a coordinated way and services such a pharmacy, physiotherapy, pain management and dietetics worked well with the nursing and medical team.
- External multidisciplinary team working regarding critical services, particularly with Scarborough Hospital, was steadily being increased. As discussed, the York Hospital and Scarborough Hospital critical care units had only merged operationally six weeks prior to the inspection.
- Partnership working for critical care between the two sites was being developed and there were monthly directorate meetings that included staff from both York Hospital and Scarborough Hospital.
- The outreach team worked closely with the critical care team and wards or departments across the hospital. Each nurse in the outreach team was responsible for their own wards or department areas and a key focus was ensuring patients who were deteriorating were recognised and managed in a timely and effective way.
- The outreach team followed-up each unit discharge to the ward to ensure ongoing care was appropriate and to provide support to ward staff.

Seven-day services

Critical care

- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week. Out of hours, medical staff were able to liaise with the on-call radiologist, if necessary.
- Pharmacy services were available between 8am to 6pm during week days and via telephone at weekends and out of hours. At night, there was an on-call pharmacy service.
- Physiotherapy services were available Monday to Friday, 8am to 6pm and there was a weekend and out-of-hours on-call service.
- Occupational therapy services were available during the week from 8am to 6pm.
- Medical consultants provided on-call support for critical care at weekends and out of hours.

Access to information

- Nursing staff we spoke with felt that information they required was straightforward to access.
- All policies and procedures we easily accessible via the intranet.
- Documents were also easy to access. For example, nursing documentation was kept together in specific 'packs'. This meant key documents were easy to locate. Such documents included all care pathways, care bundles and infection control paperwork.
- Staff were able to easily access blood results and x-rays via computer online results services.

Consent, Mental Capacity Act 2005 and deprivation of liberty safeguards

- We spoke with nursing staff about consent and it was recognised how this was a challenge in the critical care environment, due to the acute nature of the care provided.
- Nurses described how consent was gained, where possible, from patients prior to certain procedures. For example, some patients required additional sedation and this was something that was discussed with patients beforehand and documented.
- We observed two situations where staff gained verbal consent from patients before proceeding with a medical intervention. This included one instance in which a patient was given a blood platelet transfusion and another in which a patient was intubated. With the patient who required intubating, the discussion and consent was written in the notes. With the patient who required a blood platelet transfusion, the blood transfusion form was 'ticked' indicating that the patient had provided verbal consent, but the discussion was not documented in the notes, as required.
- In relation to the Mental Capacity Act 2005 and deprivation of liberty safeguards, the lead sister provided details of recent situations where such safeguards were required. For example, a patient required intubating because their breathing had deteriorated. They were aware of this, but were unable to consent. Best interest discussions were held with the family and multidisciplinary team and the patient was intubated. All discussions were recorded.
- A patient needed their arms restraining because they were pulling at the tubes and devices attached to their body and this was unsafe. After having met with the family, a decision was made to use padded cuffs to temporarily secure the patient's arms to prevent them from pulling on the devices.
- The unit had a specific restraint care plan risk assessment tool, a decision flow-chart and information for relatives.
- Training around the Mental Capacity Act 2005 and deprivation of liberty safeguards was provided via the mandatory training programme.
- The hospital safeguarding lead was easily accessible for advice and support and attended the unit if specific Mental Capacity Act 2005 and deprivation of liberty safeguards guidance was required.
- A flow chart had been introduced for the weekly ward round and this helped prompt staff around best practice and deprivation of liberty safeguards assessments. There was also a specific critical care Mental Capacity Act 2005 assessment form.

Are critical care services caring?

Good

Critical care service was caring. Of the patients, relatives and friends of patients we spoke with, comments about the care provided were positive. Patients/people felt that staff were supportive and respectful. Patients/people also felt that they were adequately involved in decisions about their care and their views were listened to.

Critical care

There were limited mechanisms in place for gaining feedback from patients/relatives. The most recent survey was two years prior to the inspection. This was recognised as an area for improvement and the intention was to reintroduce patient/family surveys.

In terms of emotional support, there was positive feedback from patients and their families about this and the support provided by healthcare staff. Support was also available from other services, such as chaplaincy, but there weren't any formal processes in place in terms of counselling and/or psychological support for patients and/or families.

Compassionate care

- We spoke with someone who had been a patient on the unit several months prior to the inspection and they spoke highly of the standard of care they received and caring nature of the staff. They described how care was personalised and that they couldn't have faulted the care they had received.
- We spoke with patients and family members on the unit. One patient, who had been on the unit for a week, said the nursing staff were very welcoming and that "nothing was a bother". They felt they were treated with respect and their designated nurse always had time to speak with them. Their wife was also able to visit at a flexible time, which was helpful.
- We spoke with another patient's wife, along with their son, and they felt the staff were very helpful and caring. They described how medical staff had contacted them at home occasionally to explain aspects of their husband's care. They felt this was helpful and supportive. They also felt staff were respectful and provided personalised care.
- The unit did not participate in the NHS Friends and Family Test, as this wasn't easily applied to critical care because patients were infrequently discharged directly home.
- The unit didn't conduct patient surveys, but this was something being considered. The main way in which feedback about care was provided was from cards from patients and relatives. Reviewing complaints was another process for gaining feedback.
- The NHS Friends and Family Test isn't a test that fits well with critical care because it is uncommon for patients to be discharged home directly from critical care. However, one NHS Friends and Family Test had been conducted and the results were all positive.
- The unit had not conducted a patient survey in the previous two years, but this was something the lead sister wanted to reintroduce imminently and recent discussions had been had about them.

Understanding and involvement of patients and those close to them

- Of the patients and family members we spoke with, all felt they had been suitably involved, informed and consulted in the care and medical interventions being provided.
- One family member said care and treatment had been explained and this meant there had been no surprises. They felt they had been fully informed throughout about the care of their relative.
- A patient we spoke with also felt adequately involved in their care and had all their questions answered to their satisfaction.
- Another patient we spoke with described how staff had explained the equipment used in supporting their care and they were able, because of this, to monitor their own oxygen flow.

Emotional support

- There was a bereavement service, which was easily accessible.
- We were informed that the safeguarding team were also accessible and they were able to provide advice in relation to emotional support.
- With certain patients, funding to access psychiatric/psychological support was available, but this was limited to neurology patients.
- Specific services, such as counselling, were not available and access to such services needed to be gained via the patient's GP.
- In relation to anxiety and depression, we were not informed of any formal assessments which were used to assess these but, according to the lead sister, aspects of this would be noticed during day-to-day care and observations/discussions around the overall wellbeing of all patients.
- In addition, the medical and nursing team were seen as being instrumental in providing ongoing emotional support on a day-to-day basis during someone's hospital admission.

Are critical care services responsive?

Critical care

Requires improvement

Overall, we found that the critical care service required improvement in this domain. As part of the Theatres and Anaesthetics Directorate, the Critical Care Units of York Hospital and Scarborough Hospital were officially merged in April 2013. We were informed that the more practical aspects of the merger, particularly in terms of joint working, did not start until September 2014. Key decisions and the clinical model design were yet to be finalised; this affected how full integration was to be achieved. The Trust was engaged with its CCGs in undertaking an external review to identify the model of critical care to be delivered and how this was to be financed. The timescales as stated on the headline directorate service plan did not reflect the existing levels of integration. At the time of the inspection, the Trust were key participants in the early stages of planning and scoping the external review and are working with external strategic partners to identify the model of critical care of the future , what is to be commissioned and how it was to be financed and delivered.

Overall, the services provided met people's needs and we found care to be person-centred. Staff were supportive and responsive to patients' needs. Staff also provided support, where necessary, to patients' family and/or friends.

Quality indicator information regarding patient flow presented a mixed picture and the key challenges were around delayed discharges, delayed admissions and running at high capacity. These areas were recognised as risks and a solution was put forward to increase staffing on the unit to enable an additional bed to be available. However, such plans were not formally set out and decision processes were not clear. The mitigating steps being taken to tackle the patient flow issues were not explicitly clear.

Formal complaints about the service provided were low and where there had been issues raised about the service, these were appropriately addressed and changes, if necessary, were implemented.

Service planning and delivery to meet the needs of local people

- We discussed, and requested documentation, around service planning and there was evidence of early discussions about critical care services for both York Hospital and Scarborough Hospital. However, the documentation provided was not dated and made reference to 'SNEY' (Scarborough and North East Yorkshire Healthcare NHS Trust, which had existed prior to the merger in July 2012). We were not presented with any recent service planning documents or up-to-date, detailed service planning options or decisions for the near and more distant future.
- We saw a headline directorate service plan, which, again, made reference to SNEY. The directorate service plan covered the years 2012/13, 2013/14, 2014/15 and 2015/16. The content of which included a full merger of the critical service to offer level 2 and 3 care on both main hospital sites for 2012/13, to consider all integrated service models for 2013/2014, agreeing the clinical model design for 2014/15 and the implementation of the integrated service for 2015/16.
- From our discussions, it seemed that key decisions and the clinical model design were yet to be finalised, which affected how full integration was to be achieved.
- The timescales as stated on the headline directorate service plan did not reflect the existing levels of integration.
- The organisation was working with its commissioning partners in the scoping of an external review of critical care services, the outcome of which would inform the development of service plans.
- The documents we reviewed had considered, to a certain extent, the needs of the local population, but this was not a detailed analysis. We were provided with meeting minutes, dated 21 November 2013, from a 'time out' session for theatres, anaesthetics and critical care. Key issues were touched upon, including which services would be best-placed where and how services could meet the needs of people while ensuring value for money.
- No other documentation was provided to highlight the key issues and planned solutions for the critical care service moving into 2015/16.
- The director of theatres, anaesthetics and critical care (York Hospital and Scarborough Hospital) was able to describe the plans for critical care as an integrated service and said the plans had been approved by senior management.
- We were not presented with final plans for the integrated critical care service and senior directorate level staff were uncertain of the future plans for the service.

- The Trust was not in a position to provide any finalised plans until agreement with key stakeholders around service provision and financing were agreed.

Meeting people's individual needs

- From our observations, as well as speaking with staff, patients and their family/friends, care was centred on meeting people's individual needs. These needs were, in the main, acute medical needs, but other needs were addressed. For example, emotional needs.
- The unit had experienced caring for, and supporting, patients with complex health needs and staff described the importance of multidisciplinary team working and care planning.
- In many cases, people with complex health needs received close support from family members or carers. Staff on the unit worked closely with family members or carers in such instances and were flexible with the times people could stay on the unit.
- Translation services were accessible via main reception and it was policy for relatives/friends not to act as translators.
- Chaplaincy services were available.
- In relation to supporting patients with learning needs there was a trust-wide nurse specialist who offered support, where necessary. They specialised in supporting people with learning needs.
- In supporting patients with dementia, nurses were trained in how to provide care and support for such patients and the safeguarding team were also accessible for extra support, if required.

Access and flow

- We reviewed the Intensive Care National Audit & Research Centre (ICNARC) data for the year 2013/14 and up to 30 September 2014.
- In 2013/14 York hospital was performing comparatively in most measures however unplanned readmission within 48 hours and Out of Hours discharges (not delayed) were above the England average.
- In terms of data 'at admission', non-clinical transfers matched the average for other, similar units.
- Patient flow data showed that out-of-hours discharges to the ward fluctuated, and during 2014, numbers had been increasing. For quarter 3 of 2014, figures were above, though not excessively, the average for other, similar units.
- Data for transfers out and non-clinical transfers out were within expected limits.
- Early reported discharges were below the average for other similar units.
- Increased levels of delayed discharges (four hour delays) are a national pattern and the numbers for the unit were within comparable limits. However, delayed discharges (four hour delays) were seen as an issue for the unit and listed on the unit's risk register. The delay in discharging patients, as described on the risk register, was also delaying admissions.
- We spoke with the director of theatres, anaesthetics and critical care (York Hospital and Scarborough Hospital) and the issues were recognised. The short-term plan was to increase the numbers of beds on the unit by one and increase nurse staffing levels. This was also listed on the risk register as being a mitigating step to improve patient flow.
- The model for normal capacity for the unit (2014) showed that funding was for 11 nurses plus a supervisory coordinator. Seventeen beds could be utilised in total, providing all necessary equipment was available.
- The timescales for the additional bed and recruitment of additional nurses was not stated during the inspection.
- Information provided to CQC prior to the inspection indicated that between June and November 2014 the bed occupancy of both the level three beds and the high dependency beds varied between 60% and 73%.
- Information provided during the inspection indicated that the unit was running at a high occupancy rate. Data provided by the trust showed that occupancy for 2013 to 2014 was consistently around 103% and for 2014 to end of February 2015 was 106%. Ideally, according to national guidance, occupancy rates should be between 80% to 85%.
- Information provided before and during the inspection did not correlate. These discrepancies may have affected planning and monitoring of the service if the actual level of usage and availability of critical care beds was not known.
- The lead clinician acknowledged the challenges with patient flow and the issues were multifaceted. One main issue was the fact that the hospital was running at high capacity, so there were often not enough ward beds to discharge patients to. For example, in January 2015, we

were told that there were 25 critical care bed days for patients who could have been managed on a ward. This, clearly, had an impact on the ability to admit patients to the unit.
- The high occupancy rates were not listed on the risk register and interim mitigating actions to help relieve the pressures were not listed.
- We spoke with the clinical lead and it was stated that there were around 1,100 admissions to the unit per year. Roughly 50% were medical and 50% were surgical. About 80% of admissions were unplanned. The number of unplanned admissions was a challenge and we were told that there were "lots" of elective surgery cancelled. Data we received on cancelled electives indicated that there had been 31 cancellations due to a lack of a critical care bed between September 2014 and February 2015.

Learning from complaints and concerns

- From data provided by the trust, there was one complaint relating to the critical care unit within the 12 months prior to the inspection.
- The lead sister for the unit was made aware of all complaints and the outcomes of any investigations.
- We were informed that any concerns raised by patients, and/or visitors, would be managed in an informal way at an early stage to prevent matters escalating.
- We were told that learning from complaints was disseminated to staff via team meetings and/or at handover.

Are critical care services well-led?

Requires improvement

There had been recent governance structure changes.. There were no clearly laid out future vision and strategic plans for the service and the York Hospital unit. The organisation was working with its commissioning partners in the scoping of an external review of critical care services, the outcome of which would inform the development of service plans. Considering the timescales involved since the decision was made to merge the two NHS trusts, there was a lack of a shared vision and structured strategic direction. The working arrangements were starting to embed but there was progress to be made in terms of joined up working with the Scarborough Hospital critical care service.

There were ambitions for the service and it was evident that changes were imminent in terms of service delivery. However, medical staff we spoke with did not seem aware of the plans for the future or the strategic direction of the service, including how the Scarborough Hospital and York Hospital services operated together in the short and longer term. At unit level, leadership was effective and nursing staff spoke positively about nurse leadership and the open and supportive culture.

The overall culture within the service, from what staff told us, was supportive and staff felt that people in leadership roles were approachable. However, in some cases, staff were not clear about the future and not involved in decision-making processes.

Vision and strategy for this service

- From discussions with the critical care leadership team, there were mixed views regarding the certainty of the future service design, vision and strategy for the trust's critical care services as whole.
- As part of the Theatres and Anaesthetics Directorate, the Critical Care Units of York Hospital and Scarborough Hospital were officially merged in April 2013. We were informed that the more practical aspects of the merger, particularly in terms of joint working, did not start until September 2014; there was still some uncertainty in terms of service delivery and joined up working.
- York Teaching Hospitals NHS Foundation Trust had acquired Scarborough and North East Yorkshire Healthcare NHS Trust in July 2012, so the imminent merger of the two services had been known about for some time. Considering the timescales involved, there was a lack of a shared vision and structured strategic direction.
- We reviewed documentation in relation to the work that had been completed around strategy, including the headline directorate service plan. The documents appeared to relate to early discussions during, and/or just after, the merger of Scarborough and North East Yorkshire Healthcare NHS Trust with York Teaching

Hospitals NHS Foundation Trust. We were not presented with any specific, up-to-date strategy documents that clearly laid out the future plans for the service and the York Hospital unit.

- The directorate manager for theatres, anaesthetics and critical care (for both York Hospital and Scarborough Hospital) confirmed that work on a new strategy document had started and there was an agreement to increase bed capacity at York Hospital and Scarborough Hospital.
- The director of theatres, anaesthetics and critical care (for both York Hospital and Scarborough Hospital) had plans for the service, which had, apparently, been approved by senior management. However, from speaking with the lead clinician, and other members of the leadership team, there was a distinct sense of uncertainty as to the future plans and structure of the service.
- The director of theatres, anaesthetics and critical care (for both York Hospital and Scarborough Hospital) stated that, in the short term, there was to be a trust-wide review into critical care with a short-term plan to increase level 3 beds at York Hospital by one and at Scarborough Hospital by one.
- Additional anaesthetic consultant posts had recently been advertised, as had a new operational director post. This was a post intended to improve patient flow.
- Some changes had occurred with the merger of Scarborough and North East Yorkshire Healthcare NHS Trust and York Teaching Hospitals NHS Foundation Trust. For example, the York Hospital unit was receiving more vascular and renal patients. Much of this was a result of Scarborough Hospital transferring such patients to York for treatment. This had an impact on the critical care unit because more patients were being transferred to the hospital and subsequently to the ICU/HDU. However, the plans and strategic thinking behind such changes were not visible in the documentation we were given.

Governance, risk management and quality measurement

- There had been recent changes to governance structures within the directorate. The clinical leadership posts were relatively new and the directorate manager for theatres, anaesthetics and critical care (for both York Hospital and Scarborough Hospital) had not been in post long.
- We reviewed the directorate of theatres, anaesthetics and critical care governance structure chart and this reflected some of the changes in terms of the recent merger. For example, there were Scarborough Hospital and York Hospital joint corporate level meetings attended by anaesthetists. However, that was the only part of the framework that showed joint working.
- The director of theatres, anaesthetics and critical care (for both York Hospital and Scarborough Hospital) stated that some cross-site working had started and one of the nine consultant intensivists from York Hospital worked one day a week at Scarborough Hospital and always went to the critical care unit and to the operating theatres. The existing cross-site working structure was acknowledged as being ad-hoc until firmer plans and additional staff were in place.
- The intention was, for the new consultant grade posts, to split their work between the two hospital sites, which would help strengthen governance and shared working/learning.
- The director of theatres, anaesthetics and critical care (York Hospital and Scarborough Hospital) had recently set up governance meetings with consultants and monthly directorate level meetings via video link with Scarborough Hospital.
- In relation to risk management, we spoke with the lead sister for the critical care unit about the processes for monitoring risk and escalating concerns. If something was deemed a risk, a risk assessment was conducted and a judgement made in terms of severity and impact. The risk assessments were stored electronically on a shared drive. The risks that were high were escalated to the divisional risk register, which were monitored at divisional level with the potential for these to be escalated to the corporate risk register, if necessary.
- The divisional risk register included the out-of-hours support for the blood gas machine, delayed discharges, lack of non-invasive ventilation beds across the hospital and lack of a clinical educator. The high capacity which the unit ran at was not listed on the risk register, nor were the concerns about delayed admissions.
- From discussions with the lead sister, it was clear that key risks were understood and escalation processes were in place.
- The ability of managers to monitor mandatory training may have been reduced due to the discrepancies between trust-wide and locally held data for training

Critical care

Leadership of service

- Nursing staff told us that they felt well led and the senior nursing team were approachable and supportive.
- Band 6 and band 7 nurses said there was a good sense of teamwork and people felt supported by colleagues at both matron and directorate manager level.
- The two consultant trainees we spoke with felt very well supported. They also felt there was good overall support during on-call shifts.
- Further development was required in terms of cross-site working, but staff felt things had started to progress, especially with the recruitment of additional consultants.
- At clinical director level, there were ambitions for the service and a focus on delivering high standards of care. However, medical colleagues we spoke with did not seem aware of the plans for the future and strategic direction of the service, including how the Scarborough Hospital and York Hospital services operated together in the short and longer term.
- The clinical director was aware of the challenges ahead and could identify the key actions that were required to improve the service, especially in terms of patient flow. They were also knowledgeable and had suitable experience to perform their role.

Culture within the service

- We spoke with a range of staff and observed several day-to-day activities, such as ward rounds, handovers and staff conversations. The culture felt, and was described as, being open and supportive.
- A matron we spoke with described the culture as open and transparent with a strong sense of teamwork and desire to improve standards.
- Junior staff we spoke with enjoyed their work and felt that staff in leadership positions were visible and approachable.
- Nurses we spoke with also felt there was a positive culture around safety and they felt engaged in the process of developing/enhancing a safety culture.

Public and staff engagement

- The involvement of other staff and consultation processes about the intended changes were not clear and members of the leadership team were not sighted on some of the plans being discussed for the critical care service.
- Staff we spoke with described how senior staff were approachable and they felt listened to.
- Messages/updates were communicated in a number of ways, including via team meetings, at handover and on message bulletin boards.
- In terms of involving staff and gaining people's views in the planning of services, staff did not describe any formal processes in place for this. There was a sense that gaining the views of staff during service planning/ strategy development could have been improved.
- It was acknowledged by senior nursing staff that gathering the views of patients/public needed to be developed and this was something which, historically, had been more actively done.
- A key aspect of patient/public engagement was the follow-up clinics. Such meetings provided a good opportunity to gain people's views and experiences to influence improvement.

Innovation, improvement and sustainability

- We spoke with the directorate leadership team about sustainability and both the clinical director and directorate manager had met with the chief executive about this. The directorate manager described how continuing to develop processes and building on existing structures were key to sustaining and developing the critical care service.
- There was a desire to improve critical care services and, from speaking with staff and observing care, we saw that staff were committed to improving services.
- An aspect of care which senior staff felt was innovative was the way in which central lines were monitored. The service had developed processes for the monitoring of central lines, which included a central line clinical pathway. The unit were finalists for an Institute for Healthcare Improvement (IHI) safety award.
- A flow chart had also been introduced as part of the weekly ward round, specifically focussing on mental capacity. The flow chart included a best practice checklist, contact information and a prompt for checking if deprivation of liberty safeguards authorisation was required or not.

Maternity and gynaecology

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

Information about the service

York Hospital provides maternity services. The labour ward had ten labour/birthing rooms, two birthing pool rooms, and two obstetric theatres. There was an antenatal ward of 12 beds, which included four induction/early labour rooms. There was a postnatal ward consisting of 20 beds and 20 cots. There were over 5,000 births per year for the Trust overall, with more than 3,300 of these at York hospital.

There were antenatal day services (ANDS). There was a weekly antenatal clinic held for pregnant women with diabetes that was supported by a consultant diabetologist working with the lead consultant obstetrician. The majority of the antenatal care was provided in the community setting by the woman's named midwife, particularly for low risk women.

The gynaecology service was a secondary referral service and included: general gynaecology outpatient clinics, emergency gynaecology, colposcopy and an early pregnancy assessment unit (EPAU). The hospital was registered for termination of pregnancy services and offered both medical and surgical services.

During the inspection at York Hospital and Scarborough Hospital, we spoke with 26 staff, 17 women and their families and looked at 14 sets of patient records.

Summary of findings

Staff were caring and treated women with respect. The services were responsive and delivered in a way that met the needs of the women accessing them. The service was well led.

There were policies and guidelines on the intranet. However, there were some guidelines in maternity services, relating separately to Scarborough Hospital and York Hospital, which were out of date and did not adhere to national guidance.Monitoring of performance was difficult to review.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

The service had incident reporting processes in place. Staff were encouraged to report incidents, however, they did not always received feedback from incidents.

Staffing levels were planned, set and actively reviewed to maintain adequate staffing levels.

The wards were clean and equipment was appropriately checked. Medication was stored correctly and checked appropriately. Safeguarding was given appropriate priority and systems were embedded across all the services.

Incidents

- We looked at incident reporting policies, a database which included maternity incidents raised by staff, and we found that there were arrangements in place for reporting patient/staff safety incidents and allegations of abuse.
- There were six serious incidents requiring investigation, which included one intrapartum death and one maternal death. 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) reported by maternity services.
- We spoke with staff at all levels of the maternity and gynaecology departments, they were familiar with reporting practices.
- There had been two incidents reported for gynaecology related to delays in medical staff attending for alternate specialty patients and medication administration delays or incorrect administration of medication.
- There was a quarterly update from the directorate management team, which included feedback on reports and a risk management update. We looked at the quarterly update for November 2014.
- However, staff told us they did not always receive feedback from incidents. The meeting minutes and obstetrics and gynaecology newsletters contained updates on action plans and lessons learned, but we did not see evidence that these were translated into a change in practice.
- There was a monthly clinical governance perinatal mortality meeting at York Hospital and all staff were encouraged to attend.

Safety Thermometer

- The service completed a Safety Thermometer dashboard for the wards, which showed that there had been no patient harms (hospital-acquired pressure ulcers, falls, catheter-related urinary tract infections, and venous thromboembolisms (VTEs) during 2014.
- The trust participated in the national maternity safety thermometer pilot which published overall data in October 2014. Maternity Safety Thermometer measures harm from Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety. In addition identifying those babies with an Apgar of less than Seven at Five Minutes and/or those who are admitted to a Neonatal Unit.
- The service took part in the national maternity dashboard, which measured outcomes in maternity care from the perspective of the woman and her baby. A monthly maternity dashboard was collated and performance was measured against safety-related targets. The indicators used included the percentage of caesarean sections and instrumental deliveries and clinical outcomes, such as: third/fourth degree tears, intensive care unit admissions in obstetrics, the percentage of women receiving one-to-one care in labour, the proportion of women with an infection within 10 days of birth and the proportion of undiagnosed breech in labour.

Cleanliness, infection control and hygiene

- We found no concerns during the inspection of the maternity unit and gynaecology ward regarding infection control practices. Ward areas appeared to be clean, and we observed domestic staff on the ward.
- Personal protective equipment (PPE), such as disposable aprons and gloves were available to staff. Staff had access to hand-washing facilities.
- There was a midwife who had responsibility for infection control on the ward.
- We saw staff regularly use hand gel between patients. The 'bare below the elbows' and isolation policies were adhered to.
- There were 'I am clean stickers' on equipment, curtains and furniture.

Maternity and gynaecology

- There were no reported cases of MRSA or Clostridium difficile on the maternity or gynaecology wards.
- We saw monthly environmental audits were undertaken and the maternity wards scored 97% in December 2014.

Environment and equipment

- There were appropriate storage facilities, and staff confirmed that the equipment for the safe monitoring of patients was available.
- Resuscitation equipment was in line with national guidance, and we saw it was checked regularly.
- The cardiotocography (CTG) electronic equipment used to monitor foetal heartbeat and uterine contractions during labour was available and regularly checked by staff.
- The maternity wards had restricted access and doors to the wards were controlled by buzzers and CCTV.
- Babies were electronically tagged for security and safety.

Medicines

- There was a ward pharmacist who reviewed medication. Medication was stored correctly and appropriately. Controlled drugs were reviewed daily and fridge temperatures were monitored and recorded correctly.
- Drug cupboards and fridges were locked when not in use.
- We looked at medication administration charts and found medication had been given to patients appropriately and information accurately recorded. However, on the gynaecology ward we found one patient who was on oxygen, which had not been prescribed.

Records

- We looked at nine sets of patient records. Patient records were kept in a paper format. We found records were completed appropriately and maintained without gaps.
- Patient records included risk assessments, such as a falls risk assessment, mental health risk assessments and nutritional risk scores.
- Records were stored in lockable trollies behind the nursing station and were stored according to data protection and information governance guidelines.

Safeguarding

- The Trust required 75% of staff to have completed the relevant level of safeguarding training.
- Sixty-five per cent of nursing and midwifery staff had completed level three children's safeguarding training. There were only 10% of additional clinical services staff and 25% of medical staff which had completed level 3 children's safeguarding training.
- Figures indicated that 3% of nurses and midwives had completed level 2 adult safeguarding training and 57% had completed level 1. There were 69% of medical staff who had completed level 1 adults training.
- Staff we spoke with were aware of the named midwife for safeguarding, who attended the safeguarding meetings and approved protocols.
- There was a safeguarding vulnerable adults policy, which included contact numbers for local safeguarding teams, and staff were familiar with the process for raising concerns. Midwives gave examples of where they had raised recent safeguarding issues.
- There was a full-time named midwife based at Scarborough Hospital, who was responsible for child protection across all sites and they had the support of a part-time midwifery child protection adviser based at York Hospital.
- Best practice regarding safeguarding children and related record keeping had been reviewed by the named midwife and had been cascaded across the trust.

Mandatory training

- The maternity dashboard for York Hospital showed 92.7% of midwives and 67.5% of doctors had attended training. Between March 2014 and February 2015 no training had been cancelled.
- Ninety per cent of nursing and midwifery staff had completed basic life support (BLS), including do not attempt cardio-pulmonary resuscitation (DNA CPR) awareness. Ninety-three per cent of nursing and midwifery staff had completed medicines management training. However, only 8% of nursing and midwifery staff had completed nutrition training.
- All midwives had access to a supervisor of midwives who would provide guidance and support to staff.

Assessing and responding to patient risk

- The service used an obstetric early warning score (OEWS) to identify patients who were becoming unwell. There was guidance for staff on escalating patient care if a patient became unwell and their condition was deteriorating.
- The service used the 'five steps to safer surgery' procedures (Patient Safety First campaign – an adaptation of some of the steps in the WHO surgical safety checklist) in obstetrics and gynaecology. There were plans for the service to audit the use of the checklist in 2015.

Midwifery staffing.

- The labour ward had introduced an acuity tool on the delivery wards to improve staffing levels for delivery. Staff told us they found the tool had indicated that staffing levels were at 70% and there was a staffing shortage on the labour ward.
- Data from the York hospital midwifery dashboard indicated that there was one midwife to 28.5 – 31 births for the period January to August 2014.
- The head of midwifery (HOM) told us the midwifery establishment for the trust was 166 whole time equivalent (WTE) midwives and this number excluded midwives who had a non-clinical role (managers and specialists). This gave a ratio of approximately 1:28 midwives to births, which is in line with accepted figures for a safe service recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour and the Nursing and Midwifery Council guidelines to allow staff to provide one-to-one care for women in labour.
- In February 2015, the labour ward achieved one-to-one care for 181 deliveries (80.8%). Overall, the average for 2014 was 80.5% of women with deliveries at York Hospital had received one-to-one care.
- In February 2015 the data from the trust indicated that the maternity antenatal ward had an average day fill rate for midwives of 199% and a night fill rate for midwives of 282.9%. The average day fill rates for unqualified care staff was 159.7%.
- In February 2015, the maternity postnatal ward had an average day fill rate for midwives of 90.2% and a night fill rate for midwives of 114.9%. The day fill rates for unqualified care staff was 80% and the average night fill rate was 176.4%.
- For February 2015, the gynaecology ward had an average day fill rate of 88.3% for nursing staff and an average night fill rate of 104.8%. The day fill rates for unqualified care staff were 84.5% and the average night fill rate was 97.4%.
- Community midwives had a caseload of 110 women, which was a good standard of provision. There was a teenage pregnancy midwife who provided care in the community and was based at Bridlington and District Hospital.
- We attended a handover and found that the handover included information about staffing and patients who were a high risk.

Medical staffing

- In 2007 the Royal college of obstetricians and gynaecologists (RCOG) report 'Towards Safer Childbirth' set a gold standard for resident labour ward cover going forward at 168 hours per week. In the interim it set some minimum standards based on the number of births annually per unit. For a unit of 2,500-4,000 births there should be a minimum of 60hours consultant cover.
- At the time of the CQC inspection, in the York hospital there was cover on the labour ward for on average 76 hours per week.
- There was also 10 anaesthetic cover sessions at the York Hospital site.
- Junior doctors felt supported and consultants and registrars were available and accessible.
- There was always an anaesthetist available from theatres to provide cover when performing caesarean sections.

Major incident awareness and training

- Staff were aware of the RCOG guidelines, which included the potential closure of the maternity unit, with contingency planning to ensure that any decision to close the unit was appropriate. We found the unit had been closed on two occasions in 2014.

There were other escalation policies available to staff, including intrapartum National Institute for Health and Care Excellence (NICE) guidelines and an abduction policy. Staff we spoke with were confident regarding reporting mechanisms, and that support from senior managers and the head of midwifery would be good in the event of a major incident.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Requires improvement

Staff were appropriately qualified to carry out their roles. There was effective supervision and appraisal for staff. There was a multidisciplinary approach to care and treatment. Staff understood the requirements of the Mental Capacity Act 2005 and obtaining consent.

There were policies and guidelines on the intranet. However, there were guidelines in maternity services, relating separately to Scarborough Hospital and York Hospital, which were out of date and did not adhere to national guidance. Monitoring of performance was difficult to review.

Evidence-based care and treatment

- There were policies and guidelines on the intranet. However, there were guidelines relating separately to Scarborough Hospital and York Hospital, which were out of date and did not adhere to national guidance. For example, the breech presentation policy was not in the trust format dated September 2010 and the anaesthetic handbook was dated May 2007. The service was in the process of implementing joint guidelines for use across both sites.
- The service was not identified as an outlier in the maternity outcome measures programme (readmissions, neonatal deaths, puerperal sepsis).
- Staff told us it was difficult to review the performance of the directorate because the electronic system for collecting the data was difficult to use and it was also difficult to use it to provide reports. We looked at the electronic system and were able to confirm that it was difficult to use and there was limited standard reports set up on the system.
- The maternity service were not outliers for readmissions, neonatal deaths or puerperal sepsis.
- The average ratio of midwifery supervisors to midwives for York hospital was 1 to 14 throughout 2014 which was in line with recognised best practice.

Pain relief

- Pain relief was available, which included epidural anaesthetic, ENTONOX® and pethidine.
- Women who had had a caesarean section told us the anaesthetist had spoken with them and explained what would happen.
- Anaesthetic cover on the labour ward was for ten sessions per week. Outside of these hours there was on on-call cover.

Nutrition and hydration

- There was a part-time infant feeding coordinator based at York Hospital to provide support to patients to breastfeed.
- The service had achieved UNICEF Baby Friendly Initiative level 3 across all sites. This is a worldwide initiative which encourages hospitals to promote breastfeeding.
- All midwives, healthcare support workers, midwifery support workers, student midwives and medical staff were trained to support women to breastfeed to UNICEF standards.
- There were also breastfeeding peer supporters and their contact details were given to patients.
- There was a frenulotomy (tongue tied) service available for women and their babies to access.

Patient outcomes

- Between April 2014 and March 2015 there was an average of 280 births per month. Between April 2014 and March 2015 there were 12 undiagnosed breech presentations, three of which were in July 2014: two antepartum stillbirths and no intrapartum stillbirths.
- In February 2015, there were 225 births, which included 55 (24.6%) induction of labour, 33 (14.7%) emergency caesarean sections, 22 (9.8%) elective caesarean sections, six (2.7%) ventouse deliveries and 22 (9.8%) forceps deliveries.
- The service had an average 4.4% per month 3rd/4th degree tears which was rated a minor concern for the service for 2014
- The proportion of women that had a post-partum haemorrhage (PPH) of more than 1000mls from March 2014 to February 2015 was approximately 10.6%. This figure was higher than those identified in the maternity safety thermometer pilot data published in October 2014.
- There were no uterine ruptures in 2014 recorded for York Maternity services.
- Figures for transfer/admission to NICU (neo-natal intensive care unit), NNU (neonatal unit) or SCBU

(Special care baby unit) from the harm-free care maternity safety thermometer tables indicated that for March 2014 - February 2015 the Trust had zero to eight per month. This ranged from zero to 18.2% per month.
- The service had no unplanned admissions to the intensive therapy unit (ITU) or the high dependency unit (HDU) between March 2014 to February 2015. However, they had an average of two women per month on high dependency unit charts per 24 hours on the labour ward.
- During 2013/14 there were no medical and three surgical termination of pregnancies at York hospital.

Competent staff

- All newly qualified staff were offered preceptorship. Preceptorship is "a period of transition for the newly qualified staff during which time he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning".
- All new staff received a comprehensive induction, which included access to training and provided support for them to develop their knowledge and skills in order to enable them to provide patient care.
- All staff had access to a supervisor for midwives and clinical supervision arrangements were in place. Staff told us there was good access to, and attendance of, mandatory training.
- Information for appraisals was collected for the directorate and 82% of staff had had an appraisal in the 12 months prior to the inspection. Staff confirmed they had had appraisals.

Multidisciplinary working

- There was good communication between hospital and community midwifery staff. Doctors covered hospital and community services.
- The midwives for safeguarding worked closely with GPs and social services when dealing with safeguarding concerns.
- The trust highlighted the good midwifery/consultant relationships as a strength within its obstetrics and gynaecology strategy.
- Midwives commented that they worked well with obstetricians
- Patients who had complex specialist needs, such as mental health concerns, could access specialist services.

Seven-day services

- Consultant cover adhered to the RCOG guidelines. There was consultant cover seven days a week supported by registrars and junior doctors.
- A consultant was on call out of hours to provide support to junior staff.
- There was a ward clerk available during the day and a healthcare support worker provided cover out of hours.
- Rotational working had been introduced for community midwives.

Access to information

- There was information available to patients about antenatal and postnatal care and breastfeeding.
- Information was available for patients who attended gynaecological services. For example, there was information about the colposcopy service.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff had an understanding of consent including the Gillick competencies and Fraser guidelines (for deciding whether a child is mature enough to make decisions and give consent) and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The patients we spoke with confirmed that staff had obtained their consent prior to treatment. We looked at patient records and found signed consent forms were present in the notes.

Are maternity and gynaecology services caring?

Good

Staff treated women with respect. Women felt supported and well cared for. Staff involved women and their families in decisions about their care and treatment. Staff were kind and caring and spent time speaking with women and their families.

Compassionate care

Maternity and gynaecology

- Women we spoke with were complimentary about the care they were given.
- Women and their families were asked to complete the friends and family survey. The NHS Friends and Family Test is a survey which gives patients an opportunity to give feedback on the quality of the care they receive. In February 2015, York Hospital scored 100% for women and their families who would recommend the labour ward to family and friends. Ninety-eight per cent of women would recommend the postnatal and community services to family and friends.
- The gynaecology service NHS Friends and Family Test had a 30% response rate and patients were positive about the service.
- During the summer of 2013, a questionnaire was sent to all women who gave birth in February 2013 (and January 2013 at smaller trusts). Responses were received from 171 patients at York Hospitals NHS Foundation Trust.
- Women were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question (the higher the score the better). The trust was performing about the same as most other trusts that took part in the survey.

Understanding and involvement of patients and those close to them

- Patients who completed the maternity survey felt they were spoken to in a way they could understand during labour and birth and felt involved enough in decisions about their care during labour and birth.
- We spoke with eight patients on the ward, who told us they were involved in the decisions about the care they received. We spoke with patients who had had planned caesarean sections who told us they had met with the consultant, midwife and anaesthetists.
- Evidence from a colposcopy patient satisfaction questionnaires sent out in July 2014 indicated that the majority of women who visited the service felt they were well informed and rated the service as excellent.

Emotional support

- There was a specialist midwife for diabetes who provided support and advice to patients.
- Patients had access to bereavement services. There was a chaplain available to support patients following a still birth. Patients were given information about a support group they were able to access. There was a yearly memorial service and patients were invited to attend this event.
- There were breastfeeding peer supporters and their contact details were given to women prior to discharge.

Are maternity and gynaecology services responsive?

Good

Women were supported to access the right care at the right time. Services were delivered in a way that met the needs of the women accessing the service.

Women understood how to complain and the provider reviewed and acted on complaints and feedback received.

Service planning and delivery to meet the needs of local people

- The trust was aligning services at York Hospital and Scarborough Hospital and supervisory midwives worked across sites.
- The trust had an escalation policy for dealing with staff shortages and staff worked flexibly to manage staffing issues and the service needed.
- The service had a bereavement room which was separate from the delivery suite, was nicely furnished and had good facilities.

Access and flow

- Antenatal visits were consultant-led in the community and in the hospital.
- The average length of stay for obstetrics was 1.2 days and for gynaecology was 1.4 days. The trust had seen an increase in bed occupancy over the previous 18 months, but were now in line with the national average occupancy rate of 60.2.
- The service had a Commissioning for Quality and Innovation (CQUIN) payment framework target of 75% for women accessing antenatal care and in February 91.6% of pregnant women accessing antenatal care who were seen within 13 weeks.
- In the 2014/15 quarter one, gynaecology had 29 patients who had waited more the 18 weeks from referral to treatment.

Maternity and gynaecology

- The unit was closed to admission at York Hospital twice during 2014, once on the 30 May 2014 for 6 hrs and again on the 7 June 2014 for 2 hrs. Information was not provided as to why the service closed.

Meeting people's individual needs

- There was a specialist midwife for teenage pregnancy who would work with teenagers and work with social services to meet young patients' needs.
- Translation services were available for patients whose first language was not English. There was a telephone-based translation and interpretation service available at all sites. However, the service did not have written information routinely available in other languages. Staff told us about how they had access to signers for women who had a hearing impairment.
- Patients were able to access a full range of birthing options, including a birthing pool, birthing chairs and beds following appropriate risk assessments being completed.
- There were no specialist services provided by the Trust such as consultant midwives, substance misuse midwives, teen midwives, or traveller liaison midwives.
- There was a vaginal birth after caesarean (VBAC) clinic at York hospital which supported women who are pregnant after a previous caesarean to where possible experience a vaginal birth.
- There was a gynaecologist oncology nurse specialist in post to support patients with cancer.

Learning from complaints and concerns

- Between March 2014 and February 2015 there had been 16 formal complaints and 11 informal complaints received by the York Hospital maternity services. Lessons from complaints were shared with staff through the obstetrics and gynaecology newsletter and clinical governance Meetings.
- Information and learning about complaints was displayed in the staff room.
- Staff were aware of the complaint procedure and how to escalate concerns.
- The service responded to comments on NHS Choices.

Are maternity and gynaecology services well-led?

Good

The trust had a statement of visions and values which was shared with staff. However, not all staff were aware of the trust values.

Risks to the delivery of care were identified, analysed and migrated against. Issues were managed and action taken.

Staff felt respected, valued and supported. The senior team were visible and communicated with staff at all levels.

The service sought feedback from patients and staff. Concerns were listened to and acted upon.

Vision and strategy for this service

- The trust had an obstetrics and gynaecology directorate strategy for 2014 to 2019 which clearly articulated the integration of services across all acute and community sites within the trust.
- There had been an analysis of the strengths. weaknesses, opportunities and threats for varying elements of the maternity and gynaecology services and a high level plan developed to reflect these.
- The trust values were displayed in all areas and they were also published in the 'Obstetrics and Gynaecology Newsflash' publication.
- However, not all staff were not aware of the values and commitment the trust had to improve care and quality of care.

Governance, risk management and quality measurement

- The service had a risk register and published risk register news in the 'Obstetrics and Gynaecology Newsflash'. Risks included junior doctor availability to review patients and failure to achieve the 18-week targets. The publication also had details of who to contact if staff identified other risks that needed to be on the risk register.
- The service held monthly clinical governance committee meetings. We looked at the agendas and minutes for three meetings. Items for discussion included performance, policy and guidance, complaints and incidents.

- At the November 2014 board meeting it was reported a senior midwife and an obstetrician from other organisations had been approached to act as a 'critical friend' and to add external scrutiny.
- Additional quality and scrutiny meetings had been planned to review and agree action plans and understand any issues. Actions and findings were reported to the clinical governance committee on a regular basis.

Leadership of service

- There were clear line management arrangements for midwives, nurses, medical and management staff which covered both York and Scarborough hospital and community services.
- Staff told us the management team were very visible on the unit and they could approach them about anything.

Culture within the service

- Staff of all disciplines reported they worked well together and spoke positively about the service. There were some concerns raised about the delay in the reopening the midwife-led unit, but staff felt that managers were keeping them informed about the delays.
- Maternity staff felt supported by the new ward manager and they felt there were improvements in the service provided.

Public and staff engagement

- The service had completed a 2014/15 staff survey and meetings had been arranged to review the results. An action plan from the 2013/14 survey had been completed and, for example, staff advocate roles on the York Hospital site had been created.
- The service had received patient feedback for their colposcopy services at York Hospital, Scarborough Hospital and Bridlington and District Hospital from Public Health England (PHE). The feedback was overwhelmingly positive, with all patients rating the services as 'outstanding' or 'good'.
- The trust had a maternity services liaison committee, where users came together to participate in discussions about maternity services.

Innovation, improvement and sustainability

- There were online antenatal classes available on the trust website, which included information about giving birth, complications and physiotherapy advice for labour.
- The service also had room available for women who had a still birth, which included a cold cot and facilities for the family to be together.

Services for children and young people

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

Information about the service

The directorate of paediatrics is responsible for services for babies, children and young people at York hospital and Scarborough hospital. Services at York hospital include ward 17, a 25-bed ward for paediatric medicine/mixed specialty, and the child assessment unit (CAU), an eight-bed ward assessment area that accepts children from the emergency department and general practice. The service includes the child development centre (CDC) and the SCBU (special care baby unit), which includes 15 special care baby cots, two of which are classified as high dependency. The surgical directorate manages a six-bed children's bay on the adult day unit where children receive day case surgery.

Based on statistics provided by children's services, the York paediatric medicine specialty (not including sub-specialties or surgery) had a total of 4,875 emergency admissions and 22 elective admissions during the period April to December 2014. Outpatient attendances in the same period were 2,987 first-time attendances and 6,400 follow-up attendances.

During our inspection we visited all clinical areas where children were admitted or which they attended on an outpatient basis, including the SCBU, ward 17, CAU, CDC and the children's day surgery bay. We talked with 11 medical staff and 13 nursing and allied healthcare professionals, and examined 12 medical/nursing records. We spoke with 27 parents, family members and children/ young people.

Summary of findings

Overall the service was good. However, there were not always adequate numbers of registered children's nurses available to meet the needs of children, young people and parents within the inpatient areas. Training records submitted by the trust prior to the inspection showed varying levels of mandatory training uptake by members of staff, but not all were achieving the 75% compliance set by the Trust.

Children, young people and parents told us that they received compassionate care with good emotional support. Parents felt informed and involved in decisions relating to their child's treatment and care.

The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy and was led by a positive leadership team.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Aspects of this area of inspection required improvement. There were not always adequate numbers of registered children's nurses available at all times to meet the needs of children, young people and parents within the inpatient areas. Training records submitted by the trust prior to the inspection showed varying levels of training uptake by members of staff, but not all were achieving the 75% compliance set by the Trust.

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms; we saw that these were reviewed and acted upon by the management team. We found that risks were assessed and monitored, and control measures put in place. We found that all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected. Members of staff of all grades confirmed that they received a range of mandatory training. Medical staffing had some gaps, but these were being managed and addressed.

Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt that their staff reported incidents when required.
- The matron told us that 38 incidents had been reported in the previous month across the York and Scarborough sites. An average of 28 to 40 incidents were reported per month; these were usually classified as low risk, with some recorded as moderate. Two serious incidents had been reported previously, but these had taken place over 12 months ago. One related to a failure to act on blood test results and the other related to a grade three pressure ulcer. We saw that both of these incidents had been fully investigated and that learning had resulted from the investigation.
- We saw that the matron had developed a bespoke incident dashboard. This enabled close monitoring of incidents that occurred within children's services across the York and Scarborough hospitals. The matron personally populated the dashboard from the trust's Datix incident-reporting system and was able to apply a range of filters to monitor incidents. The dashboard acted as a reporting tool within children's services and was used to inform monthly clinical governance and directorate meetings. We reviewed a sample of meeting minutes which showed that incidents were discussed regularly within these meetings.

Cleanliness, infection control and hygiene

- We found that ward 17, CAU, CDC and SCBU were kept very clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-washing sinks.
- During our inspection of all clinical areas, we observed members of the medical, nursing and other staff regularly performing hand hygiene measures.
- Regular hand-hygiene audits and infection-control audits were undertaken in the clinical areas by the nominated infection control link nurses. For example, we reviewed ward 17 audits for hand hygiene, 'bare below the elbow' and glove use for the period November 2014 to March 2015; these showed good levels of compliance for doctors and nurses. The only exception was December 2014, when nurse practice, at 89%, fell below the trust's 95% compliance rate.
- Other audits included a detailed environmental audit completed monthly by the matron. This audit showed reasonable to good levels of compliance for clinical areas managed by children's services. For example, in November 2014 the overall compliance total for ward 17 was 96% and CAU 98%, with SCBU and CDC each scoring 100%.

Environment and equipment

- We saw, and staff told us, that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed that the trust tested and serviced equipment according to its own policies. Some equipment, such as incubators on SCBU, were maintained and serviced by external manufacturers.
- All the children's clinical areas we visited had suitable resuscitation equipment available, which had been checked daily by members of staff.
- The matron explained that some environmental areas of ward 17 and the CAU required improvement. These

improvements included issues such as some areas of flooring, a new nurse station (on ward 17) and a parents' facility (shower, toilet and sink). We saw that there were plans in place to address all these areas. For example, we sat in a meeting with the matron, ward manager and a project manager to finalise temporary measures to be put in place to minimise risk while a new nurse station was installed for ward 17 during the spring of 2015.

- The CDC's environment was currently recorded as a risk on the risk register for children's services due to a "lack of appropriate and suitable facilities in which to provide outpatient services". We were told that current risks were being actively managed and there were architectural plans in place for rebuilding the facility.

Medicines

- We reviewed a sample of paper-based treatment records on ward 17 and SCBU and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered in these areas.
- The management team explained that children's services had a named pharmacist who attended the children's clinical areas on weekdays. The management team told us the service felt well supported by their pharmacist, who also provided advice and support and attended multidisciplinary meetings when needed.
- Training records supplied by the trust prior to the inspection recorded that 69% of nursing staff had completed medicines management training at York hospital.

Records

- We found that records were managed and handled safely during our inspection and we did not identify any unattended medical notes during our inspection.
- Nursing and medical staff completed a joint 'children's unit multidisciplinary assessment' on admission to capture a range of jointly assessed information such as family/social history, observations, allergies, nursing assessment and clinical notes. This meant that the joint assessment entries were written at the same time, alongside each other, so that it was clear what medical treatment and nursing care the child required.
- We reviewed 12 medical/nursing records throughout children's services. Nursing documentation was paper-based and included an assessment of the child or young person's daily living activities; where necessary, this was individualised to reflect the child's and family's needs. The nursing evaluation was written contemporaneously alongside each medical review entry; we found that these entries were written in detail by nursing and medical staff.
- The records we reviewed showed that children and young people had care plans that reflected their identified needs on the children's ward. Records on SCBU were tailored to meet the needs of the premature baby. Each baby had a printed neonatal core care plan with additional handwritten care plans when required.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they were to follow if a safeguarding concern arose.
- The trust had access to the necessary safeguarding staff, including the named nurse and named doctor. The chief nurse was the trust's nominated executive lead for safeguarding.
- The matron explained that the directorate was well supported by the trust's safeguarding team. Children's services in York had a dedicated child protection suite (known as Acorn suite) located within the CAU where children and families could be seen privately.
- Safeguarding children and young people: roles and competences for health care staff intercollegiate document third edition: March 2014 sets out the minimum safeguarding training requirements. It states that all staff including non-clinical managers and staff working in health care setting should have level one training. Level three is for all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Training records provided by the trust prior to inspection showed that it was not meeting the intercollegiate guidance as above: 63% of nursing staff within the child health directorate had received level three safeguarding children training against a trust-wide compliance requirement of 75%. Additionally there was only 20% of medical staff and 58% of additional clinical services staff who were complaint at level 3.
- For level 1 safeguarding children training there was 40% compliance for administrative and clerical staff,

- For adult safeguarding level 1 training there was 39% compliance for nursing and midwifery staff within the child health staff at the York site and only 3% at level 2 against a trust target of 75%.

Mandatory training

- Members of staff we talked with, including staff from ward 17, CAU, CDC and the SCBU, confirmed that they received mandatory training. This covered subjects such as fire safety, food safety, blood safety, health and safety, infection prevention and control, moving and handling, and safeguarding.
- The matron explained that mandatory training was delivered via a centralised learning hub which could be made more bespoke to the service. For example, children's services could opt out of a particular subject if it was felt that it was not relevant. Ward and unit managers managed the uptake of training with the matron providing an oversight and supportive role.
- Training records submitted by the trust prior to the inspection showed varying levels of training uptake by members of staff. For example, training compliance for fire safety awareness was 70% (nursing) and 62% (medical), while for health and safety it was 86% (nursing) and 71% (medical). However, some mandatory training uptake fell below the trust's target rate of 75%, such as food hygiene, which was reported at 36% and basic life support which was at 50% for medical staff and 69% for nursing and midwifery staff.

Assessing and responding to patient risk

- Our review of records showed that the 'children's unit multidisciplinary assessment' record included an initial risk assessment for skin integrity and skin pressure. Should initial risks be identified, the nurse would be prompted to complete a separate 'Glamorgan' pressure sore risk assessment tool. We specifically reviewed a sample of six records with the matron to audit the completion of the initial skin assessment on ward 17 and found that only two of the six initial assessments of skin had been completed. All other sections of the nursing assessment had been completed by nursing staff
- Although the nursing assessment covered a basic assessment of mobility and nutrition, children's services do not currently use dedicated individualised risk assessment tools for either nutrition or moving and handling where risks might be identified.
- The children's ward used an early warning assessment or clinical observation tool called PAWS (paediatric advanced warning score). The age-related tool included a clinical observation chart and other clinical measures, along with an assessment score to assist clinical staff in determining the action that should be taken for a deteriorating or poorly child. It was explained that the chart would help in determining whether a child required transfer to a tertiary centre for children, such as Leeds. Our review of a sample of charts showed that staff completed the PAWS charts appropriately and the service had previously audited the use of these charts.
- Ward 17 included two high dependency rooms opposite the nurse station for the close monitoring and stabilisation of poorly children. The rooms had suitable additional equipment and members of nursing staff were trained on the PILS (paediatric intermediate life support) course.
- The trust was part of the EMBRACE network; this was a specialist transport service for critically ill children and neonates in Yorkshire and the Humber region. The management team and other grades of staff told us that access to this service for advice and for the transfer of children worked very well.

Nursing staffing

- We found that staffing levels varied within the children's services provided at York hospital. The inspection focused on the staffing of three clinical areas: ward 17, CAU and SCBU.
- The 25-bed ward 17 had expected staffing levels of four registered nurses plus one support worker for daytime shifts and three plus one for night-time duties. These staffing numbers gave a ratio of one registered nurse to six patients during the day and one registered nurse to eight patients at night.
- However, duty rotas for the period 9 to 22 March 2014 for ward 17 showed that staffing levels during the day fell below the trust's expected minimum. For example, several spans of duty included only three registered nurses for daytime duty and some night duty rotas included only two registered nurses.
- The current staffing establishment for ward 17 fell below recommended minimum staffing levels for children's wards advised in the Royal College of Nursing's (RCN) staffing guidance. Ratios set out by the RCN include one registered nurse to four children (over two years of age).

- Other supportive evidence demonstrated that there may not always be sufficient numbers of staff on duty. For example, during our inspection on Wednesday 18 March 2015, there were three registered nurses on duty. The ward was busy and had two children who required close monitoring and support, which meant that staff were stretched at times. We were told by some parents and young people that there had been delays in the administration of their medications. One teenager told us that they had had to wait some time before being taken to the toilet and a parent said they were told: "There is not enough staff."
- At the time of our inspection, the children's ward was expected to use a 'safer staffing acuity tool' that had been developed specifically for adult inpatient wards. Adults' needs and dependencies differ from those of children and the tool was not likely to be suitable in determining the correct levels of staff required for ward 17.
- The matron explained that the trust had been supportive in relation to the staffing of ward 17 and the chief nurse had suggested the use of professional judgement in relation to staffing. This had allowed the ward to advertise four nursing posts for ward 17; these were in the process of recruitment.
- The CAU (eight beds) was open from 9am to 8pm five days per week and current staffing was not adequate to meet the needs of children, as it was staffed by one registered nurse with one support worker when available. All separate children's clinical areas should have a minimum of two registered children's nurses. However, we reviewed a business case and documentation which showed the trust had accepted the need to have two registered nurses for CAU. The matron told us that the service was currently recruiting these nurses. The same business case approved an uplift of 2.35 whole-time equivalent (WTE) staff from band five to band six to ensure that there were band six shift leaders available 24 hours a day on ward 17.
- The SCBU used a BadgerNET neonatal network system to monitor and record its staffing levels and to ensure that there were adequate numbers of 'qualified in specialty' (QIS) neonatal trained staff available in accordance with the BAPM (British Association of Perinatal Medicine) staffing standards. We reviewed the system for February 2015; this showed that there were generally enough QIS staff to meet the needs of babies. The SCBU manager and staff we spoke with confirmed that they had enough staff to meet families' needs.

Medical staffing

- We found that medical staffing was reasonably covered within paediatric medicine and SCBU. At York hospital we talked with doctors of all grades, including consultant paediatricians and trainee doctors.
- We were told that there was a 0.5 WTE gap at tier two (middle grade) on the medical staffing rota. This gap was covered by regular locum doctors or a consultant paediatrician. The clinical director explained that there were adequate numbers of tier one (foundation trainee) doctors.
- We attended an afternoon paediatric medical handover followed by a morning handover on ward 17. We saw that the handover was well attended by medical staff and a registered children's nurse. Handover included discussion of the child's medical plan and was followed by a ward round. We saw that the handover involved good discussion about the child's medical condition and used technology to review x-ray films and other information.
- Nursing staff did not raise any concerns about medical staffing and they felt well supported. The foundation and specialist trainee doctors we talked with were complimentary about the training and support they had received from paediatric consultant staff.

Major incident awareness and training

- The trust had a major incident plan in place that set out actions to be taken for major incidents and other similar events. The matron demonstrated awareness of the plan although they did not recall whether children's services had been involved in any exercises over the last few years. None of the training records we reviewed showed that there had been any specific training in the use of the major incident plan.

Services for children and young people

Are services for children and young people effective?

Good

The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. We reviewed information that demonstrated children's services participated in national audits monitoring patient outcomes when these were applicable.

Children and young people had access to a range of pain relief if needed and an evidence-based pain-scoring tool was used to assess the impact of pain. The nutritional needs of children were addressed. Consent forms were completed to an adequate standard. Staff had received an annual appraisal and received support and personal development. There was evidence of positive multidisciplinary working across various disciplines and specialties.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement NICE guidance and other evidenced-based best practice guidance.
- The trust submitted a spreadsheet prior to the inspection that set out which child- and neonate-specific NICE guidance the service was compliant with and which guidance was being acted upon to change policies and processes. For example, the spreadsheet noted that the service was compliant with several guidance documents such as those relating to urinary tract infection in children and constipation. The sheet noted that the service was partially compliant with guidance for children and young people with cancer, but comments noted an action plan was in place to develop the service to achieve compliance. We saw evidence showing that, during 2014, clinical staff had audited the effectiveness of some NICE guidelines, such as the guideline relating to urinary tract infection in children.
- Discussion with clinical staff and the review of submitted documents demonstrated that the service participated in national audits such as those on diabetes, epilepsy and asthma. Evidence, including action plans, was submitted which showed that the service had reviewed the audit results of these national surveys and had taken action to identify and implement improvements.
- Children's services conducted a range of clinical audits that were organised via an audit programme. The programme set out ongoing audits, including national audit requirements along with specific clinical audits covering conditions such as asthma. We saw that clinical audit led to recommendations and reinforcement of good practice. For example, an audit had been completed regarding 'asthma and wheeze' which made recommendations including the reinforcement of discharge processes.
- In York, we saw that a range of local clinical audits was discussed regularly and disseminated via the monthly clinical governance meetings. Audits were summarised via a trust template entitled 'Briefcase – clinical audit of service effectiveness - Brief report'.
- The SCBU had an information display board to disseminate information regarding NICE guidelines. The board included information presented relating to the NICE guidelines for early onset of neonatal infection as well as a revised neonatal sepsis and antibiotic therapy guideline. This demonstrated how the unit shared new NICE guidelines and took action to ensure compliance with new guidelines as they were issued.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia.
- The service used evidence-based pain-scoring tools to assess the impact of pain. Our review of the 'children's unit multidisciplinary assessment' documentation showed that all children underwent an initial assessment of pain as the documentation included a specific section on this. The PAWS observation tool required ongoing monitoring and observation of a child's pain.
- We reviewed a sample of pain score ratings; these showed that members of staff regularly assessed pain when required. Parents we talked with confirmed that their child had their pain assessed.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's daily living activities. Children

were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a meal from the two-week children's menu. Snacks and drinks were available between meals. The service did not currently use a specific nutritional risk screening tool.

Patient outcomes

- We reviewed information which demonstrated that children's services participated in national audits in order to monitor patient outcomes when this was applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP).
- We reviewed the action plan for the 2013 NNAP audit and saw that it gave examples of learning from this audit. For example, in relation to the audit question "Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?", the plan noted that 155 out of 211 (73%) eligible episodes were seen within 24 hours. The action plan noted measures to clarify and address this standard by reminding clinical staff to document all discussions and to ensure that they were timed and dated correctly.
- Children's services also participated in other national audits, such as those on diabetes and asthma and the Epilepsy 12 audit. The latest available diabetes audit from 2013 showed results that were similar to the England and Wales average. For example, median HbA1c (average blood sugar) at York hospital was 66 mmol/mol compared with an England average of 69 mmol/mol.
- The trust also shared the children's diabetes service peer review that had been undertaken on 4 March 2014 at York hospital. This document noted several areas of good practice, including a consultant psychiatrist who had a designated session for patients with diabetes who were suffering mental health problems and active participation in research trials. Some areas for improvement had been identified and actioned.
- The latest Epilepsy 12 audit summary report (for November 2014) for York hospital noted that the hospital was 'not an outlier' for 11 of the 12 performance indicators and was a 'positive outlier' for the epilepsy specialist nurse indicator.
- Children's services do not participate in the adult-based NHS Friends and Family Test. However, a children's version had been developed and we saw that the trust had arrangements in place to introduce the new child version in April 2015. Other surveys had also been set up previously to gain the views of children, young people and families about their experiences.

Competent staff

- Formal processes were in place to ensure that staff had received training and an annual performance development review (appraisal).
- We did not review any documents that captured appraisal statistics, but the matron for children's services stated that appraisal completion was 95% across all wards and departments at York and Scarborough hospitals.
- Members of staff on ward 17, CAU and SCBU gave positive feedback about the individual support they received regarding their personal development.
- Trainee medical staff we spoke with were positive about the regular training and support they received to develop their clinical and educational knowledge and skills. They felt well supported by consultant staff within paediatrics and neonatology.

Multidisciplinary working

- Medical and nursing staff within children's services gave positive examples of multidisciplinary working. We were told, and we observed, how the paediatricians and nursing teams worked together closely. They also worked well with other professionals such as dieticians, occupational therapists and physiotherapists.
- Staff told us that children's services worked closely with specialties such as general surgery.
- The consultant paediatricians and nursing team explained how children's services had excellent working relationships with the CAMHS (Child and Adolescent Mental Health Services) in York. We were given examples of how CAMHS had been supportive and responsive when children admitted to the ward required mental health support. There was currently seven-day support provided to ward 17 by CAMHS, as well as other good practice arrangements. We were told that there were plans to reorganise all mental health services within the area (including CAMHS). The children's services management team was worried that this could impact negatively on current arrangements, which were responsive to the needs of children with mental health needs.

Services for children and young people

- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty. A diabetes peer review conducted in 2014 noted this as a good practice example, due to its staged approach to transition.

Seven-day services

- Children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. The children's management team and members of staff did not raise any significant concerns about accessing these services.
- Trainee doctors working out of hours and at weekends told us they felt well supported by consultant staff, who were on call and readily available.

Access to information

- Staff we talked with told us that they were readily able to access patient information and reports, including at weekends and out of hours.
- The wards and departments had a range of information leaflets available for parents and children.

Consent

- We reviewed a sample of three records where consent had been obtained for surgery, and found that these had been completed, dated and signed appropriately by the doctor or surgeon and parent. Consent forms included a suitable explanation of the proposed benefits and risks of surgery.
- Staff we talked with showed that they understood the Gillick competency standard relating to consent for children. Staff explained that surgeons encouraged young people to be involved in decisions about their proposed treatment.

Are services for children and young people caring?

Good

Children, young people and parents told us that they received compassionate care with good emotional support. They felt they were informed and involved in decisions relating to treatment and care. We spoke with 27 children and parents who provided examples of how they had been provided with supportive care centred on their personal needs.

Compassionate care

- Throughout our inspection we observed members of medical and nursing staff who provided compassionate and sensitive care, which met the needs of the child or young person and their parents.
- We observed members of staff who had a positive and friendly approach towards the child and parent. Staff explained what they were doing and took time to speak with them at an appropriate level of understanding.
- We spoke with 20 parents and seven children and young people on ward 17, CAU and CDC. The parents provided examples of how they had received considerate and supportive care. A number of parents described staff as being caring, "friendly" and "approachable", with one parent stating that the staff "had been great".
- We saw that ward 17 was very busy during our inspection and that nursing staff worked very hard to meet people's needs. This was reflected in feedback from the parents and young people we talked with. One parent explained that they had "had to look around for staff" and another parent felt that "staff could have been more supportive to her so she could support [her child] more". One parent who was a regular attender explained that the busy ward day "was not typical".
- Parents who were attending the CDC (outpatients) were positive about their experience. They explained that the clinic letter gave clear instructions on how to find the department and another parent said that signage to the department was very clear. Parents also said that staff were "very welcoming" and friendly and they introduced themselves.
- We saw that children's services had previously conducted a number of patient and parent surveys. The matron explained that they would shortly be introducing a new survey using electronic technology. The most recent survey provided for ward 17 was conducted between December 2013 and April 2014 and involved 228 responses. A summary report stated that 94% said that they would recommend the ward to family and friends and 75% said they would rate the care as excellent or very good.
- The summary for ward 17 noted areas in which the ward did well, such as support and reassurance for parents.

Examples were provided of areas for improvement and actions that had been undertaken to address these. For example, parents fed back that they wanted better feeding facilities for babies. In response, the service ensured that it held a stock of jars of food and milk and purchased a microwave and steriliser to assist parents in making up their own bottles of milk.

- A survey was conducted on CAU during autumn 2014. In response to the question "Was the main reason for you/ your child's emergency dealt with well?", 78.79% (26 responses) said "yes, completely" while 21.21% (seven responses) said "yes, sort of". Positive comments included "friendly, helpful staff" and "practitioner very compassionate to his condition". Comments regarding things that could be done better included "cleaner toys" and "blood test results [could be] quicker".
- A neonatal outreach team parental feedback audit was conducted during 2014, with 63 feedback forms handed out and 34 returned. The survey responses were positive. For example, in response to a question relating to the amount of support provided, 97% rated the team with a top rating of five, with positive comments including one that stated: "Couldn't have done this without these visits and the care and support we received was amazing, thank you."

Understanding and involvement of patients and those close to them

- We observed that members of staff who talked with children and young people used language appropriate to their age-related level of understanding.
- A number of families we talked with told us they had felt involved in the planning and decisions relating to their child's care. Young people's views differed. One teenager said the nurse had not discussed their assessment of daily living activities with them directly on admission while another teenager said that they were fully aware of their plan of care and treatment.
- The views of parents and children differed about the information they had received. Some families explained how they had been given sufficient information to make an informed choice about their child's care. Others said that they had not been given information leaflets about their child's condition.
- Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required.

Emotional support

- Parents and children told us that they had been well supported during their visits or stays on the SCBU, ward 17, CAU and CDC.
- We observed members of staff who were responsive to and supportive of children's emotional needs. For example, we observed nurses, play specialists and other staff providing emotional care and support to children who were upset during our inspection.
- Parents we talked with gave examples of how the service and staff supported their children and themselves. For example, one parent whose child attended ward 17 regularly along with other specialist tertiary children's services explained how well supported they were in York and said that they felt all aspects of treatment and care were "all joined up" between the different services.

Are services for children and young people responsive?

Good

We found that the service was responsive to children's and young people's needs. Children's services actively planned and delivered services to meet the needs of local families. We saw evidence showing that complaints were reviewed and the service learned from them.

Service planning and delivery to meet the needs of local people

- Various evidence was available that demonstrated how children's services engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population.
- The leadership team explained how the trust had excellent relations with both the local NHS clinical commissioning group and the City of York local authority. For example, the directorate manager sat on the 'YorOK' children's board, whose membership included a range of partners who provided either direct care or support relating to children's health and social care needs.

Access and flow

- Systems to monitor access and flow had been established within children's services provided throughout the trust.
- Emergency department facilities for children were limited at York and were part of the adult service. The children's directorate had no direct influence over the provision of emergency services within the emergency department.
- There was an eight-bed child assessment unit (ward 18) located next to ward 17 where children received an assessment (and treatment when indicated) following referral from either the emergency department or general practitioners. This was currently open from Monday to Friday between 9am and 8pm and accepted children aged 0 to 16 years. The unit also accepted planned ward attenders for procedures such as blood tests. Children requiring a longer stay were admitted to the 25-bed ward 17, the children's inpatient ward. The management team explained that they hoped to increase the open days of CAU (ward 18) to the weekend in the future, subject to funding.
- Ward 17 had two established high dependency rooms highlighted with red doors and located directly opposite the nurse station. These rooms included additional monitoring and stabilisation equipment.
- Children's services made use of a comprehensive age-related PAWS monitoring chart. This assisted staff in identifying a deteriorating child and determining whether a child required stabilisation or transfer to a tertiary service such as Leeds. The management team and other staff told us that the regional retrieval service EMBRACE was very responsive, offered advice and facilitated transfer where this was required.
- The SCBU had facilities and appropriately qualified staff to stabilise babies prior to transfer to a level three neonatal unit within the Yorkshire area. In addition to 13 level one cots, the unit was also funded for and equipped with two level two cots. The SCBU manager told us that EMBRACE was "excellent" when transfers to other units were required.
- Day case surgery for children was provided within a six-bed bay within the adult day surgery unit. A children's nurse was provided by ward 17 (and funded by the surgical directorate) to care for these children. We were told that, if the children's nurse was required to go to theatre, children would be left on the ward without the direct oversight of a children's nurse. Children requiring emergency or longer-stay surgery were admitted to ward 17.

Meeting people's individual needs

- Staff told us that interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- The children's ward had facilities to promote family-centred care. For example, parents had access to a seated room with facilities to make hot drinks. Parents were able to sleep next to their child at night. There was a dedicated schoolroom for children along with areas where children could play.
- We saw that ward 17 took account of adolescents' needs. There was also an adolescent rest room accessible to teenagers on the ward and teenagers had been involved in its design.
- There were formal adolescent transition arrangements in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty, including jointly run clinics with the adult team. There was no overarching policy statement regarding the coordinated development of adolescent transitional services for children.
- The clinical director took a lead role regarding the care and treatment of young people. Clinically, this meant that other consultant paediatrician colleagues often referred teenage children to the clinical director, who held young people's clinics. This was regarded as good practice.
- The matron told us that there was a range of equipment, such as hoists and other support, for children and young people with complex physical health needs.
- We talked with a consultant paediatrician who worked across both York and Scarborough hospitals and was the children's palliative care lead. The consultant outlined with confidence and enthusiasm the range of palliative care services available. Children's services allowed the child and family to choose where they wished to receive palliative or respite care. The consultant explained how they decided together with

the nursing team which families to meet. The first consultation took place within the family's own home rather than in a clinic. The trust worked closely with the Martin House children's hospice.

- We were shown how the children's community team worked very hard to support children and families and facilitate palliative and other supportive care at home.
- We heard how there was a CAMHS nurse specialist attached to the life-limiting illness team who was based in the same office as the community nursing team on ward 18. The consultant explained how this had provided "excellent psychological support". The CAMHS nurse specialist provided psychological supervision each month; this had helped staff manage personal stress that may arise when caring for children with palliative or life-limiting conditions. This was good practice.

Learning from complaints and concerns

- The management team explained that complaints were handled and resolved straight away where possible. The children's directorate complaints register for the last 12 months was shared with us. This had logged 19 individual formal complaints for the York hospital. Where necessary, formal investigations had taken place. Learning points and actions were included for these complaints. The directorate manager explained that these complaints had related to a mixture of medical and nursing matters but there were no particular trends within formal complaints.
- We met one family during the inspection that was unhappy with aspects of care. We gained permission from the family to share their concerns with the matron. The matron met with the family straight away and began to address their areas of concern immediately.
- We reviewed a sample of York governance meeting minutes, which showed that complaints were discussed regularly. The directorate produced a monthly newsletter for staff members outlining any formal complaints that were currently open.

Are services for children and young people well-led?

Good

The service was well led. Established governance and risk management arrangements were in place. There was a clear vision and strategy for the service. The service was led by a strong leadership team that worked well together. People's views were sought regularly and the leadership team attempted to improve ways of engaging members of staff.

The service implemented innovative improvements with the aim of constantly enhancing the delivery of care for children and families. For example, the appointment of a senior specialty trainee 'quality improvement fellow' for one year had already led to improvements and promised a range of changes that would benefit the quality of service provision for staff and the public over the next 12 months.

Vision and strategy for this service

- The children's management team had a clear vision and strategy for the provision of children's services in York, Scarborough and the other areas served.
- The directorate had its own strategy: 'Child health – directorate aspirations 2014/19'. The strategy's stated aim was: "The child health strategy will achieve a safe, quality service for all children within the York and Scarborough area, working with partner organisations to ensure that every child is supported through their development to achieve outcomes that maximise their full health potential, developing the healthy adults of the future."
- There was a three-year strategy summary contained within the document that centred on management of the directorate and covered the areas of clinical, corporate and commissioning. The strategy also incorporated the trust's vision and values. The document contained a number of aspirations and priorities for development. For example, one aspiration was to establish a dedicated paediatric website. The directorate manager and matron demonstrated how this had been developed and was close to final release on the internet. The website was to contain a large range of information and support for children, young people and families.

Services for children and young people

Governance, risk management and quality measurement

- The risk register for children's services included 13 risks that related to all aspects of child health service delivery, including the school nursing service. All risks identified included key actions being undertaken to mitigate that risk, the named person leading on the actions, and the expected completion date. The register included risks such as staffing on ward 17/18, the environment of CDC, insufficient provision of paediatric life support training within the trust, and the lack of a paediatrician with an audiology qualification.
- We saw that risks were discussed regularly within the various directorate meetings. Regular meetings included clinical governance meetings held monthly. This meeting covered areas such as education, clinical audit, managing deteriorating patients, risk management and patient involvement. The directorate also held monthly meetings that covered a wider agenda including items such as staffing, finance and safeguarding, along with quality and safety. According to the sample minutes we reviewed, the directorate meeting in particular was well attended by the paediatricians, nurse leaders and other management staff.
- The management team explained that the York and Scarborough teams currently held separate governance and directorate meetings due to the distance between the hospitals. They hoped to develop and hold joint meetings on a quarterly basis.

Leadership of service

- Children's services had a clear leadership structure which fed into the trust-wide leadership structure. The clinical director acted as the lead for the directorate with direct management responsibility for the consultant paediatricians and the lead clinician for Scarborough hospital. The clinical director was supported by the directorate manager and their deputies. The matron led the nursing team and reported to the clinical director for children's services and professionally to the assistant director of nursing.
- The matron was supported by band seven ward managers. There was one ward manager for SCBU while the other ward manager was responsible for all other clinical areas, including ward 17, CDC and CAU.
- During our interviews with the leadership team (clinical director, matron and directorate manager), we observed that the team appeared cohesive and had a clear feel for and understanding of the directorate as a whole. The band seven leaders we talked with told us they felt well supported by the matron and other members of the leadership team. Similarly, staff members and clinicians felt well supported by their respective managers.
- The leadership team told us that the chief nurse had very recently been appointed as the executive team representative for children's views and rights (as distinct from their executive lead role for safeguarding children); the chief nurse confirmed this to us directly. We were told that the chief nurse intended to attend directorate meetings.
- We were also told that there was a non-executive director on the board who was nominated to represent children's views. Staff felt that children's rights had not always been adequately represented at a senior trust level in the past, but it was hoped that these arrangements were a positive step forward. They were based on good practice as it was a requirement of the NSF (National Service Framework) standard for hospital services for children.

Culture within the service

- We found a culture of openness among all medical, nursing and other staff we met within children's services. Staff spoke positively about the care they provided for children, young people and parents. We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility.
- The children's leadership team had a clear vision about future developments within the service. This was captured via the service's strategy, which considered staff members at ward and unit level.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children.

Public and staff engagement

- We found that details of people's experiences of the service were sought regularly. This had been achieved previously through periodic surveys of the children's wards and units along with specialist teams. We saw that the leadership team had new children's NHS

Friends and Family Test cards printed and ready for introduction in April 2015. In addition, the service planned to introduce an electronic exit survey via tablet or other IT devices. We saw examples of how people's views had been listened to and acted upon.

- The leadership team told us that they wished to improve public engagement by developing forums for parents and young people. We were told that the service had recently started a forum for young people with cystic fibrosis; this had met twice. The SCBU had a special care support group, which the SCBU manager said had been in place for around 30 years. Both parents and members of staff attended this group. The SCBU had established links with the York Bliss champion.
- Staff views were sought via the annual staff survey and the leadership team gave other examples of how they tried to involve members of staff. The matron explained that they had held two shared learning sessions during 2014 to share information regarding complaints, incidents and similar matters. These had not been well attended due to staffing pressures, although the matron intended to continue to explore ways of engaging staff and disseminating learning.

Innovation, improvement and sustainability

- The children's leadership team provided examples of areas of practice they felt were innovative and had brought positive improvements to the service. We also observed areas of good practice and measures to improve the quality of service.
- The clinical director explained how the service had applied to the deanery and had been successful in obtaining one-year funding for a senior specialty trainee (ST7) post for a 'quality improvement leadership fellow' based at York hospital. The aim of the post was to develop positive quality improvements, including electronic information technology that would benefit medical, nursing and multidisciplinary teams. We talked with the fellow who explained how some improvements had already been implemented, such as the use of technology in handover sessions, and also told us about their plans for future developments such as the electronic recording of clinical observations and the PAWS assessment.
- The SCBU at York had previously introduced a system for the provision of donor breast milk for new-born premature babies. The SCBU manager explained how the system worked and told us that it had been well received. The unit had just invested in two new specially designed reclining chairs that allowed parents to nurse and feed their babies safely. The chairs included special hooks or clips to hold any feeding or infusion tubes safely.
- The directorate manager explained that they were proud of the work children's services had put into the development of a dedicated website for children's acute and community services. We saw the offline draft version of the website, which will include a range of support and information for children, young people and families.
- In York, we saw a range of good examples of positive working arrangements within CAMHS to support acute paediatric services. We saw close working relationships between acute and mental health clinicians with responsive CAMHS support for various scenarios such as self-harm, chronic fatigue and eating disorders. We were told that CAMHS provided a seven-day service to the inpatient ward; this is unusual for a district general hospital setting. The community nursing team had a CAMHS specialist nurse placed with the team who provided the staff with supportive psychological supervision sessions.

End of life care

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

Information about the service

York Hospital forms part of the York Teaching Hospitals NHS Foundation Trust and provides end of life care services on site and in partnership with Scarborough Hospital, Bridlington Hospital, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital, with support from the specialist palliative care team. Specialist palliative care was provided as part of an integrated service across both hospital and community teams. At York Hospital, the specialist palliative care team comprised of one 0.8 whole time equivalent (WTE) palliative care consultant, two sessions of a hospice palliative care consultant, 3.3 WTE specialist palliative care nurses, one WTE end of life care facilitator post, administrative support and a part-time specialist registrar. We saw that referrals to the integrated service from April to November 2014 totalled 1,452, 90% of whom were patients with cancer.

During our inspection, we spoke with: a palliative care consultant, the lead end of life care nurse, the medical director, director of nursing, specialist palliative care nurses, mortuary staff, chaplaincy staff, porters, medical staff, ward managers, nursing staff, allied health professionals, discharge facilitators, quality managers, domestic staff, and an independent mental capacity advocate (IMCA). In total, we spoke with 41 staff. We visited a number of wards and clinical areas across the hospital, including: general medicine, cardiology, critical care medicine, oncology, gynaecology, general surgery, stroke medicine, respiratory medicine, gastroenterology, orthopaedic surgery, and the intensive therapy unit (ITU). We also visited the bereavement suite, the chapel, the mortuary and we observed a multidisciplinary specialist palliative care team meeting. We reviewed the records of 11 patients at the end of life and reviewed 33 do not attempt cardio-pulmonary resuscitation (DNA CPR) orders. We spoke with three patients and two relatives and we reviewed audits, surveys and feedback reports specific to end of life care.

End of life care

Summary of findings

We saw that end of life care services were safe, effective, caring and responsive, with elements of outstanding practice in terms of being well led. Staff were caring and compassionate and we saw the service was responsive to patients' needs.

There was good use of auditing to identify and improve patient outcomes and we saw measures in place to monitor key areas that had been identified. The trust had a clear vision and strategy for end of life care services and participated in regional and locality groups in relation to strategic planning and implementation. There was consistent leadership relating to end of life care and a number of positive developments had been implemented, for example, non-cancer end of life care and the development of training to improve advance care planning discussions, including those relating to DNA CPR.

Are end of life care services safe?

Good

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

Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were completed consistently. Of the 33 forms we viewed, all were appropriately signed and dated and there was a clearly documented decision provided, with reasoning and relevant clinical information to back it up. A risk register showed specific risks relating to end of life care and we saw that the trust had adequate equipment and appropriate safety checks in place for end of life care.

Incidents

- There had been no Never Events (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented), or serious incidents relating to end of life care reported in the twelve months prior to our inspection. We did not see specific incident reports relating to end of life care. We were told that all incidents were reviewed on a weekly basis by the director of nursing, the chief executive and the medical director and that, if they related to end of life care, they would be passed on to the end of life care lead nurse for review.
- Staff were aware of their responsibilities in reporting incidents. On one ward, a member of nursing staff told us of an incident relating to a patient who did not have a DNA CPR order in place and that members of the resuscitation team had expressed concern that resuscitation was inappropriate under the circumstances. The incident was reported via the trust's Datix reporting system, so that the incident could be reviewed and learning shared.

End of life care

- Staff told us they generally received feedback from incident reports they had made and that incidents were discussed, where appropriate, at staff meetings. We saw that a section titled 'compliments and complaints' had been added as a standing agenda item to the end of life care forum meetings. The end of life care lead nurse would provide feedback around investigations and share outcomes.
- Members of the specialist palliative care team told us that incidents were historically recorded based on the directorate in which the team sat. In this case, the medicine directorate. We were told that recent work had been carried out to redesign the reporting system so that end of life care incidents and complaints would be more easily identifiable.
- Patient stories were taken to end of life care forum meetings and strategic partnership board meetings. As a result, learning was identified and action taken to improve services for patients at the end of life.

Environment and equipment

- We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we viewed manual handling training records that showed staff had been appropriately trained in its use.
- There was specialist mortuary equipment available, including bariatric and height adjustable trolleys and storage units.
- Staff told us that, generally, there were no issues with obtaining relevant equipment for the care of patients at the end of life and that equipment was stored centrally, but was easily accessible to ward staff. On one ward we visited, we were told there had been previous issues with obtaining air mattresses for patients and that, following discussions with matrons and reporting concerns using the Datix system, there had been an improvement in this.
- We were told that McKinley syringe drivers were used on the wards and that nursing staff had been trained in the use of the pumps. We viewed a syringe driver policy that included the use of a syringe driver monitoring chart, with safety checks of the administration of medicines every four hours, via the pumps required.

Medicines

- We saw that the trust used the Palliative Care Formulary 4 (PCF4) Fourth Edition as guidance in prescribing medicines at the end of life. The specialist palliative care team provided up-to-date guidance in the form of algorithms and clinical handbooks for use on the wards. These were also available to staff electronically, via the intranet.
- The guidance included the use of medicines in the management of symptoms, including: pain, nausea and vomiting, breathlessness, chest secretions and anxiety. Medical and nursing staff we spoke with were aware of the guidance and told us they could access it via the trust's intranet and in end of life care folders, which were kept on the wards.
- Nurses within the specialist palliative care team were nurse prescribers or were working towards this qualification.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that they may need to make them more comfortable). The guidance they provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- The trust had implemented a syringe driver chart that included information on discontinuing unnecessary medicines at the end of life. The chart included advice around diluents, the type of syringe to use with the pump, medicine combinations and advice specific to patients with renal failure or diabetes.
- We reviewed 11 medication record charts of patients who were considered to be at the end of life and, in all cases, we saw that anticipatory medicines were prescribed appropriately and were in line with the guidance.
- We saw that controlled drugs were stored, administered and recorded in line with controlled drug guidance and that medicines for anticipatory prescribing for key symptoms were available and accessible.

Records

- We saw that, on admission, all patients were assessed and that these assessments were recorded, including: patient details, medical, nursing and risk assessments, as well as care plans.

End of life care

- Patients identified as being in the last days of life were cared for using a specific care plan that had been developed by the specialist palliative care team. The 'last days of life' care plan included daily reviews and regular assessments of the patient's condition.
- We viewed the records of 11 patients who were considered to be ill enough to die. In most cases, we saw that assessment and care records were completed appropriately and accurately. In one case, we saw that there were gaps in recording relating to the care of a patient at night. The ward manager told us they would report this via their 'safety briefing' to bring it to the attention of relevant staff. The 'safety briefing' was a board meeting used for learning from issues, as they arose.
- We reviewed 33 do not attempt cardio-pulmonary resuscitation (DNA CPR) forms. In all cases, we saw that decisions were dated and approved by a consultant and in 29 of these, there was a clearly documented reason for the decision recorded on the form, with clinical information included. Four DNA CPR forms did not include a detailed clinical reason recorded on the form; however, this was recorded in the patient's notes.
- Discussions about DNA CPR with patients and relatives were recorded in sufficient detail within the patient notes.
- As part of the policy for the administration of subcutaneous medication via the T34 syringe pump, we saw there was a syringe pump infusion monitoring chart available as part of the newly devised syringe driver chart. There were six patients receiving medicines via a syringe driver and, in all cases, the syringe driver record was up-to-date, with evidence of regular safety checks being carried out.

Safeguarding

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

Mandatory training

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

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls and nutrition and hydration risks.
- Early warning tools were in use throughout the hospital, with regular assessments guiding staff in identifying a patient whose condition was deteriorating.
- We observed an end of life care clinical multidisciplinary meeting and saw that patient safety and risk was incorporated into the discussions. We observed staff conducting team discussions around issues of concern and identifying ways to minimise risk. Discussions included issues around patient decisions to go home where they could be alone for several hours in the day.
- End of life care guidance documents included advice on identifying when a patient could be at the end of life and who should be involved in that decision.
- We viewed a risk register relating to end of life care. A particular area of risk related to data collection and poor IT systems that did not allow for data to be shared across services. Staff had identified this as being a potential risk to patients if information was not readily available and they were concerned that this could result in patient wishes not being known, or shared. Staff worked to reduce the risk of this by sharing information in multidisciplinary meetings and discussing when patients were deteriorating. The aim was to eliminate the risk and drive forward the changes at board level.

Nursing staffing

- There were 3.3 WTE specialist palliative care nurses and one end of life care facilitator based at York Hospital.
- Specialist palliative care nurses were available from 8am to 4pm, Monday to Friday. There was no on-call specialist palliative nursing cover out of hours.
- Nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns, should they arise.

End of life care

- The palliative care team provided training and education programmes for ward-based nursing staff within the trust. Since 2014, end of life care was mandatory as part of the trust induction programme. The palliative care team had developed an additional one day end of life care training session for nursing staff. At York Hospital, 19.2% of nursing staff had attended this training up to November 2014.
- Training covered aspects of end of life care including the five priorities of care, symptom management, advance care planning, preferred place of care and spiritual care.

Medical staffing

- There was a 0.8 WTE palliative care consultant based at York Hospital. In addition, there were two consultant sessions per week provided by a consultant from a local hospice.
- Junior doctors attended an end of life care training session as part of their induction into the trust. The junior doctors we spoke with told us they felt confident to care for patients at the end of life and that advice was readily available from the specialist palliative care team.
- Out of hours, 24-hour specialist palliative care telephone advice was available from the on-call palliative medicine consultant in the region, who could be contacted via either of the two local hospices.
- Ward staff told us they would refer to the written guidance out of hours and that they could access more specialist advice from local hospices.

Major incident awareness and training

- We viewed a business continuity plan and saw that arrangements for major incidents included the use of temporary mortuary facilities.
- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included in a call out when a major incident occurred.

Are end of life care services effective?

Good

The trust had taken action to plan and develop services in line with national guidance, with the implementation of a 'last days of life' care plan for the assessment and coordination of care and symptom management of patients at the end of life. We saw that the Liverpool Care Pathway was no longer in use since the national phase out date of July 2014.

Assessments of patients' pain were consistently carried out, although there was limited use of pain assessment tools. Nutrition and hydration assessments were carried out and staff we spoke with were aware of quality of life issues relating to nutrition and hydration at the end of life. We saw that the trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit and that a number of areas had been addressed at the time of our inspection. We saw that, where patients were identified by staff as lacking the mental capacity to be involved in DNA CPR decisions, that family members were consulted and decisions taken in patients' best interests. We saw evidence that mental capacity assessments were recorded in relation to DNA CPR decisions, although this was not always done consistently.

Evidence-based care and treatment

- We viewed end of life guidance and a 'last days of life' care plan, which had been introduced in November 2014.
- We saw that end of life care documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health (DoH) End of Life Care Strategy and the National Institute of Health and Care Excellence (NICE).
- An internal audit of the 'last days of life' care plan had identified changes to improve the document following discussion with staff that had used it.
- The 'amber care bundle' (an alert system to identify patients who were not responding to current treatment) had been implemented in two wards at York Hospital. The amber care bundle was being used to help identify people in the last months of life, so that they could be involved in open discussions and care planning about their future care. Staff we spoke with told us changes in the specialist palliative care team meant that progress on further embedding and expanding the use of the amber care bundle had been delayed. However, they also said that, now the team was more established, this work would be taken forward.

End of life care

- The Liverpool Care Pathway (LCP) had been phased out nationally by July 2014 and staff we spoke with at York Hospital told us it had not been used since this time.

Pain relief

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

Nutrition and hydration

- A nutritional screening and assessment tool were incorporated into the patient admission record to assess patients on admission.
- The 'last days of life' care plan incorporated both medical and nursing assessments of nutrition and hydration. Incorporated into this was guidance around the use of clinically-assisted hydration and nutrition. There were also prompts to involve patients and their families in discussions around hydration and nutrition. In addition, nursing assessment/intervention prompts were undertaken every four hours, these included offering the patient oral fluids and nutrition, as appropriate.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in as much of the patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Staff we spoke with told us they were led by patient wishes in relation to oral intake of food and fluids and we were given examples of when patients had been able to access food and drinks of their choosing.
- We viewed guidance on the use of mouth care in the last days of life that included action to be taken in the event of a patient having a dry mouth, coated tongue or pain/ulceration.

Patient outcomes

- The trust had taken part in the 2013/14 National Care of the Dying Audit, where they had not achieved six out of seven organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust performed below the England average in some of the clinical key performance indicators, including communication relating to a patient's plan of care for the dying phase, a review of interventions during the dying phase and a review of care after death.
- The trust had addressed a number of issues following the audit, including the appointment of a layperson to the trust board, with specific responsibility for care of the dying, the development of bereavement care, ensuring training in end of life care was mandatory for staff caring for dying patients and the development of the last days of life care plan.
- The implementation of the last days of life care plan addressed a number of clinical areas identified as part of the National Care of the Dying Audit, including: the assessment of nutrition and hydration, the identification of spiritual needs and the ongoing communication and involvement of patients and family members in planning care.
- We viewed examples of internal audit programmes. One example included the trust's own care of the dying audit, which focused on examining care of the dying practice prior to the implementation of the last days of life care plan. The aim of the audit was to establish current practice to ensure the care plan was focused on supporting sustained quality practice in end of life care.

Competent staff

End of life care

- We saw that the specialist nurses visited the wards on a daily basis to review patients at the end of life and to support ward-based medical and nursing staff in planning and delivering care to patients.
- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- A number of nurses across the hospital had attended a full day of training in end of life care. At the time of our inspection, 19.2% of nursing staff had attended the training. The end of life care lead nurse told us that at least one member of nursing staff on each ward had attended the training and we saw records that demonstrated this.
- Ward staff and the specialist palliative care nurses told us that training around the use of the 'last days of life' care plan had been delivered on the wards so that nursing and medical staff felt confident in its use.
- Ward-based nurses were able to shadow the specialist palliative care nurses so that they could develop more specialist knowledge and there was a programme in place for specialist nurses to mentor staff who were undertaking the programme.
- An end of life care facilitator role had been developed to support ward staff in the delivery of ongoing learning around end of life care on the wards.
- Key members of the specialist palliative care nursing team were identified as leads in specific areas of end of life care, including: the implementation of the 'last days of life' care plan, advance care planning, and the implementation of the amber care bundle.

Multidisciplinary working

- Members of the specialist palliative care team participated in multidisciplinary team meetings, working with other specialists to support good quality end of life care across clinical specialties.
- Members of the team also attended specialist lung and upper gastrointestinal multidisciplinary team meetings and were involved in heart failure and chronic obstructive pulmonary disease (COPD) multidisciplinary team working.
- The specialist palliative care team told us they met daily to discuss patient care and workloads and had a weekly multidisciplinary clinical meeting attended by other professionals, including an occupational therapist and the chaplain.
- A member of the specialist palliative care team also attended the community multidisciplinary team meetings each week.
- Regular end of life care forum meetings were attended by multi-professional hospital and community staff.

Seven-day services

- The specialist palliative care team provide a five-day, 8am to 4pm, face-to-face service, with no out-of-hours input.
- Out-of-hours advice was available 24 hours a day, seven days a week by telephone via the local hospices.
- Plans to implement a pilot of a seven-day, face-to-face service had been discussed at board level and we saw plans for the pilot to start in 2015.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover via an internal on-call system.

Access to information

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

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The trust's 'resuscitation and do not attempt cardio-pulmonary resuscitation policy' provided guidance for completing a DNA CPR form for an

individual who does not have capacity, stating that when a specific care decision was to be made the 'best interests' process under the Mental Capacity Act 2005 must be followed.

- Of the 33 DNA CPR forms we viewed across a variety of wards in the hospital, nine were for patients who staff had identified as lacking mental capacity to be involved in resuscitation decisions. We did not see the trust's mental capacity assessment form in use specific to resuscitation decisions, however, in four of the nine cases, we viewed a record in the patients' notes relating to their inability to be involved in the discussion, due to a lack of capacity. An example of documentation included details of the person's inability to understand, retain or weigh information.
- In most cases, we saw that the decision was discussed with the patient's family in order to make a decision that was in the person's 'best interest'. We saw one case where an independent mental capacity advocate (IMCA) had been accessed to support decision making for the patient who did not have mental capacity. The IMCA told us they had not specifically been contacted to discuss resuscitation, but that they were there to act on the patient's behalf in general discussions about their care and treatment.
- The trust had identified issues relating to involving patients in resuscitation decisions through a process of auditing and review. As a result, they had developed specific training for medical staff relating to this, including the development of a DVD and e-learning resources. In addition, we were told of plans to develop advance communication training for clinical staff around initiating discussions about treatment and care, including resuscitation decisions.

Are end of life care services caring?

Good

End of life care services were seen to be caring. Patients and relatives told us that, in general, they were happy with the quality of care they received and that staff were kind, caring and compassionate in their approach. A bereavement service was offered on site, with staff available to support family members with practical and support issues following bereavement.

Emotional and spiritual support was considered to be a priority within the trust and we saw this through the development of comfort boxes, the use of a prayer tree in the chapel and the development of communication training in relation to end of life care.

Compassionate care

- During our inspection, we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that showed respect for their individual choices and beliefs.
- Patients and relatives we spoke with told us that, in general, they were happy with the quality of care they received. One patient told us they had no complaints about the care and they felt well supported by staff. A relative told us their family member was cared for well and that staff were responsive to their needs.
- We saw that one relative who had concerns about the standards of care their family member was receiving had support from the specialist palliative care team to address their concerns and staff provided additional support, as required.
- A bereavement advice service was in place supporting families through the first hours and days following bereavement. There were two bereavement officers on site and the bereavement suite provided people with an environment of support and peace.
- There were arrangements in place between the trust and the registrar's office to host registrar sessions on site in the bereavement suite so that relatives could register the death more easily and with direct support from the bereavement office.
- We saw that care after death honoured people's spiritual and cultural wishes. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.
- A bereavement support leaflet was available for relatives, offering guidance on: how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved the care delivered.

End of life care

- We saw that staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient notes.
- The end of life care guidance used by the trust included prompts for discussing issues of care with patients and relatives.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen. There were also information leaflets available for patients and their relatives around the last days of life care plan and the processes involved in caring for patients at the end of life.
- The trust was participating in the National Bereavement Survey (VOICES) 2011. The survey worked to collect information from relatives and friends about the quality of care provided at the end of life. The research looked at areas such as respect and dignity, pain relief and whether the person died in their preferred place of care. At the time of our inspection, there was no data available relating to the survey, however, staff confirmed that some families had participated and the data had been submitted.
- We were told of examples where staff had supported patients who wished to get married at the end of life. Examples included staff purchasing flowers for the occasion or baking cakes. We saw that a procedure for weddings at the end of life had been developed as a result of this.

Emotional support

- Members of the specialist palliative care team participated in the delivery of communication skills training to staff in relation to discussing care and treatment issues at the end of life. This training included supporting patients and family members who were distressed.
- The specialist palliative care team showed us a tool they used to assess people's level of distress, called a 'distress thermometer'. The tool helped staff to support patients in identifying the level of distress and the factors influencing the distress. Staff told us this enabled them to identify issues such as those that were practical, social and physical as well as psychological factors, thus allowing them to support patients by developing action plans that tackled multiple aspects influencing their distress.
- We saw that visiting times were flexible for family and friends when patients were at the end of life and we saw that relatives were able to stay with patients at the end of life if they wished. Staff told us that washing facilities were made available to relatives and they were provided with refreshments. Concessionary car parking was also available to relatives of patients who were at the end of life.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy, dignity and time with relatives.
- There was a multi-faith chapel available that held information relevant to people from different faiths and religions. The chaplaincy services within the trust were geared towards providing support for patients and their relatives irrespective of their individual faith, or if they did not follow a faith. There was also a prayer room available next to the chapel. Patients and visitors were able to add requests for prayers to a prayer tree in the chapel.
- Comfort boxes were being developed for use at York Hospital following their successful use at Scarborough Hospital. The end of life lead nurse told us they had sourced funding to implement the initiative and that the comfort boxes included blankets, toiletries, drinks, snacks and a lamp for use at the patient's bedside.

Are end of life care services responsive?

Good

All patients requiring end of life care had access to the specialist palliative care team. We saw that referrals to the York Hospital specialist palliative care team between April and December 2014 totalled 455. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs.

Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. Complaints, compliments and incidents were reviewed to identify learning and this learning was explored and fed back through a number of processes including board and locality meetings. Preferred place of care was recorded by the specialist palliative care

team and was incorporated into training for generalist staff in end of life care. Fast-tracked discharges were prioritised for patients at the end of life and we saw that discharge processes were reviewed to ensure the service remained as responsive as possible. However, there was no mechanism in use to monitor achievement of preferred place of death.

Service planning and delivery to meet the needs of local people

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

Meeting people's individual needs

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

Access and flow

- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways. The aim of the specialist palliative care team was to review urgent referrals within 24 hours and routine referrals within 48 hours. Staff we spoke with told us that the palliative care nurses would generally see patients straight away if they had problems with symptoms.
- We observed the team responding quickly to a patient who was referred from an outpatient clinic, but who didn't want to be admitted to hospital. The team reviewed the patient in clinic and coordinated a response by liaising with other key professionals involved in the patient's care.
- Members of the specialist palliative care team and ward staff alike told us that, in general, patients would be

seen within hours of a referral to the specialist team. We saw examples of specialist palliative care nurses assessing patients on the same day as the referral was made.
- We saw that resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team were not available.
- The chaplaincy service was accessible seven days a week via an on-call system.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose to be cared for at home.
- We spoke with discharge facilitators who told us the hospital discharge team coordinated all fast-tracked discharges and that they were able to prioritise the discharge of patients at the end of life.
- We were shown a 'rapid discharge at end of life integrated pathway' for all rapid discharges that had recently been developed to improve the documentation, coordination and sharing of information.
- The staff were recording preferred place of death within patient's notes. However, there was no mechanism/data available to measure end of life care discharges against preferred place of care. However, we were told that 179 patients had been referred to the fast-tracked discharge service in 2013/14. Between April 2014 and December 2014, 135 patients had been referred to the service.

Learning from complaints and concerns

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

Are end of life care services well-led?

Good

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

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

Vision and strategy for this service

- There was a non-executive director nominated as the lead for end of life care within the trust and we saw minutes of meetings they attended where end of life care was discussed both at board level and with specialist staff at the end of life care forums.
- The senior end of life care team was made up of a lead nurse for end of life care, specialist palliative care consultants, the directorate manager and the non-executive board member, who met and produced quarterly reports that were submitted to the executive board to inform them of end of life care issues.

End of life care

- A clinical commissioning group (CCG) led 'end of life care board' was in operation and was attended by the lead nurse for end of life care. We were told that the board provided the structure for all strategic planning work across the region. A locality board had been developed in York Hospital to implement work plans and feed into the end of life care board.
- The trust's strategic objectives for end of life care included: increasing public awareness of end of life care, ensuring dignity and respect, minimising suffering and focusing on patients' needs and preferences.
- We viewed evidence of strategic priorities being discussed at end of life care meetings and we saw that they were incorporated into the trust's action plans in relation to developing end of life care services. For example, we saw that a patient story relating to poor communication over an advance care plan for a patient with chronic obstructive pulmonary disease (COPD) was discussed at board level. In addition, we saw that training in advance care planning had been delivered to COPD staff and that a pathway had been developed to identify trigger points when discussions about advance care planning should be initiated in patients with COPD.

Governance, risk management and quality measurement

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

Leadership of service

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- Staff spoke positively about the leadership of the specialist palliative care service and we saw evidence of specialist palliative care staff providing clinical leadership to ward staff in relation to end of life care.
- Staff we spoke with told us there was good senior level engagement, including the executive board, in improving end of life care.
- There was a non-executive director with responsibility for end of life care and we saw evidence that they were involved in meetings and discussions about end of life care. We also saw that both the medical director and the director of nursing had a good awareness of the issues affecting end of life care within the trust. We observed a commitment to address these issues and develop end of life care services in line with national guidance.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was

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

Public and staff engagement

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

Innovation, improvement and sustainability

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

Outpatients and diagnostic imaging

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

Information about the service

York Hospital outpatients and diagnostic imaging departments were situated on the main hospital site on the outskirts of York. There were a total of 597,923 outpatient appointments between July 2013 and June 2014. The ratio of new appointments to review appointments was approximately 1:2.

These services were part of the theatres, anaesthetics and critical care directorate. Outpatient clinics were held in a number of different locations and across a large number of specialties, including urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ENT and respiratory medicine. These clinics were led by different professionals, including nurses, allied health professionals and medical doctors.

Radiology services were mainly provided from three locations: York, Scarborough and Bridlington. The acute clinical work was concentrated at York District Hospital and Scarborough General Hospital, which offered a range of diagnostic imaging and interventional procedures, as well as substantial plain film reporting and an ultrasound service. Radiology services were managed by a clinical lead radiologist, who was also the head of service.

During the inspection we spoke with three patients and two relatives, nine nurses, five healthcare assistants, two allied health professionals, two phlebotomists, three student nurses and three doctors.

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

Summary of findings

Overall the care and treatment received by patients in York Hospital outpatients and diagnostic imaging departments was rated as good for safe, effective, caring, responsive and well led.

The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from York Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action had been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99). At the time of inspection the trust told us they had never had an RPA report but issues were discussed at the medical exposure committee. Following inspection, the trust told us they had a radiation protection advisor (RPA) and the RPA was invited to attend meetings of the combined Trust Ionising Radiation Safety Group (IRSG) and Medical Exposures Committee (MEC) every 3 months.

The information on staff training especially on mandatory training was kept at directorate level. This meant outpatients staff training records were with theatres, anaesthetics and critical care unit training

Outpatients and diagnostic imaging

records. Therefore we were unable to separate out and report on the compliance within the outpatients department. Data indicated that the diagnostic imaging services staff training were not compliant with training.

There was a 14% vacancy rate for consultant and registrar radiologists in York. Some of the vacancies were covered by locums. For example in February 2014 locum use was at 38%, in Marcgh 2014 it was 40%, in May 2014 12% and in August 49%. The trust told us there were 3.5 WTE specialist registrar vacancies. There was no formal tool or mechanism used to decide on staffing levels.

Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because staff were aware of the policies and how to follow them.

Patients told us that staff working in the outpatients and radiology departments were caring and compassionate at every stage of their journey. People were treated respectfully and their dignity and privacy was maintained at all times by staff. We found the services were well led and care and treatment was delivered in response to patients' needs and to ensure that the departments ran effectively and efficiently.

Are outpatient and diagnostic imaging services safe?

Good

Safety was rated as good. The managers told us that they reported any radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents from York Hospital, but this was not provided to us. This meant we were unable to judge the outcomes for the incidents and whether corrective action had been taken by the unit to promote safety. We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99). At the time of inspection the trust told us they had never had an RPA report but issues were discussed at the medical exposure committee. Following inspection, the trust told us they had a radiation protection advisor (RPA) and the RPA was invited to attend meetings of the combined Trust Ionising Radiation Safety Group (IRSG) and Medical Exposures Committee (MEC) every 3 months.

The information on staff training especially on mandatory training was submitted at directorate level. This meant outpatients staff training records were included within theatres, anaesthetics and critical care unit training records. Therefore we were unable to report the compliance within outpatients department. The diagnostic imaging services staff mandatory training was not compliant. Apart from basic life support which was 81% all of the other training such as was well below the 75% which was expected by the trust to achieve compliance.

There was a 14% vacancy rate for radiologists in York. Some of the vacancies were covered by locums. The trust informed us that there were 3.5 WTE specialist registrar vacancies.

The staff and the managers told us that they did not use any acuity tool to decide on staffing levels and that it relied on the knowledge and experience of the manager to judge the day to day staffing. This meant staffing levels could be subjective and could result in inconsistency.

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Incidents were reported using an electronic reporting system and all the staff we spoke with knew how to report incidents using the system if they needed to. Incidents were investigated and lessons learned were shared with staff. Cleanliness and hygiene in the departments were within acceptable standards. There was sufficient personal protective equipment in all of the areas we inspected and staff were aware of how to dispose of it safely within guidelines. There was sufficient clean and well-maintained equipment to ensure that patients received the treatment they needed in a safe way. There was a 36% vacancy rate for radiologists in York. Some of the vacancies were covered by locums.

Staff were aware of the various policies in place to protect vulnerable adults and those with additional support needs. Patients were asked for their consent before treatment was given. Staff were clear about who could make decision on behalf of patients when they lacked or had fluctuating mental capacity.

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

Incidents

- Across the trust, there had been 85 incidents between October 2014 and March 2015: 52 caused no harm, 28 caused minor harm, one caused moderate harm and four were still under investigation.
- The trust used an electronic system to record incidents and near misses. All staff who worked in the departments were able to access the system to record incidents.
- We spoke with staff about their knowledge of the incident reporting system. Staff said they could access the system and knew how to report incidents.
- Staff were able to give examples of reported incidents and changes in practice that had resulted from the subsequent investigations.
- The departments had systems in place to report and learn from incidents, to reduce the risk of harm to patients.
- All of the staff we spoke with were able to describe how they reported incidents and how they used Datix (the hospital incident reporting system).
- Managers told us they encouraged a culture of open incident reporting across all of the diagnostic modalities and staff we spoke with confirmed this.
- There were no never events reported in 2013/2014 (never events are serious, largely preventable patient safety incidents that should not occur if the available, preventable measures have been implemented).
- In 2014, the services reported three serious incidents to the Strategic Executive Information System. Two related to radiology/scanning incidents and the third related to delayed diagnosis.
- We looked at two of the serious incidents reported and saw the incidents had been categorised, described and investigated. The outcomes from the investigations were recorded and these had been discussed with the patients and an apology given. This demonstrated the trust's commitment to duty of candour.
- We saw evidence through our review of departmental communication processes of post-incident feedback that learning reviews and changes in practice had been implemented.
- The managers told us that they reported radiation incidents to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We requested information about IR(ME)R reportable incidents for York Hospital, but this was not provided to us.
- We requested a copy of the latest radiation protection advisor report from the trust, but this was not supplied to us. We therefore had no way of knowing when the latest checks were done, or whether there were any problems that required action. The trust was not consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

Cleanliness, infection control and hygiene

- We saw, and patients reported, that staff washed their hands regularly before and after attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons were available to staff.
- We observed staff disposing of used personal protective equipment safely and appropriately.
- The outpatient areas and clinic rooms were clean and tidy. We saw staff maintaining hygiene by using appropriate wipes to clean equipment, thus reducing the risk of cross infection or contamination between patients.

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- Equipment we saw had been labelled to show when it had last been cleaned. Labels showed that equipment was cleaned regularly.
- Staff in the outpatients and diagnostic imaging departments took part in regular hand-washing checks and environmental safety audits. We saw the most recent reports, which showed that these were part of an ongoing monitoring process. Compliance was not always 100%. Between November 2014 and May 2015 nursing staff missed the 100% hand hygiene target three times out of seven, medical staff once out of seven and allied health professionals two times out of seven. For being bare below the elbows, both medical staff and allied health professional staff missed the target once. All staff met the target for use of gloves.
- The radiology department was clean, tidy and uncluttered.
- Patient waiting and private changing areas were clean and tidy. Single-sex and disabled toilet facilities were available and these areas were also clean.
- The radiology quality assurance manager told us staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control standards. They maintained regular audits and shared the outcomes with staff. This was confirmed during staff interviews. We saw the results of these audits. Action plans were in place where applicable and were being monitored to ensure improvements were made.
- Staff told us that they took universal precautions and followed infection prevention and control principles.

Environment and equipment

- The outpatients departments were well lit, spacious and pleasantly decorated.
- During our inspection we saw that the waiting rooms got busy and staff told us that sometimes there were not enough seats for patients in the waiting areas, particularly if clinics were running late.
- Overall, the outpatients departments were big enough to meet the needs of all patients and relatives.
- We saw and staff confirmed that there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.
- We looked at the resuscitation equipment in the departments. The equipment had been checked daily as required within the outpatients departments.
- Equipment was cleaned regularly and serviced in line with manufacturer guidance. Staff showed us how they cleaned equipment. The equipment we looked at was clean and staff had maintained records.
- The departments were able to replace broken equipment in a timely manner and order new equipment if the equipment was needed for clinical reasons.
- We were unable to ascertain whether the trust was consulting and receiving regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99). At the time of inspection the trust told us they had never had an RPA report but issues were discussed at the medical exposure committee. Following inspection, the trust told us they had a radiation protection advisor (RPA) and the RPA was invited to attend meetings of the combined Trust Ionising Radiation Safety Group (IRSG) and Medical Exposures Committee (MEC) every 3 months.
- There was clear and appropriate signage regarding hazards in the diagnostic imaging department and the dermatology outpatients department.
- The diagnostic imaging / radiology department had radiological protection/hazard signage displayed throughout the department. Illuminated treatment room ‘no entry’ signs were clearly visible and in use throughout the department at the time of the inspection.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas.
- There were systems in place to ensure maintenance and servicing of imaging equipment.
- Within radiology, emergency resuscitation equipment for both adults and children was checked daily and readily available for use.

Medicines

- The outpatients departments kept a limited supply of medication.
- Within outpatients medication that needed to be refrigerated was stored in locked fridges. We saw the record charts for the fridges, which showed that temperature checks were carried out daily.
- Within radiology, medicines were stored correctly in locked cupboards or fridges. Fridge temperatures were checked and recorded correctly.

- Some staff used patient group directives to dispense drugs to patients. We checked these and found that they had been reviewed appropriately.
- There was an outpatient pharmacy on site that patients used to access prescribed medication.
- The trust had a system in place for informing GPs about changes to patients' medication.
- In the outpatients departments, 92% of eligible staff had completed medicine management training. In the radiology department, 44% had completed this mandatory training.
- Patients who needed medication such as insulin were asked to bring their own supply when they visited the outpatients departments.
- Medicines stocks were checked weekly by the nursing and pharmacy staff. We looked at a random sample of the medicines stored, including contrast medium, and found these items to be in date.
- We also looked at the controlled drugs register and saw stock counts were recorded correctly.

Records

- Records in the outpatients departments were electronic. All staff had been trained to use the system. Staff were able to access patients' current and previous medical records using the system.
- Within the diagnostic imaging department, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to patients' previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatients departments. We observed people being weighed and measured during our inspection.
- At the time of inspection within radiology, we saw patients' personal information and medical records were managed safely and securely.
- Patient x-ray records were held electronically. We looked at three records and saw these records were up to date and completed correctly.
- The Picture Archiving and Communications System is a nationally recognised system used to report and store patient images. This system was available for use by radiologists from across the trust and external reporting providers under contract with the trust.
- Records were audited monthly and the outcomes from the audits were reported and discussed with the staff at departmental governance meetings.

Safeguarding

- Information provided by the trust indicated that 66% of eligible staff from the theatres, anaesthetics and critical care directorate had completed safeguarding children level one training and 57% of eligible staff had completed level two training. This information was not provided specifically for the outpatients departments.
- For the radiology department, 55% of eligible staff had completed children's level two training.
- 56% of eligible staff from the radiology department had completed safeguarding vulnerable adults level two training.
- 64% of eligible staff from the theatres, anaesthetics and critical care directorate had completed safeguarding vulnerable adults level one training; 45% had completed level two.
- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns. Staff told us that the safeguarding lead was very accessible and very proactive around the trust.
- We saw evidence of information available to staff and patients about who to contact if they had any concerns about the safety of children or vulnerable adults. This was displayed in some staff rooms and on the noticeboards of some outpatients departments.
- Within radiology, we observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity, for example, name, date of birth and GP.
- All of the staff we spoke with were aware of the responsibilities to safeguard adults and children and were aware of the safeguarding leads within the trust.

Mandatory training

- The departments had systems and processes in place to ensure staff training was monitored.
- We looked at staff mandatory training levels provided to us. The outpatients departments were managed by the

theatres, anaesthetics and critical care department. From the information sent to us by the trust, it was not possible to separate mandatory training figures for the outpatients departments only.

- The compliance target for mandatory training was 75%. The information provided showed that across radiology only two of 13 training courses we reviewed had a compliance rate above the 75%. For the theatres, anaesthetics and critical care directorates, in the 17 training areas we reviewed the 75% was only met in five of the them.
- Staff did some mandatory training online using e-learning and some during classroom-based days.
- All of the staff we spoke with in radiology told us they received ongoing mandatory training and they were responsible for ensuring they kept up to date. They said this was difficult when there was shortage of staff.

Assessing and responding to patient risk

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

Nursing staffing

- The outpatients departments were staffed by a mixture of registered nurses and healthcare assistants. At the time of our inspection, there were vacancies within the outpatients departments.
- Vacancies were mostly being covered by current staff working extra shifts, or occasionally bank or agency staff who worked for the trust. Where possible, staff worked flexibly to cover shifts. There had been no visible impact on patient care, such as the need to cancel clinics.
- We were told that bank or agency staff could be used if there was no alternative. The managers said they had submitted a business case for replacement staff which was not yet approved
- According to information provided by the trust, the average sickness level in outpatients between May 2013 and October 2014 across administration, additional clinical services and nursing was 3.9%. However, this varied across the period, with administrative staff having very low levels of sickness (0% for 16 out of 18 months), additional clinical services ranging between 0.38% and 20.24% and nursing staff ranging between 0% and 18.8%.
- The average sickness level in the radiology department was 8%, but this varied across the time period and disciplines. For example, there were high sickness levels among medical staff (100% for three months in the breast screening service), but no sickness among the healthcare scientists for the entire 18-month period.
- There were vacancies in the radiology department. The trust had classified these as professional and scientific 13% and additional clinical services 16%. For example, there were 8.3 whole-time equivalent (WTE) band six vacancies and 2.6 WTE band seven vacancies in the x-ray department at York /hospital.
- All of the staff we spoke with told us that they worked hard but that they enjoyed their jobs. They said that staff pulled together and worked as a team to maintain good morale.
- There was no formal system, such as an acuity tool, being used to decide the staffing levels needed in the outpatients departments to cover clinics. This was because each clinic needed different numbers and skill mix of staff according to the levels of support patients and doctors needed as well as the type of clinic. The nurse in charge explained that planned staff numbers were based on the knowledge and experience of the manager to judge how many staff were needed.
- All of the staff we spoke with felt overall there were sufficient staff.

Medical staffing

- Medical staffing was provided to the outpatients departments by the various specialties that ran clinics. Medical staff who undertook clinics were of different grades, but we saw that there were always consultants available to support lower grade staff when clinics were running.

Outpatients and diagnostic imaging

- Staff told us that locums were used within the outpatients clinics depending on the staffing levels of the specialty.
- There was a national shortage or radiologists and this trust also had a shortage. Out-of-hours reporting was outsourced to a private company in Australia.
- There was a 14% vacancy rate for consultant and registrar radiologists in York. Some of the vacancies were covered by locums. For example in February 2014 locum use was at 38%, in March 2014 it was 40%, in May 2014 12% and in August 49%. The trust told us there were 3.5 WTE specialist registrar vacancies.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We found that the services provided by the outpatients and diagnostic imaging departments were good. Care and treatment were evidence-based and patient outcomes were within acceptable limits. The staff within the departments were competent and there was evidence of multidisciplinary working.

Evidence-based care and treatment

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

Pain relief

- Staff told us that the departments did not keep pain-relief medication but that the doctors in clinic could prescribe medication for any patient needing pain relief during their attendance.
- Patients we spoke with had not needed pain relief during their attendance at the outpatients departments.
- There was an on-site pharmacy where patients could purchase pain relief if required.

Patient outcomes

- In the last 12 months, the outpatients departments saw 597,923 appointments. Of these, 137,522 were new appointments and 352,774 were review appointments.
- The follow-up to new ratio for appointments at the trust was consistently worse than the national average from September 2013 to April 2014: York Hospital had performed worse than average, however Bridlington and Scarborough performed better than the national average throughout the period. At the time of the inspection, there was no further national data available.
- All images were quality-checked by radiographers before the patient left the department.
- The outpatients departments took part in trust-wide audits, such as on record-keeping, but there was little clinical audit being carried out that was initiated within the department.

Competent staff

- Staff we spoke with confirmed that they had received appraisals in the last year.
- From the information sent to us, 91% of administrative staff had undergone appraisals in the radiology department by November 2014. There was no information about appraisal rates for other staff groups in radiology.
- 96% of staff in the outpatients departments had undergone appraisal by November 2014.
- Staff told us that they did not receive formal clinical supervision as outlined in the trust policy. We asked the trust for information about this but it had not been received at the time of writing the report.

Outpatients and diagnostic imaging

- Staff did however tell us that they felt supported and that the department managers were accessible when they needed additional support.
- In both the outpatients and radiology departments there were formal arrangements in place for induction of new staff. All staff completed full local induction and training before commencing their role.
- In both the outpatients and radiology departments, performance and practice was continually monitored through appraisals and competency assessments.
- All qualified radiographers had completed equipment competencies. To help with the continual professional development of staff, the manager had organised topical subjects training.
- Medical revalidation was carried out by the trust. There was a process in place to ensure all consultants were up to date with the revalidation process.
- Managers told us of the formal arrangements in place for mentoring students and new staff and for continually assessing staff performance through supervisions and appraisal.
- Training alert updates for all staff were flagged to managers for action.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients and radiology departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as radiology and community staff when this was in the interest of patients.
- Radiologists were part of the multidisciplinary teams (MDTs) working between specialities, for example, gastrointestinal and breast MDTs.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys, such as GPs and support services.
- A range of clinical and non-clinical staff worked within the outpatients departments and they told us they all worked as a team. We observed staff working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, audiologists, nurses, booking staff and consultants.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

Seven-day services

- The outpatients departments occasionally ran clinics on a weekend and later on an evening, however most activity within the outpatients departments happened between Monday and Friday.
- The radiology services across all of the trust's locations provided a range of services. Some covered seven days a week and out-of-hours services, while some locations provided services within normal working hours five days a week.
- There was 24-hour seven days a week CT scan cover in vascular radiology.

Access to information

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

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff we spoke with were aware of how to obtain consent from patients. They were able to describe to us the various ways they would obtain consent from patients. Staff told us that in the outpatients departments, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing on the ward prior to attending the diagnostic imaging department.
- 41% of radiology staff and 100% of relevant outpatients staff were up to date with non-medical consent training.
- Patients told us that staff were very good at explaining what was going to happen to them before asking for consent to carry out procedures or examinations.

Outpatients and diagnostic imaging

- Staff we spoke with in the radiology department told us they were aware of and had received training in relation to the Mental Capacity Act and deprivation of liberty safeguards.
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients undergoing diagnostic procedures.

Are outpatient and diagnostic imaging services caring?

Good

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

Compassionate care

- All of the patients we spoke with spoke highly of the care and treatment they received in the departments. There were no negative aspects about care highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- People's privacy and dignity were respected.
- Staff made sure that patients were kept up to date with waiting times in clinic and patients told us that this meant they were able to take comfort breaks if they needed to.
- We saw that patients and staff had a very good rapport, especially as many patients had been attending clinics for a number of years.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.
- We spoke with five patients using radiology and outpatients services and their relatives and they told us they were very happy with the services provided. Staff presented as skilled, caring and helpful.
- Staff were courteous when caring for patients and staff were seen responding to patients' individual needs in a timely manner.

Understanding and involvement of patients and those close to them

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

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were given the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls advertising these groups, for example for patients who had cancer, hearing loss or who were facing blindness.
- There was formal counselling support available for patients who needed it.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

We found that outpatients and diagnostic imaging services were responsive to the needs of patients who used the services. Waiting times were within acceptable timescales with outpatient clinics only occasionally being cancelled at short notice. Patients were able to be seen quickly for urgent appointments if required.

There were mechanisms in place to ensure that the service was able to meet people's individual needs, such as those living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems in place to capture concerns and complaints raised within the department, review them and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort.
- Additional outpatients clinics were run to meet extra demand to ensure that waiting time targets were met.
- Patients were able to attend the radiology department for plain film x-rays without an appointment between 8.30am and 5pm.
- The imaging department was able to provide a comprehensive service in York Hospital.
- Referrals for imaging, particularly CT, MRI and ultrasound, were triaged and vetted and booked according to acuity.
- York Hospital provided a CT service 24 hours a day, seven days a week.
- The diagnostic imaging department had the capacity to deal with urgent referrals.
- The phlebotomy service provided daily clinics in a local supermarket with good transport links to make the service more accessible to patients.
- The oncology clinic had a phlebotomist and lab technician in clinic. Bloods were taken and results were available very quickly so that when patients saw doctors, their results were up to date. This meant that decisions made by doctors about changes in treatment were based on very up-to-date blood results.

Access and flow

- The 'did not attend' rate for York Hospital was about 4%. This is better than the England average of about 7%.
- Eighteen week referral-to-treatment times for non-admitted patients were better than the England average from March 2014 to October 2014. The trust was better than the England standard from March 2013 to October 2014.
- Eighteen week referral-to-treatment times for incomplete pathways were better than the England standard of 92% from September 2013 to October 2014. The standard states that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral.
- Since April 2013, the trust had fallen below the England average for percentage of people seen by a specialist within 2 weeks of an urgent GP referral for suspected cancer.
- Since April 2013 the trust achieved better than the England average for percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers other than in October, November and December 2013, when performance dipped. As of July 2014, the trust was better than the England average.
- Since April 2013 the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for cancer was better than the England average.
- The waiting times for patients waiting longer than six weeks for a diagnostic appointment at the trust fluctuated between 0.5% and 3.5% between March 2013 and November 2014. The trust waiting times mirrored the England average waiting times for this period.
- The trust did not routinely collect information about the average waiting time for patients once they had arrived at outpatients clinics but before they were called in to their appointment. This meant there was no data on delays experienced by patients once in clinics and the reasons for the delay.
- Staff told us that there was always capacity in clinics to see patients who were referred urgently and that double-booking two patients into one clinic slot

happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore it is not quantifiable.
- On the day of our visit patients with appointment times in the radiology department were not left waiting for long periods of time.
- Patients arriving from outpatients clinics and inpatients were booked into time slots within the departments on an as-required basis and according to the acuity of the referral.

Meeting people's individual needs

- Staff told us that they were able to access interpreting services if they needed to.
- Staff told us there was a limited supply of patient information available in different languages. They told us that they would make sure any information patients needed, for example about after care, was explained to them by the interpreter and that the patient understood.
- We saw that the outpatients and diagnostic imaging departments had leaflets for patients.
- Staff were aware of the support that was available within the trust for people with learning disabilities, if it was needed. Staff told us they would allow a patient's carer to stay with them if that was what the patient wanted.
- A number of staff gave us examples of when the learning disability team had worked with patients to help them to cope with stressful situations. For example, some patients were able to attend mock appointments and be supported by the learning disability team, who explained appointment and diagnostic processes to help to allay people's fears and phobias.
- Staff told us they were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly. Staff spoke of assessing each person as an individual and not jumping to conclusions about what support they may need.
- There was a canteen for patients to use as well as a small shop for patients to buy refreshments at the entrance to the outpatients departments.
- The departments had access to food and drinks for vulnerable patients or patients who had conditions such as diabetes. There was a system in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.
- The departments were spacious and so were able to accommodate patients in wheelchairs or who needed specialist equipment.
- Patients who were brought to the department on stretchers were accommodated in side rooms rather than left in main waiting areas. This ensured that their privacy and dignity were maintained.
- There was clear signage throughout the departments.

Learning from complaints and concerns

- There had been 93 complaints about the outpatients departments and two about the radiology department.
- The themes of the outpatient complaints were primarily relating to: all aspects of clinical treatment, appointments and attitude of staff.
- The radiology complaints related to a missed diagnosis and delay to treatment.
- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the patient advice and liaison service or make a complaint was available within waiting areas.
- Managers and staff told us that complaints and concerns were discussed at local team meetings and any learning was shared. We looked at two sets of team meeting minutes that confirmed this.
- None of the patients we spoke with had ever wanted to, or needed to, make a formal complaint. On the whole they were happy with the care they received in the departments.

Are outpatient and diagnostic imaging services well-led?

Good

Within the outpatients and diagnostic imaging departments of York Hospital, staff and managers had a vision for the future of the departments and were aware of

the risks and challenges faced. On the whole, staff felt supported by their line managers and were able to develop to improve their practice, but staff felt that general morale across the organisation was low.

There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The departments were supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments.

Vision and strategy for this service

- The departmental managers, matron and senior managers we spoke with demonstrated vision for the future of the outpatients and radiology services. They were aware of the challenges faced by the departments and the trust as a whole.
- Staff within the services were aware of the challenges faced by the organisation, for example the financial challenges faced. Most told us they were aware that there was a strategy for the trust, but were mostly interested in doing their jobs well on a daily basis.
- Radiology staff told us that there were plans to expand the department and increase capacity to meet increasing demands.

Governance, risk management and quality measurement

- There were governance arrangements in place, which staff were aware of and participated in. The departments had staff meetings where clinical governance topics were discussed.
- Staff were given feedback about incidents and lessons learned and the trust regularly produced lessons learned information that staff could access.
- The organisation had systems in place to appraise NICE guidance and ensure that any relevant guidance was put into practice.
- The radiology department held regular meetings to discuss and review any error incidents.
- Radiology reports were partly outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of outsourced radiology reports.
- We looked at the risk register for the outpatients departments at York Hospital. There were no risks recorded on the register.

Leadership of service

- Staff told us that they found the managers of the services to be approachable and supportive. All the staff we spoke with told us they were content in their role. Many staff we spoke with told us that they had worked at the hospital for many years.
- Some staff told us that the management style in the trust was negative. They told us they did not feel appreciated, were never thanked for their hard work and only ever received negative feedback about the things they had not done well.
- The line managers of the departments were seen as fair and flexible with staff.
- All of the staff were aware of the trust leadership and could access the relevant information from the intranet about how to contact senior managers.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Not all staff had annual appraisals, some told us they had not had an appraisal in the last 12 months.
- Staff were encouraged to manage their own personal development. Staff found this difficult due to the staff shortage. Staff were able to access some training and development provided by the trust, although this was not as easy as in the past because of staffing level and financial pressures. This was reflected by the low attendance rates at mandatory training.

Culture within the service

- Staff told us that the chief executive was approachable and accessible if they had any concerns.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Staff were aware of their responsibilities in relation to 'duty of candour'; to be open and honest with patients when incidents or accidents occurred and where appropriate to involve them in discussions and investigations.
- Managers told us that they felt well supported by the senior managers from the organisation.
- The radiology department had a positive 'can do' attitude with regard to patient needs.

Outpatients and diagnostic imaging

Public and staff engagement

- We saw that governance arrangements were in place and complaints and comments were discussed at team meetings.
- The outpatients departments had started to take part in the NHS Friends and Family Test, but no results were available at the time of the inspection.
- There was no specific information from the staff survey relating to the outpatients and radiology departments, however the trust as a whole performed within expectations or better than expectations in all but six elements of the 2013 national staff survey: percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff receiving health and safety training in the last 12 months; percentage of staff saying hand washing materials are always available; fairness and effectiveness of reporting errors, near misses and incidents; percentage of staff able to contribute to improvements at work; and percentage of staff having equality and diversity training in the last 12 months. All had fallen since the previous survey in 2012.

Innovation, improvement and sustainability

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

Outstanding practice and areas for improvement

Outstanding practice

- The innovative way in which central lines were monitored, which included a central line clinical pathway. The critical care unit were finalists for an Institute for Healthcare Improvement (IHI) safety award.
- The medical service had an innovative facilitating rapid elderly discharge again (FREDA) team, which provided multidisciplinary support and rehabilitation to elderly outlying patients.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The provider must ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.
- The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; nursing staff on medical and surgical wards; consultant cover within A & E; registered children's nurses on ward 17 and other appropriate clinical areas, and radiologists.
- The provider must ensure there are suitable arrangements in place for staff within the medicine and surgery, outpatient and diagnostic services to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.
- The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.
- The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16.

Action the hospital SHOULD take to improve

Urgent and Emergency services

- The provider should consider reviewing the facilities with regard to: a separate treatment area for children; access to call bells for patients in the majors treatment area and ensure that people in the waiting room could be observed by reception staff

Medicine

- The provider should review the arrangements for the allocation of patients to consultants, and the structure of medical teams and on-call arrangements, with a view to reducing inconsistency in working patterns and practice for medical team members, improving patient safety (particularly for patient outliers) and access to senior decision-making, and improving patient flow.
- The provider should review physical access to areas of the hospital for on-call medical staff.
- The provider should review access to patient information in languages other than English.
- The provider should review dedicated management time allocated to ward managers.
- The provider should consider how the high proportion of delayed transfer of care due to patients awaiting care packages in their own home (37%) or waiting for nursing home placement or availability (22.1%) could be improved.

Surgery

Outstanding practice and areas for improvement

- The provider should ensure that there is the proper and safe management of medicines including ensuring that oxygen is prescribed; medicine fridges are checked as per guidelines; learning from audits is shared with staff to identify areas for improvement.
- Discharge prescriptions for some medicines were not available when the patient left the hospital, which resulted in medicines being sent by taxi to a patient's home or the patient or relative returning to the hospital to collect them.
- The provider should further develop the integration of the surgical directorate across the hospital sites to ensure that shared protocols, guidelines and pathways of care were fully implemented

Critical care

- The provider should ensure effective plans are in place and implemented to eliminate the non-clinical delayed discharges and delayed admissions on the critical care unit.

Maternity and gynaecology

- The provider should ensure that all staff receive feedback regarding lessons learnt from incidents
- The provider should consider the provision of operating department practitioners (ODPs) within the obstetrics and gynaecology services .
- The provider should review the system for monitoring performance data within the obstetrics and gynaecology services .
- The provider should review the policies for obstetrics and gynaecology services.

Services for children and young people

- The trust should ensure that children's services have all the necessary individual risk assessment tools in place so that members of staff can conduct a robust, individualised risk assessment when a need for this is indicated during the initial nursing assessment of a child's or young person's admission and stay.

End of life care

- The provider should agree a consistent process for recording mental capacity assessments when making DNA CPR decisions, whether on the trust's mental capacity assessment form, or within the patient's notes. There needs to be consistent, clearly recorded information regarding the patient's ability to understand, retain and weigh the information specific to DNA CPR.
- The provider should develop the use of pain assessment tools, particularly for patients who may have difficulty in expressing their pain verbally and who are on end of life care pathways.
- The provider should ensure there is a mechanism in use to monitor achievement of a person's preferred place of death.

Outpatients and Diagnostics

- The trust should ensure that it consults and receives regular advice and reporting from its radiation protection adviser to comply with the Ionising Radiations Regulations 1999 (IRR99).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) Staffing, Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. We found that the Trust did not always protect patients from unsafe or inappropriate care as not all staff had received mandatory training. 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 provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) Staffing, HSCA 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

We found that the Trust did not always have sufficient numbers of skilled and experienced staff deployed to meet the needs of patients.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels; especially consultant cover within A & E; registered children's nurses on ward 17 and other appropriate clinical areas, and radiologists.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1), (2)((i) and (2)(ii) Safe care and treatment HSCA 2008 (Regulated Activities) Regulations 2014.

We found that the Trust was not always providing care and treatment in a safe way. It was not protecting patients from the risks of delayed treatment and care as patients were not having an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department. The trust was not achieving the national targets for A&E, referral-to-treatment time targets, and of cancer waiting times.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 9(1)(b)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1), (2)((i) and (2)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.

The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10(2)(a) Dignity and respect, HSCA 2008 (Regulated Activities) Regulations 2014

We found that the Trust was not maintaining patients' privacy and dignity as male and female patients were being cared for in the same bay in the nursing enhanced unit based on ward 16 and patients we spoke with had raised concerns about this.

This was in breach of regulation 17 (i)(a) & (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16.