

# Bradford Teaching Hospitals NHS Foundation Trust

## Bradford Royal Infirmary










### Quality Report

Duckworth Lane  
Bradford  
West Yorkshire  
Tel: 01274 542200  
Website: [www.bradfordhospitals.nhs.uk](http://www.bradfordhospitals.nhs.uk)

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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 (including older people's care) | Requires improvement |  |
| Surgery                                      | Good                 |  |
| Critical care                                | Good                 |  |
| Maternity and gynaecology                    | Good                 |  |
| Services for children and young people       | Requires improvement |  |
| End of life care                             | Good                 |  |
| Outpatients and diagnostic imaging           | Requires improvement |  |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Bradford Teaching Hospitals NHS Trust is an integrated trust, which provides acute and community health services. The trust serves a population of around 500,000 people in the Bradford and surrounding area. The trust operates acute services in Bradford Royal Infirmary and St Luke's Hospital. The trust has three community hospitals; Eccleshill, Westbourne Green and Westwood Park. Eccleshill Hospital was closed at the time of the inspection. In total the trust has around 900 beds and employs approximately 5,500 members of staff.

We carried out a follow up inspection of the trust from 11-13 January 2016. This was in response to a previous inspection conducted as part of our comprehensive inspection programme in October 2014. In addition, an unannounced inspection was carried out on 26 January 2016.

Follow up inspections do not always look at every service the trust provides. They focus on the areas identified as requiring improvement in the previous inspection and any areas of concern identified in the time since the last inspection. In addition, not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

At the comprehensive inspection in October 2014 we found the trust was in breach of regulations relating to care and welfare of people, assessing and monitoring the quality of the service, cleanliness and infection control, safety, availability and suitability of equipment and premises, respecting and involving service users and staffing. We issued a number of notices which required the trust to develop an action plan for how they would comply with the regulations where breaches had been found. We reviewed the trust's progress against the action plan during this follow-up inspection.

Overall, we rated Bradford Royal Infirmary as requires improvement at this inspection.

Our key findings were as follows:

- We found that there had been improvements in some of the services and this had resulted in a positive change in the overall ratings from the previous CQC inspection, notably in critical care and outpatients and diagnostic imaging.
- However, the ratings remained the same in accident and emergency, surgery, medicine and children's and young people's services. This was because we either did not see significant improvement since our previous inspection or because we identified new areas of concern.
- In relation to outpatient services, the trust had taken the necessary steps to ensure that the backlog of over 250,000 non-referral to treatment patient pathways had been clinically reviewed and actions taken to reduce risks to patients, including prioritising appointments and the assessment of potential harm. An improvement plan had been developed and systems and processes had been changed. The trust had revised executive, clinical and managerial leadership arrangements for outpatients and invested in additional administrative staff and a rolling programme of staff training.
- However, the new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems and processes. There were still a large number of patients waiting for outpatient appointments and there was a downward trend in referral to treatment times, which could delay access to treatment.
- The trust had taken action to address the staffing concerns identified in our previous inspection. The trust had introduced integrated patient acuity monitoring systems to assess patient acuity and staffing levels on a daily basis. Staffing levels were assessed in daily matron huddles that were led by the head of nursing and staffing levels were risk rated and monitored by the chief nurse. Nurse staffing levels had been reviewed across the trust and in December 2015 the Board of Directors had approved a £2.5million spend on staffing.

# Summary of findings

- However, we found that there were significant nurse staffing shortages in urgent and emergency services, medicine, surgery, and services for children and young people.
- Governance and assurance arrangements had been reviewed since the last inspection. However, we found that they were not robust enough to identify issues relating to, for example, medicines storage and reconciliation, issues relating to the availability of portable oxygen cylinders on resuscitation trolleys and gaps in records in urgent and emergency services. This was of particular concern because we identified these issues in the comprehensive inspection in 2014 and the trust had an action plan in place to address them. We wrote to the trust to ask for information about how they would address our concerns. The trust has provided us with assurance that our concerns would be addressed promptly and we have seen evidence that medicines reconciliation rates are now above the trust's target and that action has been taken to ensure that portable oxygen cylinders are available. The trust has a robust plan to improve the quality of records in the urgent and emergency service.
- Our previous concerns about the safety of children who were cared for in the stabilisation room pending transfer out of the hospital had largely been addressed. There were suitably qualified and trained staff to support critically ill children until the paediatric transfer team arrived. The service had been reviewed by the Royal College of Paediatrics and Child Health in August 2015 and an action plan had been developed to address the recommendations made in this report.
- Our previous concerns about the care of patients requiring non-invasive ventilation (NIV) had been addressed. Patients requiring NIV were now grouped together in the respiratory unit on ward 23 and the service was compliant with British Thoracic Society Standards.
- The trust had invested significantly in the estate and the environment. This included building a new hospital wing at the Bradford Royal Infirmary site, which was due to open around November 2016. Paediatric and critical care services would be relocated to the new wing, along with a new care of the elderly ward. The new wing would address many of the issues with the hospital environment identified in the previous inspection and the trust had commenced a full condition survey of the remaining estate. The trust was also in the process of redeveloping the accident and emergency department and gastroenterology.
- In the interim, the trust had taken action to address some of the issues with the environment, particularly in critical care. However, wards 7, 9 and 15 remained very cramped with limited space around beds. We were concerned that in an emergency situation this would present a challenge.
- There was a dedicated infection prevention and control team with arrangements in place to prevent the spread of infection. However, we observed staff not following infection prevention and control practices on a number of occasions. The MRSA, MSSA and C-difficile rates for the trust were above the England average for the period August 2014 to August 2015.
- Policies and procedures were not always up-to-date. We saw policies and procedures that were past their review date and in critical care some of the policies we looked at did not refer to current guidance and standards. Staff in urgent and emergency services were unable to provide us with records to support patient group directives (PGDs), which allowed nurses to administer certain drugs.
- The trust used the five steps to safer surgery process in the operating theatres to improve patient safety and reduce the risk of clinical incidents. The five steps included the use of the World Health Organisation surgical safety checklist. However, we observed patients receiving surgery when the surgical safety checklist process had not been followed fully. This meant there was a risk that safety issues might not be identified before a procedure took place.
- Confidential patient information was not always stored securely. In urgent and emergency services, we had concerns about the security of patient identifiable information relating to victims of domestic violence.

We saw several areas of outstanding practice including:

- The trust was collaborating with another local trust to work towards recruiting and retaining a workforce that reflected the 35% black, Asian and minority ethnic (BAME) population in the Bradford area. Between June 2014 and September 2015, the trust had improved the BAME representation on the trust Board of Directors from 0% to 29%.

# Summary of findings

- The trust was leading the “Well North” programme, which was a collaborative programme aimed at improving the health of some of the poorest communities in the most deprived areas in the North of England.
- The Bradford, Airedale, Wharfedale and Craven Managed Clinical Network for Specialist Palliative Care had won the British Medical Journal “Palliative Care Team of the Year” award in 2015.
- The trust had performed better than the England average for all indicators in the 2015 Hip Fracture Audit.

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

Importantly, the trust must:

- Ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and the cleaning of equipment.
- Review and risk assess the environment on ward 24 and put in place actions to mitigate the risk of the spread of infection.
- Ensure that the use of PGDs in accident and emergency is in-line with trust policy.
- Ensure that relevant staff working in surgery complies with the five steps to safer surgery process and that the WHO surgical safety checklist is consistently followed.
- Ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to ensure that patients are protected from the risks of delayed treatment and care.
- Ensure that robust arrangements are in place to ensure that policies and procedures (including local rules in diagnostics) are reviewed and updated.
- Ensure that patient information is held securely and patient confidentiality is maintained in relation to information about victims of domestic abuse in accident and emergency and the storage of property bags for deceased patients.
- Ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified assessed and managed.
- Ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed.
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients’ dependency levels.
- Ensure that all staff have completed mandatory training, role specific training and had an annual appraisal.

In addition the trust should:

- Review use of the public address system in accident and emergency to ensure that patients are aware that they are being called and where they should go.
- Review the signage to the accident and emergency department within the hospital grounds to ensure that the department is clearly signposted.
- Improve assessment facilities for patients admitted into accident and emergency with mental health concerns.
- Review the arrival to initial assessment times in accident and emergency to ensure that patients are reviewed in a timely manner.
- Risk assess the isolation facilities in accident and emergency to ensure that they meet current infection control standards.
- Ensure cramped single rooms on wards 7, 9 and 15 are risk assessed to inform staff of the procedure in an emergency situation.
- Review and monitor the demand for the outreach service to ensure the needs of deteriorating patients out of hours are met.
- Review pharmacy cover against the Core Standards for Intensive Care Units (2013) (Pharmacy cover guidelines) which states that there should be at least 0.1 whole time equivalent specialist pharmacist for each single Level 3 bed and for every two Level 2 beds.

# Summary of findings

- Complete a review of unmet demand for beds which was identified as an action from the previous inspection and quality key indicators reports.
- Ensure that the amount of epidural waste destroyed is recorded, in-line with best practice.
- In maternity, the trust should ensure that PAT testing of electrical equipment takes place and is recorded.
- Consider having a policy regarding the use, monitoring and security of the baby milk refrigerators.
- Address the environmental issues on ward 2 to ensure patients and families have privacy and their dignity is respected.
- Review the practice of transferring patients from theatre to recovery with endotracheal tubes in place without any monitoring to ensure that any risks to patients are minimised.
- Ensure that staff in surgery and theatres understand the definition of a serious incident and a never event.
- Review ward 12 to ensure that patients are cared for by staff with appropriate skills and experience.
- Review the availability of play facilities for children.
- Review nurse staffing levels in services for children and young people to increase the availability of a senior staff member to provide clinical support and leadership to junior staff.
- Review the use of interpreters in outpatients and diagnostics to ensure that patients' privacy is maintained.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement

### Rating



### Why have we given this rating?

We rated this service as requires improvement because we found that although there had been some improvements since the comprehensive inspection in October 2014, sufficient progress had not been made or sustained to change this rating. Specific concerns raised in 2014 had on the whole been addressed. However, in a number of areas changes had not led to sustained improvement and we found checking systems had not been embedded to alert staff to risk, such as inconsistent checks on equipment. Areas still in need of improvement included infection prevention and control and waiting times for patients. There was a plan in place for a new emergency department to open in autumn 2016, which was expected to address some of the concerns raised at the previous inspection.

During this inspection we had significant concerns about record keeping and the management and storage of medicines. We brought this to the attention of the trust who took immediate action to address safety concerns raised. A lack of specialist cubicles for infectious patients and mental health patients continued to put patients at risk. Some patients were still experiencing long waiting times for assessment and treatment. Privacy and dignity of patients was not adequately protected at all times.

#### Medical care (including older people's care)

Requires improvement



Overall we rated medical services as requires improvement, as we still identified areas of concern in safe, effective and well-led. Whilst we did find improvements within medical services we were not sufficiently assured and the evidence did not support a change in rating because:

- We observed infection control practice not in line with policy.
- The ward environment in some areas was still a concern, notably ward 7, 9, 15 and 24.

# Summary of findings

- Fridge temperatures were not always within acceptable limits so we were not assured medicines were being stored at the appropriate temperature.
- Mandatory training figures remained below the trust target.
- We were not assured the hyper acute stroke unit had sufficient staff to care for five patients.
- Some policies and clinical guidelines were past the date for review and lacked version control and an author.
- The risk register had a number of risks past the review date.

## However:

- The management of patients requiring non-invasive ventilation had significantly improved.
- There was an improved culture in relation to reporting and sharing learning from incidents.
- We saw evidence of good multi-disciplinary working within the areas we visited.
- Staff demonstrated a good knowledge of safeguarding.
- The nutrition and hydration needs of patients were recognised and well managed and documented.
- The management team had become more cohesive and demonstrated an understanding of the challenges to providing quality care to their patients.

There had been a focus on staff engagement and this was noted from the staff we spoke with.

## Surgery

Good



We rated this service as good overall. There were arrangements in place for reporting incidents which might affect the quality and safety of patient care. Most staff we spoke with knew how to report incidents. But we found inconsistencies in theatres about reporting and learning from incidents. Some staff were unaware of national definitions of serious incidents including never events despite the trust's investigation into two never events which had occurred recently. Staff in this service were below the trust's target for completion of mandatory training. 48% of staff requiring Level 3 children's safeguarding had

# Summary of findings

completed the necessary training and 68% of eligible staff had completed Level 2 children's safeguarding training. Mandatory training for some groups of staff in medicines administration, adult basic life support and blood transfusion were below the targets set by the trust.

The number of hours worked by nursing staff were below planned levels on nine surgical wards.

A small number of surgical procedures were carried out under general anaesthetic in a theatre at the end of ward 14. The theatre was located on the floor below the main nucleus theatre complex. We were concerned about the remoteness of this theatre suite. The trust had developed a policy to ensure surgery could be performed safely in this theatre, including emergencies. However, neither staff in nucleus theatres or on ward 14 were aware of the procedures which should be followed. Staff in theatres and on the ward were unaware of who was responsible for the theatre.

There was wide variation between surgical specialties and theatre suites for the levels of mandatory training completed.

The trust used the five steps to safer surgery process in the operating theatres to improve patient safety and reduce the risk of clinical incidents. The five steps included the use of the World Health Organisation (WHO) surgical safety checklist. The process requires that a checklist is completed for every patient undergoing a surgical procedure. However, we observed patients receiving surgery where the sign in process did not take place. This meant there was a risk that safety issues might not be identified before a procedure took place. Patient records were well maintained. Information was clear and patients' needs were well documented. Records were audited to check the early warning system for deteriorating patients was carried out correctly and information about patients' medicines was accurately recorded.

## Critical care

Good



We rated this service as good overall. We found the relationships within the unit had improved. Senior managers now attended team meetings and were more visible on the wards. Governance structures were still not embedded and clinical leads had only recently come into post.



# Summary of findings

Staffing was adequate to meet patient needs and medical staff now worked one week in seven on ICU, in-line with national standards. Nursing staff had access to critical care training at the local university. Following the previous inspection we found that the service had reviewed the ward area and redesigned access to the sinks to improve infection control. The service planned to move the four HDU beds from a bay on a ward to a larger area which would allow patients to be cared for in a more suitable environment.

The capacity of the service to meet demand remained an issue. The bed occupancy for the unit was about 92% and patients were sometimes being cared for in recovery in the nucleus theatre because there was not a bed available on ICU. It was unclear if the new unit would be sufficient to reduce the occupancy rates because the number of ICU beds was not being increased. There had been no review of unmet demand for beds, which was identified as an action from the previous inspection and quality key indicators reports. The service was still not seeing all patients within 12 hours of admission although improvements had been made and processes put in place to mitigate the risk.

Patient outcomes information was not always completed and audits from patient outcomes were not always available. However the service did complete Intensive Care National Audit and Research Centre (ICNARC) data and it was used to benchmark against similar organisations. The service had not reviewed policies and procedures to ensure they adhered to professional standards and guidelines.

Delayed discharges of over four hours still occurred. However, the number of delayed discharges of over four hours had reduced since the last inspection and delayed discharges were better than similar units. Quicker discharges were facilitated by staff attending bed meetings to discuss discharges from ICU.

## Maternity and gynaecology

Good



We rated this service as good overall. We rated safety as requires improvement. Staffing levels and skill mix had improved since our previous inspection in October 2014. However, further planned recruitment was to take place and staff

# Summary of findings

had not yet experienced the full benefit of the recruitment made towards the end of last year. Nurse staffing shortfalls continued for the labour ward, theatres and staff continued to cover shortages on the labour ward.

At the previous inspection, the morning staff handover consisted of four separate staff handovers, followed by a ward round. The arrangements were not always effectively managed, which at times resulted in overlap between teams and some delays. Since that inspection, the handover process had been reviewed. The changes were to reduce the lengthy process and improve the handover period. We found staff had not always checked the resuscitation equipment daily to ensure it was available in an emergency. This was also identified at the previous inspection.

Daily checks of medicines and infant milk storage refrigerators were not taking place. This meant staff would not know if the medication or milk products had been stored within the correct temperature range and remained safe to use.

Although the overall figures for completion of mandatory training had improved, the individual figures for basic life support and movement and handling training were below the trust target of 95%.

There were effective systems for reporting, investigating and acting on adverse events and there was an up to date incident reporting and investigation policy. Staff were able to give examples of feedback received from incidents, lessons learnt and action taken where appropriate, to prevent a similar situation occurring.

The consultant obstetricians cover for the labour ward had increased, from 60 to 98 hours per week since the last inspection. This complied with the Royal College of Obstetricians and Gynaecologists (RCOG) best practice standard for consultant labour ward cover.

Women's services were clean, well maintained and there were effective systems in place to monitor infection control.

Records relating to women's care were of a good standard and stored securely in line with the data protection policy.

# Summary of findings

## Services for children and young people

### Requires improvement



We rated this service as requires improvement. There had been recent increases in staffing to account for winter pressures and the need for staff to attend the paediatric stabilisation unit. However, nurse staffing was below recommended levels. However, there were still frequent staff shortages for shifts across the service. At times staff levels did not achieve 85% of shifts filled.

The trust was progressing in the development of a new building which would address the concerns about the environment in which children were cared for.

The trust had addressed the safety concerns raised about the paediatric stabilisation unit during the comprehensive inspection in October 2014. There were suitably qualified and trained staff to support critically ill children until the paediatric transfer team arrived.

The service had undergone a change to leadership and management structure. The trust had established a children's board and there were clear governance structures to report to the Trust Board. The trust had engaged with staff and the public to contribute to the design of the building to create an environment which was reflective of the needs of local children and families.

## End of life care

### Good



We rated this service as good because people at the end of their life were cared for within the hospital by ward staff, who were supported by a hospital specialist palliative care team. This team worked closely to the national Gold Standards Framework to ensure that patients experienced a good quality of care at the end of their life. The team was supported by a consultant in palliative care medicine ensuring that appropriate and timely advice was available to staff across the wards and district. In addition, patients and their relatives had access to support through the 'Gold Line' a telephone service, available 24 hours a day, seven days a week.

Care was arranged to meet the needs of the individual and to ensure where possible that people were able to spend the end of their life in their preferred place of death. There were systems and arrangements in place to ensure that people's

# Summary of findings

diverse needs were respected and supported. There was collaborative working across multi-disciplinary teams and other agencies to ensure that patients with cultural, religious and special needs such as a learning disability were incorporated into their individual care packages.

## Outpatients and diagnostic imaging

### Requires improvement



We rated the service as requires improvement. We found that a great deal of work had been undertaken to improve the arrangements for booking appointments, addressing concerns over the identified backlog with outpatient appointments and develop assurance mechanisms. However, the new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems and processes. A programme of training and development had been introduced as part of the improvement plan to establish the centralised patient booking service. This was work in progress at the time of this inspection.

We found that there were systems and processes in place for incident reporting and learning from incidents.

There were staff shortages across outpatients and diagnostic and imaging services, with some specialities particularly impacted at times such as dermatology clinics. There were arrangements in place to assess whether staffing levels were safe, access support through agency or locums and from colleagues in other clinics.

There had been a reduction in the number of patients waiting on the total RTT waiting lists and in particular the backlogs identified in August 2014 and April 2015. However, there were still a large number of patients waiting for appointments, which could delay access to treatment.

There were times when there were delays in accessing interpreting services and on occasion patients' relatives were translating questions, which may not have been appropriate or protecting patient privacy.

# Bradford Royal Infirmary

## 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

# Detailed findings

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## Background to Bradford Royal Infirmary

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

The hospital provided a full range of hospital services including an emergency department, general and specialist medicine, general and specialist surgery, intensive and high dependency care, paediatrics and maternity care. The hospital had approximately 810 beds.

The health of people in Bradford is generally worse than the England average. Deprivation is higher than average and around 23.9% (29,225) of children live in poverty. Life

expectancy for both women and men is lower than the England average. The Bradford area has a higher than average proportion of the population who are under 16 years old. The black, Asian and minority ethnic (BAME) population is higher than the England average, with 32.7% BAME residents compared to an England average of 14.6%.

We carried out a follow-up inspection of the trust on 11-13 January 2016 in response to a previous inspection conducted as part of our comprehensive inspection programme of the Bradford Teaching Hospitals NHS Foundation Trust in October 2014.

## Our inspection team

Our inspection team was led by:

**Chair:** Christopher Tibbs, Medical Director, Royal Surrey County Hospital

**Head of Hospital Inspections:** Julie Walton, Care Quality Commission

The team included CQC inspectors, a pharmacist inspector and a variety of specialists including a

consultant surgeon, a medical consultant, senior nurses, including a children's nurse, executive directors and a safeguarding lead. We were supported by an expert by experience who had personal experience of using or caring for someone who used the type of service we were inspecting.

# Detailed findings

## How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

However, as this was a focussed inspection we did not look at the whole service provision. We focussed on areas that were rated as requires improvement following the comprehensive inspection of the trust in October 2014. Therefore, not all of the five domains: safe, effective, caring, responsive and well-led were reviewed for each of the services we inspected.

Prior to the 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 group, Monitor, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations. We also held four focus groups in which we spoke to 37 people from local community groups who had experienced care and treatment provided by Bradford Teaching Hospitals NHS Trust.

We carried out the announced inspection visit between 11 and 13 January 2016. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses and midwives, consultants, allied health professionals (including physiotherapists and occupational therapists), healthcare assistants and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records of personal care and treatment.

## Facts and data about Bradford Royal Infirmary

The trust became a Foundation Trust on 1 April 2004.

The trust had a total revenue of £369 million in December 2015. Its full costs were £376 million.

The trust employed around 5,500 staff.

During 2014/15 there were 120,000 inpatient attendances, 475,000 outpatient attendances and 134,905 accident and emergency department attendances (November 2014 to November 2015).

## 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 | N/A                  | N/A    | Requires improvement | N/A                  | Requires improvement |
| Medical care                           | Requires improvement | Requires improvement | N/A    | N/A                  | Requires improvement | Requires improvement |
| Surgery                                | Requires improvement | N/A                  | N/A    | N/A                  | N/A                  | Good                 |
| Critical care                          | Good                 | Good                 | N/A    | Good                 | Requires improvement | Good                 |
| Maternity and gynaecology              | Requires improvement | N/A                  | N/A    | N/A                  | N/A                  | Good                 |
| Services for children and young people | Requires improvement | N/A                  | N/A    | Requires improvement | Good                 | Requires improvement |
| End of life care                       | N/A                  | N/A                  | N/A    | Good                 | N/A                  | Good                 |
| Outpatients and diagnostic imaging     | Good                 | Not rated            | N/A    | Requires improvement | Requires improvement | Requires improvement |
| 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.

2.Follow up inspections focus on the areas identified as requiring improvement in the previous inspection and

any areas of concern identified in the time since the last inspection. Therefore, at this inspection, not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.



# Urgent and emergency services

|            |                      |   |
|------------|----------------------|---|
| Safe       | Requires improvement |  |
| Responsive | Requires improvement |  |
| Overall    | Requires improvement |  |

## Information about the service

The urgent and emergency care services received 131,243 attendances last year, with around a quarter of attendances leading to an admission to the hospital. This meant that on average the department treated 360 patients daily; 25% of which were children. The department was originally built for 110,000 attendances annually. The trust had a business plan to develop a new emergency department (ED), which was planned to be ready for autumn 2016. The nearest major trauma centre was in Leeds.

The urgent and emergency services at the Bradford Royal Infirmary (BRI) had a minor injuries unit (MIU), a paediatric area and an adult area including resuscitation area and high dependency unit (HDU).

Within the children's area there were two cubicles for the treatment of minor injuries and four major cubicles, with one used primarily for the treatment of older or adolescent children. The paediatric area had a separate waiting area. Access was controlled with a locked door. There was also a dedicated paediatric bed in the resuscitation area.

The adult majors area had 18 cubicles in the main area and four cubicles used for assessment of patients who arrived by ambulance. Three of the cubicles in the main area were used for assessment and 'see and treat' services for patients who had self-presented at the department. The resuscitation area had three bays, one of which was equipped for the management of both children and adults. There were also seven HDU beds that acted as a step down from resuscitation or a step up from the major area for patients who required more intensive treatment or observation. The MIU was located within the department and had five assessment rooms and a treatment room. There was a dedicated x-ray department, which had a separate waiting area located within the ED.

We inspected this service in October 2014 and the department was found to require improvement, specifically in the areas of responsiveness and safety. During this inspection we focussed on whether improvements had been made to the safety and responsiveness of services. We spoke with 11 patients and relatives and staff of all levels and roles including those working in reception, security, nursing, medical and senior management. We observed care and treatment as well as the daily running of the department. We reviewed 30 sets of patient records and information provided by the trust.

# Urgent and emergency services

## Summary of findings

We rated ED as requires improvement because we found that although there had been some improvements since the comprehensive inspection in October 2014, sufficient progress had not been made or sustained to change this rating. Specific concerns raised in 2014 had on the whole been addressed. However, in a number of areas changes had not led to sustained improvement and we found checking systems had not been embedded to alert staff to risk, such as inconsistent checks on equipment. Areas still in need of improvement included infection prevention and control and waiting times for patients. There was a plan in place for a new ED to open in autumn 2016, which was expected to address some of the concerns raised at the previous inspection.

During this inspection we had significant concerns about record keeping and the management and storage of medicines. A lack of specialist cubicles for infectious patients and mental health patients continued to put patients at risk. Some patients were still experiencing long waiting times for assessment and treatment. Privacy and dignity of patients was not adequately protected at all times.

## Are urgent and emergency services safe?

Requires improvement



We rated safety as requires improvement because:

- Time from arrival to initial assessment was still an issue. Although the trust had taken steps to improve this some patients were still waiting a long time to be assessed. This potentially put patients at risk should they require treatment sooner than identified. We identified 15 cases out of the 30 records we examined where arrival to initial assessment exceeded the 15 minute target
- There continued to be a lack of access to isolation facilities for potentially infected patients within cubicles. Although a dedicated cubicle was used for this purpose, it was only protected by a curtain which did not reach the floor. This potentially exposed other patients and visitors to the risk of infection as bodily fluids and air born bacteria could pass this easily.
- Patient notes continued to be a concern. 16 of the 30 sets of patient records we examined had omissions. Notes observed were often incomplete, lacking key safety information and essential data such as times assessed, pain score, national early warning scores and in some cases the name of the clinician who assessed the patient. This exposed patients to the risk of avoidable harm as clinicians may not have the required information to ensure appropriate care and treatment could be given in a timely manner.
- There were a number of concerns around medicine storage, record keeping and administration which exposed patients to risk. We found examples of out of date drugs, poorly completed drug record books and the trust was unable to provide us with records to support patient group directives (PGD's) which allowed nurses to administer certain drugs.
- Nurse staffing had improved since the previous inspection but there remained vacancies. Funding had been secured for the recruitment of 11 more whole time equivalent (WTE) nurses. There continued to be high agency and bank usage to cover shortfalls.
- There was inconsistent checking of vital equipment such as resuscitation equipment and refrigerators used to store temperature dependent medications.

However, we found that:

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- Ambulance arrivals to handover times continued to consistently exceed targets.
- The previously identified issue of reception staff streaming patients on arrival had been resolved. Reception staff no longer streamed or assessed patients unless they had specific concerns which may require them to draw this to the immediate attention of nursing staff.
- The children's ED area was open throughout our inspection. We identified no concerns around the opening times of this department.
- There was effective learning from incidents.
- Cleanliness and infection control audits in relation to Methicillin-resistant Staphylococcus Aureus (MRSA) and C-difficile were completed regularly and showed positive results. Equipment was well maintained and availability was good.
- The department had effective systems in place for the safeguarding of adults and children. Training was mandatory and the majority of staff had completed this.
- Visibility of consultants and senior nursing staff was good, with staff access to senior nursing staff when required.

## Incidents

- The trust had a serious incident and never event policy, which outlined the responsibilities of the trust in managing incidents and to support staff in learning from serious incidents. This included recognising mistakes made and making changes to practice and policy to ensure these mistakes were not repeated.
- The trust had identified two serious incidents within the ED between August 2014 and July 2015. One related to a treatment delay where there was a delayed response to blood test results and one which related to a patient that was assessed in the ED and died 30 minutes after being discharged.
- The patient safety thermometer is a collection of information that allows patient harm to be measured and to be quickly compared to other health care providers. The safety thermometer for the ED reported one pressure ulcer, one fall and three catheter-acquired urinary tract infections between August 2014 and July 2015.
- Staff understood their responsibilities to raise safety concerns, and report incidents and near misses. Staff told us that they would report concerns to senior nursing staff in the first instance and then information

was recorded on the electronic incident recording system. This system was widely used throughout the NHS and was appropriate for the needs of the department.

- Where incidents had occurred, staff were involved in the investigation and findings were shared on a one to one basis. Where wider lessons had been learned, information was shared in staff handovers, meetings and via notice boards where appropriate. Staff told us they had received satisfactory feedback following reporting an incident where they had requested it. Feedback was also shared in staff meetings and handovers where appropriate. Incidents and learning were discussed in governance meetings. Findings following investigation and lessons learned were documented and this information was available to all staff.
- We found evidence of staff learning from incidents. Staff told us of recent incidents and how practice had been changed following these incidents, for example turning patients and assessing for potential pressure area support.
- A representative of the ED attended mortality and morbidity meetings when appropriate to discuss any potential learning opportunities from other directorates.
- The trust had a Duty of Candour policy in line with the requirements of the Health and Social Care Act 2014. Within each directorate, the matron was responsible for ensuring staff were aware of their duty of candour and to investigate and manage complaints on behalf of the directorate. We discussed the policy with the matron and they were able to give examples of duty of candour and how they had communicated with patients. For example, senior nursing staff told us of promptly resolving complaints by making personal contact with complainants and offering apologies.

## Cleanliness, infection control and hygiene

- The department had dedicated cleaning staff who maintained cleanliness and hygiene. There were cleaning schedules and these were completed thoroughly.
- All staff were observed as being bare below the elbows. We observed staff washing their hands between patient interactions and using alcohol hand gels, which were

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situated in various locations throughout the department. Audit results in relation to hand hygiene were displayed in the department, but no supporting evidence received from the trust.

- Cubicles were cleaned between patients by nursing staff. This included changing bedding, wiping down surfaces and domestic staff swept floors, changed bins and cleaned surfaces as required.
- Infection prevention and control training was part of mandatory training and completion rates were above target for nursing staff (98%) and medical staff (97%).
- The 2014 A&E survey identified the ED as being “about the same” as other hospitals for cleanliness.
- Audits indicated that the department had four instances of MRSA (a bacterial infection that is resistant to widely used antibiotic treatments), in the period February to July 2015. In the same period the department reported no instances of C.difficile, which is a bacterial infection that can lead to diarrhoea.
- There were no facilities to isolate patients with potentially infectious conditions in the ED. This potentially exposed patients and others to the risk of infection. . A bay in the major area was used as an isolation cubicle; however this cubicle did not have a solid door and provided no more protection than a conventional cubicle. This did not meet standards set out by Department of Health ‘Infection control in the built environment’ 2013. The trust action plan following the previous inspection indicated that by 31 December 2015 appropriate arrangements for infection prevention and control, including isolation, would be in place in the ED. We were told by senior staff that this change had not occurred due to the impending rebuild of the department that would meet the required standards.
- The curtains in the cubicles were not disposable. We were advised that these were changed when cubicles were deep cleaned or when the curtains became visibly soiled. We were told deep clean logs were kept by housekeeping staff.
- We found sharps bins were appropriately labelled and not over full. There were numerous clinical waste and domestic waste bins. These were checked and emptied regularly by housekeeping staff.
- In the paediatric area, we observed a cleaning log for the toys. Though staff said that toys were cleaned regularly, the log had not been completed fully at the time of the inspection.

## Environment and equipment

- The department consisted of five areas. The main adult’s area, the paediatric area, the MIU, the resuscitation area and the HDU. The design and layout of the department was no longer adequate for the needs of the patients attending or the staff working within the department. The trust was aware of this issue and a new department was proposed to open in autumn 2016. This new department would provide more dedicated cubicle space, more appropriate working space for staff and allow for improved access and flow of patients through the department.
- The children’s area had a separate waiting area, with a locked door (access granted by staff). There were cubicles for minor injuries and specific treatments. There was also a cubicle for older children and adolescents. Within the resuscitation room there was a dedicated bay that could be used for children or adults as required.
- Patients told us the layout of the ED was confusing, and although there were signs on walls and floors to different areas, staff told us patients often got lost or could not find specific areas, such as the MIU. This put patients at risk as delays to treatment could occur or patients may have to walk further than necessary. This was an issue identified by the previous CQC inspection.
- Equipment was well maintained. Electrical equipment we checked had current portable appliance test certificates. The ED worked closely with the hospitals clinical engineering staff to maintain and replace equipment proactively, to ensure that shortages did not occur. This was evidenced by the clinical engineering annual report, which showed effective maintenance strategies.
- Records of checks of equipment were not completed regularly. We observed two resuscitation trolleys with omissions from daily checks or incomplete checks.
- We found that the provision of portable oxygen with the resuscitation trolleys was not consistent with Resuscitation Council 2015 guidance which states that portable oxygen cylinders should be stored with resuscitation equipment. We found that two resuscitation trolleys did not have portable oxygen cylinders as required.
- Senior staff told us that resuscitation equipment was checked daily and equipment that had not been checked would be checked throughout the day.

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However, the records with the trolley in the main area indicated that checks had only been carried out on 15 days in December. The records in the resuscitation area indicated that checks had only been carried out on 17 days in December and 4 days had been missed in January 2016. This contravenes item 16 in the trust's action plan which states that they will ensure there are effective systems in operation that give assurance that resuscitation equipment is checked, including appropriate records. The trust expected 100% compliance by 30 September 2015.

- There were adequate supplies of equipment and staff told us that the department was well stocked with consumables.

## Medicines

- Medicines were not stored safely and securely. There was an open cupboard of intravenous fluids in the central area next to a patient bay and the main walkway. In the MIU we found medicines and fluids were not securely stored in one of the treatment rooms, and the door had been propped open with a waste bin.
- Controlled drugs were appropriately stored with access restricted to authorised staff. However, there were omissions in controlled drug books in several instances for dosage administered. Daily balance checks were performed in line with the trust policy.
- Emergency medicines were readily available throughout the department; however recording of checks of resuscitation trolleys had not been performed regularly and in line with the trust policy for checking medicines. Medicines that we observed were in date.
- The medicines fridge in the central area was unlocked and in an open area which meant that access to medicines was not restricted to authorised staff. The nurse in charge told us that temperatures were checked daily but staff could not produce written records for any of the three fridges in the emergency department. There were also no records available for the fridge in the paediatric area. Staff were not aware and had not reported that the maximum temperature displayed on the fridge thermometer in the central area was 21°C. This indicated a fault and meant that staff were not following trust policy and national guidance in reporting this. This was putting patients at risk of receiving ineffective medicines. This was escalated to a senior nurse and pharmacy staff immediately.

- We were told that Patient Group Directions (PGDs) were in use by some nurses, but no signed copies were available in the department. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We spoke with a senior staff member who was unsure what medicines were currently covered by a PGD and could not provide us with a list of staff who were authorised to administer them by PGD. This did not meet the trust policy for PGD management.
- Hospital outpatient prescription pads were in use in the MIU and these were stored securely in line with NHS security management policies 2008.
- Within the major incident cupboard we observed a large quantity of out of date drugs in a controlled drugs cupboard, including some that had expired in January 2013. The alarm in this controlled drugs cupboard had been disabled. We found a drugs trolley which contained a variety of drugs, some of which were out of date. We found fluids that were out of date in backpacks that would be taken to the scene of major incidents. We raised these issues at the time of the inspection and the trust acted immediately and we were informed that these drugs were not used and the cupboards and drugs contained in them were condemned and were disposed of as a result of our inspection.
- Colour coded charts were available in the paediatric area and in the resuscitation area, outlining paediatric drug dosages and equations for working out dosages were also displayed.
- 78% of nursing and medical staff had completed mandatory training on the safe administration of medicines; the trust target was 95%.

## Records

- Patient records were recorded manually on paper. There were plans to introduce an electronic patient record system by the end of 2016.
- We reviewed 30 sets of patient notes including 10 paediatric patients. We found omissions from notes in four cases where the name and grade of staff member assessing patient was not recorded. Pain scores were not documented in 15 sets of notes, where the presenting complaint would make pain recording appropriate. National early warning score or clinical observations were not complete in ten sets of notes. We also found evidence of one entry completed by a



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student nurse not being countersigned by a qualified member staff. There was no record of consent requested or gained in any of the notes reviewed. Of the 30 sets of notes reviewed, 16 did not have key times recorded such as assessment time, time seen by doctor and time discharged.

- Notes were not always legible and there was a high use of acronyms and abbreviations. This could make it hard for other clinicians to review notes, and understand what had been recorded.
- Allergies were not recorded in six of the 30 patient notes reviewed. This put patients at risk because they may be administered medicines which may cause harm or not receive appropriate treatment.
- Risk assessments were not routinely recorded for falls, pressure ulcers or nutrition and hydration. Only two of the 30 records made reference to risk assessment of these areas.
- Senior staff told us that they were aware that record keeping was an issue within the department. Staff had completed mandatory training on information governance (75% of nursing staff 70% medical staff, the trust target was 95%) and an information board in the corridor outlined expected standards and responsibilities around record keeping. There was evidence of a record keeping audit, however results were not available. We were told that patient records were assessed at random and feedback was given to staff as required.
- The recording of pain scores had been identified in the trust's action plan following the previous inspection in 2014. A simple "smiley face" pain score system was printed on the front of patient records to encourage staff to document appropriately. There was a trust wide audit in place and plans to achieve 100% compliance with all patients having pain scores recorded, and where they have acute pain, a series of pain scores should be recorded. The expected completion date was 31st March 2016. Current trust wide figures identified that 92.3% of patients had a recorded pain score. Specific figures for the ED were not available.

## Safeguarding

- Systems were in place to ensure vulnerable adults and children were kept safe. Staff were aware of their responsibilities in relation to safeguarding, the processes to make referrals effectively and were confident in their knowledge of safeguarding.

- Staff completed safeguarding training at induction and this was included in mandatory training. 94% of nursing staff had completed adult safeguarding training and 96% had completed children's safeguarding. 97% of medical staff had completed adult safeguarding training and 100% had completed safeguarding for children training. Clinical staff were trained to a minimum of Level 2 for safeguarding adults. Paediatric staff were trained to Level 3 for safeguarding children. Senior staff and doctors were trained to Level 3 for adults and children.
- The department had kept a record of all patients referred to safeguarding for domestic violence. This comprised of a book, with patient identity stickers, and a hand written overview of the issue. We raised concerns regarding this with the nurse in charge, as this contravened data protection laws in relation to holding information for longer than necessary and security of that data. We were advised that this data was collected so that electronic records could be updated to flag potential victims of domestic abuse. We raised this with a senior nurse, who informed us that the member of staff responsible for this no longer worked for the trust. We queried why data was still being collected and were informed by the senior nurse that someone else may take over the role.

## Mandatory training

- Mandatory training covered a variety of safety systems, processes and practices. Some areas such as manual handling and safeguarding were provided to all staff. Some staff also completed role specific mandatory training such as medicines management.
- Trust mandatory training rates had a target of 95% compliance across all areas for all staff (clinical and non-clinical). ED nurse training rates were below target in all areas except infection prevention and control (98%) and safeguarding children (96%). ED medical staff were below target in all areas except safeguarding adults (97%), safeguarding children (100%) and infection control (97%). We discussed these figures with senior staff and were advised that staff were expected to be at 100% compliance by April 2016. Some of the lowest areas of training compliance included conflict resolution (38% for nursing staff) and adult basic life support (31% for medical staff, 65% for nursing staff).
- Mandatory training comprised of face to face sessions and e-learning packages. Staff were supported in

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accessing face to face sessions and were able to record training needs and subscribe to courses in advance by a booking sheet on a notice board that highlighted available course dates. Staff told us that E-learning was completed in their own time and that access to computers could be challenging.

## Assessing and responding to patient risk

- The previous inspection in 2014 identified that when the department was busy, reception staff were streaming patients to particular treatment areas depending on their presenting complaint. This practice was reported as being unsafe by the CQC. At this inspection we found that reception staff were no longer streaming patients. All patients reporting to reception were now assessed by a triage nurse or doctor, unless they were less than 16 years of age, in which case they were seen in the paediatric area. Where reception staff had particular concerns about a patient's condition, they could contact the triage nurse or staff in the main area for immediate assessment. However, reception staff told us that often contacting nursing staff was difficult as assessment staff rarely left the assessment cubicles, phones would often not be answered and at night, when there was only one member of reception staff on duty, they could not leave the desk to speak to staff face to face.
- Patients presenting at reception were streamed by a triage nurse or doctors in three cubicles. They would then be directed to the appropriate area of the department.
- Patients arriving by ambulance were assessed by a separate triage nurse in one of four cubicles dedicated for this purpose.
- In patient records examined, we found in 15 of 30 cases, patients were assessed within the 15 minutes of arrival national standard. This meant that only 50% of the 30 cases looked at were assessed promptly.
- The national early warning score (NEWS, a simple system of scoring clinical observations to provide a single number that indicates a patient's clinical state) was used throughout the department. The paediatric area used a modified version, the paediatric advanced warning score (PAWS, a simple system of scoring clinical observations to provide a single number that indicates a patient's clinical state, that has been adjusted to take into account the physiological difference of children to adults.). In 10 of 30 patient records reviewed, early warning scores were not recorded.
- Where a patient deteriorated or required more intensive treatment they were transferred to the high dependency unit (HDU) or resuscitation areas where they received more focussed treatment and monitoring. Staff were unable to identify specific criteria for transfer to these areas, but stated that they would discuss the patient's suitability with the clinician in charge.
- The ED ran the Bradford Rapid Assessment and Treatment Service (BRATS) during the afternoon and evening periods offering assessment and treatment by a senior doctor for patients that presented with conditions that could have been managed in a primary care setting, for example, urinary tract infections. The trust had plans to employ general practitioners to further support this role in the future.
- Robust clinical deterioration plans were in place. Where patients were deteriorating or felt to be at risk of deteriorating, they would be transferred to either the HDU area or the resuscitation room. These areas were able to provide more intensive treatment and monitoring. Staff recorded NEWS scores to indicate trends within clinical observations and identify quickly patients that were at a higher risk. Within the paediatric area, deteriorating children were monitored closely in two bays, or if more intensive care was required they were treated in the paediatric bay of the resuscitation area.
- The department did not have a clinical decisions unit, and patients that required further treatment, assessment or diagnostic testing were admitted, either to a specialism or to the medical admissions unit.
- When patients were being transferred for diagnostic testing, for example to x-ray or CT they were escorted by nursing staff, healthcare assistants or a doctor led team, dependent on their needs. Those who were mobile and able to support themselves were not routinely escorted as staff in diagnostic areas were able to provide care as required.

## Nursing staffing

- Planned and actual staffing levels were displayed prominently within the department. The department used an electronic rostering system that identified shortfalls in staffing. These were filled by bank workers or agency staff where possible. Staffing was between 10 and 15 registered nurses (dependent on day/time) and 3 to 5 health care assistants.

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- Despite high agency usage, the ED was often short staffed (by 58 shift periods (morning, afternoon, evening, night) in August 2015, 52 shift periods in September 2015 and 91 shift periods in October 2015). These figures included agency use. The latest data provided was for November 2015 when 60 shift periods were understaffed but the figures for this were not for the whole month.
- Agency staff completed a trust induction prior to commencing work, and priority was given to bank workers employed by the trust, who were often ED staff completing overtime shifts.
- Staff were allocated roles each day by the nurse in charge, often changing over part way through the shift. These roles reflected the skills and training of individual staff members, for example, using more experienced or qualified nurses for assessment roles.
- Nursing handovers occurred at the beginning of the morning shift and at the beginning of the night shift. Shortfalls in staffing were identified and adjustments were made as required. Handovers were organised, thorough and fully attended.
- Within the children's department there were qualified paediatric nurses on duty during the inspection. Where shortfalls occurred adult nurses were rotated into the children's area, however the staffing log did not show how often this was the case as rotas were for the whole department.
- The Royal College of Paediatrics and Child Health had reviewed paediatric stabilisation services at the trust in August 2015. The review recommended that paediatric nurse staffing was reviewed to ensure that it was in-line with requirements. The trust had developed an action plan to address this, which was being monitored by the Children and Young Peoples Trust Board.
- At the time of the inspection we were told that funding had been secured and the trust had begun recruiting 11 WTE nurses for the ED.

## Medical staffing

- The ED was a consultant led service, which had consultant presence within the department for 16 hours per day, seven days a week. Throughout the week there was at least three consultants available through the day and two consultants working each evening, one until 10pm and then on call and the second working until

midnight. At the weekend there was one consultant on from 8am until 10pm. After 10pm there are two staff identified as senior decision makers with the on call consultant for cover.

- The department had a 15 person middle grade rota which allows for two decision makers to be available throughout the night. The department also had three WTE advanced nurse practitioners who complemented the medical rota and 4.94 WTE Emergency Nurse Practitioners who provided cover for the minor injuries area of the department.
- The paediatric area of the department had 1.2 WTE consultants, 1.32 WTE staff grade practitioners and 1.0 WTE paediatric advanced nurse practitioner.
- This did not provide specific paediatric cover 24 hours a day, seven days a week. When there were no paediatric medical staff on duty the area was covered by the remaining medical staff. The trust had not provided a risk register for ED so we were unsure if this had been risk assessed.
- The department also supported three trainee advanced nurse practitioners one of whom is undertaking paediatrics as a specialism.
- Locum staff used were long term staff who had worked in the department previously, or were experienced ED doctors from other hospitals.
- Handovers occurred throughout the day as staff came on duty. There was a formal handover in the morning, the afternoon and the evening.

## Major incident awareness and training

- Staff were aware of major incident plans and had completed training on the location of equipment and the roles they would be expected to carry out. There was good documentation available in the form of cards to hand to staff, including an explanation of roles, location and who they reported to. However, the policies relating to major incident were out of date both on the intranet and printed versions available in the sister's office. The major incident plan was due for review in March 2015, the Chemical, Biological, Radiological and Nuclear (CBRN) plan was due to be reviewed in November 2012 and the burns major incident plan was due for review in September 2013.
- The major incident store was tidy, well stocked and equipment was found to be in a good state of repair. See Medication section for details of issues of out of date drugs found in this area.



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- We were told by senior nursing staff and doctors that the trust worked closely with the emergency services to ensure provision of service was up to date and effective.

## Security

- A security office was located by the entrance to the department and this was monitored 24 hours a day. Staff were able to monitor the waiting areas and corridors of the ED by closed circuit television cameras.
- Security staff were trained in restraint techniques by the police and were registered with the local authority.
- Security staff told us that they felt they were short staffed, and that as they were expected to provide security for the whole hospital, parking services and escorting nursing and medical staff across site late at night, the lack of security staff was putting staff at risk. Security staff also raised concerns regarding increased usage of agency security staff, who were not used to working in a hospital environment and were not providing the level of service expected as a result. Staff told us they had raised the issue with their management team but felt their concerns were not addressed.

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

Requires improvement



We rated responsive as requires improvement because:

- The facilities and layout within the department was no longer sufficient or appropriate for the increasing demand on the service. Concerns continued over the lack of side rooms, which limited access to isolation facilities and the layout in the reception area which did not protect people's privacy and dignity. There were plans in place to build a new department.
- A shortage of side rooms impacted on patient flow from ambulance arrivals and ambulance assessment bays were sometimes used for more than one patient when cubicles were full.
- There was a cubicle that was used for patients suffering with mental distress; however this was not a dedicated facility and mental health staff felt that this was not suitable.

- Not all patients were being assessed within 15 minutes of arrival and the time spent in the department by patients was consistently higher than the national average.
- A public address system was used to call patients for assessment. Although this was loud, it was often unclear leaving patients confused about what was announced.
- The outside of the department was well lit and sign posted, however signs to the department within the hospital grounds, for example from the car park, were not always clear.

However, we found that:

- The trust was generally meeting national 4 hour targets for admitting, discharging or transferring patients, and where the 95% target was not met, the figure was rarely below 90%.
- Patients with learning disabilities or living with dementia were managed appropriately, receiving care and support relative to their needs.
- Patient information relating to complaints was visible, available and patients were aware of how to make complaints. Complaints were investigated thoroughly and managed appropriately.
- The trust had involved other stakeholders such as commissioners in the planning of the service and in particular the design of the new department.

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

- Members of the management team told us that the department saw a high proportion of patients requiring primary care treatment (such as that available from a GP). As a result the department had recruited two GP's to work on a see and treat basis and there were plans to recruit into this role further. The out of hours GP service was based within the hospital and patients were referred to this service if appropriate. This had reduced waiting times for people with relatively minor complaints.
- Commissioners, other providers and key stakeholders had all been involved in the planning of the new department. Changes to the current layout and service provision had been discussed with the ambulance service and mental health teams to ensure needs were being met, for example in the provision of increased space for ambulance crews to transfer patients.

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- Where people's needs were not met, staff attempted to adjust practice to overcome this. For example, there had been a complaint made relating to communication between staff and patients. Staff were now checking with patients if they understood what they had been told and if they had any questions. We were told by nursing staff and doctors that patients who frequently attended the unit were often seen and assessed quickly by doctors where the patient's history indicated that the presenting complaint was normal for the patient.
- The facilities and premises were no longer appropriate for services offered. They were not meeting the needs of the population due to the increasing number of attendances. This had been addressed in the plan for the new department and an increase in capacity was expected to ease congestion.
- A specific cubicle was used for the treatment of patients with mental health problems. The area had been risk assessed and was appropriate for its purpose. However the area was enclosed by a curtain which did not provide much privacy. Mental health staff were based in the department within office hours and a crisis team was available out of hours. Mental health and nursing staff told us that this service had improved dramatically since the last inspection. We were told that response times were improved.
- The waiting area had adequate seating provision, however seats were close together so many patients left a spare seat between themselves and the next patient to avoid invading personal space. Many patients were observed standing, waiting in the corridor or moving around the department. This made it hard to keep track of patients and security staff told us they had been used to locate missing patients.
- The department operated a virtual ward for patients who were well enough to be discharged but were waiting for test results or would require follow up. Guidelines were in place to ensure only suitable patients were referred to this service. Care plans were created and agreed with patients prior to discharge.
- The department worked closely with social services, substance misuse services and homeless services in developing care plans for patients where appropriate. Known risks were identified and managed appropriately to ensure referral to these services was safe and effective.
- Where a patient's first language was not English, the department was able to provide a telephone translation service. The population in Bradford city is diverse and the hospital workforce reflected this. We were told that, where available, a member of staff who spoke a patient's language would be used to assist with translation. Many patients brought a family member or friend to translate; however staff in the ED were discouraged from using them to ensure information from the patient was accurate and confidentiality was maintained as much as possible.
- Patient information leaflets were not available in other languages. This was considered impractical and excessively expensive due to the variety of languages spoken in the area. The department had decided to use a telephone interpretation service to read leaflets to patients.
- Staff made every effort to accommodate the needs of people, for example helping patients to a room where they could pray. Staff told us they were proud to provide a service that was not discriminatory in any way.
- Staff told us they were aware and considerate of the needs of different religions and cultures. A member of staff told us of advice they had given to colleagues to help patients who had been fasting during Ramadan and become unwell.
- Where patients had complex needs, such as living with dementia, the department had a pathway of care, whereby a patient could be managed in a way that took into account their specific needs. Dementia boxes were available which contained items that may be familiar to patients and advice on caring for people living with dementia was available. Staff told us they would try to ensure the patient was seen by as few members of staff as possible, was not moved around within the department and waiting time was minimised. Patients with learning disabilities were managed in a way that was caring and reflective of individual needs, such as being seen quickly and involving patients in decision making.
- The paediatric area was decorated appropriately for children, with suitable furnishings. There were toys and games to provide distraction.
- The whole department was accessible by wheelchair. Doors were wide and there was a lowered reception desk. Hearing loops were available to assist people with hearing impairment.

## Meeting people's individual needs

# Urgent and emergency services

- Patients deemed to be in vulnerable situations were supported to access support services. Information was available in both leaflets and posters displayed throughout the department offering support with alcohol services, substance misuse and domestic violence amongst others.
- Patients told us that parking was very difficult and there was little parking near the department. The main carpark was situated on the other side of the hospital.

## Access and flow

- The department used electronic recording systems to monitor the flow of patients through the department. Staff were competent in its use and told us that it was an effective system for managing flow.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at the ED. The trust had been consistent in meeting the national 4 hour target in the period November 2014 to November 2015. The weekly average was 90.9%. The department fell below 90% on three occasions during this period and failed to meet the 95% target on 27 occasions. The percentage of patients leaving the department before being seen was in line with national averages, peaking at 3.3% in December 2013 and a low of 1.1% in January 2015.
- The total time spent in the department was consistently higher than the England average. From July 2013 to September 2015 the median waiting time had risen from 150 minutes to 165 minutes (national average peaked at 145 minutes over the same time period). In the last 12 months (September 2014 to September 2015) the total minutes in ED per patient ranged between 150 minutes and 176 minutes. At this time the England average ranged between 135-145 minutes.
- The department had done a lot of work to reduce ambulance handover times since the previous inspection. From the period of December 2014 to July 2015 there had been 6 black breaches (where the time from arrival by ambulance to hand over completion exceeds 1 hour) in the department. The average handover time was 92.54% handovers completed in fewer than 15 minutes between April 2014 and March 2015. The national target is 85%.
- During inspection we observed the flow of patients self-presenting at reception. These patients were booked in and then assessed by a nurse or doctor who decided which area within A&E they should go to (except children who were directed to the paediatric area to be assessed by nurses separately). No information was made available to patients in relation to waiting times. There was a sign displayed at reception advising patients that reception staff had no information relating to waiting times. Several patient information screens were present, but these were all turned off. On reviewing patient notes we found that of 30 patients reviewed, 10 were assessed within 15 minutes. All patients that had arrived by ambulance were seen in less than 15 minutes.
- At night there was often only one receptionist on duty, which staff told us could lead to delays in booking people in to the department.
- Reception staff told us that when a patient presented that required immediate assessment it could be difficult to get help from nursing staff. Phone calls would often take a long time to be answered and triage nurses did not leave assessment rooms to enter the waiting area.
- The assessment nurses used a public address system to call patients, however, often this was not clear and we observed patients asking at reception whose name had been called and where they were to go. We did not see the assessment nurse enter the adult waiting area or come to find an adult patient personally during the inspection. In the paediatric waiting area patients were called by nurses.
- There was a nurse dedicated to 'meet and greet' patients arriving by ambulance. A verbal handover was taken from ambulance crews and the nurse then introduced themselves to the patients and gathered more information. Observations were completed and patients were either moved into a major area cubicle, referred to the waiting area, referred to minor injuries or kept in an assessment cubicle if appropriate. When assessment cubicles were full, patients were 'doubled up' with patients sharing cubicles (this was divided between male and female.). A shortage of side rooms exacerbated this problem. The trust aimed to address with the new department, due to be completed in autumn 2016.
- Patients were assessed in arrival order. Treatment was given in order of medical priority, whereby the most urgent cases were seen first. Patients with symptoms of life threatening illness or injury were seen in the resuscitation area.

# Urgent and emergency services

## Learning from complaints and concerns

- Patients were aware of how to make complaints. Information was available in leaflet and poster form. Patients stated that they would feel comfortable raising concerns either verbally or by letter if they needed to.
- Staff were able to explain the complaints procedure, stating that they would either try to de-escalate the situation themselves, or involve a senior nurse. Staff were able to advise patients of the complaints process where a patient wanted to make a formal complaint.
- The department gathered feedback through the friends and family test, comment cards and via the NHS choices website. Senior staff addressed individual complaints made on the NHS choices website and gave feedback to the complainant and staff. Feedback via the friends and family test was limited by a low number of respondents. The ED was working to improve the response rate by utilising volunteers. Comment cards were addressed in team and governance meetings as appropriate. Where contact details were given, senior staff would contact the patient to discuss their concerns.
- Where a complaint was made, an acknowledgment letter was sent to give the complainant a named person to liaise with. This letter outlined the process and time frames and also provided further advice around making a complaint.
- We spoke with the department matron who gave examples of complaints that they had investigated, how they were managed and how favourable outcomes were reached. Complaints were handled sensitively and confidentially and concerns were respected. Complainants were initially contacted by telephone. Where this was not satisfactory a meeting could be arranged. Complainants were kept up to date with the investigation, and at conclusion the outcomes and changes made were shared with the complainant.
- Individual complaints were discussed at clinical governance meetings so that learning could be shared. This was cascaded to all staff through handovers and department meetings. The matron told us that common themes in complaints were around waiting times and communication with staff. The development of the new department was hoped to reduce waiting times. Staff communication was a regular feature in team meetings.

# Medical care (including older people's care)

|           |                      |   |
|-----------|----------------------|---|
| Safe      | Requires improvement |  |
| Effective | Requires improvement |  |
| Well-led  | Requires improvement |  |
| Overall   | Requires improvement |  |

## Information about the service

The Bradford Teaching Hospital NHS Foundation Trust provides medical care, including older peoples care across two sites. Bradford Royal Infirmary provides medical care over 12 medical wards and an ambulatory care unit. The medical wards covered many specialities including elderly medicine, elderly rehabilitation, ortho-geriatrics, cardiology, gastroenterology, respiratory medicine and stroke, including a hyper acute stroke unit.

We spoke with 11 patients and 49 staff members including the management team, doctors, nurses, specialist nurses, therapy staff, health care assistants, domestic and administration staff. We reviewed 46 sets of patient records. We visited 12 wards, the ambulatory care unit and the diabetes centre, where we observed care and the environment. We observed meals being provided to patients, nursing handover and a multidisciplinary team meeting. Prior to the inspection we reviewed the hospitals performance data.

In October 2014 the CQC carried out an announced comprehensive inspection and overall we rated medical care as requires improvement. We rated safe, effective and well-led as requires improvement, caring and responsive were rated as good.

This inspection took place on the 11, 12 and 13 January 2016 and was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection.

## Summary of findings

Overall we rated medical services as requires improvement, as we still identified areas of concern in safe, effective and well-led. Whilst we did find improvements within medical services we were not sufficiently assured and the evidence did not support a change in rating because:

- We observed infection control practice not in line with policy.
- The ward environment in some areas was still a concern, notably ward 7, 9, 15 and 24.
- Fridge temperatures were not always within acceptable limits so we were not assured medicines were being stored at the appropriate temperature.
- Mandatory training figures remained below the trust target.
- We were not assured the hyper acute stoke unit had sufficient staff to care for five patients.
- Some policies and clinical guidelines were past the date for review and lacked version control and an author.
- The risk register had a number of risks past the review date.

However,

- The management of patients requiring non-invasive ventilation had significantly improved.
- There was an improved culture in relation to reporting and sharing learning from incidents.
- We saw evidence of good multi-disciplinary working within the areas we visited.
- Staff demonstrated a good knowledge of safeguarding.
- The nutrition and hydration needs of patients were recognised and well managed and documented.

# Medical care (including older people's care)

- The management team had become more cohesive and demonstrated an understanding of the challenges to providing quality care to their patients.
- There had been a focus on staff engagement and this was noted from the staff we spoke with.

## Are medical care services safe?

Requires improvement



We rated safe as requires improvement because:

- We observed infection prevention practice which was not in line with hospital policy, including poor compliance with handwashing and the use of personal protective equipment.
- On ward 24 there was a lack of handwashing facilities and no en-suite facilities, this ward predominantly cared for patients who had infections. One portable sink had been installed at one end of the ward following the previous inspection.
- Concerns had been raised at the previous inspection over some of the ward environments, the lack of side rooms and en-suite facilities. We found wards 7, 9 and 15 remained very cramped with limited space around beds. We were concerned that in an emergency situation this would present a challenge.
- We had concerns over the low percentage of medicines being reconciled and the number of gaps in medication records, which meant that there was a risk that patients may not have been receiving the appropriate medication in a timely manner.
- The temperatures of refrigerators used for storing medication were not consistently monitored. Records showed that temperatures were out of the recommended range for some of the refrigerators. The recording sheets indicated any problems had been escalated to matrons or pharmacy, however following this there were still days when temperatures were out of range. We were therefore not assured that medications within refrigerators were always stored at the appropriate temperatures.
- Although the overall figures for completion of mandatory training had improved, the individual figures for basic life support and adults and children's safeguarding Level two were well below the trust target of 95%.
- We were not assured that there was the sufficient number of appropriately trained nursing staff to support five patients on the hyper acute stroke unit.

However, we found that:



# Medical care (including older people's care)

- The management of patients requiring non-invasive ventilation (NIV) had significantly improved; this included creating a new ward to ensure all patients requiring NIV were cared for in one area.
- The introduction of the integrated patient acuity monitoring system (IPAMS) meant staffing and acuity could be assessed on a daily basis.
- There was an improved culture in relation to incident reporting and feedback with learning from incidents taking place.
- Documentation was found to be of a good standard with risk assessments completed.

## Incidents

- Trust policies for reporting incidents, near misses and adverse events were embedded within the medical service. Incidents were reported on the trust's electronic reporting system. Staff of various roles and grades could tell us how they would report an incident and many could describe the process for a recent incident they had reported.
- The 2015 National NHS Staff Survey rated the trust at 33% for witnessing potentially harmful errors, near misses or incidents. This was higher (worse) than the national average of 31%.
- Staff reporting potentially harmful errors, near misses or incidents in the same survey was 90%, this was the same as national average of 90% and had improved from the previous year where it was reported to be 88%.
- A total of 3433 incidents were reported in medicine at Bradford Royal Infirmary between December 2014 and November 2015. Of these 74% resulted in no harm. Staff told us that the main themes from feedback on incidents were falls and pressure ulcers.
- Between December 2014 and November 2015, 21 serious incidents were reported in medicine. 12 of these were grade 3 pressure ulcers which were all reported between December 2014 and March 2015, with none reported since April 2015. This downward trend was supported by safety thermometer data from the medical division between January 2015 to November 2015, which indicated that the percentage of new pressure ulcers recorded was only between 0.6% and 1.7%.
- The previous report for this hospital had found inconsistent feedback regarding incidents and staff were not aware of feedback mechanisms. We observed the

morning safety huddles which had been introduced as a way of sharing information. These took place between the matrons and also on each ward. Any incidents from the previous day were discussed and shared with staff.

- We reviewed minutes of divisional clinical governance meetings, which showed that incidents and lessons learnt were discussed.
- We also reviewed ward meeting minutes on ward 23. These meetings were well attended and demonstrated shared learning and lessons learned from incidents. For example, there had been a recent incident requiring a root cause analysis investigation where a patient developed pressure ulcers on their ears from the oxygen tubing. Patient's ears were now specifically checked as part of skin checks, and we were told specific paperwork was being developed to monitor these pressure areas. Root cause analysis is a method of investigating how and why an incident has occurred.
- Ward 29 had the highest incidents of falls within medicine. The ward was using falls sensors in an attempt to reduce the number of falls and were working with the improvement academy to try and reduce these further. During the morning safety huddle, patients at risk of falling were identified to ensure all staff were aware of the risk. The staff told us they would group together the patients that were at high risk of falls into one bay to enable better observation. The ward was working with the improvement academy to trial an infra-red falls sensor.
- Staff on ward 9 told us that reporting and feedback from incidents had improved and this had resulted in better access for nurses to fall sensors.
- On ward 30 we saw thorough nursing documentation and reporting of pressure ulcers, with clear actions and referrals to the tissue viability nurse.
- There were no reported never events reported for Bradford Royal Infirmary medical services for 2014/2015. Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken.
- We were told mortality and morbidity was reviewed within clinical governance meetings. We reviewed minutes of these meetings across the medical specialities and found inconsistencies in the recording and reviewing of mortality and morbidity as some included discussion of mortality and morbidity and some did not. This was unchanged from our previous inspection in 2014.

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- The duty of candour regulation sets out specific requirements that providers must follow if something goes wrong with a patient's treatment or care. The regulation ensures that providers are open and transparent with people who use their services. This regulation was introduced to all NHS trusts in November 2014. Most of the staff we spoke with were aware of the duty of candour and spoke about being open and honest. There was a matron who took responsibility for governance and ensured the duty of candour requirements were met.

## Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer measures the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and urine infections to be measured on a monthly basis.
- We saw that safety thermometer data was displayed on each ward that we visited; this had not been the case on our previous inspection.
- For example the dashboard on ward 9 reported that there had been no pressure ulcers for September, October and November 2015, and ward 29 had 17 falls in November 2015. To try to reduce falls on ward 29 patients at risk of falls were grouped together to enable better observation and the ward was working with the improvement academy to trial an infra-red falls sensor.

## Cleanliness, infection control and hygiene

- From September 2014 to September 2015 there were five cases of Methicillin Resistant Staphylococcus Aureus (MRSA) infection within medicine. The trust target was zero.
- Data from the trust quality dashboard stated from September 2014 to September 2015 there were a total of 28 cases of Clostridium difficile within the medical service. Of these 17 were stated to be a result of lapses in care. Four cases from June 2015 to September 2015 were being reviewed by the Clinical Commissioning Group (CCG).
- Infection control audits took place monthly. We reviewed data from April 2015 to October 2015, which showed good compliance in areas such as hand hygiene, dress code, central venous catheters, peripheral venous catheters and urinary catheters.

- We reviewed data on ward kitchen hygiene inspections and waste services audits which looked at sharps disposal containers and the disposal of clinical waste. Any actions were noted with a time frame and a named person to take responsibility. For example damaged sealant around a sink was identified and noted to need immediate action.
- We were concerned that whilst observing infection prevention practice and staff members' use of personal protective equipment (PPE), trust policies were not always being followed. For example on ward 9 we observed a bedpan full of urine left on the toilet floor. We also saw a staff member going from bed to bed wearing the same pair of gloves. We also observed a ward round, and the six staff involved did not wash or gel their hands between patients. We also observed a doctor on a ward round who did not use hand gel between patients. On ward 6 we observed a member of staff walking around the ward still wearing PPE which had been worn when attending to a patient. On ward 30, we observed a member of staff coming in and out of an isolation room wearing PPE and then walking around the ward. This was raised with the ward manager who addressed the situation immediately.
- On ward 29 we checked two bedpans, which seemed visibly clean but had no 'I am clean' labels on them. Three of the four commodes we checked also had no 'I am clean labels'. This meant staff could not be certain that they had been cleaned after patient use.
- We looked in sluice areas and found them to be visibly clean and organised. Waste was segregated and disposed of in accordance with trust policy. PPE was available on each ward, although it was not always available outside side rooms. Alcohol gel was available at the entrance to each ward.
- An alert system was used for patients requiring isolation and instructions were on the doors, for example, "see the nurse in charge before entering".
- The wards we visited were all visibly clean and tidy. Patient-led assessments of the care environment (PLACE) were reviewed from wards 23, 24 and 29, which showed they had achieved between 97% and 100% for cleanliness.
- The ward environments presented a challenge and it had been identified on the previous inspection that there was a lack of side rooms, many of the side rooms did not have en-suite facilities and some wards did not



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have suitably placed hand washing facilities. A report to the Health and Social Care Overview and Scrutiny Committee in November 2015 identified that an additional 15 side rooms were required.

- If a patient required isolation, and there were no en-suite facilities, a commode would be used and cleaned after use. On ward 24, which is the infectious diseases ward, we observed a nurse take a commode from a room where the patient had an infection and wheel it the length of the corridor to the sluice to empty it and then brought it back to the patient's room (within approx. 2 mins). The ward sister was unable to give assurances that it had been cleaned in line with IPC policies.
- We were particularly concerned about the environment on ward 24, which had 12 single rooms, none of which were en-suite. The ward had two bathrooms, and we were told if a patient had a shower staff would then have to arrange for it to be deep cleaned. If there were several patients wishing to have a shower, some may have to wait until later in the day.
- There had been no handwashing sinks available outside of rooms on ward 24, the ward sister stated staff were advised by the infection control team that they could wash their hands in the side room and then use gel outside of the room. The staff challenged this decision and a portable sink had been installed at one end of the ward. The ward sister stated the concerns were on the risk register and they were hoping to move to another ward. We were also told that a second portable sink had been ordered. An order had been placed for more commodes, which would take the total number to nine. This meant if a number of patients required isolating there would be sufficient commodes.

## Environment and equipment

- The previous report had identified that the age and layout of some of the wards presented a challenge in meeting patient's needs. The new hospital wing was in the process of being built at the time of inspection. Within this a new dementia friendly elderly care ward was planned.
- Other wards had been relocated and refurbishment work completed. The respiratory ward had been re-located to ward 23 in February 2015. The environment allowed patients requiring non-invasive ventilation to be cared for in one area. It included a high dependency and a step down area. The high

dependency area was a little cramped and this was supported by the external review of the service. The amount of equipment required for patients on NIV and interventions needed presented a challenge if all four beds were occupied, although overall this was an improvement on previous arrangements.

- The refurbishment of the ward 1 side of the medical admissions unit had been completed, which had significantly improved the environment. The ward 4 side had yet to be completed.
- The environments on ward 7 and 15 had been on the medical risk register since March 2013 when serious concerns were raised by a national peer review team. There were plans to co-locate the two wards working closely with patients and Macmillan, the move was not expected to be until 2017. On ward 15 the environment was cramped with limited space in the bays. The ward had 20 beds and 11 bed spaces did not have piped oxygen. The ward sister stated they would use oxygen canisters that were kept in a separate locked store. The ward used a labelling system to identify which oxygen cylinders were full, half full and empty. All the oxygen cylinders were correctly labelled and 4 out of the 5 large oxygen cylinders were full.
- There had been some work to try and improve the areas, for example on ward 7 the number of beds had been reduced to 12 by reducing the double side rooms to single rooms. However, the remaining single rooms were cramped and if there was an emergency situation the limited space would present a challenge, because a number of people and the resuscitation equipment would need to be taken into the room.
- On ward 9 the bay area's felt very cramped with limited space between the beds. This was particularly noticeable at visiting times and when curtains were around a bed space when patients were being attended to. The room in which handover took place was also very small with four members of staff unable to sit down and staff having to move their seats to allow people to enter the room.
- At the time of our unannounced inspection, work had begun to increase the size of the therapy room on ward 9 and create additional office space.
- The previous report had identified a lack of side rooms with en-suite facilities and this situation had not changed. It was particularly noted on ward 24, the

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infectious diseases ward. Commodes were used on this ward as well as wards 9 and 15 when patients required isolation. The lack of en-suite facilities meant the isolation of patients was more difficult.

- The report to the health and Social Care Overview and Scrutiny Committee from November 2015 had identified that further en-suite side rooms were required and that further work had to be done to determine the exact number and how they would be created. Senior nursing staff said that the status with regards to the number of side rooms available was on a central point on the intranet and was red, amber, green (RAG) rated. They felt the number of side rooms was more of an issue when they were needed for reasons other than infection prevention, for example providing a more tranquil environment for a patient.
- We inspected the diabetes centre where the specialist nurses were based. The clinic rooms had been decorated. The office space accommodated 11 members of staff and space was extremely limited. This was on the medical risk register with the area being reviewed as part of the estates strategy and ward reconfiguration.
- Wards 29 and 30 were dementia friendly with thought and detail in the environment. We observed clear signposting, reminiscent pictures and two projectors showing films for patients to watch. We saw memory boxes placed behind patient's beds where items related to the patient were placed to help them locate their beds.
- At the previous inspection we found there were gaps in checking records of resuscitation equipment on wards 7 and 9. We reviewed checks of resuscitation equipment on eight wards, including wards 7 and 9 and the only gap was five days missed in December on ward 9.
- Resuscitation Council Guidance 2015 states portable oxygen cylinders should be available on resuscitation equipment. On ward 29 there was no portable oxygen on the trolley, we informed the ward sister who stated that the empty cylinders had been removed that morning. We visited the ward the next day and found portable oxygen in place. The oxygen cylinder on ward 3 was also empty. Portable oxygen was not available on the resuscitation trolleys on wards 1, 4, 7, and 24; this issue was raised with the trust during the inspection. On our unannounced visit portable oxygen was in place,

however the cylinder on ward 24 was empty, this could have resulted in a delay in treatment in an emergency situation. We informed the ward sister who immediately arranged for it to be replaced.

## Medicines

- The pharmacy team had the responsibility of achieving the trust target of 75% of patient medicines being reconciled. The average figure for April 2015 to September 2015 was 30.7%. Medicine reconciliation is the process of creating the most accurate list of a patient's medication to ensure what should be prescribed is prescribed.
- On each of the wards we visited the medicine trolleys were locked and secured, intravenous fluids were kept in locked rooms and medications were generally stored appropriately. The only exceptions were ward 7 where there were numerous medications left on the worktop. This was within a room which could only be accessed by a key code. On the medical admissions unit there were several tablets which had been removed from their original packaging. This meant that staff could not be certain that the medicines were safe to use.
- Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed the controlled drugs records on eight wards and on seven of these accurate records were maintained and balance checks were performed in line with the trust policy. On ward 7 balance checks of controlled drugs had not taken place since 12 September 2015. This was raised with staff at the time. At the unannounced inspection on 26 January 2016 there had been one balance check of controlled drugs on the 13 January 2016.
- We observed a medication round and the appropriate patient and medication checks were made when administering medication. Data provided by the trust showed that 94% of nursing staff in the medical division had completed training on the safe administration of medicines.
- The storage and monitoring of medicines requiring refrigeration was of concern across all wards that we visited. For example, records on ward nine showed that the temperature had been out of the normal temperature range at minus five Celsius on two days in December and no action had been taken or recorded. On the day of our visit, the thermometer showed a maximum temperature of 10.2C, which is outside of the normal range. On the medical admissions unit records

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were incomplete for eight days in December. On ward 29 records showed 14 instances of temperatures below the recommended range in December, with no evidence of any action taken. On the day of our visit, the thermometer showed a current temperature of minus 4.2C, and the contents of the fridge were frozen. We advised the nurse in charge to take those medicines out of use immediately as it was highly likely they were unsafe to use.

- We reviewed 30 medication administration records. Patients were given their medicines in a timely way, as prescribed, including pain relief. Records of administered medicines were not always completed. For example, we saw gaps in the recording of medicines administration in seven of the 30 records we reviewed. A total of 32 administrations had not been signed for. Following our inspection the trust had commenced an audit of missed doses of medications.
- On ward three we found a lack of clarity over the administration of 'when required' medicines. For example one patient had been prescribed Lorazepam (a drug used in the treatment of anxiety) but there was no indication stated on the medication record drug card as to how often it should be given and under what circumstances. A dose had been administered on 09 January 2016 at 6pm despite the nursing notes stating "settled and comfortable, no concerns at this time" at 5pm. The next entry at 9:15pm stated "pt assisted into bed". A further dose had been administered at 4pm on 08 January 2016 and there was no reason documented in either the nursing or multidisciplinary notes.
- From reviewing medication administration records we saw that oxygen was prescribed in line with the medicines policy.

## Records

- We reviewed 46 sets of records across the 12 medical wards. We found them to be completed appropriately and each contained completed risk assessments on topics such as: Malnutrition Universal Screening Tool (MUST); skin integrity; and falls.
- We found wards 23, 29 and 30 had particularly good documentation which was thoroughly completed and risk assessments reviewed and updated.
- Data for the division of medicine as a whole showed the completion of VTE risk assessments was consistently above the target of 95%.

- We observed medical notes and nursing documentation stored in trolleys with lids behind or next to the nurse's station in all the areas we visited, so they could not be accessed by the general public.
- As part of the NHS five year forward view, the trust was working towards electronic patient records to be introduced later in 2016.

## Safeguarding

- Mandatory training at the trust included adults safeguarding levels one and two, and children's safeguarding training, levels one, two and three. We reviewed data on mandatory training attendance figures in the medical division. The trust had set a target of 95% for completion of adult and children's safeguarding training. Training figures for level one adults and children's safeguarding training were 95% and 97%. However level two training for adults and children was 56% and children's safeguarding level three was 52%.
- The trust had policies relating to adult and children and young people's safeguarding and staff could access these on the intranet. Staff had a good understanding of safeguarding and their role and responsibilities within this. The level of knowledge and understanding was appropriate to the different grades of staff we spoke with. Staff knew who they could contact if further information or advice was needed, including the safeguarding team.

## Mandatory training

- The previous inspection found mandatory training figures within medicine were 60%, below the overall trust target of 75%. Data from September 2015 showed this had improved to 72%.
- The trust target for individual mandatory training courses was 95%. We reviewed data for nursing and medical staff within the medical division. The lowest (worst) figures were for basic life support and ranged from 51% to 68%. Other areas had figures ranging from 87% to 100%.
- The staff said they were up to date with their mandatory training and the 'sweeper' days which covered most aspects of mandatory training meant most training could be covered in one day.
- Mandatory training was a mix of practical sessions and e-learning. Some wards had key trainers to enable ward based training to take place, for example on ward 3 one of the staff members was a moving and handling trainer.

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## Assessing and responding to patient risk

- The national early warning score system (NEWS) was used in each ward area as a tool for identifying deteriorating patients. The documentation we reviewed across all wards areas showed accurate completion of NEWS scores and we saw evidence of raised NEWS being escalated appropriately.
- This was supported by NEWS audit data provided by the trust. The audit was conducted in seven medical wards in November 2015. Four of the wards had completed 100% of scores; one ward had scored 97% and the other 85%. We were not aware of any action plans for the wards which had not scored 100%.
- There was a critical care outreach team who would come and support ward staff if a patient was deteriorating.
- We observed good systems on ward 15 to manage potential neutropenic sepsis. There was a pathway in place for this. Day care patients were given information to check their temperature and phone the unit if they had any concerns. The senior nurse in charge assessed patients over the phone if there were any concerns over their clinical condition and could arrange to admit them directly to the ward.
- We asked staff about caring for patients who were at risk of falling as many of the wards were long and observing patients could be difficult. We were told if the patient was at high risk of falls then they would ensure the patient had their buzzer, that the bed rails were up and staff would check on the patient regularly. We saw evidence of regular checks in the nursing documentation. Staff also told us if patients required one to one supervision most of the time this could be arranged. Patients would also be 'cohort' nursed if there was a group of patients at risk of falling.
- We witnessed an emergency situation on one of the wards which did not seem well co-ordinated with no clear lead or designation of roles. There was a delay in pulling curtains round and consideration of other patient's needs. On our unannounced inspection staff spoke about this situation saying they had not expected the patient to become so unwell.
- All patients requiring non-invasive ventilation (NIV) were cared for on ward 23. The only exceptions to this were those patients on the high dependency unit or those whose cardiac problems outweighed their respiratory

problems and these patients would be on the coronary care unit (CCU). We reviewed a draft operational protocol for NIV on the CCU, which included information on admission and discharge pathways.

- All patients requiring NIV on ward 23 were under the care of a respiratory consultant and the ward had high dependency, step down and general ward areas. Staff told us these changes had unified the service and it meant that patients requiring NIV were being cared for in a designated area with the appropriately trained staff.
- The services for acute stroke for another local hospital had been transferred to Bradford Royal Infirmary in August 2015. This had been a planned change, however circumstances meant this happened much more quickly than expected. Information from the CCG commended the trust on their response and noted that there had been no adverse impact on patients requiring treatment for acute stroke during this quick transition period.

## Nursing staffing

- The integrated patient acuity monitoring system (IPAMS) was used to collect and RAG (Red, amber, green) rate staffing on the wards each day. This information was reviewed in the matrons' safety huddle each morning and plans could be made for any 'red' areas. This could include relocating staff or in extreme circumstances closing beds. This system for collecting data had been in place for two months with a view to collating and reviewing data in the future to gain an overall picture of staffing requirements.
- We reviewed staffing rotas which were produced electronically. These were well planned and took skills mix of the staff in to account. There was also the ability to change/request shifts with minimal impact on patient care.
- The most recent data provided by the trust showed 169 whole time equivalent (WTE) vacancies at band 5 to 7 within nursing and midwifery. The vacancy rate for band 5 nurses in medicine in September 2015 was 21.7% which equates to 93 WTE posts. We were told by the senior nursing team there were a number of nursing vacancies across medicine and vacancies within elderly care were particularly difficult to recruit to. This was supported by a work force report produced by the trust in August 2015. There had been attempts to address this by looking at different ways to recruit in terms of rotational posts and also the recruitment of nurses from overseas.

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- Ward 23 was one of the better staffed wards with fewer vacancies (five WTE). The ward ensured that they were always staffed as though they had the maximum number of patients on NIV so the ratio of 1:2 for patients receiving NIV was always achieved for the first 72 hours. The step down unit was staffed with a ratio of 1:4. The ward also had a staff surge (escalation plan), which we were told had been successfully implemented over the Christmas period.
- On one visit to the medical admissions unit (wards 1 and 4) and found they were short of two qualified nurses on the late shift and one on the night shift. Extra health care support workers could not be arranged so staff told us they would prioritise their workload and escalate if they had any concerns.
- Particular wards with high numbers of vacancies were Ward 3, which was the elderly assessment unit, and had 10.54 WTE staff nurse vacancies, and ward 9 which had 13.1 WTE vacancies for staff nurses. Ward 9 incorporated the hyper acute stroke unit (HASU). The British Association of Stroke Physicians (BASP) stroke services standard 3.4 (2014) states that HASU should provide sufficient trained nursing staff in the first 72 hours of an acute stroke patients admission. BASP recommend a nurse to patient ratio of 1:2.
- There were four beds and a side room in the HASU. The HASU staffing statement provided by the trust said that in the event of the fifth HASU bed opening the number of qualified staff would be raised to three. It also stated the nurse in charge and the stroke responder were supernumery (extra) to staffing numbers. We were not assured that if all beds were occupied on HASU the 1:2 ratio could be achieved. During our announced and unannounced inspection we visited the HASU on three separate days. On two of these there was only one qualified nurse in the HASU with three patients, they were being supported by the nurse in charge but they were not just based in the HASU. On the third occasion there were two nurses in HASU and two patients but three further admissions were expected with no plans in place to arrange a third qualified nurse. Each of these patients had been on the HASU for less than 72 hours meaning the 1:2 ratio was required.
- We reviewed staffing rotas for ward 9 and the HASU for an eight week period. Planned levels were not achieved with their own staff for any of these days. We also saw four days within the same time period where staffing was RAG rated. For each of these they were rated red for more than eight hours less than planned of qualified nurse hours. We also saw that on two occasions the matron was working on the ward to achieve safe staffing levels. This supported our concerns over the ability to staff five HASU beds as we could not be assured that an extra qualified nurse with the necessary skills and experience would be available. Staffing for ward 9 was on the medical risk register which acknowledged the poor uptake of recruitment in this area.
- Information on planned versus actual staffing numbers was displayed on each of the wards we visited. Actual levels were achieved in most areas. The exceptions were ward 29 which were short of one qualified nurse on the early shift and the night shift, and two qualified nurses on the late shift. These gaps had been filled with health care support workers. Ward 7 were also short of a qualified nurse on the late shift, there were no plans to cover this.
- We were told the decision for all nursing staff to work long days had a negative impact on some staff members who left the trust as they were unable to arrange childcare for such a long period of time. It also meant there was no overlap of staff, which had previously allowed managers to be released from clinical duties.
- Gaps in staffing were covered by the hospital's own temporary nurse register (bank staff) or staff working additional shifts. Data provided by the trust showed that the medical wards generally had a higher percentage use of nursing bank staff than other areas in the hospital. It was between 0.5% and 7.5% from January to March 2015 compared to the surgical wards which was between 0.4% and 3% for the same time period.
- The wards were using health care support workers to fill shifts if qualified staff could not be obtained. We visited ward 29 on two days and found gaps in the actual qualified nursing numbers, which had been filled by health care support workers. We saw data from the trust about three incidents which highlighted the reduction in registered staff to patient numbers on ward 22 as a result of staffing of the additional surge beds. They had not resulted in patient harm but the incident reports stated it had increased the risk of harm occurring and caused the nursing staff on duty to experience increased stress levels in prioritising the care delivered to the patient group.
- The Board of Directors' meeting minutes from September 2015 stated the 0.5 WTE supervisory status of band seven nurses was to be implemented from



# Medical care (including older people's care)

October 2015. We spoke with the band seven sisters on each of the wards; none of them were able to undertake supervisory work due to insufficient staffing levels. Management time was taken as and when able. Senior nursing staff told us there were plans to work towards a 50% supervisory and 50% clinical work pattern for band seven sisters in the new financial year.

- We observed the handover on ward 9, there was a clear plan for each patient given with the appropriate reason for admission and medical history. Patients due for discharge, or who were living with dementia or at risk of falls were highlighted. There was reference to NEWS. The handover sheet was very concise with relevant information. An agency nurse was also to give the same standard of handover.
- We also observed the handover on ward 30, which was robust and conducted in a professional way with no interruptions.

## Medical staffing

- The medical staffing skill mix was slightly better than the England average with a slightly higher (better) consultant percentage (43% against an England average of 39%) and a slightly lower (worse) registrar percentage (33% against an England average of 38%). The percentage of junior doctors was 5% higher (better) than the England average.
- There was consultant cover available Monday to Friday for general ward areas. Out of hours cover was provided at weekends and at night.
- Consultant cover on the medical admissions unit was from 8am to 9pm Monday to Friday and 8am to 8pm at weekends.
- The medical rota for HASU had been separated so there was a doctor nominated for thrombolysis in the accident and emergency department, a doctor nominated for HASU and another for the transient ischemic attack (TIA) service.
- For ward 23 and NIV patient's consultant cover out of hours was provided by the on call general medical consultant, however they had a robust system in place and patients had clear escalation plans. A respiratory consultant while not officially on call was available if necessary in extra ordinary circumstances. The lead for the NIV service told us that the trust was working towards having a separate respiratory consultant on call

rota. Patients were reviewed each morning on the ward round and the team would go back in the afternoon if there were any problems. There was a registrar available on site overnight.

- Information provided by the trust showed that medical locum usage rates were amongst the highest in the trust. Data from December 2014 to March 2015 indicated this was on an upward trend.
- Junior doctors told us they felt well supported and senior doctors were available for advice when needed.
- Nursing staff told us foundation year two doctors would visit the wards out of hours to complete any jobs or review patients and hand relevant information over to the responsible day team.

## Major incident awareness and training

- The trust had a major incident plan which staff were aware of.

During our visit there was a junior doctors strike, plans had been put in place to ensure the continuity of services and care for patients, for example on the medical admissions unit an additional health care support worker had been arranged to support with taking blood and cannulating patients.

## Are medical care services effective?

Requires improvement



We rated effective as requires improvement because:

- Results from national clinical audit showed there were mixed results in relation to patient outcomes. For example there had been improvements for stroke services and heart failure but results for heart attacks and elective readmission rates were worse than the England average.
- Policies and guidance for patient care were evidence based, however we found some were past their review date and did not have version control or an author. We also saw guidance on an emergency trolley which had a review date of April 2014. Some staff also reported they were not able to access policies quickly.

# Medical care (including older people's care)

- Appraisal rates for staff were low in some areas and there did not appear to be any plans to address this. We were also provided with different sets of figures which presented a confusing picture in relation to staff appraisals.
- Mandatory training figures for the mental capacity act (2005) for medical and nursing staff were below the target of 95%.

However, we found that –

- The management of patients requiring non-invasive ventilation had significantly improved with patients been cared for on a designated ward being cared for by respiratory consultants and appropriately trained nursing staff.
- There were experienced staff working on the wards who could demonstrate good clinical knowledge. There was an effective preceptorship package for newly qualified staff and some health care support workers had taken on extended roles.
- There was good multidisciplinary team working throughout the areas we inspected with the involvement of specialist teams.
- Pain relief was offered to patients and pain scores were recorded appropriately.
- The nutrition and hydration needs of patients were attended to with good documentation to support this.

## **Evidence-based care and treatment**

- Staff used both the National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines to determine the treatment they provided. Local policies were written in line with this. For example ward 6 used the clinical institute withdrawal assessment (CIWA) guidance for alcohol withdrawal.
- On the medical admission unit sepsis and acute kidney injury bundles were used and we saw evidence of this in the records we reviewed. They were often started in the accident and emergency department. The unit had also recently implemented a patient group direction (PGD) for MRSA suppression treatment and adrenaline in an emergency.
- Policies were stored on the trust intranet. We were shown two policies, the acute oncology operational policy which had no version control or review date, the other was a policy for the treatment of neutropenic sepsis, the review date was May 2015 and it had not been reviewed at the time of inspection.

- A further policy review found the cardiopulmonary resuscitation policy was for review in September 2015 and the chemotherapy procedure for cytotoxic spillages, in April 2015. On ward 15 we observed a laryngectomy and tracheostomy management chart on the emergency trolley, which had a review date of April 2014 and had not been reviewed at the time of inspection.
- Monthly audits were completed by the ward sisters as part of ward assurance documents, these included areas such as dementia and infection prevention. This information was not reported to the Board. However we were told it was discussed at team meetings. If there were particular concerns or trends this would be reported to the chief nurse through the matrons.
- In relation to NIV, the trust had completed internal audits scoring well on all six quality indicators.
- The quality and safety report from October 2015 identified the trust had taken part in all mandatory national audits and 94% of clinical audits reportable were within quality accounts.

## **Pain relief**

- We saw evidence of pain being assessed by means of pain scores in patient documentation. The medication charts showed pain relief had been prescribed and administered appropriately.
- Staff had access to medical staff at all times if additional pain relief was required for patients.
- The pain team could also be contacted if pain management was problematic.

## **Nutrition and hydration**

- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (Must). This was found to be completed in the 46 sets of records we reviewed.
- Protected meal times were in place and on the wards we visited at lunchtimes these were adhered to. Assistance was offered to patients during mealtimes, and handovers identified any patients known to require assistance or any special dietary requirements. This was particularly noted on ward 9 where there were a number of patients requiring thickened fluids and puree meals.
- We checked food and fluid charts on a number of wards and found that generally they were well completed.
- Drinks were available to those patients able to take fluids.

# Medical care (including older people's care)

## Patient outcomes

- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMR's are usually expressed using 100 as the expected figure based on national rates. Figures from May 2015 indicated no evidence of risk.
- The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level throughout NHS hospitals in England. The SHMI is represented as a ratio and indicates the number of patients who died following being in hospital, compared to the England average of the number who would be expected to die looking at the characteristics. The figures are represented at trust level and data from May 2015 indicated no evidence of risk.
- The national diabetes audit provides a comprehensive view of diabetes care, measuring it against NICE guidelines and standards. Published data from January 2016 indicated the trust performed better than the England and Wales average for 15 of the 22 indicators. This was an improvement from the 2013 audit. Other areas which were still below the England and Wales average still showed some improvement from the previous audit, for examples staff knowledge.
- In the Sentinel Stroke National Audit Programme (SSNAP) audit, the trust had previously scored at a level 'D', on a scale of A to E, with E being the worst. Data from July 2015 to September 2015 showed this had improved to a 'C'. The rating is based on ten domains relating to different aspects of care delivery for patients experiencing a stroke. The trust had improved in three of these domains. The trust was aware of the areas where further improvements were needed for example, not achieving screening swallows in four hours, and staff sickness impacting stroke responders. We were told by medical staff further funding was being sought to provide additional posts to address some of these issues.
- The Myocardial Ischemia (heart attack) National Audit Project (MINAP) for 2013/2014 showed that the trust scored worse than the England average on three of the measures. The trust had also deteriorated on two of the measures from their previous year's performance.
- The trust's performance in relation to the heart failure audit 2015 showed a significant improvement from their previous year's performance. They achieved the same or better than the England average in eight of the 11 measures.
- The National Hip Fracture Database is a clinically led audit system of care and secondary prevention for patients following a hip fracture. The annual report for 2015 showed this trust had met all the criteria for best practice tariff and this was significantly higher (better) than the average for the Yorkshire and Humber region and the overall average. (Trust score 80.5%, region average 61.5%, overall average 63.3%). The elderly service took over the care of fractured neck of femur (hip fracture) in 2012.
- The average length of stay for elective patients in the medical division from September 2014 to September 2015 was 2.4 to 5.0 days. For the same time period for emergency admissions it was between 3.8 and 5.1 days. The trust had not identified a threshold for this.
- The standardised relative risk of readmission for elective and non-elective medical patients was slightly higher than the England average. However, for non-elective cardiology 33% more patients were likely to be admitted than the England average.
- Concerns were raised at the comprehensive inspection in 2014 in relation to the management of patients requiring non-invasive ventilation (NIV). Significant improvements had been made in this area. A dedicated unit had been established in February 2015 ensuring all patients were cared for in a designated area. The unit had been subject to an external review looking at the service provision for patients requiring NIV, with recognition and positive comments on the changes in provision and environment. This was supported by a quality assurance audit and a nomination for team of the year within the trust.

## Competent staff

- We found a confusing picture over the number of staff who had received an appraisal. We reviewed data provided by the trust relating to appraisal rates for staff within the medical division. They ranged from 8% to 100%. However these did not always match what we were told on individual wards. For example the data showed 50% of appraisals had been completed on ward 23; however the ward sister told us they had been completed for all staff. Senior nursing staff told us the



# Medical care (including older people's care)

overall appraisal rates for nurses within the medical division was 52%, however the divisional dashboard indicated for September 2015 the figure was 44%. Matrons and department leads had been asked to develop action plans to address this and individual staff with no date for appraisal booked were to be sent a letter asking them to arrange a time with their manager. The target to resolve this had been set at March 2016.

- Senior nursing staff said it was difficult to find time to conduct staff appraisals due to staffing levels.
- There was a comprehensive preceptorship programme for newly qualified nursing staff, however there were no specific staff competencies for working on HASU. Staff told us new or junior staff would work on HASU but would have the support of an experienced nurse. However, we found no evidence of this having an impact on patient care.
- On ward 23 one of the band six nurses had dedicated teaching time to support new staff and had developed a respiratory and NIV teaching plan. We were told all but two qualified staff on the ward were trained to work in the respiratory high dependency unit caring for all types of NIV.
- Ward 30 staff demonstrated a good knowledge of the patients they were caring for. Demonstrating good clinical knowledge of orthopaedics and care of elderly.
- Some health care support workers had been trained in additional roles, for example catheterisation and cannulation.
- Senior staff told us the lack of supernumery time meant they had less teaching time for students and junior staff. They also said they did not undertake clinical supervision with their staff.
- Student nurses told us mentors came in on their days off to complete their paperwork as there was no time whilst on the ward.
- The trust had put on events to highlight the requirements for nursing revalidation. Ward sisters felt the staff were prepared and aware of their responsibilities in relation to revalidation.

## Multidisciplinary working

- We observed multidisciplinary working in all areas we visited. Staff reported good working relationships between disciplines.
- We observed a safety huddle on ward 29 with the multi-disciplinary team (MDT) including the ward doctor. Risks on the ward such as staffing, pressure

sores and patients who were at high risk of falls were discussed. The discharge coordinator and community staff were also in attendance to discuss patients' discharge plans.

- Staff handovers were MDT focused with reference to the involvement of speech and language therapy and physiotherapy.
- Staff had access to specialist nurses and teams had formed good working relations with departments such as dietetics.

## Seven-day services

- Consultant cover was available Monday to Friday with the medical admissions wards having seven day cover. On call cover was available out of hours and medical staff had no concerns in accessing this when it was required.
- Physiotherapy input was available Monday to Friday with on call cover available at weekends.
- Other health professionals such as occupational therapy and speech and language therapy provided a Monday to Friday service.
- Out of hours imaging was available if the clinical situation required it.
- Pharmacy cover on the medical admissions wards was seven days a week. Pharmacy cover on the medical wards was available from 9am to 5pm with an out of hour's service available.

## Access to information

- Nursing and medical staff could access trust policies and guidance on the intranet. Staff told us they could not always locate policies quickly and the inspection team independently searched for specific policies, such as continuous positive airway pressure management (CPAP) and we could not locate them.
- Patients test results could be accessed electronically by nursing and medical staff.
- There were electronic bed management screens on several wards we visited, which were not in use. Hand written white boards were in use to manage patient flow, which relied on individuals keeping them updated. Staff did not report any issues with this system.
- On discharge a copy of each patient's discharge letter was sent to their GP.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

# Medical care (including older people's care)

- Training figures for medical staff on the Mental Capacity Act (MCA) 2005 were 78% against a trust target of 95%. Figures for nursing staff were broken down in to medicine and speciality medicine and were 66% and 75% respectively.
- Deprivation of Liberty Safeguards (DoLS) training was covered on the 'sweeper' days. We were not provided with training figures for this. The head of safeguarding was working with the wards sisters to increase staff members' understanding of when DoLS applications should be made.
- The staff we spoke with had a good understanding of MCA and DoLS. We saw examples of them in practice and in the documentation we reviewed.
- Ward 9 highlighted patients with a DoLS in place during handover and noted that one needed reviewing due to a change in the patient's condition, as it may no longer be appropriate to have it in place.
- We saw DoLS documentation completed on ward 6 with mental health reviews completed with MDT involvement.
- We saw evidence in patients' notes of written and verbal consent being gained and staff were aware of their responsibilities in regards to patient consent.

## Are medical care services well-led?

Requires improvement



The inspection team saw improvements in the domain of well-led. However there were still some fundamental issues which meant it was rated as requires improvement.

- There had been an improvement in managing risk and governance arrangements meaning information was shared and lessons learnt following incidents. However the risk register had several risks which were past their review date with no mitigating actions in place.
- Due to issues identified with medicines reconciliation, medications not being signed for, fridge temperatures and infection control practices we could not be assured that the leadership within medicine had effective oversight processes in place.

- With 93 band five WTE vacancies within medicine it was felt that plans to expand the HASU to six beds would be a challenge. There were plans to reconfigure some wards which would help address some staffing gaps however these plans had not been finalised.

However:

- The medical services at the trust were led by an experienced and dedicated team who were aware of the challenges of providing high quality care to this patient group.
- Services had a vision of where they wanted to be and there were plans being developed to support this.
- There had been a focus on staff engagement and although the trust identified there was further work to be done, improvements had been made.
- Staff spoke positively about local leadership and the senior management team who were felt to more visible.

## Vision and strategy for this service

- The management structure had changed within the medicine division since the last inspection. The annual plan for medicine recognised that there was still further development required within the teams. Staff felt things seemed more settled and calmer with a more positive attitude.
- There were clear visions and strategies in terms of the new hospital wing. This in turn meant some wards were relocating and merging, for example the haematology and oncology wards, although specific details of this were not yet known.
- Particular services had a clear vision of where they wanted to be with strategies to support this. For example stroke services were keen to improve and develop the increased service they were providing. However, they were aware of what areas needed investment and development, such as the role of band 6 nurses to ensure patient flow and facilitate sip testing for patients. Sip testing is a way of assessing a patient's ability to swallow.
- Within the stroke pathway there were plans to expand the HASU to six beds. The trust was also considering relocating the ward on to ward 6 to provide a more suitable environment, this work was overseen by the ward configuration group.

# Medical care (including older people's care)

- The NIV service had made significant improvements and following an external review was looking at the ability to provide 24/7 consultant cover. They had implemented a programme of audits to be able to review and improve their services.
- Within elderly care there was a clear vision to ensure the right care in the right environment was delivered for this patient group. There had been a focus on admission avoidance with plans to develop this further with comprehensive geriatric and MDT assessments within a day unit.

## **Governance, risk management and quality measurement**

- We reviewed minutes from clinical governance meetings. They had very comprehensive agendas, which covered various areas including incidents and learning, and any complaints.
- We reviewed the risk register for the medical division and there were 72 risks identified. Several of them were past their review date with no clear actions in place to mitigate any risk. Several related to the hospital environment and it was hoped that the new hospital wing and subsequent reconfiguration of wards would help address some of the issues as previously mentioned around the environment on wards 7 and 15.
- Staffing and recruitment issues were highlighted on the risk register with areas such as ward 9 and ward 3 mentioned. There was ongoing recruitment and careful management of staffing rotas.
- We reviewed the recently developed risk escalation framework, which outlined the process, the monitoring and key roles and responsibilities in terms of risk management.
- During our inspection we had identified that not all resuscitation trollies had portable oxygen in place. This was addressed immediately with a checklist added to ensure compliance.
- The concerns found at the previous inspection relating to the management of patients requiring NIV had been addressed with the lead for the service praising the immediate response and leadership from the trust.
- Information on quality performance was collected and this was displayed on all the ward areas we inspected. Data was collated monthly in a divisional dashboard and RAG rated with actions identified such as recruitment initiatives.

## **Leadership of service**

- The management team demonstrated an understanding of the challenges of providing high quality safe medical care with the reconfiguration of services and ongoing review of patient acuity and activity.
- From speaking with many disciplines of staff the leadership at different levels within the trust was viewed very positively. It was felt there had been a change in the model of leadership and individuals were encouraged to become leaders. Medical staff felt able to take a lead within their specialist areas and develop plans for the service.
- We observed good leadership on the wards we visited. Many had to manage staff shortages. We saw that skills mix and the organisation of work was a priority to ensure safe working. We saw evidence of staff being developed and taking on extended roles and the empowering staff to drive improvement. However it was identified that this process was made more difficult due to the lack of supervisory time for ward managers.
- Staff reported increased visibility of the senior management team.

## **Culture within the service**

- We were told by the senior management team there had been a focus on the culture within the trust in relation to the new hospital wing and relocation of some services.
- We observed good multidisciplinary working and staff were positive about their work despite staff shortages in many areas.
- Staff felt able to escalate concerns and there was improved feedback and sharing of information with the introduction of daily safety huddles, which showed a move towards a better safety culture.

## **Public engagement**

- Friends and family test data was displayed in the wards we visited. On the medical admissions unit information on future patients was displayed.

## **Staff engagement**

- We observed daily safety huddles to share information. We reviewed staff meeting minutes and the staff felt involved and aware of what was happening in their work areas.

# Medical care (including older people's care)

- 'Let's talk' a newsletter was distributed to share information with staff and keep them updated with any developments within the trust, for example the new ambulatory care unit.
- Staff told us updates were also sent by email, such as changes in policy.
- The 2015 National NHS Staff Survey showed that the overall score for staff engagement had improved from 2014 from 3.74 to 3.77, this remained slightly below (worse) than the national average of 3.79.

## **Innovation, improvement and sustainability**

- The development of the frail older people pathway using MDT working and focusing on skills and training has enabled the elderly care directorate to be one of the highest performing in the country. It is in the top 10% for length of stay.
- The trust provided a home NIV service and had 100 patients receiving complex ventilation.

# Surgery

Safe

Requires improvement



Overall

Good



## Information about the service

Bradford Royal Infirmary provides a surgical service for people living in Bradford and the wider area of West Yorkshire. Emergency surgery, specialist surgery and day case surgery are all provided by the trust for adults and children. The Trust provides a comprehensive range of surgical services, including: general surgery and gastroenterology, vascular surgery, urology, oral and maxillofacial surgery, orthodontics, ENT, ophthalmology, plastics, breast surgery, orthopaedics, and pain services.

The trust has a total of 20 operating theatres across five locations on site. There were 40,870 episodes of care provided by the service, 39% of which were emergencies.

During this inspection, we visited 12 wards. Ward 5 is a day surgery and admissions unit which can accommodate a maximum of 31 patients. Patients requiring more major surgical procedures are admitted to the day surgery unit first before being transferred to another inpatient ward after surgery.

We also visited ward 8, a male surgical ward with 28 beds caring for patients receiving general surgery. Patients requiring emergency surgery are admitted by ward 20, the surgical assessment unit, and receive their follow up care on ward 8 or 11. We visited ward 11, a women's general surgical ward and ward 12 which provides care for women having breast surgery, including reconstructive surgery, other plastic surgery procedures and gynaecology. The ward also provides an early pregnancy assessment service, treating women with complications in pregnancy.

Ward 14 is a urology ward with 17 beds. Ward 18 has 20 ear, nose and throat (ENT), maxillofacial and ophthalmology beds. There were also four progressive care beds for patients requiring head and neck surgery.

Ward 20 is a surgical assessment ward with 21 beds and a trolley area for six patients. Ward 21 has 18 progressive care

beds. Ward 26 has 28 beds and specialises in vascular surgery. Wards 27 and 28 are both orthopaedic wards with 28 beds. Ward 27 also cares for trauma and acute plastic surgery patients.

This was a follow up inspection. The service was previously inspected in October 2014. At that inspection we rated the service as 'requires improvement' overall. Surgery was rated good for the domains of effective, caring, responsive and well-led. However, we rated the domain of safe as requiring improvement. Although there were arrangements in place for reporting incidents staff did not always receive feedback on investigations into the incidents reported. There was a lack of isolation areas and side rooms throughout the division's wards. This meant that some patients were not always cared for in the most appropriate environment. There were also concerns about the receipt, recording and storage of some surgical instruments and the adequacy of facilities within the endoscopy unit. The recovery area was poorly staffed on the day of inspection with only one recovery nurse for two operating theatres.

At this follow up inspection we inspected the safety domain only to see if the trust had made improvements to these areas.

We visited 5 operating theatres and observed surgery in progress. We also visited the nucleus operating theatre suite as part of an unannounced visit a week later to see how the theatres worked in the evening.

We spoke with 15 patients and relatives and 22 members of staff. We observed the care provided for patients and reviewed the care records of 15 patients.

# Surgery

## Summary of findings

There were arrangements in place for reporting incidents which might affect the quality and safety of patient care. Most staff we spoke with knew how to report incidents. But we found inconsistencies in theatres about reporting and learning from incidents. Some staff were unaware of national definitions of serious incidents including never events despite the trust's investigation into two never events which had occurred recently.

Staff in this service were below the trust's target for completion of mandatory training. 48% of staff requiring Level three children's safeguarding had completed the necessary training and 68% of eligible staff had completed Level two children's safeguarding training. Mandatory training for some groups of staff in medicines administration, adult basic life support and blood transfusion were below the targets set by the trust.

Staffing on nine surgical wards was below planned levels

A small number of surgical procedures were carried out under general anaesthetic in a theatre at the end of ward 14. The theatre was located on the floor below the main nucleus theatre complex. We were concerned about the remoteness of this theatre suite. The trust had developed a policy to ensure surgery could be performed safely in this theatre, including emergencies. However, neither staff in nucleus theatres or on ward 14 were aware of the procedures which should be followed. Staff in theatres and on the ward were unaware of who was responsible for the theatre.

There was wide variation between surgical specialties and theatre suites for the levels of mandatory training completed.

The trust used the five steps to safer surgery process in the operating theatres to improve patient safety and reduce the risk of clinical incidents. The five steps included the use of the World Health Organisation (WHO) surgical safety checklist. The process requires that a checklist is completed for every patient undergoing a surgical procedure. However, we observed

patients receiving surgery where the sign in process did not take place. This meant there was a risk that safety issues might not be identified before a procedure took place.

Patient records were well maintained. Information was clear and patients' needs were well documented. Records were audited to check the early warning system for deteriorating patients was carried out correctly and information about patients' medicines was accurately recorded.



# Surgery

## Are surgery services safe?

Requires improvement



We rated safety as requires improvement because:

- Staff on the wards told us they reported incidents but the picture varied in the operating theatres. There were inconsistencies in the reporting and learning from incidents across theatre staff. Some staff were also unclear as to what constituted a never event or a serious incident.
- We observed the World Health Organisation surgical safety checklist was not followed on two occasions. There was inconsistent application of the checklist and although audit results were improving, it was not yet fully embedded.
- Staffing on all surgical wards was below planned levels on nine surgical wards. This ranged from a shortfall of 8% on ward 14 to 28% on ward 28.
- There was wide variation between surgical specialties and theatre suites for the levels of mandatory training completed. Only 48% of staff in surgery had completed training in the safe administration of medicines, 62% of theatre nurses had completed adult basic life support, 67% had completed training in blood transfusion.

However, we found that:

- Mortality and morbidity meetings had been introduced following our last inspection.
- The needs of deteriorating patients were identified and there was an escalation process for ensuring they received appropriate care.
- The trust had made improvements to the systems for cleaning and storing surgical instruments. The endoscopy service now complied with the health technical memorandum (HTM) 106 which set the standards required for endoscopy departments.

### Incidents

- There was one never event and 16 serious incidents reported by the trust for this service between August 2014 and July 2015. 10 of the serious incidents were grade three pressure sores. The trust's analysis of the incidents showed the number of serious pressure sores had reduced during the year.

- The never event related to a surgical procedure carried out on the wrong surgical site which occurred in March 2015. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
- The investigation into the never event identified the lessons which could be learned and there was an action plan for implementing the recommendations from the report. The report found the trust's safety procedures had not been followed and staff had not received formal training in the use of the surgical safety checklist. The report recommended improvements in marking operation sites and improvements to the pre-operative checking processes. Staff we spoke with were not aware of any formal training or procedural changes which had been implemented following the never event investigation. Three theatre nurses we spoke with were not familiar with the definition of a never event.
- The trust used the World Health Organisation (WHO) surgical safety checklist which requires that a core set of safety checks are completed at safety critical time points within the patient's intraoperative care pathway. The surgical safety checklist prompted checks at three stages of a surgical procedure: before the patient is anaesthetised (sign in), before surgery begins (time out), and at the end of surgery before team members left the room (sign out). The trust had audited the completion of the checklists. The audit showed that on average 53% of 'sign in' documentation was fully completed. 78% of 'time out' documentation was completed. The 'sign out' sections of the checklists were completed in 90% of records. As a result of the audit the trust had developed an action plan for improved recording and a daily 'real time' audit was introduced to enable the theatres matron to monitor compliance. Following our inspection the trust have provided us with the results of a more recent audit carried out in December 2015 which showed compliance has improved to 88.8% for sign in, to 99.3 % for time out and 98.9% for sign out.
- The deputy clinical director of surgery and anaesthetics told us the findings of the report were discussed at the Clinical Executive and the Quality and Safety Group to share the learning.
- At our previous inspection we found there were arrangements in place to enable staff to report incidents but staff did not always receive feedback on reported



# Surgery

incidents. We spoke with a member of staff who had submitted several incident reports about an aspect of clinical practice. They said they were not aware the incidents were being investigated and were unsure whether they should continue to report their concerns. Three other staff we spoke with told us they had not received feedback on incidents they had reported and would raise concerns with their manager rather than submit an incident report.

- A further never event occurred in October 2015 which was in the process of being investigated. Staff confirmed revised procedures had been implemented soon after the incident occurred. Staff told us the case was reviewed at an audit study day and staff had received training in the revised procedures. The trust's investigation into the incident was not yet complete at the time of the inspection. We received a copy of the report into the investigation after the inspection.
- In addition to the never event, the trust also reported 16 serious incidents between August 2014 and July 2015. These were reported to NHS England so that the number and type of incidents across trusts could be monitored nationally.
- The trust reported 33 pressure ulcers, five falls and 8 urinary tract infections (UTIs) between September 2014 and September 2015 for surgery.
- Staff working on the wards knew how to submit incident reports and said the learning from incidents was discussed by the teams on the wards. For example, they had introduced two hourly rounding for some patients who were at risk of deteriorating. This is a process used in hospitals to carry out two hourly nursing assessments of patients to check their key care needs are being met. Staff said safety was discussed at ward meetings and we could see minutes of these were available for staff to read with references to incidents and the actions taken as a result.
- Minutes of acute surgery clinical governance meetings showed incidents were reviewed and key learning points discussed.
- One member of staff told us data reconciliation issues on the theatre management computer system had resulted in a high number of administrative incidents being reported, which made it difficult for managers to work through and prioritise those requiring action to maintain patient safety. When we spoke to the trust about this they said they were in the process of working through the backlog of reports.

- We saw the results of a root cause analysis which had been carried out after a patient had developed a grade three pressure sore. Root cause analysis is a process used by hospitals to investigate incidents thoroughly. The investigation revealed risk assessments and checks had not been effectively completed. The actions agreed included ward sisters checking patient's records to ensure risks of pressure damage were being identified earlier to enable pressure relieving equipment to be obtained and staff to ensure patients were re-positioned. The deputy chief nurse brought the results of the investigation to the attention of nurse managers throughout the trust.
- Multi-disciplinary mortality and morbidity meetings had been introduced since our last inspection. We saw the minutes of these meetings which showed that deaths and patients whose condition deteriorated were reviewed and any lessons for improving practice were identified.
- Duty of Candour was introduced as a statutory requirement for NHS trusts in November 2014. Staff told us they understood the need to be open and honest with families when things went wrong. For example, staff had apologised immediately to the person who had received surgery on the incorrect operation site. The trust had sent them a copy of the investigation report and had invited them to meet with staff to discuss what went wrong.

## Safety thermometer

- The results of the patient safety thermometer were displayed in all the ward areas we visited.

## Cleanliness, infection control and hygiene

- Theatre areas and the wards we visited were clean and staff observed good infection control practices for example by washing their hands and using hand sanitising gel between patients.
- There were no daily cleaning records for theatres or the anaesthetic rooms. A stool used in theatres had rusty legs and the material on the top was ripped. Staff removed this it when we brought it to their attention. We also saw blue trolley protection covers for paediatric trolleys which were split exposing the foam filling, which was an infection control risk.
- Infection control information was visible in most ward and patient areas. Patients admitted for surgery were

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screened for Methicillin resistant Staphylococcus Aureus (MRSA). MRSA is a bacterial infection that is resistant to widely used antibiotic treatment. Procedures were in place to isolate patients as required by the trust's infection control policy. Nursing staff told us they were able to access advice from the infection control team when they needed it. They said the number of isolation rooms was a continuing problem in the trust. When we discussed this with trust they told us accommodation would be reviewed once the project to develop the new hospital wing was completed in 2016. There were isolation facilities on the surgical admissions unit which meant patients with an infection could be nursed away from other patients awaiting surgery

- We saw the results of infection control audits carried out during 2014-2015. The audits included monthly hand hygiene, Methicillin resistant Staphylococcus Aureus (MRSA) screening rates and patients at risk of developing C difficile. C difficile is a bacterial infection that can lead to diarrhoea. The audits showed the trust had effective processes in place for dealing with infection control.
- The trust also collected and submitted surgical site infection information to a national surveillance service. This provided the trust with information showing how they compared with other similar hospitals. This showed the infection rates for hip surgery was 1.0% of all cases and 0.5% for knee replacements. The results of the national audits showed the trust compared well with other trusts nationally with low infection rates.

## Environment and equipment

- At our previous inspection we had concerns about the receipt, recording and storage of some surgical instruments and the adequacy of facilities for staff and patients within the endoscopy unit. At this inspection we found these issues had been fully addressed and the endoscopy service complied with health technical memorandum (HTM) 01-06 which set the standards required for endoscopy departments.
- We also found improvements had been made to the systems for the receipt, recording and storage of surgical instruments.
- We visited an operating theatre located at the end of ward 14. This was used mainly for urology procedures carried out under local anaesthetic. However, we saw

that five procedures were carried out under general anaesthetic between October 2015 and January 2016. We were concerned about the remoteness of the theatre which was located on the floor below the main nucleus theatre suite. It was not clear how staff would access help in an emergency. When we discussed this with the trust they provided us with a policy which had been developed to ensure surgery could be performed safely including emergencies. However, neither staff in nucleus theatres or on ward 14 were aware of the procedures which should be followed. Staff in theatres and on the ward were unaware of who was responsible for the theatre.

- When we spoke to the trust about this they told us this theatre area was used for day case lists only. The majority of patients underwent procedures under local anaesthetic. Occasionally a small number of pain management and gastroenterology patients required sedation. They said for both specialities the theatre lists were consultant led, supported by a team of qualified and unqualified members of staff. Due to the remote location of the theatre and recovery area the trust told us two qualified members of staff were always allocated to the recovery area, which was equipped to the same level as other recovery areas within the main theatres. They told us there were emergency call buttons located in the recovery area which were linked to Ward 14 in case of emergencies. The trust also provided us with an escalation policy they had developed for situations where anaesthetic support was required.
- A large number of oxygen cylinders were stacked in a corridor area in nucleus theatres which was not designed for the storage of gas cylinders. Staff acknowledged this was a health and safety risk and these were removed when we drew this to their attention.
- We checked a sample of four resuscitation trolleys in theatres and on the wards. Staff checked the equipment daily and signed a checklist to confirm the equipment had been inspected. We also checked equipment on the wards and found the appropriate electrical and mechanical checks had been completed. We checked and found equipment complied with the relevant guidelines.
- Fridge temperature records on six wards we visited showed medicines were being stored correctly. We saw

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the temperature of one fridge had exceeded the recommended level of 8 degrees. The sister told us ward staff had contacted pharmacy who checked the medicines and disposed of any which might have deteriorated as a result of being stored at the incorrect temperature.

## Medicines

- We checked the record of controlled medicines on four wards and found these were completed appropriately with checks on medicines stocks and two staff signatures. One member of staff told us there had been a discrepancy with a controlled medicine on one occasion which staff had reported as an incident. An investigation was undertaken but the reason for discrepancy was not resolved.
- We found medicines in four theatres anaesthetic rooms were drawn up and left unattended. This meant there was a risk these medicines could be tampered with.
- We looked at 15 records on the surgical wards and found medicines reconciliation had been signed as completed on 11 records. Of those, four records had outstanding queries and five records did not have regular medications prescribed and no entry was made in the notes to explain why. One patient on a high risk medicine had been in hospital for two days and no medicines reconciliation had occurred.

## Records

- The records we reviewed were paper records which were well maintained. Information was clear and patient's needs were well documented.
- We reviewed 15 patient records which included risk assessments for falls, hydration and pressure ulcers which had actions in place to mitigate the risk. We saw several examples of completed preoperative health screening assessments.
- Audits of the early warning system for deteriorating patient were undertaken which showed charts were being completed correctly within an hour of admission to the ward.
- Other records audits were undertaken by ward sisters to check patient's medications were recorded correctly

and risk assessments for example patients' nutritional needs were completed. An annual records audit was undertaken in November 2015 which reviewed the completeness and accuracy of patients' records.

## Safeguarding

- Staff were aware of their responsibility to report any safeguarding concerns and they were familiar with the role of the safeguarding team who they would contact for assistance. Staff spoke highly of the team and said they were easy to contact and helpful.
- Mandatory training records showed over 90% of all medical and nursing staff had completed training in safeguarding for children and adults.
- However, only 48% of staff requiring Level three children's safeguarding had completed the required training and 68% of eligible staff had completed Level two children's safeguarding training. This was below the targets set by the trust.

## Mandatory training

- The trust had set a target of 75% for staff to complete essential training. The surgical division's overall achievement rate for mandatory training was 78% in September 2015.
- There was wide variation between surgical specialties and theatre suites for the levels of mandatory training completed.
- Only 48% of staff in surgery had completed training in the safe administration of medicines.
- 100% of the nurses working in general, urology and vascular surgery had completed training in 2015 for 11 out of 15 subjects. These included procedures for managing blood transfusions, administering medicines, adult basic life support and infection control. Only 29% of nurses had completed fire safety training. All medical staff working urology, vascular and general surgery had completed training in the Mental Capacity Act and infection control. Medical staff received training in 10 subjects. The lowest level of compliance for medical staff was for adult basic life support. Only 62% had completed this training.

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- Theatre nursing staff had all completed infection control training, one of the 15 mandatory training topics. 62% had completed adult basic life support, 67% had completed training in blood transfusion.
- All nursing staff working in orthopaedics, plastic and breast surgery had completed infection control training. 64% had completed training in basic adult life support, 73% for administering medicines, and 55% for blood transfusion. 48% of medical staff had completed adult basic life support training and 67% had completed blood transfusion training. Only 32% of nurses had completed training in blood transfusion.
- Within head and neck, including ear nose and throat surgery, 100% of nurses, 98% of medical staff and 100% of theatre staff had completed infection control training. All nursing staff had also completed medicines administration training but only 32% had completed their mandatory blood transfusion training. 53% of medical staff had completed adult basic life support training.

## Assessing and responding to patient risk

- When we visited one of the four theatre areas, we found that not all the World Health Organisation (WHO) surgical safety checks were being completed. We saw a patient being prepared for the commencement of surgery without the surgeon being present to contribute to the checking process. This meant there was a risk that the surgeon carried out the incorrect procedure or operated on the wrong patient. It also meant that the trust's policy and the key learning from the never event in March 2015 had not been fully implemented in all theatre areas.
- We observed one patient who did not have stockings on used to help prevent the formation of a deep veined thrombosis during their operation. A member of staff told us the patient should have had stockings on but it was the responsibility of the staff on the ward to check.
- The patient was anaesthetised without the surgeon present. Staff called for the surgeon on call to carry out the procedure. This meant the surgeon had not participated in checks to make sure the correct procedure was being performed on the right patient
- During our inspection we observed a patient with an endotracheal tube in place being moved from the operating theatre to the recovery area without any monitoring equipment in place. The operating theatre was located at the end of a corridor, approximately 20 meters from the recovery area. When we spoke with staff about this they said this happened usually once a week and that the practice had been discussed and it was recognised as not following national guidelines.
- There were systems in place for monitoring patients whose condition was at risk of deteriorating. Adult modified early warning charts (MEWs) were used for assessing patients' conditions and we found examples of these fully completed in all the records we reviewed. These included assessments of the level of pain patients experienced. Staff were knowledgeable about the processes in place for monitoring patients and knew how to escalate concerns if they arose. We saw audits had been completed to ensure these warning charts were being completed. 10 sets of patients' records were selected at random and checked to see if the patient had been assessed within an hour of admission and if the scores had been correctly identified and recorded.
- During our visit we observed theatre staff looking after patients requiring Level 3 critical care support in the operating theatre recovery area. Level 3 support was normally required by patients needing advanced respiratory support or basic respiratory support with support also provided for at least two organ systems. This is the level of care normally provided on an intensive care unit (ICU). The trust confirmed that this level of care occurred in the operating theatre recovery area when all the ICU beds were full patients admitted to recovery remained the responsibility of the ICU team. If medical care was urgently required and a member of the ICU team was not immediately available then the anaesthetic team staffing the acute operating theatre was called. A patient cared for in recovery would have one dedicated nurse. At night the on-call nurse ICU was called in.
- Anaesthetic staff told us patients requiring level 3 care were managed safely but that consultant presence was required in recovery which resulted in a registrar providing anaesthetic cover for the operating list in theatres resulting increased pressures on staffing. Recovery staff told us that caring for level 3 patients in recovery added to the pressures of caring for patients in recovery and felt the trust did not fully appreciate the impact on staff.

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## Nursing staffing

- The surgical and anaesthetic directorate had 626 qualified nursing posts. There were 187 care assistants. Figures supplied by the trust showed there were 87 vacancies for nursing staff. 71 of these vacancies were for qualified nursing staff out of a total establishment of 610 (12%). The surgical and anaesthetic division were engaging 18 agency staff on average per month between February 2015 and January 2016.
- The chief nurse monitored the number of staff and the hours worked for all surgical specialties. This information was included in a report prepared for the trust's Quality and Safety Committee. We saw four monthly reports from August to January 2016. The number of hours worked by nursing staff was below planned levels on nine surgical wards. In January 2016 the most recent figures provided by the trust showed the number of hours worked by nursing staff on ward 12 (a gynaecology ward) were 14% less than planned, 17% less than planned on ward 11 (a general surgery ward) and 8% less than planned on ward 14 (a urology ward). Staffing levels on wards 20 and 21 were 15% below planned levels and ward 21 was 11% lower. Ward 26, a vascular surgery ward, was particularly low with 25% less staff than planned. Staffing levels on trauma and orthopaedic wards 27 and 28 were 13% and 28% less than planned, 16% less on ward 8. The report noted the difficulties that the trust was facing in filling these shifts with bank and agency staff.
- We saw the number of care assistants had been increased on many wards where the number of registered nurses was less than planned. For example, on Ward 26 qualified nurse staffing levels were 429 hours (23%) below planned levels. The number of care staff hours had been increased by 322 (53%) more hours than planned.
- We saw that during the period October 2015-January 2016 there had been an increase in the number of areas where the pool of registered nurses was spread more thinly. Where shifts were unfilled each ward looked to existing staff to work additional hours, use staff from the trust staffing bank and use agency staff. Senior nurses also re-deployed registered nurses to the areas with the highest need. Nursing staff told us that qualified staff were often re-deployed, leaving wards with reduced staffing levels.
- Within surgery and anaesthesia daily meetings took place to review staffing levels and ensure plans and cover was in place.
- Nursing staff completed incident reports when staffing levels were less than planned. 21 staffing related incidents were reported for the month of July, 11 of which were in surgery. In August there was one staffing related incident reported with none reported in September. The incident reports included the occasions when staff have been moved from one area to support another area where required.
- Staff told us the trust was using a recognised acuity tool to review the needs of patients and staffing levels required. A ward sister told us they had collected data on the ward about the dependency levels of patients and had contributed to reviewing staffing levels. They told us their ward had a complex mix of patients and the data collection period was extended to ensure sufficient information was collected about patients' needs to determine the required staffing levels. A safe staffing and escalation policy was in place which was used daily to check the adequacy of staffing levels.
- We observed a nursing handover. Nursing staff had a printed list of patients for recording information about their condition. The nurse in charge updated staff following a ward round and allocated them particular roles, for example to organise patient's discharge.
- A range of services for women were provided on ward 12. These include gynaecology, early pregnancy advice and breast surgery. The gynaecology service had transferred from the women's directorate and the breast service had transferred from ward 25. Staff with gynaecology experience, staff with breast experience and staff from plastic surgery were brought together on to one ward to care for patients. Staff told us they were working together to share their skills and expertise but they had lost some staff with specialist knowledge for example, about breast surgery. They said the ward had a rapid throughput: lengths of stay for procedures including breast surgery had reduced significantly. When we visited there were also eight elderly medical patients on the ward. Staff told us they felt they did not always feel they had the skills and expertise they needed to make sure the range of patient's needs was met. They said they sometimes felt pulled in four directions. An example of this was the four different



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types of patient records they completed. The clinical director for surgery told us they were aware of the issues raised by staff. They said they intended to look at the issues but there were no immediate plans to change the mix of patients cared for on the ward.

- The trust assessed the number of staff required in theatres against the needs of patients on a daily basis.

## Surgical staffing

- Clinical staff were concerned about the number of junior doctors available in surgery. Junior doctors provided cover at night for general surgery, plastic surgery, ENT and maxillo facial surgery. They said it was difficult to recruit to junior medical staff posts because they were expected to cover so many specialties. The deputy divisional clinical director told us they had recently appointed eight additional oral maxillo facial surgeons to contribute to the rota, which would contribute to reducing the pressures in other specialties. Nursing staff on the vascular surgery ward told us patients had to wait a long time for medical staff to attend. Consultant medical staff we spoke with all said additional investment in middle grade medical staff was required to improve cover out of hours and make the posts more attractive to doctors in training. The directorate had developed plans for making these posts more attractive to applicants.
- Figures supplied by the trust showed there were eight junior medical staff vacancies, seven posts were vacant

for other career grade posts and there were six consultant medical staff vacancies, which were covered by locum or agency staff. Plastic surgery was one of four specialties in the trust with a high reliance on locum staff throughout 2015.






- At our last inspection staff told us there was a lack of availability of junior doctors, which impacted on weekend and out of hours working, as well as discharge planning. At this inspection ward staff said it was still difficult to obtain junior doctor support out of hours.
- Consultants were available on-call and out of hours and would attend, when required, to see patients at weekends. Surgery at weekends was limited to emergency surgery. The trust was developing plans for seven day working. Radiology was open on Saturday morning and Sunday morning routinely.
- Medical staffing within the division had a higher number of doctors at consultant level (47%) when compared to the England average (41%). However, the number of doctors at registrar level was lower (33%) than the England average (37%).

## Major incident awareness and training

- Business continuity plans had been developed for surgery to ensure surgery could carry on in the event of a loss of service such as water.
- A major incident plan was in place but staff told us they had not practised this.



# Critical care

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

## Information about the service

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

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

The trust was building a new 16 bedded ICU which was due to open in the Autumn of 2016; the new unit will have 16 individual rooms. The rooms would be more spacious and each would have designated hand washing facilities. There would be flexibility to alter the bed areas to provide Level two and Level three care as required.

In October 2014 the CQC carried out a comprehensive announced inspection and found the service was good for caring. Improvements were required in the safe, effective, responsive and well led domains.

During the inspection, we visited both the ICU and HDU. We looked at five sets of patient notes and spoke with 16 staff.

## Summary of findings

We rated this service as good overall.

We found the relationships within the unit had improved. Senior managers now attended team meetings and were more visible on the wards. Governance structures were still not embedded and clinical leads had only recently come into post.

Staffing was adequate to meet patient needs and medical staff now worked one week in seven on ICU, in-line with national standards. Nursing staff had access to critical care training at the local university. Following the previous inspection we found that the service had reviewed the ward area and redesigned access to the sinks to improve infection control. The service planned to move the four HDU beds from a bay on a ward to a larger area which would allow patients to be cared for in a more suitable environment.

The capacity of the service to meet demand remained an issue. The bed occupancy for the unit was about 92% and patients were sometimes being cared for in recovery in the nucleus theatre because there was not a bed available on ICU. It was unclear if the new unit would be sufficient to reduce the occupancy rates because the number of ICU beds was not being increased. There had been no review of unmet demand for beds, which was identified as an action from the previous inspection and quality key indicators reports. The service was still not seeing all patients within 12 hours of admission although improvements had been made and processes put in place to mitigate the risk.

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Patient outcomes information was not always completed and audits from patient outcomes were not always available. However the service did complete Intensive Care National Audit and Research Centre (ICNARC) data and it was used to benchmark against similar organisations. The service had not reviewed policies and procedures to ensure they adhered to professional standards and guidelines.

Delayed discharges of over four hours still occurred. However, the number of delayed discharges of over four hours had reduced since the last inspection and delayed discharges were better than similar units. Quicker discharges were facilitated by staff attending bed meetings to discuss discharges from ICU.

## Are critical care services safe?

Good



We rated this service as good for safety because:

- Learning from incidents was shared with staff to help prevent recurrence. Staff told us they knew how to report incidents and learning from incidents was shared through team meetings, newsletters and directly to individuals.
- At the inspection in October 2014 we were concerned that the service did not hold regular formal mortality and morbidity meetings. At this inspection we found the service had started to hold mortality and morbidity meetings since December 2015. The meetings were used to identify what went well and how they could improve patient care.
- Staff completed patient records and patient information was shared at handover meetings and ward rounds to ensure patient care was delivered safely.
- At the previous inspection it was noted that there was limited availability of isolation rooms for patients with infections, resulting in patients being barrier nursed on the main unit. During this inspection there was still limited availability of isolation rooms and patients were still being barrier nursed on the main unit. Risk assessments were undertaken to ensure that appropriate practices were in place to prevent cross infection. It was intended that the move to the new ICU facilities would resolve this issue.
- Planned and actual staffing numbers were displayed in the unit. We found that actual levels of staffing matched the planned level of staffing.
- On ITU, we observed Level 3 patients being nursed one to one, on HDU we observed Level 2 patients being nursed on a two patients to one nurse basis. This matched best practice guidance.
- Action had been taken to address low safeguarding adults Level 2 training rates. In March 2016 95% of staff had completed Level 2 adult safeguarding training

However we found that:

- There were some delays in the discharge of patients, which impacted on the patient experience and bed occupancy rates were high.

# Critical care

- Areas of concern raised at the previous inspection had been reviewed and progress was being made to improve patient safety. Until the new unit was opened we could not fully assess the concerns about infection control and isolation of patients because of the limited changes the service could make to the existing unit. The service was unable to deal with all the issues without moving into the new unit.
- We found the service did not meet the Core Standards for Intensive Care Units (2013) Pharmacy cover guidelines for intensive care units for pharmacy cover on the unit. Pharmacy cover should be at least 0.1 whole time equivalent specialist pharmacist for each single Level 3 bed and for every two Level 2 beds. Pharmacy cover was half of the recommend level for the number of Level 3 and Level 2 beds provided by the trust.

## Incidents

- ICU had no never events and one serious incident (SI) requiring investigation between December 2014 and November 2015, The SI related to a hospital acquired pressure ulcer and learning from the incident had been shared with staff. Staff told us the number of pressure ulcers had reduced following learning and improved understanding of the prevention of pressure ulcers and completion of risk assessments.
- We looked at the 128 incidents reported between November 2014 and December 2015. There were 15 incidents when a side room was not available for patients who needed to be isolated. Staff completed risk assessments for patients who needed to be treated in the main ward area who should have ideally had a side room.
- Between November 2014 and November 2015 there were 13 new pressure ulcers. The prevalence rate of pressure ulcers fluctuated over the reported period.
- Incidents were discussed at a monthly sisters meeting and unit meeting.
- Learning from incidents was shared with staff to help prevent recurrence. Staff told us they knew how to report incidents and learning from incidents was shared through team meetings, newsletters and directly to individuals.
- At the inspection in October 2014 we were concerned the service did not hold regular formal mortality and morbidity meetings. At this inspection we found the service had started to hold mortality and morbidity

meetings since December 2015. We saw copies of two presentations given at these meetings and these showed that the patient journey in the hospital and the transfer to ICU was considered together with a review of the immediate and subsequent interventions. The meetings were also used to identify what went well and how they could improve patient care.

## Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. Information was displayed on the wall in the unit.
- Between November 2014 and November 2015 ICU reported 13 new pressure ulcers, no falls with harm and only one catheter acquired UTI reported during the period.
- 100% of patients were assessed for the risk of venous thromboembolism (VTE) in November and December 2015. The target for the trust was 95% of patients assessed for the risk of VTE.

## Cleanliness, infection control and hygiene

- During this inspection we found the unit was visibly clean. We observed regular cleaning was taking place and all the equipment and surfaces were clean.
- When equipment had been cleaned it had a green 'I am clean sticker' attached with the date it was cleaned.
- At the previous inspection we saw that each bed space had a chair at the end of each bed that staff used when completing documentation and charts. We observed six chairs and all had visible stains on the fabric covering.
- At this inspection we found all the chairs had been replaced and were now visibly clean and were covered in a fabric which could be wiped clean.
- At the previous inspection we found hand wash basins were situated near to every bed space, but were all positioned at the back of the beds against the wall. Access to the hand wash basins was restricted, particularly because of the amount of equipment around the beds.
- During this inspection we found the curtains and beds had been moved to allow staff behind the bed to access the hand wash basins. We observed staff used the sinks for hand washing with soap and running water.
- At the previous inspection it was noted that there was limited availability of isolation rooms. Some patients who should have been cared for in a side room, in

# Critical care

compliance with the trust's infection prevention and control guidelines, had to be barrier nursed on the main unit. Barrier nursing is a method for caring for patients while preventing the transmission of highly contagious diseases. These occurrences were reported via the electronic incident reporting system.

- We observed staff barrier nursing a patient on the main unit. They used personal protective equipment (PPE) and adhered to hand washing protocols.
- During this inspection there was still limited availability of isolation rooms and patients were still being barrier nursed on the main unit. Risk assessments were undertaken to ensure that appropriate practices were in place to prevent cross infection. It was intended that the move to the new ICU facilities would resolve this issue. The new ICU would have 16 single occupancy cubicles. The new unit was due to open at the end of 2016.
- The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC) to allow the unit to monitor outcomes and compare performance with similar units.
- The ICNARC infection control data from 1 April 2015 to 30 June 2015 showed unit acquired infection was similar to expected in similar units. It showed the unit was lower than similar units for *Clostridium difficile* (C.difficile) at patient admission. C.difficile is a bacterium infection that affects the bowel and can cause diarrhoea.
- Infection control data for ventilated admissions showed that unit mortality was consistently just above the average for other similar units but it was not by a significant percentage. This showed the same trend as at the previous inspection for ICNARC data from 1 April 2014 to 30 June 2014.
- Hand Hygiene Audits showed ICU were above the 95% target for the audits. In September 2015 the unit had scored 100%. In November 2015 there was a hygiene spot check and results were shared at the sisters meeting. The unit scored 92.5%. The check found the sharps bins were not closed when not in use. As a result, staff were reminded to keep them closed.

## Environment and equipment

- At the previous inspection we noted a range of necessary technical equipment around patient beds which made the working environment cramped. At this inspection the environment was less cluttered and we were told by the unit sister that steps had been taken to

improve tidiness. This made it easy for staff and visitors to move around beds. The environment remained tight for space and this would not be fully resolved until the move to the new ICU.

- At the previous inspection the sluice room was adjacent to the clean storage room and access to the sluice was via a 'clean' area. At this inspection we found that the 'clean area' had been cleared of equipment and was now used as a barrier between the sluice room and entry to the main equipment store. The risk of contamination from the sluice room on clean equipment stored in the 'clean area' had been removed.
- We looked at the resuscitation equipment and appropriate daily checks were completed and documented.

## Medicines

- The Core Standards for Intensive Care Units (2013) (Pharmacy cover guidelines) states there should be at least 0.1 whole time equivalent specialist pharmacist for each single Level 3 bed and for every two Level 2 beds. We found the service did not meet these standards.
- During this inspection we found the ICU did not have a full time pharmacist. The pharmacist covered the unit between 9:00 am – 12:00 pm and they did not have any other commitments whilst covering ICU. The pharmacist for ICU told us they were running at about half the recommended levels. Staff felt that the ICU pharmacy cover was adequate. We did not see any evidence of medication not being available when required. Staff told us they did not experience delays in getting medication
- There was some flexibility in the pharmacy rota to send a pharmacist back to the unit if work was needed to be completed in the afternoons during the week.
- There was support from stores for stock control and rotation of medication to ensure medicines were available and medication was still in date for use.

## Records

- We looked at five patient records and they were appropriately completed. Care plans were used and completed for each patient.
- The patient records were a mixture of paper and electronic records. The trust was introducing an electronic patient record to replace the current records in early 2017.

# Critical care

- Risk assessments were completed and care was given to reduce any risks identified. For example patients who were at risk of pressure ulcers were nursed on pressure relieving mattresses.

## Safeguarding

- Safeguarding policies and procedures were available to all staff on the trust intranet. Staff we spoke with were aware of how to access information and how to raise a safeguarding concern.
- Safeguarding concerns were discussed at monthly sisters and unit meetings.
- In November 2015, 96% of staff in the surgical and anaesthesia division had completed adult safeguarding training Level 1 and 51% of staff had completed adult safeguarding training Level 2.
- The November 2015 Division of Surgery and Anaesthesia Performance Review acknowledged the poor progress with Level 2 safeguarding training. The trust provided figures which showed that in March 2016, 95% of staff had completed Level 2 adult safeguarding training. We did not receive training information broken down by wards.
- No staff on critical care were required to complete Level 3 safeguarding training.

## Mandatory training

- All staff were expected to update their knowledge on core subjects on an annual basis, mandatory training included infection control, fire safety, health and safety and administration of medicines.
- In July 2015, 90% of ICU nursing staff and 86% of consultants had completed their mandatory training requirements.
- Mandatory training was reviewed as part of the surgical and anaesthesia division monthly performance report.

## Assessing and responding to patient risk

- The trust continued to use an early warning score system which supported the process for early recognition of patients who were deteriorating and who required prompt medical assessment/intervention.
- Assessing and responding to patient risk continued to be supported by the outreach service which ran five days per week between 8am and 5pm hours, with an escalation policy for the deteriorating patient out of hours. The adult critical care quality key indicators

report 2014 stated that demand for the outreach service should be monitored and reviewed to ensure the needs of deteriorating patients out of hours are met. The trust told us this review had not taken place.

- At the previous inspection members of the medical team acknowledged that not all patients were consistently reviewed by a consultant, in person, within 12 hours of admission.
- During this inspection every patient had a consultant review within 12 hours but this was not always a face-to-face review. This was because the on-call consultant could leave work at 6pm hours Monday to Friday and a patient could be admitted at 7pm and not be reviewed face-to-face by a consultant until the following morning. However, the unit would speak with a consultant or on call staff by phone if there was a concern out of hours and they would attend the patient if required.
- The service had submitted a proposal to increase resident consultant staffing until 9pm, 7 days/week and this was discussed at divisional level and the trust told us it would feed into the 7 day working group programme for 2016. This proposal had the support of the ICU consultants.
- If medical care was urgently required and a member of the ICU team was not immediately available then the anaesthetic team staffing the acute operating theatre was called.
- We observed a ward round and all patients were reviewed and discussed by staff.
- During our visit we observed staff looking after patients requiring Level 3 critical care support in the operating theatre recovery area. Level 3 support was normally required by patients needing advanced respiratory support or basic respiratory support with support also provided for at least two organ systems. This is the level of care normally provided on an intensive care unit (ICU).
- Staff told us the recovery area sometimes had two patients requiring this level of critical care during the busy winter period when intensive care beds were full and it was not possible or in the interests of the patient to transfer them to another hospital. Clinical staff sometimes made the decision to proceed with a major case, which required Level 3 support post-operatively rather than cancel the procedure if there was no critical care bed available.

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- The clinical director for surgery and anaesthetics told us there were times when current intensive care capacity in the trust (8 Level three beds and 8 Level two beds) was exceeded but any decision to provide this level of care outside ICU was closely monitored. Following our inspection the trust sent us a document describing the trust's policy for managing critically ill patients in the nucleus theatre recovery area when all ICU beds were full.
- The trust told us patients admitted to recovery remained the responsibility of the ICU team and the parent specialty, as was normal practice for any critically ill patient. A minimum of twice daily reviews took place, sometimes more if required by the patient's condition. Reviews were recorded in the patient record. If medical care was urgently required and a member of the ICU team was not immediately available then the anaesthetic team staffing the acute operating theatre was called.
- The post anaesthetic recovery area was identified on the risk register because they did not have continuous a capnography. Since 2007 the Association of Anaesthetists of Great Britain & Ireland (AAGBI) has recommended that all areas where patients may be managed with airway devices in place should have access to continuous capnography so that the early detection of airway problems can be recognised. There were no mitigating controls put in place on the risk register to reduce the risk of airway problems not being recognised. The trust told us that the current position is that additional capnography machines had been purchased and were available for all patient transfers as well as devices being available on every ventilator. All anaesthetic and intensive care staff are aware of this development and were following recommended use of capnography to assess correct tube position and ventilation following movement of the patients.
- There were structured handovers to the ward staff for patients being discharged.

## Nursing staffing

- At the inspection in October 2014 we received some concerns that ICU nurses were being used on occasion to fill short staffing on other wards. The trust confirmed that only when there was legitimate ICU/HDU nursing

capacity available above that required to meet the needs of patients within ICU/HDU would consideration be given to moving a nurse to a non ICU/HDU environment.

- During the inspection in January 2016 we were told ICU nursing staff were no longer sent to cover shortages on other wards. Nursing staff we spoke with confirmed they were no longer sent to cover shortages on other wards.
- Staffing numbers for critical care was 13 registered nurses (RN) and two Health Care Assistants (HCA) for a long day. Of these staff, 11 RNs and one HCA staffed ICU and two RNs and one HCA staffed the four HDU beds on ward 21. There were 13 RNs and one HCA for nights. Of these staff, 11 RNs and one HCA staffed the main unit and two RNs staffed ward 21 for nights.
- We looked at the staffing fill rates on ICU for November and December 2015. In November the fill rates for nursing staff was 98.1% during the day and 96.2% at night. In December 2015 the nursing fill rates were 95.8% during the day and 85.4% at night. Care staff worked during the day and the fill rates were 81.4% in November 2015 and 75.8% in December 2015. Any gaps in the rotas were covered by ICU staff. Staff told us there was always enough staff on duty.
- Planned and actual staffing numbers were displayed in the unit. We found that actual levels of staffing matched the planned level of staffing.
- On ITU, we observed Level 3 patients being nursed one to one, on HDU we observed Level 2 patients being nursed on a two patients to one nurse basis. This matched best practice guidance.
- During the inspection we were told by theatre staff and senior managers that sometimes critically ill patients were cared for in the Nucleus theatres recovery area. This would happen when ICU was full and the patient needed a higher level of care. The trust told us when patients were cared for in theatres, ICU staff would provide support and advice to theatre staff. When the patient was admitted, one recovery nurse was dedicated to the patient. If this happened overnight, the on-call nurse was called in. Where appropriate, the ICU nurse responsible for critical care outreach for the day would care for the patient or provide support.
- At this inspection, we spoke with the unit matron about numbers of healthcare assistants (HCAs) on the unit. The unit had 6.8 whole-time equivalent (WTE) HCAs,



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which will be increased 9.31 WTEs. There were two HCAs on duty during day shifts and none on night shifts. However, the unit was imminently putting in on one HCA during night shifts.

## Medical staffing

- The medical consultant cover was the same as found during the previous inspection and there remained a mix of accredited intensivists who covered the unit for a week at a time, and consultants in anaesthesia and intensive care, who covered on a sessional and on-call basis.
- The consultant on-call rota was one consultant to 14 patients. This was in-line with core standards for intensive care units guidance (2013) which suggests a consultant / patient ratio of not in excess of 1:14.
- At the previous inspection, we were informed by medical staff working in the unit that anaesthetic theatre cover was an issue. At the time of the previous inspection proposals had been put forward from the divisional clinical director and divisional general manager to permanently remove the weekday daytime second consultant with a view to relieve pressures on the theatres anaesthetic rota.
- During this inspection we were told by the clinical director and operational manager and staff that the removal of the second consultant was no longer going to happen. We looked at the rotas for November 2015 and there was appropriate consultant cover on the unit.
- We found medical staff were still covering maternity as second on call at night but the trust told us they were reviewing this. Staff told us it was not a problem because they were rarely called off the ward to cover maternity. The trust told us they were currently reviewing the cover until 8pm to ensure compliance with the NHS England D16 NHS Standard for Adult Critical Care standards.

## Major incident awareness and training

- We observed the major incident folder was available at the nurse's station for staff to access easily.
- There was yearly training on major incident awareness. Staff told us the folder was accessible and it contained action cards as prompts they followed.

## Are critical care services effective?

Good



We rated this service as good for effective because:

- We looked at the mortality and morbidity ratios for the service and overall there were no areas for concern.
- We looked the Intensive Care National Audit and Research Centre (ICNARC) data for April 2015 to June 2015. We found the unit was performing as expected to other similar units for 37 of the reported outcomes including length of stay in all hospital admissions, transfers out and non-clinical transfers out.
- The service was performing better than similar units for eight of the reported outcomes including discharges out of hours, early discharges and unit acquired infections in blood (ICNARC).
- The medical staff now worked one week in seven on ICU and therefore met the Core Standards for Intensive Care Units.
- Nursing staff had access to critical care training at the local university. The service was in discussion with the university for four student places to be available for nursing staff to attend training annually.
- The unit provided patients with information about support available following discharge. Patients were also able to contact the unit for advice.

However –

- We found policies were out of date and had not been reviewed and updated. Policies we looked at did not refer to current guidance and standards. There was a risk that patients would not be receiving care and treatment in line with evidence based standards and procedures.
- The service was still not seeing all patients within 12 hours of admission although improvements had been made and processes put in place to mitigate the risk.
- The unit was still not compliant with NICE guidelines on rehabilitation after critical illness in adults because they did not have one to one contact with the patient following discharge.

## Evidence-based care and treatment

- At the previous inspection a sample of critical care policies were reviewed which were on the trust's intranet site. The policies reviewed during that

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inspection did not conform to the trust format or have a review date. For example, the policy on ventilator management was written in November 2013 and the policy for the management of sepsis was written in 2010.

- During the inspection in January 2016 we looked at 11 policies used on ICU. We saw that all 11 policies had passed the date for their review and were not in trust format. For example, we looked at the policy for the management of sepsis and it had not been reviewed following the previous inspection. We looked at five policies which did not have a start or a review date and they did not have an author for the policy. Policies we looked at did not refer to current guidance and standards. There was a risk that patients would not be receiving care and treatment in line with evidence based standards and procedures.
- During the inspection in October 2014 the service was not collecting and auditing Ventilator Associated Pneumonia (VAP) data. At this inspection the service had started to collect VAP data but had not yet collected enough information to complete an audit. They planned to complete an audit when they had collected six months of data in June 2016.
- The ward consultant and ICU consultant were involved in the decision to admit to ICU. Discharge from ICU occurred during the hours of 7am – 10pm if possible. We looked at five patient records and saw the reason and decision to admit was documented.
- We observed care was supported by evidence based guidance and practice. For example we observed a patient's level of sedation was reviewed in line with guidance. Nutrition and pressure care were assessed in line with national guidance.

## Pain relief

- As in our previous inspection, there was an acute pain team that worked across the trust and covered ICU/ HDU. As before, visits were not on a daily basis and were dependent of the type of pain control interventions patients were receiving.
- Pain relief was available and patient pain scores were recorded and monitored on the patient record as part of daily routine monitoring. We looked at five patient records and pain levels were recorded and assessed appropriately.

- Pain relief was discussed during the ward round. We observed medical staff discussing pain relief for three patients during the ward round.
- Staff told us they assessed patient pain levels by observing non-verbal signs, such as facial expression as well as talking with patients.
- Staff were able to access the pain assessment team if they required advice to manage a patient's pain levels. Staff told us the pain team would visit the ward if required.

## Nutrition and hydration

- Nutrition and hydration assessments were completed for all patients. We looked at five records and all patients had a completed Malnutrition Universal Screening Tool (MUST) score and risk assessment. The MUST record is a means of preventing malnutrition by, for example, recording changes in weight and body mass index. One patient had been referred to a dietician.
- There was a dietician who attended the unit daily to review patients in ICU.

## Patient outcomes

- At the previous inspection we looked at the 2013 adult critical care quality key indicators report for Yorkshire & Humber, which made reference to the NHS England D16 NHS Standard for Adult Critical Care. In relation to this standard, the critical care service fell short in several areas such as patients being reviewed by an ICU consultant within 12 hours of admission, compliance with NICE guidance for rehabilitation and consultants being freed from other duties and clinical commitments when covering ICU on-call.
- The trust told us the current arrangements regarding consultant assessment for patients within 12 hours of admission had been reviewed by the medical director. Following the review consultants were available Monday to Friday and at weekends. The arrangement was that consultants were informed of all admissions to ICU in person or by telephone by the ICU doctor on duty and they would attend if requested or if the situation called for them to attend. We were assured the unit was working on an improving picture.
- The trust had developed a proposal to increase resident consultant staffing until 9pm, seven days a week. These

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proposals were being discussed at divisional level and were supported by the ICU consultants. Medical staff we spoke with told us they had been involved in the review of consultant cover.

- We looked at the mortality and morbidity ratios for the service and overall there were no areas for concern and figures were within expected limits.
- The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC) to allow the unit to monitor outcomes and compare performance with similar units. The ICNARC Audit data for April 2015 to June 2015 showed the unit was performing as expected to other similar units for 37 of the reported outcomes including length of stay in all hospital admissions, transfers out and non-clinical transfers out. This was the most recent available data that had been externally validated, that was available to us at the time of inspection.
- ICNARC data showed the service was performing better than similar units for eight of the reported outcomes including discharges out of hours, early discharges and unit acquired infections in blood.
- ICNARC data reported the ICU mortality for ventilated patients was slightly higher than similar units. Patient mortality was reviewed at mortality meetings attended by all staff to look at how they could improve patient care and outcomes, including for ventilated patients.
- For elective surgical admissions the unit mortality was as expected with similar units.
- For admissions with trauma, perforation or rupture the unit mortality was as expected to similar units but there had been a spike in mortality for quarter 4.
- For admissions with severe sepsis mortality was slightly higher and admissions with pneumonia were lower than similar units.
- The unit was still not compliant with rehabilitation after critical illness in adults NICE guidelines (CG83) because they did not have one to one contact with the patient following discharge. The unit found follow up appointments after discharge were not well attended by patients. Therefore the unit provided patients with information about support available following discharge. Patients were also able to contact the unit for advice.

## Competent staff

- At the previous inspection there was a concern that critical care competency levels for some medical staff

was variable and the exposure to critical medicine for the eight non-intensivist consultant anaesthetists was too limited. This was affecting on-call rotas and ward rounds in terms of patient safety and expertise.

- During this inspection the Clinical Director for the service told us that medical staff now worked one week in seven on ICU and that they now met the Core Standards for Intensive Care Units. Medical staff we spoke with confirmed they now worked one week in seven on ICU which helped maintain their competence and exposure to critical care medicine.
- Nursing staff had access to critical care training at the local university. The service was in discussion with the university for four student places to be available for nursing staff to attend training annually.
- In November 2014 medical and nursing standards at Bradford were fully compliant with the quality key indicator standards at that time.
- We looked at the appraisal records and found 70.65% of nursing staff had had an appraisal in September 2015.

## Multidisciplinary working

- At the last inspection, and from speaking with staff at this inspection, there continued to be a sense of positive multidisciplinary team working. Staff told us they were able to access dietitians, physiotherapy and pharmacy.
- There were daily ward rounds with medical and nursing staff. Allied health professionals such as physiotherapists did not routinely attend, however allied health professional staff would attend staff handovers to discuss any patient concerns or needs.

## Seven-day services

- At the previous inspection we looked at 2013 adult critical care quality key indicators for Yorkshire & Humber report, it stated that the outreach service did follow-up all discharges from the ICU and all patients referred to outreach were assessed. However, a negative point was that the outreach service was not available as a 24-hour service, seven days a week.
- During this inspection we found the outreach service was still not available seven days a week but there were plans to increase the service when the new unit opened at the end 2016. The Outreach service worked Monday to Friday (8am – 5pm) and there was an escalation policy for the deteriorating patients out of hours. A

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seven day outreach service could have the potential to improve patient experience, contribute towards a reduction in mortality rates, reduce length of stay and improve performance.

- X-ray and computerised tomography (CT) facilities were available as a 24 hour service, seven days a week. Magnetic resonance imaging for cord compression was accessible to the critical care service at weekends.
- Physiotherapy services were provided Monday to Friday during working hours and on Saturday and Sunday mornings.

## Access to information

- Patient information was a mixture of electronic and paper records. Records were available to staff to access.
- Discharge information was kept electronically and discharge information was shared at handovers.
- Patient information documenting who was ready for discharge was shared with all wards.
- There were leaflets available for patients about critical care and support available following discharge.
- Unit meetings were held to discuss issues and share information. For example, staff morale, visiting and complaints had been discussed. A record was kept of the meeting and shared with all staff.

## Consent and Mental Capacity Act

- We observed medical and nursing staff reviewing a patient who lacked capacity and arranging for a 'best interest' meeting to take place to discuss future care options. If a patient lacks the capacity to give consent, a decision on whether to go ahead with the treatment will need to be made by the health professionals treating them. In order to make a decision, the patient's "best interests" must be considered.
- We observed staff asking for permission when providing care to patients. We observed staff asking patients if they wanted to be washed and changed.

## Are critical care services responsive?

Good



We rated this service as good for responsive because:

- Staff now attended bed meetings to discuss discharges from ICU to facilitate quicker discharges from ICU.

- The number of delayed discharges of over four hours had reduced since the last inspection, although some delayed discharges of over four hours still occurred.
- The service planned to move the four HDU beds from a bay on a ward to a larger area which would allow patients to be cared for in a more suitable environment.

However:

- The bed occupancy for the unit was about 92%. It was unclear if the new unit would be sufficient to reduce the occupancy rates because the number of ICU beds was not being increased. According to NHS England NHS Standard for Adult Critical Care, the optimum ICU bed occupancy rate is around 85%.
- Patients were being cared for in recovery in the nucleus theatre because there was not a bed available on ICU. The trust sent us a report which stated that in 2015 the ICU managed an average of 6.5 patients per month for periods outside of the ICU. In February and July 2015, 14 and 20 patients respectively were cared for short periods in areas outside ICU.

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

- At the inspection in October 2014 we looked at the plans for the new unit and it contained the same number of beds (16) as in the existing unit. With the bed occupancy rate at 95%, it was unclear if the same number of beds would be sufficient for the future.
- We reviewed the bed occupancy rate in ICU for 2015 and it had consistently been above 92% except for September 2015 when it had fallen to 86% occupancy. The clinical leads monitored the occupancy rates for ICU and nationally the use of ICU beds had increased. The clinical director had requested one of the clinical leads to review and audit occupancy on ICU.
- During the inspection in January 2016 there were plans to improve patient care and experience by moving the HDU from ward 21 to the former discharge lounge to allow patients to be cared for in two two-bedded bays.
- We reviewed the area identified for HDU and observed that work was being undertaken to make the area suitable for caring for HDU patients.

## Meeting people's individual needs

- Staff were aware of resources available for a patient who had learning disabilities.

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- During the inspection there were concerns raised about the care of a patient who had learning disabilities. We spoke with staff and they told us the patient had a community learning disability worker who would attend all decision making meetings about the patient's care.
- The staff used picture information to communicate with the patient. We looked at the care plan for the patient and there was evidence that the community worker had attended meetings to discuss patient care.
- Interpreting and translation services were available for staff to access if a patient was admitted whose first language was not English.
- There was a relative's room which provided information about the service and support available.
- Relatives could stay overnight and visiting times were flexible according to patient need.
- For patients a delayed discharge can result in psychological and emotional trauma. Studies have found that patients who are cared for on ICU often suffer psychological stress due to the environment of the units and the increased activity within the unit (Jacobs et al 1988, Franklin et al 1983 and Coyle 2001).
- There was other evidence during this inspection that suggested the unit was struggling to meet demand in terms of bed capacity. We found that patients who needed intensive care support were, with increasing regularity being cared for in the recovery area of nucleus theatres.
- During the inspection of the nucleus theatres and recovery area, we observed staff looking after patients requiring Level 3 critical care support in the operating theatre recovery area. Staff within the theatres told us the recovery area sometimes had two patients requiring Level 3 care particularly during the busy winter period when intensive care beds were often full and it was not possible or in the interests of the patient to transfer them to another hospital.

## Access and flow

- At the October 2014 inspection we found there were aspects of the service that presented significant challenges, including high bed occupancy rates and delayed discharge.
- At this inspection, these remained a challenge. Bed occupancy had been at 95% for the previous three years. According to NHS England D16 NHS Standard for Adult Critical Care, the optimum ICU bed occupancy rate is around 85%.
- There were issues with patient discharge from critical care to a ward not being within four hours of the decision to discharge being made. Over 50% of patients had a delayed discharge. However, the ICNARC data for April 2015 to June 2015 showed delayed discharges (4 hours) was as expected compared to similar units
- Staff told us they now attended the bed meetings for the hospital and discharge from ICU was discussed and prioritised to try and ensure patients were moved to an appropriate ward in a timely manner. However, lack of bed availability in the hospital meant that delays in discharge occurred outside of the unit's control.
- The ICNARC data for April 2015 to June 2015 showed discharges out of hours to other wards were better than similar units. Although delayed discharges were better than similar units members of the West Yorkshire Adult Critical Care Operational Delivery Network Clinical Advisory Board (2014) reported that facilitating discharge of patients from critical care appeared to be considered a low priority within the trust. This resulted in delayed discharges and reduced bed availability.
- The trust sent us a report which stated in 2015 the ICU managed an average of 6.5 patients per month for periods outside of the ICU. In February and July 2015, 14 and 20 patients respectively were cared for short periods in areas outside ICU. ICU bed occupancy was an average of 96% in these months.
- In January 2016 the numbers of patient managed for short periods outside ICU had increased to 31. Bed occupancy for ICU was 100% for January 2016.
- We were informed that clinical staff sometimes made the decision to proceed with a major operation on a patient which required Level 3 support post operatively rather than cancel the procedure if there was no critical care bed available.
- The clinical director for surgery and anaesthetics told us there were times when current intensive care capacity in the trust was exceeded but any decision to provide this level of care outside ICU was closely monitored.
- The trust told us that when a patient was admitted to a theatre area, the ICU consultant was contacted and the case was discussed in line with usual practice for any Level 2 or Level 3 admission. The consultant was made aware of the fact that the patient was being admitted to the theatre area. The plan for transferring the patient from the theatre area was discussed at this stage. It was



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planned that the patient would be transferred either to a ward or the ICU within six hours. If this was not possible then the consultant would consider a non-clinical transfer out.

- We looked at data for seven patients who had been looked after in recovery between 2 January 2016 and the 13 January 2016. We found four patients had been admitted from a ward, two patients had been admitted from theatres and one patient had been admitted from ICU. Four patients had stayed in recovery over six hours; for example, one patient had a length of stay of 15 hours and one patient had stayed for 10 hours. Three patients had stayed in recovery under 6 hours. The trust was not adhering to the guidance that patients would be transferred within six hours.
- At the previous inspection there were concerns about the cancellation of elective surgery because of the lack of ICU beds.
- During this inspection we found there had been a reduction in the number of operations cancelled. For the month prior to this inspection there had been five cancelled operations due to a lack of ICU beds. We looked at the board performance report and found between April and October 2015 that 101 operations had been cancelled due to an ICU/HDU not being available. There had been a reduction in the number of operations cancelled from 24 in June 2015 to 8 cancelled in August and September 2015. However in October 2015, 28 operations had been cancelled due to a ICU/HDU bed not being available.

## Learning from complaints and concerns

- There was a policy for managing complaints. Information about complaints was available on hospital website. Information about how to complain was available on the wards.
- Learning from complaints was shared at staff meetings. The unit had not received any complaints between July 2015 and December 2015.
- Learning from complaints received within the division was shared with unit staff.

## Are critical care services well-led?

Requires improvement



We rated this service as requires improvement for well led because:

- At the previous inspection there was a distinct tension between senior clinical staff, particularly medical consultants, and senior directorate level staff. It was clear from discussions that management of change was not always conducted in an open and collaborative way.
- During the inspection we found the relationships within the unit had improved.
- Governance structures were still not embedded and clinical leads had only recently come into post.
- Policies and procedures were not consistently reviewed and kept up to date with the latest guidance.
- Bed occupancy figures were still high and there were limited actions to address this issue. There was no review of unmet demand for beds which was identified as an action from the previous inspection and quality key indicators reports.

However:

- Staff understood the visions and strategy for the new unit.
- Staff told us the relationship between senior managers and themselves had improved,
- Senior managers now attended team meetings and were more visible on the wards.

## Vision and strategy for this service

- The overall vision and strategy for the new unit was understood by most staff.
- At the previous inspection we found there was uncertainty around aspects of the service in relation to the new unit. The new unit was now under construction but the number of beds had not been increased and the service had not completed an audit of bed occupancy and unmet need to ensure the number of beds in the unit would meet the needs of the service.
- The division was planning for a consultant led ICU, implementation of four hour discharge from ICU and



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preparatory work for the development of a critical care unit to be delivered by March 2016. However, there were no actions documented on how the service would achieve these developments.

- There was no review of unmet demand for beds which was identified as an action from the previous inspection and quality key indicators reports.

## **Governance, risk management and quality measurement**

- At the inspection in October 2014 new governance structures had been implemented but were not yet embedded within the service. At this inspection we found the unit had reviewed bed capacity, poor patient flow and cancellation of operations which were on the risk register. Actions to mitigate the risk for bed capacity, poor patient flow and cancellation included the ward manager now attending bed management meetings to facilitate discharge.
- There was a risk identified in PACU for capnography access to monitor patient airways. The directorate had purchased equipment and they were confident staff had been trained to use the equipment and systems and practices were embedded and, therefore, this risk was now resolved. The risk was closed on the risk register on 21 March 2016.
- The ward manager now attended bed meetings to discuss discharges from the unit and to improve patient flow. We saw that the length of time a patient waited for delayed discharges had reduced and improvements were being made to improve patient flow. The trust had improved the length of time patients waited to be discharged. In May 2014, 46 patients had a delayed discharge. The average delay for each patient was 40 hours. In June 2015, 39 patients had a delayed discharge and the average delay for each patient was 19 hours. Although the delayed discharges were improving they still did not meet the four hour discharge target.
- At the previous inspection it had been identified that an audit of bed occupancy on the unit had been completed in 2013. The audit showed that occupancy in the ICU had been consistently at 95% for the previous three years. This was a high occupancy rate. According to the NHS England D16 NHS Standard for Adult Critical Care the optimum ICU bed occupancy rate is around 85%. Senior managers told us that they planned for one of the clinical leads to undertake a new audit of bed occupancy for the unit to identify what improvements

could be made to reduce bed occupancy. However this had been identified as a concern at the previous inspection and the service had still not completed an audit of bed occupancy. The quality key indicators report 2014 recommended the service complete a review of bed occupancy because they did not feel the new unit would reduce the high occupancy rates. The new unit was not planned to have any more beds and if the outreach service became a seven day service then more patients could be identified as requiring an ICU bed.

- We found 11 policies that had passed their review date and were not in trust format. This has been brought to the trust attention at the previous inspection and had not been addressed in a timely way.

## **Leadership of service**

- At the October 2014 inspection there was a distinct tension between senior clinical staff, particularly medical consultants and senior directorate level staff. It was clear from discussions that management of change was not always conducted in an open and collaborative way.
- During our inspection in January 2016 we found that there were new clinical leads in post who spoke positively about the improving relationships between the senior clinical staff and the senior directorate staff.
- We found relationships between ward staff and the senior management had improved. Nursing staff felt supported by the ward manager, who staff told us was approachable and visible on the unit.

## **Culture within the service**

- At the October 2014 inspection the culture of the directorate as a whole had altered, particularly in light of recent governance structure changes, and there was an 'us and them' tension between some consultant grade staff and senior management, which was negatively impacting on change management processes and morale.
- At this inspection we found that relationships between consultant grade staff and senior management had improved. We spoke with nursing and medical staff on the unit who worked on the unit who confirmed that relationships had improved. Senior management now attended unit meetings.

## **Public engagement**

# Critical care

- Patient feedback was collected in May/June 2015. Nine patients provided feedback. Eight patients were satisfied with their overall care.
- The unit had developed an action plan for improving patient experience. Noise levels were identified as a concern by six patients. The action plan highlighted staff should encourage the use of ear plugs by patients to reduce noise levels.

## Staff engagement

- Staff engagement had improved since the inspection in October 2014. Senior managers now attended team meetings and were more visible on the unit.
- The medical director had visited the unit and had talked with staff. Staff confirmed the medical director had visited the ward and found him to be approachable and supportive.
- There were monthly sister and unit meetings which discussed incidents, recruitment and ways of working.
- There had been time out meetings in June and July 2015 to discuss roles and responsibilities, quality improvements and the new unit.

- There was a weekly bulletin for staff published on the intranet.

## Innovation, improvement and sustainability

- Bradford had volunteered to be a pilot site for the neurosciences electronic referral system and was working with the regional neurosciences unit at Leeds Teaching Hospitals NHS Trust.
- The service was moving into a new ICU unit at the end of 2016. The new unit would improve patient experience and care.
- The new ICU would comply with the NHS England D16 NHS Standard for Adult Critical Care.
- The service was reviewing nurse staffing and introducing non-qualified staff to provide extra cover at night.
- The service was moving HDU beds from ward 21 to the former discharge lounge to allow patients to be cared for in two 2 bedded bays instead of a single four bedded bay.

# Maternity and gynaecology

Safe

Requires improvement



Overall

Good



## Information about the service

The maternity service at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) provided a full range of maternity and gynaecology services for women and families based in the hospital and community settings. These ranged from specialist care for women who needed closer monitoring, to a home birth service for women with healthy pregnancies. Six teams of community midwives delivered antenatal and postnatal care in women's homes, clinics and general practitioner locations across the city. An integrated women's health unit also provided a range of treatments for gynaecological problems.

Between July 2014 and June 2015, the total number of births at the maternity unit was 5,770.

The service offered both medical and surgical termination of pregnancy. Between April 2014 and March 2015, there were 853 medical abortions and 217 surgical abortions.

In October and November 2014, CQC carried out an announced comprehensive inspection and rated the service as good overall. We rated effective, caring, responsive and well led as good and the safe domain required improvement. The staffing levels and skill mix did not always meet national recommendations, and staff handovers were not always effectively managed. Completion of mandatory training rates were between 60-78%, which meant staff may not have accessed up-to-date knowledge and skills. There were gaps in recording new born and adult resuscitation equipment checks and the daily medicines, refrigerator temperature checks.

This inspection took place on the 11, 12 and 13 January 2016. It was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection. We visited the antenatal clinics, antenatal day unit, early pregnancy assessment unit, birth centre, labour ward, obstetric theatres, transitional care and postnatal wards. We spoke with three women and 47 staff, including

midwives, midwifery support workers, doctors, anaesthetists, consultants and senior managers. We observed care and treatment, looked at 11 sets of women's care records and reviewed the trust's performance data.

# Maternity and gynaecology

## Summary of findings

We rated this service as good overall but required improvement for safety. Staffing levels and skill mix had improved since our previous inspection in October 2014. However, further planned recruitment was to take place and staff had not yet experienced the full benefit of the recruitment made towards the end of last year. Nurse staffing shortfalls continued for the labour ward, theatres and staff continued to cover shortages on the labour ward.

At the previous inspection, the morning staff handover consisted of four separate staff handovers, followed by a ward round. The arrangements were not always effectively managed, which at times resulted in overlap between teams and some delays. Since that inspection, the handover process had been reviewed. The changes were to reduce the lengthy process and improve the handover period.

We found staff had not always checked the resuscitation equipment daily to ensure it was available in an emergency. This was also identified at the previous inspection.

Daily checks of medicines and infant milk storage refrigerators were not taking place. This meant staff would not know if the medication or milk products had been stored within the correct temperature range and remained safe to use.

The trust was not meeting its 95% target for mandatory training. Although attendance rates for movement and handling training for nurses and midwives was 98 - 100% for other clinical staff it was 55% and administration and clerical staff it was 49%. Fire training was between 61 - 100% compliance.

There were effective systems for reporting, investigating and acting on adverse events and there was an up to date incident reporting and investigation policy. Staff were able to give examples of feedback received from incidents, lessons learnt and action taken where appropriate, to prevent a similar situation occurring.

The consultant obstetricians cover for the labour ward had increased, from 60 to 98 hours per week since the last inspection. This complied with the Royal College of Obstetricians and Gynaecologists (RCOG) best practice standard for consultant labour ward cover.

Women's services were clean, well maintained and there were effective systems in place to monitor infection control.

Records relating to women's care were of a good standard and stored securely in line with the data protection policy.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Requires improvement



We rated safe as requires improvement because:

- The births to midwife ratio was 1:30 against the nationally recommended Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007) ratio of 1:28. Staffing levels and skill mix had improved since our previous inspection in October/November 2014. However, further planned recruitment was to take place and staff had not yet experienced the full benefit of the recruitment made towards the end of last year. Nurse staffing shortfalls continued for the labour ward theatres and staff continued to cover shortages on the labour ward.
- We found staff had not always checked the resuscitation equipment daily to ensure it was available in an emergency. This was identified at the previous inspection.
- Daily checks of medicines and infant milk storage refrigerators were not taking place. This meant staff would not know if the medication or milk products had been stored within the correct temperature range and remained safe to use.
- The trust was not meeting its 95% target for mandatory training. Although attendance rates, for movement and handling training for nurses and midwives was 98 - 100% for other clinical staff it was 55% and administration and clerical staff it was 49%. Fire training was between 61 - 100% compliance.

However, we found that:

- There were effective systems for reporting, investigating and acting on adverse events and there was an up to date incident reporting and investigation policy. Staff were able to give examples of feedback received from incidents, lessons learnt and action taken where appropriate, to prevent a similar situation occurring.
- Women's services were clean, well maintained and there were effective systems in place to monitor infection control.

- Records relating to women's care were of a good standard and stored securely in line with the data protection policy. These were detailed enough to identify individual needs or risks and how they were to be managed.
- There were clear safeguarding processes in place. Staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- Labour ward consultant obstetric cover had increased since the last inspection from 60 to 98 hours per week. This complied with the Royal College of Obstetricians & Gynaecologists (RCOG) (2007) best practice standard for consultant labour ward cover.

### Incidents:

- The trust had an incident reporting and investigation policy. Staff used a risk grading matrix to identify and report incidents. The trust had a weekly quality of care panel, which enabled the executive directors to review all incidents that met the threshold for declaration as a serious incident.
- Within three days of being reported, the nominated individual where the incident occurred carried out a review. The review looked at the grading of the incident, confirmation of the priority and level of investigation/ response required and considered any trends. Where a serious incident was identified, the trust had procedures available on their internet for staff to immediately follow. These included informing key senior management staff.
- Between 1 January 2015 and 31 December 2015, there were 1055 incidents reported in women's services. One incident was reported as serious, three moderate, 540 were low risk and 511 incidents were reported as no harm.
- A Route Cause Analysis (RCA) report had been completed following the serious incident, which highlighted lessons learnt and contributing factors.
- Staff were able to give examples of feedback received from incidents, lessons learnt and action taken where appropriate to prevent a similar situation occurring. For example, following the learning from the serious incident, there was a change in guidelines as to when women should have fetal monitoring following induction. However, several staff were not all aware of

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changes, which had taken place. This was because they were new to the service and the changes in practice, including the update to the trust guidelines, had taken place prior to their appointment.

- On ward M4, a midwife had the responsibility to keep staff up to date with incidents that had arisen within the service and any 'hot topics of the week.' This included learning from incidents and changes as a result.
- The risk management midwife sent out emails and memos to staff relating to incident themes and trends. There was a monthly newsletter and staff briefings for maternity services. They included risks, themes, trends and lessons learnt from incidents.
- Clinical practice issues were referred to the midwifery supervisors who played an active role in managing maternity risks. There were clinical managers and staff drop in sessions for doctors as part of their learning. There were also discussions at staff meetings and clinical supervision.
- Monthly perinatal mortality and morbidity meetings were held and attended by a multidisciplinary team. Serious cases, including stillbirths and neonatal deaths, were reviewed and presented at a peer group.

## **Duty of Candour:**

- Duty of Candour was introduced as a statutory requirement for NHS trusts in November 2014. Staff told us they understood the need to be open and honest with families when things went wrong.
- The trust had a policy document 'Duty of Candour, including Being Open.' The policy had initially been dated 2013. We saw the document had been up dated and was awaiting ratification by the Clinical Executive.
- We saw an example of the duty of candour being met where a women's delivery had not gone according to plan. The patient had received a debrief and explanation from their midwife, registrar involved in their care and the clinical lead and matron for the service. This showed the trust was open and transparent with patients about their care and treatment when things went wrong.

## **Safety thermometer:**

- The safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Information for 2015 indicated that there were no noticeable trends for pressure ulcers, falls with harm or catheter acquired urinary tract infections.

- In the period April 2015 to October 2015, the maternity service performance against carbon monoxide testing achieved 98.8% performance. There was 100% referral to Smoking Service performance.
- The performance report for obstetrics and gynaecology showed that between November 2014 – October 2015, 100% of women had received a venous thromboembolism (VTE) assessment against a trust target of 97% in five out of seven unit/ward areas. The other two areas achieved between 81% and 100%
- Prevention of venous thromboembolism (VTE) documentation had been correctly completed in all 11 care records we inspected.

## **Cleanliness, infection control and hygiene:**

- The areas we visited were visibly clean and equipment had stickers on them, which showed they had been cleaned.
- The Patient-led Assessment of the Care Environment (PLACE) was 100% for cleanliness in 2015, compared with the England average of 98%.
- Staff reported they had infection control training and data showed between 96% – 100% of staff had received training.
- We saw that staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons. Hand sanitising gel dispensers were available at the entrances to clinical areas.
- Women were screened for Methicillin-resistant Staphylococcus Aurous (MRSA) before undergoing an elective caesarean section. From August 2014 to August 2015, there had been no cases of either MRSA bacterial, or Clostridium difficile infections.
- Women were screened for Hepatitis B and HIV at booking. This ensured early detection and the correct pathway of care was commenced.

## **Environment and equipment:**

- Access to the delivery suite and wards was via an intercom system which enabled staff to monitor people visiting these areas. There were environmental systems and procedures in place to protect the security of new born babies. Staff attended baby abduction drills. A drill had taken place in August 2015, information showed learning and action needed by staff was recorded.
- With the exception of one community member of staff, all staff confirmed they had sufficient equipment to



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meet patients' needs. This included equipment on the wards to ensure safe care, such as cardiotocography (CTG), which records the fetal heartbeat and resuscitation equipment.

- On ward 3, the Dinamap Portable Appliance Testing (PAT) expired in November 2015, and the Ophthalmoscope had no test date label on it. On the labour ward, there was a set of baby scales which had been tested in December 2013 and were out of date. This meant there was a risk the scales did not weigh properly. All other portable electrical equipment inspected was in date.
- There was no risk assessment or policy/procedure for the storage of baby milk products in the ward milk refrigerators. The refrigerator was not locked. This meant anyone could have access and potentially tamper with the contents. The temperature of the milk refrigerator was not monitored and recorded to ensure it was maintained at the required temperature.
- The resuscitation equipment checks had not consistently been recorded daily and in all areas. For example, on ward M3, although there were occasional omissions in record keeping, daily checks of the adult and baby resuscitation trolleys had taken place. However, in the theatre recovery room, the adult resuscitation trolley had not been checked on 11 occasions between 1 December 2015 and 12 January 2016. A further five baby resuscitation trolleys were inspected across the unit and there were several omissions in the daily recordings during December 2015 and January 2016.
- There were three birthing pools. One pool had a hoist and all pools had an evacuation sling. Staff confirmed they had training in the use of both the hoist and evacuation sling. We also saw a standard operating procedure for use of the equipment.

## Medicines:

- Medicines were stored and maintained correctly and appropriate checks recorded. This included controlled drugs. However, on the labour ward, epidural wastage was not being disposed of correctly, in line with best practice.
- On the labour ward, we saw several blood sample collection bottles had passed their expiry date. These were brought to the attention of staff and taken out of use at the time.

- In the labour ward theatre, we saw three infusions (of Hartman's solution) had been prepared in readiness for the theatre list that day. The list had been cancelled and the infusions had not been disposed of. This was brought to the attention of the trust. The trust confirmed, although it was good practice for anaesthetists to prepare the drugs in advance, (as agreed by the Royal College of Anaesthetists,) they would be auditing the practice to ensure that drawn up drugs are discarded immediately when a patient's operation is cancelled.
- At our previous inspection in October/ November 2014, the refrigerator temperatures had not been consistently recorded on a daily basis. Although we noted there had been improvements in record keeping, there continued to be omissions.
- For example on ward M4, between 1 December to 31 December 2015, there had been 22 occasions when the temperatures had not been recorded for one of the two refrigerators. With the exception of one day, the temperature of the second refrigerator had been recorded consistently between 1 December to 26 December 2015. However, there were three occasions (Between the 1 - 21 January 2016,) when the temperature had exceeded 8°C and had reached 10.1°C. There was no record as to any action taken at the time of these recordings. We brought this to the attention of the ward manager at the time of inspection. On the labour ward, completed refrigerator record sheets had been mixed up. This meant staff had no way of identifying which record sheet related to which refrigerator.
- The refrigerator temperature in the labour ward theatre had not been recorded. This meant staff would not know if the medication had been stored within the correct temperature range and remained safe to use.

## Records:

- We inspected 11 sets of women's (in-patient) clinical records, which had been completed to a good standard. Each record contained a clear pathway of care, which described what women should expect at each stage of their labour. When not in use records were kept safe in line with the data protection policy.
- Risk assessments were completed and we saw they identified potential or actual risks.

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- Audits of records formed part of each midwife's annual supervisory review.
- Electronic antenatal records were introduced in April 2014. Staff members' experience of the process was positive.
- Women's personal child health records (also known as the PCHR or 'red' book) were given back to parents before discharge. We saw an example of one of the records, and it had been completed correctly.

## Safeguarding:

- The trust had an up to date safeguarding adult and children policies. There was an effective system for safeguarding mothers and babies.
- Risk assessments and clear pathways of care were in place to identify women and children at risk.
- The service had a lead midwife for safeguarding, responsible for managing child protection and domestic violence issues.
- Staff had a good understanding of the need to ensure that vulnerable people were safeguarded and understood their responsibilities for identifying and reporting any concerns.
- Safeguarding training was mandatory. The trust training matrix dated 12 December 2015 showed 94% of nurses and midwives had received children's safeguarding training and 98% had received adult safeguarding training.
- A guideline and flow chart was in place to support staff in the identification and management of those at risk of female genital mutilation (FGM). The World Health Organisation defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. It is mandatory for all acute trusts to report to the Department of Health, on the number of patients who have a family history, or had FGM. Staff were aware of the guidance and procedure in place. Between September 2014 and December 2015, there were 71 reported cases.

## Mandatory training:

- Staff received a combination of face-to-face training and electronic learning. At the previous inspection in October/November 2014, the mandatory training figures were between 60%-78%. Although there were areas where improvements were needed, the training figures since the last inspection had improved.

- Mandatory training figures for women's services in December 2015 showed:
- Movement and handling training for nurses and midwives was: 98% - 100%; for other clinical staff it was 55%, and administration and clerical staff it was: 49%
- Fire training was between: 61% - 100%
- The trust provided figures following the inspection, which showed in March 2016, adult basic life support training was between 62% and 100%, with overall compliance of 73.5% against the trust target of 95%. Movement and handling training was between 56% and 71%, with overall compliance of 65.5%. Fire safety training was between 29% and 92%, with an overall compliance of 73%.
- Staff expressed mixed views about the mandatory training they attended.
- At a focus group meeting, band 7 midwives and above told us all training was booked a year in advance and that the head of midwifery supported three mandatory training days. They also told us staffing levels were improving, not as many permanent staff were covering shortfalls and more staff were managing to attend their booked training.
- Some midwives below band 7, told us they had problems managing to attend training sessions. Some staff also told us that on occasions they had to complete their on line training in their own time. One member of staff also told us they had escalated the fact that the training on the Mental Capacity Act 2005 was 94 pages long which meant staff had difficulty completing the training on-time.
- Update skills, drills and fetal monitoring training for January 2016 was at 79% compliance across the multi-professional team. This included midwives, community midwives, nurses, and health care assistants. Just over 4% of new staff had not yet received the training.
- The head of midwifery told us figures for mandatory training should improve now staffing levels had improved.
- Staff told us they worked supernumerary during their induction and felt supported.
- New qualified midwives undertook a period of preceptorship. During this time, they had access to extra support and training.

## Assessing and responding to patient risk:

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- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. Records we inspected contained completed MEWS tools. Observation audits carried out on wards M3 and M4 in December 2015, showed they were 96.77 and 96.88% compliant respectively.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in line with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery guidelines – a surgical safety checklist in operating theatres.' We inspected four checklists and saw they had been completed correctly.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- High dependency care was provided in a designated room on the labour ward. If a woman required this care, the consultants and registrars in obstetrics and anaesthetics were involved in the decision-making process.
- We saw evidence the unit used the 'fresh eyes approach', a system that required two members of staff to review foetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation.
- At our last inspection, we found that staffing levels might not have always been satisfactory to adequately cover shifts. Staff were regularly moved to the labour ward during the night shift, leaving one midwife to cover the ward.
- At this inspection staff told us, and we saw, how the 'hot desk' midwife managed the midwifery staffing through the day. Band 7 midwives told us they rotated to cover this position one day every six weeks and when on duty they liaised with the coordinators/ managers. Out of hours, the band 7 labour ward coordinator carried out this role and had access to a supervisor of midwives (SOM) on call. This meant staffing levels were monitored, better organised and staff allocated appropriately.
- There was an escalation policy to address staffing shortfalls and we heard how an overview of the unit was taken throughout each 24-hour period. Changes were made where needed to ensure sufficient staff and this may have included the reduction in bed numbers to maintain safety. We saw the hot desk midwife had assessed the activity level on the adjoining birthing unit when there was increased activity on labour ward. Because there had been little activity on the birthing unit a member of staff was asked to work on the labour ward.
- We saw that the board of directors' agenda for 10 December 2015 had included maternity services and a six monthly staffing review. It stated it had used staffing ratios based on the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) recommendations of one midwife to 28 births for a number of years. Latterly, they had used the Birthrate Plus (BR+) study. (This is a national tool that for any given maternity service which calculates the number of clinically active midwives required to deliver a safe high quality service). The study had taken place three times and each time demonstrated the need for more staff in maternity services.
- The document stated the trust was now in line with the regional average ratio of 1:30. The last BR+ study in 2014 demonstrated the need for an additional 22 whole time equivalent (WTE) midwives and 2.6WTE midwife support workers (MSWs).
- Investment was made in the recruitment of the MSWs and 6.5WTE midwives. Bringing the deficit from the BR+ recommendation to 15.5WTE midwives. The document

## Midwifery staffing:

- The births to midwife ratio was 1:30 against the nationally recommended Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007) ratio of 1:28.
- The maternity dashboard showed that between April and December 2015, women received 1:1 care in labour between 72.5% and 79.7% of the time. On three occasions this was not in line with the trust goal of more than 75%. However, during the inspection, we did not receive any concerns from women who had received treatment or care. All of the women we spoke with confirmed they had received 1:1 care throughout their labour.

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also stated the trust would assess the impact of the investment of the midwives who were recruited into post in October 2015. This was to take place in April 2016.

- The trust figures showed 3.78WTE midwives, band 5/6, vacancies had gone out to advert with a closing date of 15 and 16 January 2016. Further Health Care Assistant (HCA) posts (2.22WTE) and MSW posts (2.47WTE) had also been given recruitment approval.
- In January 2016, figures showed the nursing/midwifery sickness rate was 4.81%WTE. Matrons held regular clinics with an HR representative, to support staff to return to work and maintain regular attendance.
- At this inspection we were informed ward M4 was now used as a postnatal ward and had nine transitional care beds. (The transitional care beds meant babies who would normally go to special care were able to stay with their mother). The transitional care beds were staffed by a nurse trained in this field of expertise.
- Ward M4 had one registered nurse and five midwives in the morning, four in the afternoon and two at night, with additional support staff. One member of staff told us they had been in post since September 2015. They said since joining the ward none of the staff had been asked to work in another area during the night. This showed staff movement to other areas of work was reducing. Staff said there was a shortage of one midwife on the night shift on the ward and the hot desk midwife had planned to move someone from either the birth centre or labour ward. They said staffing felt much better and it had, "Never been better." We inspected the duty roster for the previous month and saw there was an occasional reduction of one staff at night.
- Ward M3 was a mixed antenatal and postnatal ward. During our inspection, the planned and actual staffing numbers were the same. This was five midwives in the morning, four in the afternoon and two at night. A pilot was also taking place on the ward, which meant between three and seven days a week an extra member of staff worked a twilight shift. This meant during those hours there was three staff instead of two. Staff on this ward said the twilight shift had improved the ward. However, they also told us when this person was not available, due to the uncertainty of activity on the ward, the work could become challenging. Some staff did not think two midwives at night was acceptable.

Some community staff told us they thought the staffing numbers were much better and should improve further, once everyone was, "Up and running." We also saw the duty rotas and saw between 9-13 January 2016 and 17 – 23 January 2016 the staffing levels were maintained and shortfalls were not seen.

- During a meeting with staff, they told us that due to previous shortfalls in staffing, they were now finding it difficult to fit annual leave in and had to be paid. One of the staff also told us waiting for the recruitment of administration and clerical staff was frustrating and additional support workers were needed.
- At our previous inspection, there was a rota to provide a theatre team for obstetrics 24 hours a day. Staffing for obstetric theatres was separate from the labour ward roster for elective cases during the week. However, for all emergency cases and out of hours, midwives from the labour ward provided the theatre scrub nurse role. Should the labour ward be busy, the absence of this staff member could have an impacted on the staffing levels within the labour ward. At this inspection, the staff reported a business case had been drafted and was ready for submission. It included the request for a second member of permanent staff to cover the obstetric theatres. In the interim, the labour ward staff continued to provide cover. If staff were not available, the coordinator would follow the escalation procedure and pull staff from wards, or escalate the situation to the supervisor of midwives (SOM) who would attend the hospital if called.
- At the previous inspection, the morning staff handover consisted of four separate staff handovers, followed by a ward round. The arrangements were not always effectively managed; which at times, resulted in overlap between teams and some delays. Since that inspection, the handover process had been reviewed and changes to improve the process were planned for the 28 January 2016. The changes were to reduce the lengthy process and improve the handover period.
- We observed a morning staff handover on the labour ward. The unit used a recognised communication tool: Situation, Background, Assessment and Recommendation (SBAR). The handover was comprehensive and included information such as, the use of cell salvage for a patient who was a Jehovah's Witness.

## Medical staffing:

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- At the previous inspection in 2014, consultant obstetricians cover on labour ward was 60 hours per week. In July 2014, a business case was approved by the Board of Directors to employ four extra consultant obstetricians. This would allow presence on the labour ward of 98 hours per week with resident cover from 8am-10pm each day. In addition, at the weekends, a second consultant would undertake ward rounds on the ante/postnatal wards and support the labour ward in the morning.
- At this inspection, we were informed by one of the consultant obstetricians that further consultant appointments had been made and the cover for the labour ward had increased to 98 hours. This complied with the Royal College of Obstetricians & Gynaecologists best practice standard for consultant labour ward cover.
- Junior doctor rotas were compliant with working time directives. Out-of-hours cover was available, including one resident middle grade and two senior house officers who covered maternity and gynaecology.
- Daily antenatal and postnatal ward rounds took place and consultants were contactable when required.
- We observed a medical handover, which was comprehensive and involved a multidisciplinary team of staff and the patient.

## Anaesthetic cover:

- The trust assured us that out of hours anaesthesia cover in obstetrics was provided by a duty anaesthetist; who

was a resident trainee that had undergone extensive training in obstetrics. They had also been 'signed-off' as competent. The cover was 24 hours a day and the anaesthetist was resident within the hospital.

- In the event of requiring additional anaesthetic support, this would be provided by a more senior resident anaesthetic trainee, whose duties were to provide immediate support and supervision to the resident duty anaesthetic trainees.
- There was an additional two person consultant rota for out of hours on call. This complied with the Royal College of Anaesthetics guidelines.
- Intervention rates at the unit were low, with Epidural and Lower Segment Caesarean Section (LSCS) rates in the region of 20% (the national average is 24%).
- A review of incident reports over the past two years relating to the obstetric unit had not found any incidents related to anaesthetic staffing or capability.

## Major incident awareness and training:

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



# Services for children and young people

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

## Information about the service

Bradford Teaching Hospitals NHS Foundation Trust provided inpatient children's services at the Bradford Royal Infirmary site. There were three inpatient children's wards and a neonatology unit.

Ward 16 was a 10 bedded medical ward and included a two bed stabilisation room. Children were cared for in the stabilisation room until the paediatric retrieval team transferred them to another hospital as there was no paediatric intensive care or children's high dependency beds within the hospital. The children's assessment unit was based on Ward 16; this provided three assessment cubicles and four short-stay observation beds. The assessment unit accepted medical referrals from the emergency department, direct GP referrals and children with direct access.

Ward 17 was a 25 bed medical ward and Ward 2 was a 27 bed surgical ward, reducing to 16 beds at night. The hospital also provided neonatal services on a unit of 29 cots.

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

All of the above services were inspected during a comprehensive inspection in October 2014, in which the

service was rated as requires improvement. At that time, we rated safe as inadequate, responsive and well-led as requires improvement, effective and caring were rated as good.

During our follow up inspection we reviewed the safe, responsive and well-led domains. We visited the following areas: Wards 16, 17 and 2, and the neonatal unit. We spoke with eight senior managers, 10 medical and nursing staff members, 12 children and their families. We looked at 13 sets of medical and nursing records and we observed both a nursing and a medical handover.



# Services for children and young people

## Summary of findings

We rated this service as requires improvement; there had been recent increases in staffing to account for winter pressures and the need for staff to attend the paediatric stabilisation unit. However, nurse staffing was below recommended levels. However, there were still frequent staff shortages for shifts across the service. At times staff levels did not achieve 85% of shifts filled.

The trust was progressing in the development of a new building which would address the concerns about the environment in which children were cared for.

The trust had addressed the safety concerns raised about the paediatric stabilisation unit during the comprehensive inspection in October 2014. There were suitably qualified and trained staff to support critically ill children until the paediatric transfer team arrived.

The service had undergone a change to leadership and management structure. The trust had established a children's board and there were clear governance structures to report to the Trust Board. The trust had engaged with staff and the public to contribute to the design of the building to create an environment which was reflective of the needs of local children and families.

## Are services for children and young people safe?

Requires improvement



We found that there had been some improvements since the last inspection, but that there were areas that still required improvement. We found that -

- Nurse staffing levels were not at best practice standards and at times staff levels did not achieve 85% of shifts filled. There had been increases in staffing to account for winter pressures and the need for staff to attend the paediatric stabilisation unit, but at the time of inspection, this was not improving day to day nurse staffing levels across the service.
- A Paediatric Acuity and Nurse Dependency Assessment tool (PANDA) was not embedded in practice to enable adequate staffing of the wards, according to patient acuity.
- The trust was not meeting its 95% target for Level 3 safeguarding training.

However, we found that:

- The trust had addressed the safety concerns raised about the paediatric stabilisation unit during the comprehensive inspection in October 2014. There were suitably qualified and trained staff to support critically ill children until the paediatric transfer team arrived.
- There was appropriate incident reporting and evidence that lessons were learnt, through newsletters and direct feedback from senior staff.

### Incidents

- There were no never events in this core service between August 2014 and July 2015. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented.
- Two serious incidents were reported in children's services. These incidents occurred on the neonatal unit where there were interruptions to the oxygen supply. We saw evidence that serious incidents were investigated and action plans for sharing lessons learnt were implemented. For example, the neonatal unit had oxygen cylinders for emergency use, in response to the incidents.

# Services for children and young people

- A total of 590 incidents were reported between November 2014 and November 2015. No information has been provided on the level of harm associated with these incidents.
- The trust reported incidents using an electronic reporting system. Staff told us they were aware of incident reporting and confident in using the system, however they spoke of the time constraints to report incidents during working hours.
- During our inspection, we were made aware of an incident which had occurred during the night and had not been reported onto the electronic reporting system by the following morning. Senior nursing staff on the ward were aware of the incident and were planning to report it onto the system.
- We saw evidence of information at work stations advising staff of changes in practice related to lessons learnt from incidents. For example there was information for staff about ensuring discharge medication was accurate, to facilitate timely and safe discharge.
- In December 2015, the service produced its first edition of a children's services quality and safety newsletter. This provided an overview of incident reporting across the trust and the changes implemented as a result of incident reporting. We saw this displayed in staff offices.
- During a nursing handover we attended, a senior staff member shared information about medicines management. We were told that sharing information about incidents occurred during handovers and staff meetings. Staff also received emails.
- NHS safety thermometer data indicated there had been one incident of a pressure ulcer, from use of an oxygen mask, in September 2014. All other months between July 2014 and July 2015 were reported as 100% harm free.
- Mortality and morbidity data was discussed as a standing item on the unit's paediatric governance meeting minutes.
- Duty of Candour was introduced as a statutory requirement for NHS trusts in November 2014. Staff told us they understood the need to be open and honest with families when things went wrong. We saw an example, documented in a patient's records, where an apology had been provided to parents about a child's treatment.
- All ward areas were visibly clean. We saw completed checklists for cleaning equipment and toys.
- There were separate toilet facilities for boys and girls. All these areas were clean and tidy.
- Wall mounted alcohol gel was available at all entrances and exits to the departments, personal protection equipment and alcohol gel was available at all sink areas. We observed staff to be compliant with the bare below the elbow policy.
- Infection control audit data was provided for the period April 2014 to March 2015. The women and children's directorate demonstrated consistent compliance against the target of 95%. Examples of audits included dress code, hand hygiene, cannula care and Multi-resistant Staphylococcus Aureus screening (MRSA). Data was not specific to the children's wards.
- We saw safe care audits which were undertaken at ward level on the trust intranet dashboard. For example, data for ward 2 demonstrated compliance in hand hygiene as 99% in September 2015, 100% in November 2015 and 100% in December 2015.
- Staff had access to up to date infection prevention and control policies and guidance on the trust intranet.

## Environment and equipment

- The children's wards were locked to prevent unauthorised access. There was a buzzer system for access outside each ward.
- Following our previous inspection, there were concerns about the lack of bathroom facilities on ward 2, due to the bathroom area being used for storage space. The trust was required to ensure they provided facilities to meet care needs.
- We saw that the bathroom area had been removed and replaced with a waiting area to facilitate access to a daily clinic on the ward. We were told by staff that care pathways had been updated to reflect current practices and that their shower facilities met the needs of children receiving surgical care.
- Concerns were raised in the previous inspection about the layout of ward 16 and 17 in facilitating observation and care of patients. The trust had begun a new building development which would accommodate ward 16 (including the children's assessment unit) and ward 17 to provide a safe environment. In the interim, staff were nursing patients in cohorts, for example patients with respiratory infections, to facilitate better nursing observation and flexible use of staff.

## Cleanliness, infection control and hygiene

# Services for children and young people

- We were given the data from the patient led assessment of the care environment (PLACE) audit 2015 for ward 16. Patients and relatives rated cleanliness at 93.3%, privacy 92.31% and condition, appearance and maintenance of the ward environment as 77.08%. There was no data available for the other wards where children were cared for.
- We saw that resuscitation equipment was available on all the wards. All resuscitation equipment was checked daily and there was a checklist to document this. We saw this was up to date with daily checks.
- The equipment we saw was physically clean. There were stickers on all equipment to show it had been serviced and when the next service was due. We were told equipment safety was managed by the medical engineering team. There was a medical engineer based in the neonatal unit, Monday to Friday, to provide rapid support if staff had problems with equipment.
- The records showed a number of risk assessments undertaken that were appropriate to the patients' condition. There were a number of care pathways in use across the wards. For example, asthma, cystic fibrosis and gastroenteritis.
- All records relating to patients having surgery included a completed WHO safer surgery checklist.
- We saw that patients with complex health needs had ongoing care plans, which provided continuity between community and acute services.

## Safeguarding

- The trust safeguarding team had recently been recruited to. The trust had a named nurse and a named doctor for safeguarding children. They led a team of staff to promote information sharing and safeguarding support for clinical staff. This included two staff to provide seven-day paediatric liaison cover and three specialist practitioners.
- The team undertook a programme of audits to evaluate how well lessons were learnt from incidents and serious case reviews were adopted by staff. We saw an example of an action plan from a serious incident as to how to promote learning from incidents. The team led a lessons learnt event in October 2015 for hospital staff.
- The team provided safeguarding Level 3 training. This training was required by nursing and medical staff working with children and babies. The training included female genital mutilation and child sexual exploitation. The safeguarding team had reported 76 cases of female genital mutilation, since the mandatory requirement to report concerns came into force in October 2015.
- Following our previous inspection, we were concerned that staff training in Level 3 safeguarding was not meeting the trust target. In May 2015, safeguarding Level 3 training levels for staff were at 63%, according to the trust's safeguarding children annual report 2014-15. The report set out strategies to improve training rates as the trust was still not meeting its target of 95%.
- The report showed that access to safeguarding supervision for staff had increased by 50%. 360 staff had received supervision in 2014/15, against 170 staff the previous year.
- We saw evidence of safeguarding children committee meeting minutes, discussing issues such as risks, serious case reviews, audits and training. The meetings were held bi-monthly, and information was escalated to the Trust Board.

## Medicines

- Medicines were stored and dispensed safely. We saw from the drug charts that medicines were administered at appropriate times and signed for.
- Controlled drugs were handled, stored and recorded according to national guidelines.
- Fridge temperatures were monitored with the maximum and minimum temperatures recorded daily. There was written evidence of action taken if a temperature recording was not within the range of two to eight degrees.
- Patients who had a drug allergy had a different prescription sheet to clearly alert staff.
- In the paediatric stabilisation room there was information available to staff regarding drug dosages required for children of different ages and weights.

## Records

- Records were paper based. Nursing and medical notes were stored together, securely. However, any safeguarding documents were separated and stored unsecured on a shelf at the nurse's station.
- We looked at 13 records across the wards and found that the notes were well maintained. They were legible, dated and signed.

# Services for children and young people

- All children admitted had a safeguarding profile completed to assess risks.
- Staff demonstrated safeguarding knowledge. They told us they worked closely with the safeguarding team when there were safeguarding concerns and they had access to safeguarding supervision.
- There was an up to date safeguarding policy in place (2014), and the trust had an action plan in response to the Savile investigation to ensure that volunteers were appropriately selected.

## Mandatory training

- There was a programme of mandatory and statutory training available for all staff, which covered areas such as moving and handling, safeguarding, information governance and infection control. The trust target for mandatory training was 75%.
- Staff received a combination of face-to-face training and electronic learning. At the previous inspection in October 2014, the mandatory training figures provided for June 2014, 61%. Mandatory training figures in December 2015, for women and children's services showed an average training figure of 76% across the training schedule. Preparing to administer blood had the least compliance at 43% and risk management the highest compliance at 100%.
- However, staff told us places on mandatory training were booked into their rotas by the team leaders and all staff we spoke with said they had completed their mandatory training.

## Assessing and responding to patient risk

- During our previous inspection we found that staff were not adequately trained to care for patients on the paediatric stabilisation unit, and did not have the specialist skills to use the ventilation equipment. The trust was required to ensure that suitably skilled and qualified staff were available to staff the stabilisation unit.
- During this inspection, we saw that the service had implemented a programme of training to ensure there were appropriately skilled nursing staff to support the paediatric stabilisation unit on ward 16. Staff who were trained then held a paediatric critical care passport which was based on guidance from Time to Move On (2015) by the Royal College of Paediatric and Child Health. The Royal College of Paediatric and Child Health

had also been involved in providing an external review of the stabilisation unit, and had provided the trust with recommendations to promote the unit's safety, which reflected the need for suitably trained staff.

- We saw the rota of trained staff who would attend the stabilisation unit as required. The service also had an additional qualified nurse on the staffing rota in order to fill the gap if a nurse was required to care for a patient on the stabilisation unit.
- When a child required care in the stabilisation unit, an anaesthetist would take responsibility for ventilation equipment, if required, and stay with the patient until handed over to the paediatric medical transfer service.
- Data provided showed the trust had used the paediatric medical transfer service 26 times between October and December 2015. There was evidence that the transfer process was audited and times in stabilisation were being monitored, including staff attending the unit. In 88% of cases there was a consultant paediatrician present and in 71% an anaesthetist during this period.
- The trust had a contract with Embrace, a paediatric medical transfer service. Guidance on how to access Embrace was seen on the wards and it was also available to staff on the intranet. The Embrace service provided support in an advisory capacity over the telephone when patients deteriorated and would also come to the hospital to help stabilise a patient as necessary.
- During our inspection, we saw the paediatric stabilisation unit in use and confirmed that medical and nursing staff supported the unit as described.
- We saw evidence of monthly meetings to discuss the stabilisation unit, highlighting risks and areas of improvement. We saw the quarterly reports on the stabilisation unit following the previous inspection. The reports provided a commentary as to how operational improvements to the unit were made and monitored.
- Children admitted to the wards were seen within 24-hours by a consultant paediatrician.
- The children's ward used the Paediatric Advanced Warning System (PAWS) to monitor and assess patient condition. We saw a standard operating procedure which was being validated for use, to ensure staff responded to PAWS appropriately. In the records we looked at, we saw that pain scores were completed and acted upon.

# Services for children and young people

- Audit data provided by the trust reported 100% compliance in completing the PAWS across the women and children's directorate in November 2015.

## Nursing staffing

- The Royal College of Nursing (2003) recommended the following levels of staff for day and night shifts: For children's wards the staff to patient ratio should be:

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

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

- The wards did not have an establishment of staff to the recommended level at the time of inspection. We were told that funding for the service was based on previously recommended level of staffing. However, the service was undergoing a recruitment drive to enhance staffing levels, but there were challenges due to the lack of paediatric nurses nationally.
- The wards had a variable level of sickness. Ward 2 had a sickness rate of 8.86%, ward 16 was 6.06% and ward 17 was 4.6%.
- The children's wards were staffed to an establishment of 1 qualified nurse to five patients, based on a full ward. The wards also had healthcare assistants, and aimed to have one per shift, but this was not always happening.
- The wards displayed the staffing establishment and the actual staffing levels each day. We saw, on the days of our inspection, that actual staffing levels were the same as the establishment levels of staff expected on each shift.
- However, we were provided with data on nurse staffing fill rates between August and December 2015, which showed reducing staff availability over the period. Fill rates are the percentage of actual staff on shifts against the number of staff planned to be on a shift across a period of time. For example, the paediatric service had more than the actual planned staff filling shifts across the month of August (104%), in November the fill rate had reduced to 84 % and by December it was 78%.
- We were provided with the staff rota for 20 days during January 2016 across the paediatric service. Of the staffing numbers for the three shifts provided for each day, 15 out of the 20 days had shifts where the actual staff levels were less than planned.
- The service had used a Paediatric Acuity and Nurse Dependency Assessment tool (PANDA) since July 2015. We saw that this tool was not yet embedded into the services planning of staffing levels, and was not being used on a daily basis. Senior staff told us they were still evaluating the benefit of PANDA in assessing the acuity of patients with complex health needs.
- There were high levels of nursing vacancies in the neonatal unit. Data provided by the trust showed 13 whole time equivalent vacancies in September 2015 for the unit. We were told there was an ongoing recruitment drive.
- Gaps in staffing on all the wards were generally filled by regular bank staff, who were usually already part of the service's team. The ward was also reliant on agency nursing staff, particularly to fill the extra nursing establishment on a night shift. We were told recruitment was ongoing to address this. We were told agency staff underwent induction at ward level.
- As part of planning for winter pressures the service had a qualified member of staff on each shift available to work in areas where there was shortfall, for example due to sickness, which had helped to maintain the staffing levels in the short term. This was in addition to the member of staff on the rota who would fill the gap left when a member of staff was called to the paediatric stabilisation unit. However, at the time of inspection, this was not improving day to day nurse staffing levels in meeting the establishment of staff on each shift.
- The service had two advanced nurse practitioners. These were qualified paediatric nurses who had undertaken further training to be able to support medical staff in diagnosing and treating health conditions. One working on the neonatal unit and one working on the children's assessment unit. A further two staff were in training to be advanced nurse practitioners.
- We saw the trust escalation policy on display at the nurses' station, which informed staff how to escalate concerns about staffing levels.
- We observed a nursing handover. Handovers occurred twice a day at each shift change over in the nursing office. The information was clear and concise identifying the care given to the patients, what care was required, and the involvement of parents. Safeguarding information was also shared, including the involvement of other agencies and the safeguarding team.

## Medical staffing



# Services for children and young people

- There were no vacancies in medical staffing. There were separate medical staff rotas for paediatrics and neonatology. Both areas had two consultants during the day on weekdays. In neonates there was on site cover 08.30am-18.00pm weekdays and between 9pm and 10 pm there was an evening ward round.
- At weekends one consultant was available covering paediatrics from 9am-2pm. There was also consultant cover on neonatology from 9am to 1pm, and at the 9pm-10pm ward round. At all other times there was access to a consultant on-call.
- There were two registrars available from 8.45am and 9.30pm during the week in both areas, and overnight medical cover was provided by one registrar.
- There were two to three junior medical staff providing 24 hour cover, seven days a week on the wards.
- The service had two advanced nurse practitioners, one in neonatology and one on the paediatric wards, who supported the medical staff.
- We observed a medical handover. The handover was between the medical staff covering all the children's wards. All patients were discussed and prioritised for assessment on ward rounds, to ensure the most ill patients and new admissions were seen first, and to facilitate access and flow. Safeguarding concerns were also discussed.
- The trust was in the process of building a new department for the paediatric service to address the environmental issues on the paediatric wards, although previous concerns remained until this was completed.
- Waiting times for children awaiting assessment for communication difficulties or autism were longer than 18 weeks.
- Not all complaints were dealt with in a timely way.
- There was a lack of play facilities during evenings and weekends.

However, we found that -

- Paediatricians ran a rapid access clinic from the child development centre. The clinic provided clinical assessment to prevent admission of children to hospital where possible, and to support early discharge from the wards.

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

- The trust was in the process of building a new department for the paediatric service to address the environmental issues on the paediatric wards. It was envisaged that the children's wards and children's assessment unit would transfer to the new building by November 2016. The new building would also accommodate some children's surgical beds and ward 2 would provide surgery for children on a day case basis only.
- The new department would address the issue of lack of privacy and dignity on ward 2, by reducing the beds in this area and therefore more space to accommodate families' needs.
- The new department would provide a better working environment for staff to observe patients and respond to their needs. This issue is currently managed by nursing patients in cohorts, but was not ideal.
- The new department would have areas to meet the needs of adolescent patients, which are lacking in the current wards.
- Paediatricians ran a rapid access clinic from the child development centre. The clinic provided clinical assessment to prevent admission of children to hospital where possible, and to support early discharge from the wards.

## Major incident awareness and training

- Major incident and business continuity planning was in place as part of the wider trust's continuity planning, and staff were provided with training.
- During our inspection, staff were aware of the initiation of 'bronze command' in response to the doctor's strike. Senior staff were involved in two hourly updates on the impact to their services. This was a level of monitoring implemented as part of the major incident plan to ensure hospital services continue to meet the needs of patients.

## Are services for children and young people responsive?

Requires improvement



Although we found that there had been improvements since the last inspection we rated responsive as requires improvement because -



# Services for children and young people

- Specialist consultants from other trusts held clinics at Bradford Royal Infirmary to support the care of children with complex health needs, for example, the regional metabolic disorder clinics.

## Access and flow

- Following our previous inspection, there were concerns about the amount of time children had to wait to receive an assessment if there were concerns they may have autism. Some children were waiting up to two years.
- We were told by senior staff that, following the previous inspection, the trust had secured funding from the Clinical Commissioning Group to reduce the waiting list. Senior staff told us that children were now waiting for up to four months for appointments.
- However, data provided showed that as at December 2015, 53 children were waiting for assessment and the average wait was 28 weeks.
- Waiting times for children remained on the trust risk register and the trust had submitted service development plans to address this issue, which were in the process of being reviewed.
- Paediatricians provided clinical oversight of their outpatient waiting lists, to ensure children received appointments based on their clinical needs.
- There was a referral pathway. Paediatricians should triage referrals within 48 hours and a decision made whether the referral should be forwarded to the child development centre or community paediatrics. If the referral inappropriate, then it was returned to the GP.
- Data provided showed averages over 90% for general paediatric referrals seen within 18 weeks.
- All medical patients were admitted to the children's wards through the children's assessment unit. To facilitate access the surgical ward would admit any overflow medical patients. We were told that the surgical ward was well supported by the paediatricians, for the outlying medical patients (children receiving medical care on the surgical ward) and also for those children receiving surgical care.
- Surgical lists specifically for children had been established to reduce excessive waiting and fasting times for children.
- The length of stay for patients was similar to the national average.

- Weekly ward rounds were held with children's community nurses to support discharge plans for children with complex needs.
- Patients and families were not provided with an expected date of discharge at the beginning of their stay in hospital, unless admitted for routine day surgery. Staff told us discharge planning was an area in which they could improve.

## Meeting people's individual needs

- We observed that staff involved patients and relatives when delivering care and worked in a way which was family centred.
- The unit allowed 24 hour visiting to meet the needs of parents, and there were facilities on all the wards for parents to stay overnight with their child.
- We saw a range of equipment available to staff to care for children with physical needs, for example hoists.
- The service had a number of specialist nurses to support patients with long-term or complex conditions, on the wards and in the community. For example, epilepsy, cystic fibrosis and diabetes.
- There was a transition service to support patients aged 15 to 21 years old with complex and continuing physical care needs.
- Staff told us that they had rapid access to CAMHS service if there was a patient with mental health needs. We were told that those patients would be seen within 24-hours from the time they were medically fit.
- Staff had access to a 24-hour translation service to support families whose first language was not English.
- Patients on the wards had access to educational materials and a learning mentor during term time and school hours. There were playroom facilities on the wards; however, these were only open and accessible to children when the play leader was on duty. This meant that there were not always play facilities at weekends and evenings. This had been highlighted in the trust clinical governance meeting minutes in response to the outcomes of the CQC children's survey 2014. There were plans to increase play leader hours but it was not clear when this would happen.
- There had also been concerns about the layout of ward 2 and the ability to provide patients and their families with privacy. We saw the layout of the ward had not changed. There was still limited space between beds for

# Services for children and young people

patients and their families and this meant there was little privacy and respect for dignity. This would be addressed by a decrease in beds when the new build was completed.

## Learning from complaints and concerns

- Between September 2014 and June 2015, 25 complaints had been received about the service. Aspects of clinical treatment was the most common theme, accounting for 60% of the complaints.
- We were not given examples of lessons learnt from complaints.
- The matron was responsible for dealing with complaints for the service. Data provided showed that there was a variance in the times that complaints were resolved. One complaint took up to 173 days to resolve, whereas others were resolved within a week. The data showed half of all complaints were closed within one month. Overall, 65 days was the average time it took the service to close complaints. The trust target for dealing with complaints was 25 days.

## Are services for children and young people well-led?

Good



We rated well-led as good because:

- The service had undergone a change to leadership and management structure. The trust had established a children's board and there were clear governance structures to report to the Trust Board.
- The trust had engaged with staff and the public to contribute to the design of the building to create an environment which was reflective of the needs of local children and families.

However, we found that:

- Due to nurse staffing levels, there was not always a senior staff member on duty to provide clinical support and leadership to junior staff.

## Vision and strategy for this service

- At the time of inspection there was no non-executive director on the executive board to promote the voice of

children, as recommended by the National Service Framework for Children (2003). We were told by senior leaders that a non-executive was expected to be appointed by March 2016.

- Since the previous inspection, the trust had set up a children's board. Meeting minutes of December 2015 were provided. The minutes outlined the purpose of the board to influence the development of quality children's services across the trust in partnership with external organisations. There was evidence that service users were to be invited to the board, to provide patient experience and the child's voice into the decision making.
- The strategy for children's services was part of the wider division of women and children's directorate. The strategy provided showed that staffing, training and community paediatric funding were priorities for 2015/16.
- Funding had been secured from the CCG and there were development plans to address long waits for children referred to autism assessments, with clinical input.

## Governance, risk management and quality measurement

- There were 56 risks on the women and children's directorate risk register, relating to children's services. The highest rated risks and priorities for senior staff in the children's units were nurse staffing (on both paediatric and neonatal units), paediatric stabilisation unit, medication incidents and the ward environment. The risk register was reviewed bi-monthly by matron and head of nursing.
- The service had a practice development nurse who supported staff in clinical supervision and practice. For example they undertook assessment and training of staff involved in medication errors.
- There was a director of clinical governance to promote quality and safety. We were told their work involved improving the systems for governance. For example, promoting a culture of reporting to improve reporting times and the feedback of themes.
- We saw evidence in clinical governance meeting minutes that standing agenda items of patient safety, patient experience, effectiveness, workforce and review of the risk register were discussed. We saw a clinical governance newsletter for staff, sharing information about incidents and learning from incidents.

# Services for children and young people

- We saw evidence that staff on the wards were involved in completing audits, for example record keeping. There was a rolling programme of auditing which was supported by all levels of staff. The audit data could be accessed on the intranet, on the safe care dashboard. The dashboard showed evidence of audits being reviewed when compliance was not at the level required.

## Leadership of service

- The service had recently undergone a change in leadership and management structure. There was a recently appointed head of nursing for paediatrics to provide strategic and clinical leadership. The service was supported by a band 8 matron.
- Each ward had a band 7 nurse to provide day to day management and leadership. We were told that this role was part supernumerary, however due to staffing pressures this was not always achieved.
- The service aimed to have band 6 nurse cover in each clinical area, to provide clinical support for junior staff, but this did not always occur.
- Staff on the wards told us the senior managers were visible and approachable. They spoke positively about recent changes in the service, for example, training for the paediatric stabilisation unit.

## Culture within the service

- Staff spoke positively about the service they provided to children and families. They said they were proud to work at the trust.
- We saw staff of all disciplines working well together.
- Staff reported the service to have an open and honest culture. They were happy to raise their concerns to senior managers.
- Staff told us they were looking forward to moving into the new building. They said they had been given opportunities to be involved in the planning and felt it would improve the care and service provided for children and families.

## Public and staff engagement

- The wards had boxes for parents to leave comments cards. We were told the cards were given out to parents on a daily basis. The outcome of the comment cards were displayed on the ward for parents and visitors to see.
- The staff encouraged children to rate the service. There was a system where children could colour in a cut-out figure and pin it to the notice board, ranking the service from one – ten, with ten being good. At the time of inspection, we saw that all the cut-outs were in the good ranking.
- The service had involved children from local schools in providing artwork and fundraising for the new children's wards which were under development. Local children were encouraged to be involved in the naming of the new unit.
- Board minutes of October 2015 reported on the Young people's event at Bradford City football ground called "Your future, your health". The event engaged young people into discussions about health and wellbeing.
- The trust undertook a staff survey in the women and children's directorate in 2015. There was a 25% response rate to the survey. 79% of respondents said they felt supported by their line manager and 46% said they thought communication in the division was good.

## Innovation, improvement and sustainability

- The service was developing care pathways in partnership with GP's and emergency departments. The aim of the pathways was to promote consistency in the management of illnesses and to ensure children had care at the right time and place.

# End of life care

Responsive

Good



Overall

Good



## Information about the service

Bradford Teaching Hospitals Foundation Trust (BTHFT) provided End of Life Care (EOLC) in ward areas throughout the hospital, with support from the hospital specialist palliative care team (HSPCT). The service offered by this team was an advisory one, in which patients remained under the care of the referring medical team. There were two community palliative care teams (from another NHS trust) and local hospices in the city with whom the team worked closely.

In October and November 2014, CQC carried out an announced comprehensive inspection and rated the service as good overall. We rated safe, effective, caring and well-led as good and the responsive domain required improvement. This was because the chaplaincy and the mortuary facilities were insufficient to meet the demands of the service. There was also insufficient physical space and a lack of facilities to meet the spiritual and cultural needs of different faiths.

This inspection took place on the 11, 12 and 13 January 2016. It was part of an announced focused inspection to follow up the areas for improvement in the responsive domain identified in the previous inspection. We visited the chaplaincy and mortuary facilities and eight wards, which included those specialising in: oncology, older people, stroke, respiratory, renal and gastroenterology. We spoke with three relatives of patients receiving EOLC and 15 staff. These included chaplains, mortuary manager, specialist palliative care team members, staff nurses, ward sisters, The chief nurse, discharge coordinators, a healthcare assistant and a student nurse. We also observed care and treatment, reviewed the trust's performance data and inspected seven sets of patient care records.

## Summary of findings

We rated this service as good because people at the end of their life were cared for within the hospital by ward staff, who were supported by a hospital specialist palliative care team. This team worked closely to the national Gold Standards Framework to ensure that patients experienced a good quality of care at the end of their life. The team was supported by a consultant in palliative care medicine ensuring that appropriate and timely advice was available to staff across the wards and district. In addition, patients and their relatives had access to support through the 'Gold Line' a telephone service, available 24 hours a day, seven days a week.

Care was arranged to meet the needs of the individual and to ensure where possible that people were able to spend the end of their life in their preferred place of death. There were systems and arrangements in place to ensure that people's diverse needs were respected and supported. There was collaborative working across multi-disciplinary teams and other agencies to ensure that patients with cultural, religious and special needs such as a learning disability were incorporated into their individual care packages.

# End of life care

## Are end of life care services responsive?

Good



We rated this service as good for responsive because:

- We were assured the trust had robust plans in place for a new department for the multi-faith, chaplaincy services. These included toilet/ ablution facilities to address the environmental issues identified at the previous inspection. In the interim, temporary accommodation would help address shortfalls and these would be available by the end of April 2016. We were also assured the trust continued to provide robust support, to people who used the service.
- End of life services were effectively planned, designed and delivered to meet the needs, including spiritual and diverse needs of patients who used the service.
- There were processes in place to ensure patients had timely access to assessments, diagnosis, treatment and care.
- Systems were in place to encourage patients and those close to them, to provide feedback about their care. Learning from complaints was addressed through training of staff and changes made where appropriate to documentation and practice.

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

- The BTHFT specialist palliative care team was available 9am -5pm, Monday to Friday for face to face assessments. There was a consultant in palliative medicine on call 24 hours per day for telephone advice to professionals across the district. According to the National Care of the Dying Audit of Hospitals 2014 data, only a fifth of participating trusts currently operated a seven day, face to face service. At the previous inspection, the trust was using the framework, "The route to success in end of life care – achieving quality in acute hospitals" (2010) to develop and pilot a Last Year of Life Project. The project has now been rolled out across the medical division and included a comprehensive education programme aimed at ward staff, senior nurses and clinicians. The programme included training for staff on the use of the Amber care

bundle, which provides a systematic approach to manage the care of patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.

- Patients on the Gold Standards Framework continued to have access to 'The Gold Line.' This was a dedicated service using tele health for patients and carers, which could be accessed as an alternative to phoning 111, when the GP surgery was closed, or if patients were finding it difficult to get help during the day and required advice. A senior nurse staffed the Gold Line service, which was available 24 hours a day, seven days a week.
- A pilot survey had been given out (when relatives collected the death certificate) to obtain the views of the care delivered. However, only a few responses had been returned because there had been issues providing stamped addressed envelopes and the surveys had not been continued for several months.
- New individualised medical and nursing end of life guidance had been developed and implementation was due for completion in July 2016.
- The National End of Life Care Audit: Dying in Hospital was completed in September 2015, and the report is due out in spring 2016. The local audit, review of end of life care guidance is to be undertaken in spring 2016.
- The Chaplaincy team had developed an education and training programme for the trust staff for 2016. The programme included, culture, last days of life, bereavement care and support, diversity awareness, stereotyping, discrimination and the Equality Act. The training of staff meant they would be more aware and responsive to people's cultural and diverse needs when caring for people in the last days of life.

### Access and flow

- The HSPCT received 571 referrals during April 2014 and March 2015. Two hundred and twenty eight (40%) were for patients with non-malignant disease, and 343 (60%) were cancer. Compared to the previous year, there was a decrease of two patients (6%) of those with cancer and an increase of 43 patients (6%) of patients without a malignant disease.
- The team aimed to respond to urgent referrals on the same day, or within one working day and saw routine referrals within two working days. Figures for the last 12 months showed on average patients who received an urgent referral were seen on the same day.



# End of life care

- Data for July to December 2015 showed that 9% of patients died in hospital, and 91% of patients were discharged and achieved their preferred place of death.
  - Clinical review meetings continued to take place each week. All newly referred patients were discussed and the discussion was based on the initial holistic assessment of their needs. Patients who had been recently discharged or deceased were also reviewed at this meeting. The lead palliative care keyworker was responsible for presenting, implementing and communicating agreed action plans and these were recorded on the electronic patient record.
  - There were escalation processes in place to ensure patients at the end of life who were admitted via the accident and emergency department, or the medical assessment unit, were transferred to their preferred place of death or appropriate wards as quickly as possible.
  - Processes were in place to facilitate rapid discharges at the end of life. The service had a rapid discharge at end of life integrated pathway, which was used alongside the fast-track tool and nursing needs assessment. This included guidance on prescribing take home drugs, community prescriptions and out-of-hour's handover forms. The integrated pathway had helped improve the coordination of care and sharing of information between teams.
- accordance with the person's needs and wishes and decisions should be regularly reviewed and revised accordingly. The documentation we reviewed clearly reflected this information.
- Service planning was in place to ensure patients with complex needs were reviewed by a multidisciplinary team group of professionals to discuss care needs and agree future care plans. Aspects of care included complex symptom management, difficult family situations and ethical issues regarding treatment decisions.
  - There were also systems in place to ensure that end of life care was delivered and coordinated to take account of patients' complex needs. For example, there was evidence of collaborative working with national networks to ensure palliative care needs for people with learning disabilities were met. The Bradford & Airedale Network for Palliative Care for People with Learning Disabilities had a team of nurses, doctors, psychologists and social workers who supported people, their families and carers.
  - The HSPCT included an ethnic liaison worker who accompanied South Asian patients and their carers through their end of life journey, providing emotional support and identifying a holistic and culturally appropriate care package, which included repatriation following death. The ethnic liaison worker attended all weekly multidisciplinary team meetings and worked with staff to ensure care and treatment was planned and delivered to reflect the patient's ethnic, spiritual and cultural needs.
  - The service worked with a charity and introduced 'Bradford Comfort Bags', which included toiletries, a blanket and a neck pillow to try and make relatives more comfortable when staying with patients at the end of life. Recliner chairs for overnight stays were available. Free parking permits were also provided.
  - In August 2015, EOLC champions were 'launched' to provide individualised patient EOLC. They were also used as link nurses between the ward staff and the specialist palliative care team.
  - Pictorial books were used to communicate with patients to make sure their basic needs were understood and met.
  - Two clinical nurse specialists were trained in cognitive behavioural therapy, providing support to patients at the end of their life.

## Meeting people's individual needs

- The End of Life Operational Group with clinical and non-clinical representation had developed a policy for Caring for Patients in their Last Days of Life. The purpose of the policy was to support staff in delivering care to adult patients in the last hours and days of life. There was a separate policy for children under the age of 16. Information relating to end of life care and support was available in easy read formats, through use of British Sign Language interpreters and interpreters for people who were not able to communicate in English.
- The EOLC educator visited patients daily in order to check compliance with 'One change to get it right' (Leadership alliance for the care of the dying people, 2014). This guidance states that when it is possible that a person may die within the next few days or hours, this should be recognised and communicated clearly, decisions should be made and actions taken in



# End of life care

- Relatives told us the medical staff had been excellent in the way they had explained their relative's change in symptoms and this had made them feel less anxious. They said their relative had received excellent care and the staff could not do enough.
- The bereavement office had procedures in place to ensure the timely issue of death certificates. In addition, the registrar had a separate office on site located close to the bereavement office. The registrar attended three days per week (Monday, Wednesday, and Friday), which allowed families to register deaths at the hospital, rather than having to go to the city's main office.
- The bereavement team continued to arrange funerals for patients who died with no next of kin.
- At the previous inspection in October /November 2014, the chaplaincy and prayer room facilities were not adequate. The multi-faith chapel and Muslim prayer room lacked sufficient space and there was difficulty meeting the spiritual and cultural needs of a larger family or groups of people.
- At the previous inspection the single toilet/ ablution facilities was not adequate or appropriate to meet people's needs. It was also used as a disabled toilet and was accessed by using a radar key. This meant the toilet could have been opened with the key whilst occupied.
- We also found that there was a small multi faith chapel and at times, particularly on a Friday this could have over 100 people attend for prayer. The family room adjacent to the chapel was very small with no natural light. Staff told us that, as part of the trust's estates strategy, it was anticipated that these areas would be included in the proposed new build.
- At this inspection we were assured by the trust that they had plans to provide a purpose built chaplaincy and prayer facilities within the proposed new build. However, the business case for this was pending. As an interim measure, the trust was in the process of putting in place alternative arrangements to help address the shortfalls of these services. Following the inspection the trust confirmed that interim arrangements would be in place by the end of April 2016.
- There were operational procedures for the management of deceased patients' belongings. The trust used specially designed property bags rather than hospital bags, in order to allow families to take personal belongings home following bereavement. On the day of our inspection property bags, with identifiable patient's belonging were stored in the family room. This was a confidentiality issue because patient identifiable information was not being stored securely. The room was also being used to store boxes of the property bags. The room was not a storeroom and should not be used as such. These issues were brought to the attention of the trust who reassured us they would be removed.
- Arrangements had been made with the local coroner's office to ensure that bodies could be released promptly where necessary for religious and cultural reasons.
- At the previous inspection we noted the National Care of the Dying Audit of Hospitals (NCDAH) 2014, showed the trust scored above the national average for the care of the patient and their nominated relative immediately after the patient's death.
- The NCDAH 2014 also showed the trust had achieved four of the seven organisational key performance indicators. The three areas not achieved were access to specialist support for care in the last hours or days of life, Trust Board representation and formal feedback processes regarding bereaved relatives' views of care delivery. The service had taken action to address these areas and work was ongoing regarding the provision of seven day face-to-face working.
- The palliative care team had good working arrangements with the ambulance service. The service made it a priority to be available to transfer patients from hospital to their preferred place of care at the end of life, so that they did not have to wait. Staff told us that the ambulance would generally be available when they requested it.
- 'Fast track' discharge statistic data for July to December 2015 showed that 66% of patients were discharged to their preferred place of care within 24 hours and 77% were discharged within 48 hours.






## Learning from complaints and concerns

- In 2012 the HSPCT were part of a national project reviewing end of life complaints and as part of the project it was agreed that an end of life complaint should be defined as, "Any complaint relating to an admission where a patient died, or where a patient died within three months of discharge."
- The trust complaints team forwarded any complaints that fulfilled the criteria to the HSPCT to identify common themes, or areas that needed addressing on a trust-wide basis relating to end of life.

# End of life care

- There was a complaints policy. Complaints were dealt with on an individual basis, investigated in a timely manner and where required in partnership with other agencies.
- Between April and September 2015, there were 15 complaints across the whole service relating to end of life care and the general theme identified was communication. Learning from complaints was addressed through training of staff and changes made where appropriate to documentation and practice. Complaints were also discussed at palliative care clinical review meetings. The EOLC champions were re-launched in August 2015 to most wards. They were used as links between the ward staff and the specialist palliative care team. This helped to improve communication and ensured patients' needs were met in a timely way.
- Staff were aware of their responsibilities in supporting patients and family members who wished to make a complaint.
- The majority of complaints were resolved through a meeting with bereaved families and senior clinicians involved in their relatives' care.

# Outpatients and diagnostic imaging

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

## Information about the service

Bradford Teaching Hospitals NHS Trust provided a wide range of outpatient clinics at Bradford Royal Infirmary (BRI) and St Luke's Hospital, predominantly at BRI. Between January 2014 and June 2015, 709,602 patients attended outpatient clinics across the two sites.

The outpatient services were managed through the diagnostic and therapies directorate and had recently transitioned to a centralised booking service, which was located at St Luke's Hospital. Diagnostic and imaging services provided on an outpatient basis included radiology (plain film), general and maternity ultrasound, clinical physics, fluoroscopy, angiography, computerised tomography (CT) and magnetic resonance imaging (MRI) scans. Each clinic area comprised of a reception, a waiting area and consulting rooms.

We inspected the outpatients department at Bradford Royal Infirmary in October 2014 as part of a comprehensive inspection. We rated the service overall at that inspection as inadequate. We rated safety, being responsive and well led as inadequate. Caring was rated as good. The effectiveness domain was inspected but not rated.

We had serious concerns over the large backlog of patients waiting for a review of their outpatient care pathway. There had been around 205,000 patient pathways to be reviewed. This figure was revised in April 2015 when a further 47,000 non-refer to treatment (RTT) backlog was identified.

We have inspected this service as a follow up to the last inspection and inspected the safety, responsive and well led domains. We visited the diagnostic and imaging

services and a number of outpatient clinics, including orthopaedic, haematology, vascular and oncology services. We spoke with 15 members of staff, checked equipment and looked at 13 sets of medical records.

# Outpatients and diagnostic imaging

## Summary of findings

Overall we rated the service as requires improvement. We found that a great deal of work had been undertaken to improve the arrangements for booking appointments, addressing concerns over the identified backlog with outpatient appointments and develop assurance mechanisms. The new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems and processes.

There were staff shortages across outpatients and diagnostic and imaging services, with some specialities particularly impacted at times such as dermatology clinics. There were arrangements in place to assess whether staffing levels were safe, access support through agency or locums and from colleagues in other clinics.

There had been a reduction in the number of patients waiting on the total RTT waiting lists and in particular the backlogs identified in August 2014 and April 2015. There were still a large number of patients waiting for appointments, which could delay access to treatment.

There were times when there were delays in accessing interpreting services and on occasion patients' relatives were translating questions, which may not have been appropriate or protecting patient privacy.

However, we found progress being made; a programme of training and development had been introduced as part of the improvement plan to establish the centralised patient booking service. This was work in progress at the time of this inspection.

We found that there were systems and processes in place for incident reporting and learning from incidents.

## Are outpatient and diagnostic imaging services safe?

Good



We rated safety as good because:

- The trust had taken the necessary steps to ensure that the backlog of patients on the non-RTT pathway identified in May 2014 and April 2015 had been clinically validated and actions taken to reduce risks to patients, including prioritising appointments and the assessment of potential harm.
- There were systems in place to report incidents and lessons from incidents were shared with staff.
- There were robust safety and assurance systems in place within the imaging and diagnostic services.
- There were generally sufficient numbers of staff across outpatients and the diagnostic and imaging services. Where there were shortfalls in staffing, there were arrangements in place to access cover.
- The environment within outpatients and diagnostic and imaging services was clean. There were systems and practices in place for the prevention and control of infection, including an audit programme and isolation facilities.
- Mandatory training rates across outpatients and diagnostic and imaging services were above the trust target of 90%.

However, we found that:

- Not all staff were aware of the guidance available on reporting incidents or what was a reportable incident and feedback to individuals was sometimes inconsistent.
- Although there were arrangements in place to ensure clinics remained safe when there were staff shortages; the dermatology clinic had a high number of sessions where the clinic's own staff were not available which could impact on the continuity of service.
- In the wound treatment outpatient clinic not all patient records were kept together in one document. This meant that there was a risk that not all the relevant patient information may be available for staff when reviewing a patient's main medical record.

# Outpatients and diagnostic imaging

- Access to records within the outpatients' department was inconsistent, resulting in staff spending significant amounts of time tracking records in preparation for clinics.

## Incidents

- There had been one serious incidents reported on the Strategic Executive Information System (STEIS) between August 2014 and July 2015. A review had been undertaken of 13 patients from the first cohort backlog of cases on the non-RTT pathway without an appointment, of these six had been assessed as resulting in no harm, 6 resulting in low harm and 1 with moderate harm. An investigation was in progress regarding this patient.
- There were no never events reported during this period. Never events are serious, preventable patient safety incidents that should not occur if the available preventative measures are in place.
- Staff were aware of how to report incidents and had been trained in using the trust's electronic reporting system. Staff who had not yet received training on the system reported incidents through their line manager.
- Not all staff were aware of the guidance about what incidents should be reported, although they were clear about some events, for example a fall in clinic.
- Some staff in diagnostic and imaging services stated that not all changes relating to referral requests and 'did not attend' (DNA) were reported on the electronic reporting system.
- Learning from incidents was discussed at team meetings, although three staff members told us that there was some inconsistency in receiving individual feedback.
- Incidents were discussed at monthly governance and team meetings.
- We were told that a 'huddle' took place in some outpatient departments. This was an informal meeting, which took place at the start of the week to discuss service provision and any issues that had arisen. There were no minutes of these meetings.
- Within the diagnostic and imaging service, incident reporting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) linked to moderate harm and above were fed back at team meetings. In addition, learning took place through emails to staff and at other meetings.

## Cleanliness, infection control and hygiene

- All outpatient areas visited were visibly clean and equipment, such as weighing scales had been marked with green stickers to indicate that it was clean and ready to use.
- The environment within the diagnostic imaging departments appeared clean and well maintained. There was a deep clean service and segregated areas available to isolate patients who may have an infection.
- The outpatient and diagnostic imaging departments completed infection control audits every month, which monitored compliance with practices such as hand hygiene, dress code and environment. Audits also included spot checks on hand hygiene practices and cleaning standards. Audit results ranged from 88 – 100% from February 2015 to December 2015. Action plans were developed to address any identified issues and we saw within the documentation where concerns were escalated for example to the maintenance department.
- Data was displayed in some outpatient areas to show compliance with cleaning and infection prevention and control audits. Examples of this included the latest audit data from the vascular clinic in November 2015, which showed 99% compliance on the cleaning audit and 100% compliance with hand hygiene since May 2015. Another example was in relation to the orthopaedic outpatient clinic, which showed that there had been 100% compliance in all hand hygiene audits since October 2015.
- We saw staff follow the trust bare below the elbows policy and wore disposable gloves and aprons when required. Hand sanitising gel was available and regularly used by staff.
- In outpatient clinics there were systems in place to manage patients with a suspected infection, with isolation facilities available.
- Appropriate arrangements were in place for disposing of clinical waste in outpatient clinics and the diagnostic imaging department.

## Environment and equipment

- Outpatient clinics comprised of reception, waiting areas and consultation rooms.

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- We checked three pieces of equipment, which did not have stickers in place to show whether it was compliant with electrical testing requirements. The stickers that were visible showed that the equipment test label was out of date for testing purposes.
- Emergency resuscitation trollies were accessible in all outpatient areas we visited. We saw that the majority of the equipment had been regularly checked and appropriate supplies were available on the trollies. However, resuscitation guidelines were out of date with no superseding guidance in place.
- Daily checks were taking place on adult and paediatric resuscitation and monitoring equipment within the diagnostic and imaging services.
- Oxygen equipment was available and in date.
- The trust had maintained compliance with their annual programme of assurance for the testing of x-ray equipment across all modalities. There were systems in place for responding to national medical equipment alerts. There was a strong electronic quality system in Medical Physics/Nuclear medicine.
- The IR(ME)R safety checklists were displayed.
- There were appropriate risk assessments in place for the introduction of new equipment and protocol changes.
- Appropriate licences and contingency for Administration of Radioactive Substances Council (ARSAC) (Nuclear Medicine) Picture Archiving System (ACS) were in place
- Radiation risks were clearly sign posted and displayed.

## Medicines

- We found few medicines used in the outpatient clinics.
- Medicines observed were stored appropriately according to national guidelines, including dressing materials in the vascular clinic.
- Medicines seen were all in date.
- Medicine fridges were checked daily to ensure that medicine requiring a controlled temperature range were stored correctly and safe to use.
- There was a robust training programme in place within the diagnostic and imaging service for the use of patient group directions.

## Records

- We reviewed 13 sets of medical records during our inspection. These were completed appropriately and contained all relevant patient information. The trust was

in the process of moving to an electronic patient record system, which it anticipated would address many of the issues encountered with handling and storing paper records.

- We saw that records held by the wound treatment outpatient clinic were stored in a separate blue folder, away from the main medical records. We were told that the main record was considered at the first patient appointment to inform the treatment plan, but that separate records were then held to document the treatment of the wound. These records were not reconciled with the main medical record once treatment was completed. This meant that there was a risk that all the relevant patient information may not be available for staff when reviewing a patient's main medical record.
- We saw that outpatient records were paper based. These were requested in advance of outpatient appointments from the records team.
- Records were appropriately stored in secure areas of the outpatient clinics we visited. No records were left accessible to patients or visitors.
- When it came to the availability of medical notes, we found a mixed picture. A report provided by the trust for the period October 2014 to October 2015 showed between 92 and 93% of records were delivered to clinics by 3.30pm on the day prior to clinic. The report showed that between 97 and 98% of records were delivered to clinics on time, with less than 3% of patients being seen with loose paper notes.
- The administrative staff, however, told us that they often encountered significant problems in collating records for clinics. It was explained that not all records were returned or checked into the main medical records department. It was stated that this often led to staff having to spend considerable time 'tracking down' records. For example, we saw that for the orthopaedic speciality of 107 records required for clinic, only 54 were available from medical records. The remaining 53 had to be 'tracked down' by staff.
- The Audit of Clinic Utilisation and Efficiency Report September 2015 showed that of 33 completed audit forms, 13 of these related to surgical clinics, 7 medical clinics and 13 clinics for women's and children's services. Out of a total of 490 patients seen 17 records were on loose sheets of paper. Of the 33 clinics audited, 64% had medical notes available, and 85% had the clinic outcome form available. Overall, 64% of forms had incomplete data.



# Outpatients and diagnostic imaging

## Safeguarding

- Completion rates for safeguarding training in outpatient and diagnostic and imaging services generally ranged from 90 – 100% for adult safeguarding Levels 1, 2 and 3 apart from the gynaecology outpatient clinic, which had 67% completion. For children's safeguarding training Levels 1, 2 and 3 there was from 90 – 100% completion, except for four clinic areas, plastics and trauma 62%, dental clinics 82%; haematology and oncology clinics 84% and orthopaedic clinics 88% completion.
- Staff working in the outpatients department and in diagnostic and imaging services could explain the safeguarding process and who they would contact for support and to report any concerns.
- Staff were aware of the safeguarding lead within the trust and how to access information on safeguarding policies and procedures via the trust intranet.
- We saw that posters and information leaflets were on display in outpatient areas setting out the safeguarding process and encouraging patients and visitors to raise any concerns.
- Senior staff considered that they could recognise domestic abuse and knew where to go for support and advice.
- Senior staff were in the main aware of the national reporting expectation for female genital mutilation (FGM) and related guidelines.

## Mandatory training

- Mandatory training rates in October 2015 generally ranged from 85 – 100%. The trust target was 90%. However, a small number of areas were below this; completion rates for these were - orthotic clinics 67%, Hepatitis C clinics 68%; plastics and trauma clinics 70% and Haematology clinics 74%. Just over 90% of staff in diagnostic and imaging had completed their mandatory training.
- Staff confirmed that they were up to date with their mandatory training or were booked on to the necessary courses.
- Access to training was via an electronic system and face to face sessions. Staff also received updates from the electronic system to confirm when training was due to be completed.
- Staff told us that they did not always receive dedicated time for mandatory training and this often had to be completed around the working day.

## Assessing and responding to patient risk

- In May 2014, the trust identified a significant backlog of patients waiting for a review of their outpatient care pathway. There were over 205,000 patient pathways to be reviewed. This number increased in April 2015 when a further group (cohort) of 47,000 patients were identified resulting in a total of over 250,000 patients who did not have an active referral to treatment pathway or were on a review waiting list. Of the 47,000 the trust identified that 9,400 patients had no 'see by date'. This extended across all specialities. This meant that there was a significant risk that decisions about treatment or diagnostics were delayed for some patients
- The trust commissioned an external organisation to assist it with the validation of the cohort of patients and these were reviewed by the medical directors' office in order to identify any patient safety issues.
- An administration review of the patient pathways and a clinical review was undertaken for both cohorts identified. Actions were taken to address any risks identified and assess any harm caused.
- Staff could describe how they would contact the resuscitation team if they saw a patient's condition deteriorating or they required life-saving treatment.
- There was guidance within the diagnostic and imaging service on risk assessing patients undergoing procedures and these were clearly documented. For example, appropriate identification and pregnancy checks were in place across all modalities, with vetting of booking forms.

## Nursing staffing

- Staffing levels within outpatients were dependent on the numbers of patients attending clinics across the two hospital sites.
- We looked at a range of staffing tools from October to December 2015 across eight outpatient services and found that on the whole the majority of sessions had actual staffing numbers matching planned. Where there were shortfalls, the clinic session was assessed as either safe to run or support was given through agency staff or colleagues from other clinics. For example on ward 7 day case unit for October 2015 there was 10.5 sessions (a session is a morning or an afternoon clinic) where there were only 8 registered nurses as opposed to the 12 planned for. This was amber rated and assessed as safe

# Outpatients and diagnostic imaging

to run. In November 2015, for the outpatients west clinic there were only six sessions where a registered nurse was available for the month; support was given by six specialist and trained nurses from the vascular clinic and the sessions were assessed as safe to run.

- Staffing levels within the dermatology clinic were of particular concern as the staffing tools for October to December 2015 showed that there were regular shortfalls in staffing, particularly in registered nurses. For example in October 2015, for two sessions with a planned 16 registered nurses the actual was 8, for six sessions where 20 were planned for the actual was 12; for four sessions 24 were planned for the actual was 16 and for 15 sessions 28 were planned for with only 20 actual. The documents state that the shortages were mainly due to sickness and that agency support was given and sessions were assessed as safe.
- During our inspection most departments were staffed to establishment levels. The haematology/oncology outpatient area did not have the established level of nurse staffing for the afternoon clinic (one qualified staff member was planned, but none were available). Both planned health care assistants were present. We were told that the afternoon clinic was run by a clinical nurse specialist who would be able to offer wider nursing support within the department.
- There were systems in place to request additional staff or to cover gaps in rotas.
- Staff told us that there was frequent use of agency staff within the outpatient areas. These were routinely drawn from a single agency and we were told that many agency staff were 'regulars' within the trust.
- All health care assistants had completed the trust's competency based training framework.

## Medical staffing

- Medical staffing was agreed and arranged through the specialities' division for example surgery or medicine.
- The individual divisions were responsible for mandatory training, appraisal and the revalidation of staff.

## Other staffing

- Staff within the diagnostic and imaging services covered the on call for clinical areas; however due to low staff numbers staff reported this meant that they were frequently on the rota. There was a high use of locum staff within these services, although recruitment was taking place.

- Staff within the record management teams told us that they had to employ agency staff in order to meet demand. They provided examples of established staffing levels being below the level needed to meet demand. Examples of this included the orthopaedic service where two permanent staff and two agency staff had been required above the planned establishment of staff in order to operate the service. In the ear, nose and throat service three additional agency staff were employed to meet the needs of the clinic.

## Major incident awareness and training

- The trust had a major incident policy and business continuity plans, which staff could refer to if needed.

### Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate



### Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires improvement because:

- It was clear that there had been a great deal of development undertaken to streamline and improve services. However, the processes within the central patient booking service were not embedded leading to delays, inconsistent practices and confusion to patients and staff.
- There had been a reduction in the number of patients waiting on the total RTT waiting lists and in particular the backlogs identified in August 2014 and April 2015. However, there were still a large number of patients waiting for appointments, which could delay treatment.
- There were times when there were delays in accessing interpreting services and on occasion patients' relatives were translating questions, which may not have been appropriate or protecting patient privacy.

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

# Outpatients and diagnostic imaging

- The trust had changed the way it booked patients' clinic appointments and had moved from the majority of specialities managing arrangements to a centralised patient booking service (CPBS). The ultimate aim was to have all appointments booked through the centralised system processes.
- The trust commissioned external reviews of the outpatient services including the CPBS following the identification of a large backlog of 200,559 patients pathways in August 2014 and a further group (cohort) of 47,360 in April 2015 on the non-RTT pathway waiting for appointments.
- It was identified that of the original 200,559 cases around 150,000 had no record of appointment on the system meaning that the trust was unable to identify which patients required follow up. To address this situation the trust obtained external support to individually validate each case, ensuring that each one was recorded on the trust's electronic system and that follow up appointments were made for patients who required these. A clinical review was also undertaken through the medical director's office to identify if any harm had been caused due to delay and also to prioritise patients' appointments according to need. The validation of the 9,355 highest risk priority pathways was completed by the end of April 2015.
- Many staff we spoke with were critical of the newly created CPBS. Staff told us that this had caused issues in appointment booking, including appointments being booked into the wrong clinic, patients not being informed of cancellations, and difficulty in contacting the centralised booking team to discuss concerns.
- We found a mixed picture about the CPBS performance over responding to calls. Trust data showed that the number of calls answered in the CPBS within 60 seconds had improved from 93.2% in May 2015 to 99% in October 2015. The number of abandoned calls had decreased from 15.7% to 6.6% over the same period.
- However, staff told us that phone lines at the CPBS were routinely closed between 1.30pm - 3.00pm. During this time the service could only be reached by e-mail. Staff told us that it could take some time before e-mails were responded to, which meant that urgent issues in regard to active clinics were often not resolved in a timely way. Calls to the booking system were routinely put on hold for considerable amounts of time or the call would be dropped.
- Patients interviewed on both sites highlighted problems with booking with five out of nine patients telling us of these problems.
- All the outpatient clinics we visited had the ability to book some appointments within specific timescales without the involvement of the CPBS team. This varied from a six month follow up in haematology to around three month periods in other specialties. In addition, medical secretaries told us that they could also book patient appointments at short notice or where they felt that it was not appropriate to refer the patient back to the centralised booking service due to delays.
- We were told that the fast track cancer service also had the ability to book two week cancer appointments without the involvement of the centralised booking service. This meant that there were a variety of different ways in which appointments could be booked within the trust. Patients told us that they found this confusing and staff confirmed that patients often expressed confusion about who to contact in order to discuss appointments.

## Access and flow

- Since the identification of the backlog in April 2015 of around 45,000 non-RTT patients, there had been a steady decrease to around 11,790 patients by December 2015. The trust was working to a base level of around 6,000, which they were aiming to reach by February 2016.
- In November 2015, there were 1,654 patients within the non-RTT process failure position for which an RTT or non-RTT pathway had been completed but the referral remained open with no clinically defined see by date.
- Planned patients waiting more than six weeks past their see by date had reduced from 263 in August 2015 to 66 in December 2015.
- The trust had not achieved the 90% target for admitted RTT performance from April to October 2015. The performance had been trending down and in October 2015 it stood at 76.67%.
- Referral to treatment within 18 weeks for non-admitted patients had been trending downwards since May 2015. The performance committee report dated 25 November 2015 stated that between April to October the trust had only achieved the 95% target in May. The performance in October 2015 was reported to be 90.67%.

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- The target of 92% for the 18 week incomplete pathway had been achieved and stood at 92.02% for October 2015.
  - The number of patients on the RTT total waiting list as of October 2015 stood at 22,087 patients.
  - The number of patients waiting less than 18 weeks on the RTT total waiting list as of October 2015 stood at 1762 patients.
  - The specialities that did not achieve the admitted RTT standards up to October 2015 for the admitted pathway were general surgery, urology; trauma and orthopaedics; ENT; ophthalmology; oral surgery; plastic surgery and cardiology.
  - The specialities that did not achieve the non-admitted RTT standards up to October 2015 were general surgery, urology; trauma and orthopaedics; ENT; plastic surgery; gastroenterology; cardiology; thoracic medicine and neurology.
  - The specialities that did not achieve the incomplete RTT standards were oral surgery, ENT; cardiology; thoracic medicine and neurology.
  - The trust performed above the England average in all cancer waiting measures except in Q2 2014/15.
  - Did not attend rates at Bradford Royal Infirmary were similar to the England average.
  - The trust performed below the England average in diagnostic waiting times up to and including July 2015, apart from August and September.
  - Referrals into the service could be made through a variety of means, including GP and NHS Choose and Book. Staff told us that the majority of referrals were sent directly to the centralised booking system. However, some referrals were received directly into the departments and then had to be forwarded to the centralised booking team.
  - It was evident from interviews with senior staff that there had been a great deal of development work undertaken within the CPBS, much of it aimed at streamlining and strengthening assurance processes. However, when speaking with staff in clinics and administration offices the process for accepting a referral was criticised. Staff explained that if a referral was received directly in a department then this was first sent to the centralised booking office. The centralised booking office noted the referral and sent it back to the department. The referral was then shared with clinical staff and sent back to centralised booking office to confirm appointment details. Finally, the referral was then sent back to the department in advance of a patient attending for their appointment. Staff raised concerns that this process did cause delay and the possibility for confusion.
  - Staff provided us with evidence showing that some referrals were not returned from the centralised booking service in advance of appointments, for example on one day in January 2016 out of 107 patients, 13 referrals were 'missing'. When this happened staff had to contact CPBS to locate the referral or contact the referrer to request a copy.
  - Staff were unaware of any policy in place for patients that did not attend their appointments and could not show us a copy of this policy on the trust intranet. Staff told us that any decision to discharge a patient for non-attendance would lie with their treating clinician. Staff said it was difficult to link patients not attending appointments to their vulnerability.
  - Staff told us that the central booking system often allowed clinics to be overbooked by as much as 50%. Staff told us of times when 30 patients were booked into a 20 patient clinic. This placed pressure on clinicians to see patients and on administrative staff in completing pre-clinic preparation.
  - Nursing staff completed patient outcome forms at the end of outpatient appointments. This pro-forma identified whether patients were for follow up (and the timescale), discharge, or if they had not attended clinic. Administrative staff in the clinic then entered details onto the electronic appointment system. If the patient was for a further appointment and it was within the timescale in which the clinic could book appointments then one would be booked at the time. If this was not, then staff told us that the patient was added to the waiting list to be managed by the central booking office.
  - The Audit of Clinic Utilisation and Efficiency Report September 2015 showed that of 33 completed audit forms, 13 of these related to surgical clinics, 7 medical clinics and 13 clinics for women's and children's services. Of the 33 clinics audited, 85% started on time, 64% had medical notes available, and 85% had the clinic outcome form available. Overall, 64% of forms had incomplete data.
- ## Meeting people's individual needs
- Outpatient waiting areas had sufficient seating available for patients and visitors.

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- We saw that magazines and newspapers were available in some waiting areas. Water was available in most outpatient areas and we saw that hot drinks were available in the haematology/oncology outpatient waiting room.
- Staff told us that patient information leaflets were not routinely available in different languages. We did not see any patient information on clinical issues on display in different languages within the departments. We did see a complaints leaflet displayed in another language, but this had become out of date in 2012. This had been replaced by another 'Tell us what you think' leaflet (also on display) that was not available in another language in the department. This was also past its review date.
- Staff told us that they had access to translation services. Routinely, face to face interpretation was booked for patients who required support. Staff told us that any need was identified on the patient referral or when staff reviewed notes the day prior to clinics taking place. Any delays in receiving referrals or records could lead to insufficient time to book interpreter support. Staff were unsure if there was a translation policy.
- There was appropriate directional signage to the various areas within the diagnostic imaging department, including patient waiting rooms, which were single sex and had disabled toilet facilities.
- There was a mixed response about relying on family members or carers to provide interpretation for patients. Some would not use family members but other staff told us that they would feel comfortable using family members to interpret. This included reference by staff in diagnostic imaging to using family members to ask about patient pregnancy. There was a risk that this could lead to a patient being placed in a difficult position in disclosing sensitive information.
- Staff in the departments told us of times when people with learning difficulties were cared for based on their individual needs. An example of this was in haematology outpatients where staff told us that a quiet room was used as a waiting area for patients with learning difficulties if they found the main waiting area to be too busy. All staff told us that they would actively engage with patients and carers to tailor care to the individual's preferences.
- The quiet room was also used for oncology clinics for breaking bad news, to discuss sensitive diagnoses and allow patients time away from the waiting area. There was art on the walls and comfortable leather seating available, which offered a less clinical environment.
- Staff told us that chaperones would be available for patients attending outpatient clinics where this was necessary. Health care assistants routinely acted as chaperones in the areas we visited. However, there was no visible signage informing patients that they could request a chaperone at their clinic visit.
- There was a Dementia Strategy and leads within outpatient clinics to ensure that staff were meeting the needs of people living with dementia. The leads attended regular trust wide link meetings to keep up to date with developments and changes in practice.

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

Requires improvement



We rated well-led as requires improvement because:

- There had been a difficult transition to a centralised patient booking service, which had revealed a range of problems such as poor quality data, incomplete data entries on the system, multiple routes of referral and inconsistent booking across the service. This had resulted in delays in access for patients to appointments, confusion and frustration amongst staff and patients across the service.
- However, the trust had invested a great deal of time and funds into developing an improvement plan that incorporated recommendations from external organisations and information generated internally. External reviews had been commissioned and work was in progress to address identified issues and move the service to a much more structured, streamlined and responsive system. A programme of activities had been introduced including a staff training and development programme and more robust reporting and monitoring systems. Assurance mechanisms had been strengthened.
- It was clear from speaking with staff in the outpatients' service that there was still frustration over the changes and that further engagement would be needed.



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- The service was experiencing challenges over staffing levels, although arrangements were in place to ensure that clinics ran safely. Some specialities had recovery plans in place to address backlogs in waiting lists and a range of contingencies had been put in place such as working with external providers in order to reduce the numbers of patients waiting.
- The diagnostic and imaging services had well established governance and assurance arrangements in place. There was a high level of confidence in the leadership and management of the service and staff felt well supported and actively encouraged to develop as professionals.

## Vision and strategy for this service

- Across the outpatients' service the majority of staff were unclear on the wider vision or strategy for the trust. However, staff were able to tell us that they aimed to provide safe and high quality care, but were unable to articulate the trust's mission or values.
- Outpatient services were allied to their core medical or surgical services. This meant that the vision and strategy for the outpatient services was allied to the strategy for the core service. An example of this was in the haematology/oncology clinics where staff were aware of the move to a new day unit and the benefits that would bring to the wider service.
- The orthopaedic outpatient area had a department philosophy on display showing the values its staff aimed to achieve, such as achieving a 'safe and friendly' environment for patients. The band 7 senior nurse was able to offer a vision of the service and was keen to develop all levels of staff in achieving this.
- Within the diagnostic and imaging services, there was a local department vision and staff reported there was strong leadership and investment in staff development.

## Governance, risk management and quality measurement

- There had been significant development work across outpatient services including the governance arrangements within the CPBS and individual clinics over the last 18 months. The trust had worked with external agencies and organisations in order to identify issues and develop improvement plans.
- The trust invited in the NHS England Intensive Support team to undertake a follow up review of the booking system and delivery of the 18 week refer to treatment

(RRT) standard in February 2015. This review highlighted issues with the new system. Problems associated with the transition to the new booking system included the quality of data and recording, poor clinical involvement and lack of training for staff.

- In addition, the trust commissioned two external organisations; one to review the incomplete pathway and the other to assist with the backlog and implementation of changes to the CPBS.
- The independent review of the incomplete pathway found that there were multiple issues that were required to address the situation but also to sustain improvements in the future. A varied approach to the cashing up clinics (this is when the clinical outcomes to a consultation with a patient are recorded), issues over data entered onto the system including timing delays, concerns over the capacity of the teams transitioning into the new CPBS and training issues were some of the findings of the review. Recommendations included strengthening assurance processes such as the committee structures and formalising processes for escalation.
- An action plan had been developed that captured areas for improvement from a number of sources including external reports and information generated internally.
- The trust had introduced weekly monitoring at speciality level which was reviewed at the corporate divisional general management performance meeting. In addition, there was continued divisional monitoring at clinical governance meetings. These included a clinical review process for the non-RTT waiting list to remove the risk of harm due to delays. Any suspected harm found due to delay following a review appointment was to be logged on the electronic incident reporting system, investigated and escalated to the medical directors' office. The progress with access and the CPBS was added as an agenda item at the monthly performance meeting.
- The trust introduced weekly validation by the corporate access team to close referrals and add patients to review waiting lists with see by dates.
- An education and training programme had been introduced as part of the improvement work within the CPBS. The development programme was aimed at staff across the service in admissions, ward clerk roles and medical secretary teams.
- Recovery plans had been developed for each speciality with a backlog, for example with gastroenterology. The



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endoscopy service was working with external providers to reduce the backlog with the diagnostic gastroenterology surveillance patients. The trust had aimed to reduce the backlog by October 2015, but this had been extended to January 2016.

- A corporate tracking tool had been created to monitor and report clinical reviews.
- Management staff told us that there were monthly governance meetings within the directorates which they attended. Minutes were available on the intranet. These were service specific and no overall outpatient themes were evident on those seen.
- Risk registers were maintained in outpatients and the diagnostic and imaging services, these were fed up to the corporate risk register and the executive team. Senior staff were able to tell us what was on their risk registers and what action was being taken, such as staff recruitment. One example was in orthopaedics where there was a 'trips and falls' risk highlighted because of the porch floor becoming slippery when wet. This had been mitigated by work to extend the carpeting into the porch area.
- A significant challenge experienced by the service was the shortage of staff to operate outpatient clinics. Some areas such as dermatology were particularly impacted by the lack of registered nurses. There were arrangements in place to assess the requirements of each clinic and whether they were safe to operate. Contingency arrangements were in place to access agency/locum workers and to seek support from colleagues in other clinics.
- There continued to be delayed access to some clinics and targets for RTT and non-RTT were not always being met. There were a range of specialties who were not achieving their access targets. Recovery plans had been put in place to support these services and reduce patient waits.
- Staff on both sites reported good multidisciplinary (MDT) working especially those areas which had associated in-patient beds.
- It was also reported that there was good external MDT working, for example when transfers between sites was required and that there were service level agreements in place to cover these.
- Within the imaging and diagnostic services there were local governance frameworks in place with active national and local clinical auditing. However, we found that policies under IR(ME)R were out of date, including

the Local Rules. We were told these were under review and a risk assessment had been undertaken to assess continued use of documents whilst updated documents were ratified. There were no standardised protocols or version control evident on the documents examined.

## Culture within the service

- Clinical staff felt supported to deliver care and were comfortable in approaching their managers for advice and support.
- Staff within the diagnostic and imaging service felt well supported. New staff had clear orientation, competencies were well established and there was a buddy scheme in place. Staff returning to work were put on the buddy scheme and staff were encouraged to develop additional skills for promotion purposes. Post graduate studies were particularly supported. Staff reported that there was excellent clinical supervision and mentorship within the service.
- Some staff had only recently returned to work after periods of absence. They felt well supported by colleagues in returning to work and there were individual plans in place that they were happy with.
- Administrative staff provided us with examples of times when they were not supported. One example of this was a staff member who had indicated that they were under a great deal of pressure/stress on a shared staff notice board using a tool to monitor staff mood. They told us that no action had been taken to address their comments or support them during that period.
- Staff told us that they felt supported by their immediate managers and that they had confidence in their leadership. A number of band 6 staff had completed the trust's leadership course. In the orthopaedic area in particular, there was encouragement for all staff to develop new skills. For example, HCA's were involved in handwashing and dress code audits.
- Senior staff felt supported in furthering their own personal development. One example of this was the senior nurse in vascular dressing service who was undertaking a Master's Degree. He considered that the study time and other resources for this were good

## Public engagement

- The wound management unit had conducted an annual patient satisfaction survey in 2015. This had involved

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asking 30 patients to complete questionnaires about the service they received. The survey showed positive feedback from patients, with over 96% rating staff as 'excellent'.

- The orthopaedic outpatient areas displayed patient feedback and examples of actions taken to address patient concerns. An example of this included feedback that seating in the area was poor. The service had responded by seeking charitable funding and replacing the chairs.
- We observed that staff encouraged patients and their relatives to complete the family and friends (FFT) feedback survey.
- Results from the FFT survey showed that between 97 – 100% of patients attending women and children's clinics would recommend the service, between 83 – 100% of patients would recommend the surgery and anaesthetic clinics, between 92 – 100% of patients would recommend the medical clinics and between 93 – 100% would recommend the diagnostic and imaging services.

## Staff engagement

- Staff expressed frustration about the transition to the CPBS and the impact this had on the service, staff and

patients. Some staff felt that there had been little engagement and support with the transition. Some staff felt that they had not been listened to when they had raised concerns about the transition.

- Continued problems associated with the transition and the establishment of the new system persisted and there was a lack of confidence in the new ways of working in many areas. However, the trust had put in actions to improve the communication with the service and work was progressing on improving engagement with clinicians and staff as part of the improvement plan.
- One staff member told us that they had been engaged in the trust moving to electronic prescribing. They had attended meetings on the topic and said that they would be involved in training and roll out.

## Innovation, improvement and sustainability

- There were two nurse led clinics in the orthopaedic area and a nationally recognised course in plaster casting being held regularly to 'grow' in house expertise in this field.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and the cleaning of equipment.
- The trust must review and risk assess the environment on ward 24 and put in place actions to mitigate the risk of the spread of infection.
- The trust must ensure that the use of PGDs in accident and emergency is in-line with trust policy.
- The trust must ensure that relevant staff working in surgery comply with the five steps to safer surgery process and that the WHO surgical safety checklist is consistently followed.
- The trust must ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to ensure that patients are protected from the risks of delayed treatment and care.
- The trust must ensure that robust arrangements are in place to ensure that policies and procedures (including local rules in diagnostics) are reviewed and updated.
- The trust must ensure that patient information is held securely and patient confidentiality is maintained in relation to information about victims of domestic abuse in accident and emergency and the storage of property bags for deceased patients.
- The trust must ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified assessed and managed.
- The trust must ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed.

- The trust must ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.

### Action the hospital **SHOULD** take to improve

- The trust should review use of the public address system in accident and emergency to ensure that patients are aware that they are being called and where they should go.
- The trust should review the signage to the accident and emergency department within the hospital grounds to ensure that the department is clearly signposted.
- The trust should improve assessment facilities for patients admitted into accident and emergency with mental health concerns.
- The trust should review the arrival to initial assessment times in accident and emergency to ensure that patients are reviewed in a timely manner.
- The trust should risk assess the isolation facilities in accident and emergency to ensure that they meet current infection control standards.
- The trust should ensure cramped single rooms on wards 7, 9 and 15 are risk assessed to inform staff of the procedure in an emergency situation.
- The trust should review and monitor the demand for the outreach service to ensure the needs of deteriorating patients out of hours are met.
- The trust should review pharmacy cover against the Core Standards for Intensive Care Units (2013) (Pharmacy cover guidelines) which states that there should be at least 0.1 whole time equivalent specialist pharmacist for each single Level 3 bed and for every two Level 2 beds.

# Outstanding practice and areas for improvement

- The trust should complete a review of unmet demand for beds which was identified as an action from the previous inspection and quality key indicators reports.
- The trust should ensure that the amount of epidural waste destroyed is recorded, in-line with best practice.
- In maternity, the trust should ensure that PAT testing of electrical equipment takes place and is recorded.
- The trust should consider having a policy regarding the use, monitoring and security of the baby milk refrigerators.
- The trust should address the environmental issues on ward 2 to ensure patients and families have privacy and their dignity is respected.
- The trust should review the practice of transferring patients from theatre to recovery with endotracheal tubes in place without any monitoring to ensure that any risks to patients are minimised.
- The trust should ensure that staff in surgery and theatres understand the definition of a serious incident and a never event.
- The trust should review ward 12 to ensure that patients are cared for by staff with appropriate skills and experience.
- The trust should review the availability of play facilities for children.
- The trust should review nurse staffing levels in services for children and young people to increase the availability of a senior staff member to provide clinical support and leadership to junior staff.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

| Regulated activity                       | Regulation   |
|--|--|
| Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and the cleaning of equipment.</p> <p>The trust must review and risk assess the environment on ward 24 and put in place actions to mitigate the risk of the spread of infection.</p> <p>The trust must ensure that the use of patient group directions in accident and emergency is in-line with trust policy.</p> <p>The trust must ensure that relevant staff working in surgery comply with the five steps to safer surgery process and that the WHO surgical safety checklist is consistently implemented.</p> <p>The trust must ensure there are improvements in referral to treatment times and action is taken to reduce the number of patients in the referral to treatment waiting list to ensure that patients are protected from the risks of delayed treatment and care.</p> |
| Regulated activity                       | Regulation   |
| Treatment of disease, disorder or injury | <p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p>  |

This section is primarily information for the provider

## Requirement notices

The trust must ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified assessed and managed.

The trust must ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed.

The trust must ensure that robust arrangements are in place to ensure that policies and procedures (including local rules in diagnostics) are reviewed and updated.

The trust must ensure that patient information is held securely and patient confidentiality is maintained in relation to information about victims of domestic abuse in accident and emergency and the storage of property bags for deceased patients.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels.

The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.