

# Harrogate and District NHS Foundation Trust

## Harrogate District Hospital

### Quality Report

Harrogate District Hospital  
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Date of inspection visit: 2-5 Feb 2016 with an  
unannounced on 10 February 2016  
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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		Good	
Urgent and emergency services	Good	Good	
Medical care (including older people's care)	Good	Good	
Surgery	Good	Good	
Critical care	Outstanding	Outstanding	
Maternity and gynaecology	Good	Good	
Services for children and young people	Requires improvement	Requires improvement	
End of life care	Good	Good	
Outpatients and diagnostic imaging	Outstanding	Outstanding	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected Harrogate District Hospital as part of the comprehensive inspection of Harrogate and District NHS Foundation Trust from 2 to 5 February 2016. We carried out an unannounced inspection of the hospital on 10 February 2016. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

Overall, we rated Harrogate District Hospital as good. The majority of services were rated as good across the hospital, with some areas rated as outstanding. However, further work was needed at the hospital to develop the children's and young people's services, the trust were aware of this and new leadership had been introduced. There was no strategic plan in place for end of life care, although in its absence the trust had developed a care of the dying adult and bereavement policy. The service had a leadership structure split between two directorates, which the trust had recognised could be more effective and was being reviewed.

We rated caring as outstanding, effective, responsive and well-led as good; and safe was rated as requires improvement.

We rated critical care and outpatients and diagnostic imaging as outstanding, urgent and emergency services, medical care, surgery, maternity and gynaecology and end of life as good. We rated services for children and young people as requires improvement.

Our key findings were as follows:

- The trust values and vision were well known across the hospital services. There was strong leadership and staff reported that the leadership team were visible and that local management was supportive. However, the senior leadership within the children and young people's services had only been in post for a relatively short time. Therefore, the service had yet to fully develop a comprehensive vision, strategy and further work was needed to embed the governance structures.
- There was good morale amongst staff, they told us they were proud of their hospital and the care they delivered to patients.
- There were governance, risk management and quality measurements in place to promote positive patient outcomes. Care was delivered in accordance with national and best practice guidance. Policies, procedures and local guidelines were based on evidence based practice and were in line with the National Institute of Clinical Excellence guidance.
- There were no risks identified for in-hospital mortality, the Dr Foster Hospital Standardised Mortality Ratio Indicators or the Summary Hospital-level Mortality.
- There was openness and transparency about incident reporting and learning lessons. The hospital had a strong safety culture and staff were confident in the reporting of incidents.
- A redesign project was underway which aimed to improve patient flow and enhance the patient experience for acute medical admissions. To aid with patient flow, discharge liaison nurses facilitated the timely discharge of complex patients.
- Patients were treated with dignity and respect. There was consistently high scores in the Friends and Family Test for patients who would recommend the service. Some medical wards regularly achieved 100%. Staff were alerted when a patient with specific needs was admitted or attended clinic and reasonable adjustments were made for patients living with dementia or had a learning disability.
- Staff had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards and there were well established processes in place for the obtaining of consent.
- The safe use of innovative approaches to care was encouraged; collaborative team working was positively promoted. Patients' access to pain relief and nutrition was good.

# Summary of findings

- We rated critical care services as outstanding. People's individual needs were central to the planning and delivery of critical care. The service engaged patients and the public to plan and improve the service. There was a proactive approach to understanding the needs of difference groups of people, and appropriate support was provided. For example for patients who had a traumatic experience in critical care. Patients were seen by the nurse and clinical psychologist in the supporting intensive therapy unit (Situp) patients' service.
- Outpatient and diagnostic imaging services were outstanding. These services were tailored to meet the needs of individual people and were consistently exceeding performance targets
- Staff told us there were good training opportunities available to them and nurses were well supported with completing their nurse revalidation. However, in some areas, for example medical care junior doctors told us that work pressures were affecting their training as they did not have enough opportunities to learn and were not having regular supervision. Not all staff, particularly in the children's and young people's service had completed the relevant children's safeguarding training.
- The hospital had not undertaken a risk assessment for the admission and care of children and young people with a mental health illness. Plans were in place to obtain training from a local trust for the care of young patients with a mental health illness.
- The urgent and emergency care department was generally meeting the 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival. However, the department was no longer large enough to suitably accommodate the number of patients, equipment and consumables needed, as these had increased over the years.
- Staffing levels and skill mix across services were generally planned in line with best practice and based on patient acuity. However, actual staffing levels did not always meet planned, for example in the urgent and emergency care department, maternity services and surgery. A recognised acuity tool was not used within children's and young people's services and staffing levels were not always compliant with safer staffing guidance. The trust was actively recruiting to posts and taking action to improve staffing levels through better use of the skill mix of staff.
- The standard of cleanliness throughout the hospital was to a good standard and infection control audits showed a good performance. There had been no incidence of Methicillin-resistant Staphylococcus Aureus and 16 cases of Clostridium difficile from May 2015 to August 2015. In some medical wards we found poor adherence to infection prevention and control (IPC) policies and procedures, particularly with the care of patients in isolation and the use of personal protective equipment.
- Patients received compassionate and understanding care from hospital staff at the end of their lives. All ward staff were expected to care for patients at the end of their life. There was no specialist palliative care team employed within the hospital; this support was provided by the local hospice and was only available face to face five days a week which did not meet national guidance. At weekends and out of hours advice was provided by a consultant on call service via the hospice. The trust recognised the importance of improving their approach to end of life care and had established the 'Rethinking Priorities Programme'
- The facilities in the mortuary required improvement and updating. There was limited access for bereaved families at weekend and the environment was in a poor condition in places. There was a large volume of records stored; the environment was unsuitable for this purpose.

We saw several areas of outstanding practice including:

- There were innovative services that improved the care of patients on and following intensive care, such as the "Supporting intensive therapy unit patients (situp) service and the clinical psychology service to inpatients and outpatients at the follow up clinic in critical care. In addition there was the use of patient diaries on critical care by the multidisciplinary team. The critical care outreach team's leadership, advanced clinical skills and commitment to education. There was also a critical care online "virtual" journal club.
- The main outpatient department was an accredited centre for the treatment of faecal incontinence using percutaneous tibial nerve stimulation. Staff told us they were the first NHS centre to be awarded this accreditation.

# Summary of findings

- A review of the glaucoma pathway had led to; the redesign of the layout and content of the clinic rooms, the introduction of a virtual clinic for lower risk glaucoma patients and the ongoing development of nurse practitioners.
- We spoke with the diabetes specialist nurses who demonstrated how they used information from the Electronic Prescribing and Medicines Administration (EPMA) system to monitor patients' blood sugar readings and insulin doses. If a patient had a blood sugar reading of less than 4 or more than 15, a specialist nurse would proactively visit them. This enabled the team to target those patients early who required a review and allowed interventions to be made before referrals were received. This also helped to streamline the team's workflow. We thought this was innovative practice.
- The redesign of the acute admissions and assessment pathway, known as the 'FLIP' project was outstanding. The project was initiated and driven by staff. It involved the redesign and integration of the CATT Ward and the CAT team. Although the project started in October 2015, the benefits of the project were already being seen. Despite a 30% increase in non-elective in-patient activity within general medicine, the percentage bed occupancy had decreased from October 2015 to January 2016 compared to the previous year. Managers attributed the fact that the hospital had not needed to open up the 12 bedded winter pressures escalation ward to the success of the project.

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

Importantly, the trust must:

- take steps to ensure that the environment on the Woodlands ward is appropriate to allow the needs of children and young people with mental health needs to be fully taken into account.
- ensure that accurate nursing records are kept in line with professional standards particularly in urgent and emergency services and that medical records are stored securely in services for children and young people and within the mortuary area.
- ensure that good infection protection and control practices are adhered to particularly on all medical wards
- ensure that all medicines are stored safely and are disposed of when out of date. This particularly applies to oxygen cylinders and drugs on the emergency trolleys in the hospital. 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 particularly in medicine, end of life care and children and young peoples' services.
- ensure all staff have completed mandatory training, role specific training and had an annual appraisal particularly: appraisal rates within maternity and gynaecology; mental health training for paediatric staff and; safeguarding training in both community and acute services for children and young people.
- ensure guidelines and protocols are up to date and there is an effective system in place to review these in a timely manner particularly in maternity and gynaecology and radiology.
- improve the facilities in and access to the mortuary.

Additionally there were other areas of action identified where the trust should take action and these are listed at the end of the reports.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

Openness and transparency about safety was encouraged and there was a strong culture of reporting incidents. Staff followed infection prevention and control guidelines and managed medicines effectively.

Care delivered reflected national guidelines. There were policies and procedures in place that were developed in conjunction with national guidance and best practice evidence from professional bodies. Multidisciplinary working was established with a 24-hour seven-day service provided.

However; some services were available out of hours as an on call service. The trust was working towards the delivery of sustaining seven-day services.

Patients and relatives were treated with dignity, respect and compassion. We heard staff use language that was appropriate for patients to understand their treatment and to be involved in decisions about their care.

The service had systems and processes in place to facilitate the flow of patients through the department and the department was generally achieving the 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival.

There were governance, risk management and quality measurements and processes in place to enhance patient outcomes. There was strong leadership and management, and a strong supportive culture of openness, transparency and honesty. Staff were proud to work in the department.

However, the service had 'out grown', the current size of the department as the number of patients, equipment and consumables had increased over the years. Although, staffing levels and skill mix was planned in line with busy periods; the planned nurse staffing numbers were not always met. Documentation was not always completed appropriately.

# Summary of findings

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

Good



Patients were treated with dignity and respect. We saw some individual examples of staff demonstrating great empathy and kindness. There were consistently high scores in the Friends and Family Test Scores for patients who would recommend the service. Some medical wards regularly achieved 100%. Patients told us they felt well informed and included in decisions about their care. There was good emotional support particularly within the Robert Ogden Centre. Services were effective. Protocols and policies based on current evidence were available for staff on the ward and on the intranet. We found local guidelines based on the National Institute for Health and Care Excellence (NICE) guidelines. There were good examples of multidisciplinary working. Nursing and therapy staff told us that there were good training opportunities available to them and nurses were well supported in completing their revalidation. However, junior doctors told us that work pressure was affecting their training as they were not having enough opportunities to learn and were not having regular supervision. Staff we spoke to had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Access to services was good with cancer waiting times data showing good performance. A redesign project was underway which aimed to improve patient flow and enhance the patient experience within acute medical admissions. Discharge liaison nurses facilitated the timely discharge of complex patients. Reasonable adjustments were made for patients with a learning disability and staff completed 'all about me' forms for patients living with dementia. The senior management team for medicine were clear on their greatest risks and we saw this clearly documented on the directorate risk register. Control measures were in place to reduce the level of risk. Staff often saw senior managers, especially the chief nurse who was on the wards regularly and staff said was approachable. Staff spoke highly of their managers and told us they felt well supported.

# Summary of findings

and listened to. The trust vision and values were well known. We found good morale amongst staff and they told us they were proud of their hospital and the care they delivered to patients. However, we found medical care services to required improvement for safe. Although wards appeared clean, we observed some poor infection control practices on several wards we visited. Doors to isolation rooms were often left open and staff did not always observe good hand hygiene and correct use of personal protective equipment. We found several issues with medicines. Hypo-boxes were not always checked according to the policy and the contents of the box were not always complete. One injection was found to be out of date on the resuscitation trolley on one ward and we found three cylinders of oxygen which were out of date and not stored safely on one ward. We also discovered medicines left unattended on the nurse's station on Fountains AMU. Nurse staffing was an issue however, the trust had recognised this and had taken measures to minimise the risk to patients.

## Surgery

Good



Staff protected patients from avoidable harm and abuse, openness and transparency was encouraged. There was a holistic approach to assessing, planning and delivering care and treatment to patients who use the services. All wards used an early warning scoring system for the management of deteriorating patients. The safe use of innovative approaches to care was encouraged; teams were encouraged to work collaboratively. Staff were able to meet the needs of patients' through the way services were organised and delivered. Patient's access to pain relief and nutrition was good and performance outcomes post-surgery were mainly better than the England average. Patients were respected and valued as individuals, feedback from patients was positive. We observed positive interactions between staff and patients during the inspection. Staff were proud of the level of care they delivered and wanted to improve the lives of the patients they cared for.

# Summary of findings

Senior managers had a clear statement of vision for the service. The directorate and wards had quality priorities identified. Staff on the wards worked well together with respect for other specialities. At times staffing levels did fall below established levels, but the trust were actively recruiting to posts and taking action to improve staffing levels through improvements in the skill mix of staff. However, we did have concerns over the effectiveness of the five steps for safer surgery; the trust had recognised the issue and had actions in place to improve the process. Access for staff to appraisals required improvement as only 52.3% of staff had received an appraisal.

## Critical care

### Outstanding



People's individual needs were central to the planning and delivery of critical care services and the management team worked with leads in the trust to plan service delivery. The service engaged patients and the public to plan and improve critical care services.

Access to care was managed to take account of peoples need. The unit's bed occupancy was mainly lower than the England average and the delayed discharge and out of hours discharge rates were much better than similar units and the national average.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs. For example, patients who staff knew had a traumatic experience in critical care were seen by the nurse and clinical psychologist in the supporting intensive therapy unit patients (situp) service. Patient diaries and a follow up clinic formed part of the rehabilitation after critical illness service.

There was clear nursing and medical leadership on the unit and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively. It was clear that staff had confidence in the leadership and there were high levels of staff engagement and satisfaction. We observed a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other's opinions. Staff considered patients individual preferences and were motivated and inspired by leaders to

# Summary of findings

deliver person centred, holistic care. Patients received psychological support from specialist staff during and following their critical care stay to help them cope emotionally with their care and treatment. Feedback from patients and relatives was continually positive about all aspects of their care. Staff had been nominated for awards for their patient care.

The service had a good track record in safety and had provided 100% harm free care between September 2014 and September 2015. Systems and processes in infection control, medicines management, patient records and the monitoring, assessing and responding to risk were reliable and appropriate to keep patients safe. Staffing levels and skill mix were planned and reviewed to keep people safe at all times.

Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence based guidance, standards, best practice and legislation.

However, the service did not meet all the recommendations in the Guidelines for the Provision of Intensive Care Services (2015), for example, a lack of a supernumerary nurse, aspects of the medical staffing arrangements and the percentage of post registration qualification for critical care nurses on the unit.

## Maternity and gynaecology

Good



Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff. Systems were in place to protect patients from abuse and staff were aware of the procedures to follow.

Records relating to women's care were of a good standard. Risks to women were identified, monitored and managed to keep them safe. Records were kept secure in line with the data protection procedures.

The unit was meeting the nationally recommended birth to midwife ratio of 1:28. However, there had been some recent vacancies, which the trust was actively recruiting to. In the interim, any increased demand on the service was met by moving staff, between departments and the community. Managers informed us that all new staff would be in post and operational by April 2016.

# Summary of findings

However, medication training for community midwives was 29%. All staff must receive appropriate training necessary to carry out their duties.

We found worn wooden storage units were being used in delivery suite. The units could not be effectively cleaned and therefore a risk to infection control. There was not always an appropriate sized cuff available for use with the blood pressure machine. Although there were alternative methods available to obtain a blood pressure recording, the trust should ensure variable sizes of blood pressure cuffs are available.

## Services for children and young people

### Requires improvement



The senior leadership group had only been in post for a relatively short period. This meant that there had not yet been time for the service to develop a comprehensive vision and strategy for children's services within the trust. Governance structures required further embedding, including ward meetings to establish engagement with staff groups and with the public.

Nurse staffing was not planned in accordance with recognised acuity tools or compliant with safe staffing guidance. Staff felt that incidents were under reported due to staffing pressures. Children and young people attending for surgery or via A&E were not always cared for in a suitable environment and were placed on adult surgery lists, which was not in accordance with national guidance. The trust understood this issue and plans were being developed to increase paediatric day surgery provision.

No formal risk assessment had been carried out to consider the needs of children and young people who attended the ward with mental health needs. Staff had identified that there were shortfalls in training for this and had arranged training with a local NHS trust. The trust had not met its target for staff receiving appropriate levels of safeguarding training in accordance with national standards, although staff were achieving targets for mandatory training overall.

Cleanliness and infection control audits showed good performance. Pain was managed effectively and nutritional needs of patients were met. Care

# Summary of findings

was appropriately recorded in the medical records, although the child's voice did not appear reflected in records. Records were also not always stored securely.

Staff adhered to evidenced based practice and the service was accredited by external schemes, such as the UNICEF baby friendly initiative. Children and young people could access inpatient services at any time. Clinical staffing was appropriate with medical cover on site at all times and consultant support available via a consultant of the week system. Pharmacy advice and support was also available seven days a week.

Appropriate policies and procedures were in place to consider consent and we noted good consent practices in place. The trust faced a challenge in staff receiving up to date appraisals and ensuring all staff received clinical supervision and had appropriate training to care for children and young people. The trust was aware of these challenges and this was due to be addressed by the new leadership team.

Services were planned to identify the needs of the local population. Children and young people attending services were routinely seen in dedicated ward and outpatient areas for the majority of the care they received. The trust had identified the needs of the local population and planned to create a paediatric assessment unit.

Staff told us that they previously felt that there was a lack of senior leadership within the service. However, they were positive about the new service and trust level leadership and felt that this would lead to improvements in services for children and young people.

## End of life care

Good



The end of life care services were rated good overall. We rated the service as good for safe, effective, caring and well-led. We rated responsiveness as requires improvement. We found patients received compassionate and understanding care on all the wards at the hospital and from the hospital chaplaincy service.

## Summary of findings

There was a strong culture of incident reporting. Staff knew how to report incidents and there was feedback and learning from incidents. Staff had a good understanding of the duty of candour and apologised when things went wrong.

The trust participated in the National Care of the Dying Audit of hospitals. The 2015 results showed that staff recognised that the patient would probably die in the coming hours or days in 96% of cases. The care of the patient was discussed with a nominated person important to the patient in 87% of cases and 69% of patients received a holistic assessment and care plan in the last 24 hours of life. The audit results for 2014 indicated that the trust scored better than the England average for eight out of 10 clinical indicators and three out of seven of the organisational indicators.

The trust had produced new guidance for staff that was based on up to date evidence and national guidelines. There were multi-disciplinary team (MDT) meetings in place. A care planning process had been developed and was being used based on current national guidance. Staff could access evidence based guidelines for symptom management. Equipment was available promptly from the equipment library when requested.

There were senior Board level executive and non-executive leads in place and an end of life steering group. The trust recognised the importance of improving their approach to end of life care by establishing the 'Rethinking Priorities Programme'. This was a development programme which involved consultant medical staff evaluating some of the most challenging aspects of providing a high quality service to patients approaching the end of life.

The trust was working with their local clinical commissioning group (CCG) and community teams to develop a five year strategic plan for end of life care. Progress developing the strategy was slower than planned and was not completed in February 2016, when we inspected. However, in the absence of an agreed local strategy the trust had developed a care of the dying adult and bereavement policy. However,

The service level agreement with the local hospice to provide specialist palliative care clinical nurse

# Summary of findings

specialists (CNS), the supportive care CNS had expired. Specialist face to face palliative care was only available Monday-Friday which was not meeting the national guidance of a seven day service. There was 24 hour specialist palliative care telephone advice available from an on call palliative medicine consultant in the region, who could be contacted via the local hospice. Care for people at the end of their life was not part of the trust's mandatory training.

The trust were unable to fully measure the quality of the service provided or measure improvements because they did not collect quality information such as recording the preferred place of care for patients. The trust recognised this and planned to develop quality measures.

Facilities in the mortuary required improvement and updating; the drainage and floor covering in the mortuary was old and appeared dirty with poor facilities for viewing and arrangements for transferring patients from the ward. The mortuary's facilities for accommodating bariatric patients were limited as they could only accommodate patients up to a certain size. There was limited access to the mortuary at weekends for relatives. Porters were trained to transfer bodies to the mortuary but were not mortuary technicians so were not able to prepare the body for viewing. This relied on the trained mortuary staff being available and they only worked Monday to Friday although there were some on call facilities.

We found a large number of historical autopsy post mortem reports stored in the mortuary, some of which dated back to 1970. This breached the NHS Code of Practice, which states that these records should have been destroyed once they are 30 years old.

## Outpatients and diagnostic imaging

Outstanding



Patients received safe care and staff were aware of the actions they should take in case of a major incident. Incidents were reported, investigated appropriately and lessons learned were shared with all staff. The cleanliness and hygiene in the departments was within acceptable standards. Staff were aware of the various policies designed to protect vulnerable adults and children. Patients were protected from receiving unsafe treatment as

# Summary of findings

medical records were available 99% of the time and electronic records of diagnostic results, x-ray images and reports and correspondence were also available. There were sufficient staff to deliver services safely.

However, The WHO surgical safety checklist was not yet fully implemented in imaging areas, the phlebotomy room was not ideal for patients from infection prevention, and control perspective as it contained stores and staff coats. The environment at Ripon hospital outpatients and imaging departments needed some updating and repair. Care and treatment in outpatients and diagnostic imaging was evidence-based and performance targets consistently met. Staff were competent, received an annual appraisal and there was multidisciplinary working established. Staff undertook regular audits in imaging and pathology departments regarding quality assurance to check practice against national standards.

However, there were a number of pieces of equipment, which were ageing, and in need of replacement, this was particularly in the imaging services.

Staff in all areas treated patients with kindness and respect. Privacy and dignity was maintained at all times. Staff were able to signpost patients to support groups and counselling services when necessary.

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. Initiatives including virtual clinics, and nurse led services meant patients could easily access specialist advice and support. The trust was consistently exceeding its performance targets and England averages for referral to treatment times (RTT) and for diagnostic waits. The trust consistently exceeded cancer waiting time targets. The Trust was actively managing its waiting lists for both new and follow-up patients and there was a clear plan to reduce the numbers of ophthalmology patients awaiting review appointments. The trust had developed a number of one-stop services for patients and had well-embedded outreach services.

## Summary of findings

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The clinical assessment team, fast track systems and the rapid access clinics meant patients could access specialist assessment and diagnostics very quickly.

The services were visionary and innovative and there was a well-embedded culture of service improvement. Staff and members of the public were engaged in service improvements.

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# Harrogate District Hospital

## Detailed findings

### Services we looked at

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

# Detailed findings

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## Background to Harrogate District Hospital

Harrogate and District NHS Foundation Trust became an integrated provider of hospital and community services in April 2011, when it acquired a number of community services from North Yorkshire Primary Care Trust. The trust has 402 beds and employs around 2,860 staff.

Harrogate and District NHS Foundation Trust (HDFT) provides urgent and emergency care services at Harrogate District Hospital and two minor injury units at Ripon Community Hospital and Selby War Memorial Hospital.

The Emergency Department at Harrogate District Hospital is a designated Trauma Unit, which serves a population of approximately 300,000. This hospital provides acute medical and surgical care, with some services also provided through an alliance with York Teaching Hospitals NHS Foundation Trust, including vascular, urology (on-call), ear, nose and throat (ENT) and maxillofacial. Endoscopy services are provided at Harrogate District Hospital and Wharfedale Hospital, Otley.

Critical care services are provided at Harrogate District Hospital. The Critical Therapy Unit provides Level 2 and Level 3 care in a combined ward with a current maximum capacity of five Level 3 beds, the

equivalent Level 2 beds or a mixture of both depending on demand. There is a High Dependency Unit. The unit is an acute member of the Critical Care Operational Delivery Network across North Yorkshire and North East Lincolnshire.

The Maternity Department is based in the Strayside Wing at Harrogate District Hospital. The maternity service also provides community midwifery services in a number of outreach settings, including Otley Children's Centre and Yeadon Health Centre.

The Paediatric service is based at Harrogate District Hospital and includes a 16 bed inpatient ward with 6 additional day beds (Woodlands) and a seven bed Special Care Baby Unit, as well as outpatient services and a Child Development Centre (CDC). All specialist paediatric surgery is undertaken in Leeds. The CDC is a multidisciplinary children's outpatient service that provided developmental care, support and advice in both the hospital and community setting for children with long term conditions and children with additional needs. The multidisciplinary team provides care in various aspects of child development including health and wellbeing, speech and language, physiotherapy and podiatry.

End of life care is provided throughout the trust. The specialist palliative care team from the local hospice provides an integrated service across both the hospital and community.

# Detailed findings

Outpatient services are provided from the main Harrogate District Hospital site as well as a number of locations within the community.

## Our inspection team

Our inspection team was led by:

**Chair:** Elaine Jeffers, Independent Chair

**Head of Inspection:** Julie Walton, Care Quality Commission

**Team Leader:** Karen Knapton, Inspection Manager, Care Quality Commission

The team included: CQC inspectors and a variety of specialists, namely, Director of Nursing and Midwifery,

CEO/Director, Operations Manager, Nurse Manager, Critical Care Consultant, Consultant in Palliative Medicine, Matron in Critical Care, End of Life Care Nurse, Consultant Obstetrician, Midwife Antenatal Services Manager, Matron in Trauma and Orthopaedics, Outpatients Nurse, Infection Prevention Nurse, Radiographer, Paediatric Nurse, Medicine Doctor, Medicine Nurse, Surgeon, Surgery Lead Nurse, Mental Health Act Reviewer, Safeguarding Specialist, Junior Doctor and a Student Nurse.

## How we carried out this inspection

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

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

A comprehensive inspection was carried out to review the acute hospital in 2014. However, at this point in time CQC were not rating its inspections. The February 2016 inspection was to rate the Trust's services within the acute and community setting for the first time using the Care Quality Commission's (CQC) new methodology for comprehensive inspections.

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

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children, young people and families
- Outpatients and diagnostics
- End of life care

### • Outpatients and diagnostics

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

We held a public engagement session prior to the inspection to hear people's views about care and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended this event.

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

# Detailed findings

We carried out an announced inspection on 2 to 5 February 2016 and an unannounced inspection on 10 February 2016.

## Facts and data about Harrogate District Hospital

### Finance

Revenue £185,585,026

Full Cost £186,162,069

Deficit £577,043

### Activity

Outpatient attendances July 2014 to June 2015 262,561

Accident and Emergency November 2014 to October 2015 45,689

### Population Served

North Yorkshire and Your and North East Leeds.

The trust serves a population of around 900,000 people.

### Foundation Trust Status

The trust was authorised Foundation Trust status in January 2005.

Over 17,000 members of the community involved in the running of the organisation.

### Public Health Profile

Harrogate is less deprived when compared to the England average.

The three indicators that are worse than the England average include road injuries, the incidence of deaths through malignant melanoma and alcohol specific hospital stays under 18 years

## Our ratings for this hospital

Our ratings for this hospital are:







# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	★ Outstanding	Good	Good	Good
Critical care	Good	Good	★ Outstanding	★ Outstanding	Good	★ Outstanding
Maternity and gynaecology	Good	Requires improvement	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	★ Outstanding	Good	★ Outstanding
Overall	Requires improvement	Good	★ Outstanding	Good	Good	Good

## Notes

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

# Urgent and emergency services

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

## Information about the service

Urgent and Emergency services were provided from the emergency department at Harrogate District Hospital, which is the main emergency department (ED) and minor injuries units (MIU) at two hospitals in the community, Selby and Ripon. This report will focus on the CQC inspection findings at the main emergency department at Harrogate. A separate report will discuss the findings of the CQC inspection at the minor injury units.

The emergency department at Harrogate District Hospital provides a 24-hour, seven-day a week service to the local population. In total, including the MIUs, there were 68,500 attendances in 2014/15. From the beginning of October 2015 to the end of December 2015 there were 11,270 patients seen in the emergency department this was an average of 3756 patients each month. This number was slightly lower than the previous three months. On average 19% of attendances were from children (age 0-16 years old).

Patients presented to the department by either walking into the main entrance of the hospital and immediately enter the reception area that is accessed by double doors, or they arrived by ambulance. If a patient arrived on foot, they were booked in at reception before being seen by a triage nurse... If a patient arrived by ambulance, they enter through a separate entrance and are initially assessed by a senior nurse and allocated a cubicle where they are seen by a doctor.

The emergency department had a total of nine cubicles and three resuscitation bays. One of the resuscitation bays

was set up for the management of both children and adults. There were additional rooms, one set up for assessing and treating a patient with an eye injury, one suitable for the assessment and treatment of a patient with a mental health problem, and one room for children. All the cubicles could be flexed in their use at times when the department was busy. There was one triage room, and two treatment rooms in the adjacent fracture clinic used by an emergency nurse practitioner to treat patients.

A waiting room was available for patients who self-presented with minor illness or injuries. This was used for both adults and children. In the corner of the waiting room there were toys available for children.

The emergency department was a designated trauma unit. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised at Harrogate District Hospital and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department had a nearby open grassed area where the helicopter could land and a protocol was in place for the transfer of the patient into the emergency department.

During our inspection, we spoke with 23 members of staff including receptionists, nurses, doctors, domestics and paramedics, seven patients and five relatives. We viewed 46 sets of records and reviewed a range of performance information about the emergency department.

# Urgent and emergency services

## Summary of findings

We rated the emergency department at this hospital as good because:

Openness and transparency about safety was encouraged and there was a strong culture of reporting incidents. Staff followed infection prevention and control guidelines and managed medicines effectively.

Care delivered reflected national guidelines. There were policies and procedures in place that were developed in conjunction with national guidance and best practice evidence from professional bodies. We saw evidence of multidisciplinary working. The department offered a 24-hour seven-day service however; some services were available out of hours as an on call service. The trust was working towards the delivery of sustaining seven-day services.

Patients and relatives were treated with dignity, respect and compassion. We heard staff use language that was appropriate for patients to understand their treatment and to be involved in decisions about their care.

The service had systems and processes in place to facilitate the flow of patients through the department and the department was generally achieving the 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival.

There were governance, risk management and quality measurements and processes in place to enhance patient outcomes. There was strong leadership and management, and a strong supportive culture of openness, transparency and honesty. Staff were proud to work in the department.

However, the emergency care service had 'out grown', the current size of the department as the number of patients, equipment and consumables had increased over the years. Staff flexed the use of the department to accommodate the individual needs of patients. Although, staffing levels and skill mix was planned in line with busy periods; the planned nurse staffing numbers were not always met. Documentation was not always complete.

## Are urgent and emergency services safe?

Requires improvement



We rated the emergency department as requires improvement because:

- We saw evidence that the department did not always meet the planned nurse staffing numbers.
- Not all staff had completed the appropriate level of children's safeguarding training.
- The completion of nursing documentation was inconsistent and did not always follow best practice guidance.
- Patient group directives were not all up to date and signed appropriately

However:

- Openness and transparency about safety was encouraged and there was a strong culture of reporting incidents. Feedback and lessons learnt because of incidents were shared amongst the staff.
- The department was visibly clean and we observed good hand hygiene.
- The department used an electronic dispensing system for dispensing medicines which was accessed using finger print technology that also provided an audit pathway and improved inventory control.
- Care provided reflected national and professional guidance and legislation, and staff training was in place. Staff responded in a timely way to patients who showed signs of deterioration and had plans in place to deal with medical emergencies.
- Safeguarding vulnerable adults and children were given sufficient priority and there was active and appropriate engagement in local safeguarding procedures.
- Medical and nursing staffing levels and skill mix was planned in line with busy periods. The department had the skill mix and flexibility of the staff on duty that they were able to deploy themselves as demand and workload dictated across the different parts of the department.

### Incidents

- There was a strong culture of reporting incidents. From August 2015 to the end January 2016 there were 125 reported incidents. Three resulted in 'moderate harm',

# Urgent and emergency services

13 resulted in 'low minimal harm' and the remaining resulted in 'no harm'. The themes of the incidents with moderate harm were patients who had pressure ulcers that had been present before they attended the department. There were incidents where patients had absconded; we saw evidence the staff followed the correct policy and procedures for absconded patients. Incident forms were completed when the department had inadequate staffing numbers. .

- To report incidents staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents.
- Between January 2015 and December 2015 the emergency department did not report any 'never events', (which are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- Serious incidents were reported through the Strategic Executive Information System (STEIS). There were no serious incidents between January 2015 and December 2015.
- Two of the incidents that caused moderate harm were pressure ulcers. We saw little evidence in the patients notes we inspected that pressure ulcer assessments were carried out however, a pressure ulcer screening tool had been introduced as a pilot during the week of the inspection, we saw evidence of this being used, however, and it was too early for practice to be embedded.
- Following investigations of incidents of harm or risk of harm, staff told us they always received feedback.
- In the Emergency Department Care Quality Group monthly meetings, incidents and any actions taken because of those incidents, as well as lessons learnt were discussed. For example an incident was discussed which occurred in maternity regarding a missed intra-uterine death, it was discussed to remind staff to pay attention to mothers reporting lack of foetal movements and to refer on for assessment by specialists.
- Mortality and Morbidity reviews took place. These involved looking at the notes of patients who had died within 48 hours of admission. A review of any key learning points and lessons learnt were shared and discussed at the Emergency Department Care Quality Group meetings and the Hospital Mortality Group meetings.

- Staff told us they were aware of the statutory duty of candour, which sets out key principles, including a general duty on the organisation to act in an open and transparent way in relation to care provided to patients. This means that as soon as reasonably practical after a notifiable patient safety incident occurs, staff should tell the patient (or their representative) about it in person. The department had a system to ensure patients were informed and given an apology when something went wrong and informed of any actions taken as a result. Examples were given where the duty of candour had been used.

## Cleanliness, infection control and hygiene

- The department was visibly clean and we saw cleaning in progress during the inspection.
- We reviewed areas including the sluice, administration stations and relatives waiting areas and found them clean and tidy.
- The majority of the needle sharp bins in the areas were over full (more than  $\frac{3}{4}$  full). This could cause a needle stick injury which could lead to an infection. The bins we looked at were dated and signed by a member of staff, (as required by the trust's policy).
- Staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care.
- We observed medical and nursing staff following the trust policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were adequate hand washing facilities throughout the department and hand gel dispensers were available in each cubicle.
- Monthly audits of hand hygiene and the cleanliness of commodes were undertaken. The results were 100% from April 2015 to September 2015
- Cleanliness scores from April 2015 to September 2015 were between 97% to 98%
- Staff did not routinely carry out mattress audits. On inspection, we checked four mattresses and found three had tears or had tape to cover the tears. This is an infection risk as the foam underneath the tear can be contaminated with bodily fluids.
- There were two cubicles with doors; these cubicles were used for isolating patients with an infectious condition. The cubicles did not have a toilet however; staff said they would put a commode in the cubicle if necessary.

# Urgent and emergency services

- Disposable screening curtains were in use in the resuscitation area and fabric curtains were used to separate the cubicles in the other areas.
- The children's waiting area was partitioned off, separating it from the adult waiting area. It was clean, tidy and well equipped. Toys were visibly clean however; there was no evidence of a cleaning schedule for them.
- A completed daily checklist for cleaning the bays was in place, which indicated high levels of cleaning compliance in this area.
- Water flushing was carried out by the domestic in the decontamination room, which had sinks and showers that were not used often.
- Mandatory training for staff included infection prevention control.
- There were two identical resuscitation trolleys in the department. The policy was to check these daily however, we found gaps where the trolleys had not been checked (11 days were missed in January 2016).
- There was a triage room, and two rooms in the adjacent fracture clinic used by the nurse practitioners to see and treat patients with a minor illness or injury.
- Walk in patients entered the department through the main hospital entrance and could turn and walk through a set of double doors to the emergency department reception and waiting room. Patients brought in by ambulance entered through a separate entrance that also provided direct access to the resuscitation bays.
- A waiting room was available for patients who self-present with minor illness or injuries. This was used for both adults and children. In the corner of the waiting room there were toys available for children.
- To ensure staff had the correct equipment available, equipment trolleys had a checklist which listed the equipment on each trolley.
- There were adequate stocks of equipment and we saw evidence of good stock rotation.
- Storage and space was limited due to the age of the department.
- The medical engineering department carried out portable appliance testing of electrical equipment (PAT) and on a rolling programme basis serviced all equipment. Stickers were used to confirm servicing had been done and these were up to date.
- Waste was managed in line with effective infection control practices
- There was no security on site, however, an escalation policy was in place and staff told us the police attended in a timely manner if necessary.

## Environment and equipment

- The department had nine cubicles. The use of these were flexible (flexed) and could be used for minor or major illness cubicles. There were additional rooms, one set up for assessing and treating a patient with an eye injury, one suitable for the assessment and treatment of a patient with a mental health problem, and one room for children. All the cubicles were able to be flexed in their use at times when the department was busy.
- In A&E there was a designated paediatric room in which children could be seen. This was separated from the A&E bays, was decorated for children, and contained toys and entertainment equipment. Staff told us that if more than one child attended A&E then any other children would need to be nursed in the standard A&E bay. Similarly, if the A&E was busy the room was utilised for adult patients and children may have to be seen in a bay if the room was in use.
- During our inspection adults were treated in the children's cubicle and we observed children treated in the adult cubicles.
- A separate three bedded resuscitation room was equipped appropriately. We checked a range of resuscitation equipment and found it accessible, and fit for purpose.
- One of the resuscitation bays was set up for the management of both children and adults.
- The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner.

## Medicines

- Staff followed systems that demonstrated compliance with the Medicine Act 1968 and the Misuse of Drugs Act 1971.
- The department used an electronic dispensing system for dispensing medicines which used finger print technology to control access and provided an audit pathway and improved inventory control. Staff told us they felt this system had definitely improved patient safety.
- All intravenous infusions were stored in their original boxes or in appropriately labelled containers.

# Urgent and emergency services

- A locked medicine fridge was part of the electronic dispensing system that meant the pharmacy department were automatically alerted if the temperature of the fridge was 'out of range'.
  - Medical gases were stored safely in a separate area.
  - Medicine prescribing was done on paper records; however, we were told the trust planned to roll out electronic prescribing in April 2016.
  - The department did use patient group directives. We found many of these had passed the date they should have been reviewed to ensure they were up to date with best practice.
  - We observed patients were given a red wrist band if they had an allergy, to enable easy identification.
  - We reviewed seven paediatric and fourteen adult patient records and found that records showed medicines had been administered as prescribed.
  - The resuscitation room contained two Hypo Kits, these are kits used in the management of hypoglycaemia, and checks had not been carried out in line with trust guidance. For example one kit had only been checked 11 times in January 2016 the second 14 times in January 2016. One item had been recorded as expired in December 2015 and had taken seven days to replace.
  - We were told that Patient Group Directions (PGDs) were in use within the department. Paper copies of PGDs were not always the most recent edition, for example four PGDs had expired and their dates had been changed by hand and staff could not direct us to the most recent copy. The authorised signature lists were not up to date and there was no system in place to ensure that signatures corresponded to the most recent edition of the PGD. The trust policy stated it was the ward/department managers' responsibility to ensure PGDs were suitable for use and that staff were appropriately trained. In addition, signatures were not always ratified by a senior authorising healthcare professional
- We initially reviewed 21 sets of patients' records fully and found completion of documentation was variable for example, we could not tell if nursing care was actually given because no record of nursing care was seen in any of the notes. We saw a check list known as a 'patient contact round' document which prompted the nurses to ask if the patient was comfortable, and if they needed anything such as pain relief or food and drink. On checking, these were not completed.
  - We looked at a further 25 sets of notes for patients over 75 years of age and none of these contained a completed 'patient contact round' document.
  - Screening questions for dementia were printed on the A&E card of all over 75 patients to service as a prompt for medical staff. Out of the 25 sets of notes of over 75 year olds, we found none of the dementia screening questions were completed.
  - All writing was legible and all patients' records were dated and timed.
  - The frequency and documentation of the recording of patients' observations was not in line with best practice guidance. In 12 out of the 21 sets of records, these were either not completed or not done as often as required.
  - The recording of the patients' allergy status was not on one set of the paediatric records and two of the adult patient records that we checked. This increased the risk that patients may be given inappropriate medicines that could have a harmful effect.
  - The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
  - Reception staff collated and filed the patient notes at the end of the visit and arranged for safe storage of notes.
  - We observed during our inspection as patients checked in their Accident and Emergency (A&E) card was placed in a box for the triage nurse. People standing at the reception could view this which was a breach of patient confidentiality. This was pointed out during the inspection and changed.

## Records

- Patient records were in paper format. Following discharge the patient emergency department record was stored on site for two months then scanned into the IT system and the paper notes were archived off site.
- An electronic system was used that links with the rest of the hospital patient administration system (PAS) and the IT system used at the nurses' station.

## Safeguarding

- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- We reviewed seven children's records. All the children had been assessed regarding safeguarding.

# Urgent and emergency services

- Staff said they knew how to recognise and report both adult and children safeguarding concerns.
- We observed staff accessing the trust safeguarding guidelines, which was readily available behind the nurses' station. This provided information of how to make referrals when staff had concerns about a child or adults' safety.
- There were safeguarding lead nurses and a robust referral system in place.
- Mandatory training records indicated staff received safeguarding adults Level 1, and children's' Level 1 and Level 3 training. 78% of nursing staff had completed safeguarding adults Level 1 training, 81% of nursing staff had completed safeguarding children Level 1 training and 44% of nursing staff who required it had completed safeguarding children Level 3 training. We were told there were plans in place to ensure these staff were trained by March 2016.
- Staff were aware of the assessment for child exploitation and female genital mutilation.
- In other areas where children were looked after (such as A&E and theatres) there was no consistent practice in staff undergoing safeguarding level three training. In A&E, 44% of nursing staff had completed training

## Mandatory training

- There was a trust mandatory training policy in place which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act 2005 and the deprivation of liberty safeguards (DoLS).
- For each training element, staff groups were identified and the frequency of each training element. Employees had a personal training account, which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.
- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or

above – this was explained as the trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.

- The department was 81% compliant with mandatory training.
- The compliance rates for the completion of adult advanced life support training were 81% of medical staff, 58% of senior nurses (band 6 and above) and 97% of all registered nurses had completed intermediate life support training.
- The completion rates for paediatric advanced life support training was 62% of medical staff, 42% of nursing staff and 97% of registered nurses had completed paediatric intermediate life support training.
- Staff completed most mandatory training using e-learning however, there were some clinical skills that resulted in competency based classroom sessions.
- Time was allocated in the off-duty for face to face mandatory training although staff did on line learning in their own time or at work if time was available.
- New staff received a corporate induction programme that included some face to face mandatory training.
- Consultants and junior doctors received training in paediatric life support and a paediatrician provided additional support. All senior doctors (middle grade and above) and senior nurses (band 6 and above) received advanced paediatric life support training.

## Assessing and responding to patient risk

- A National Early Warning Score (NEWS) system for acutely ill patients was used, which supported the process for early recognition of those patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- Patients who walked into the department were registered by the receptionist and directed to the waiting room where a nurse triaged them.
- Patients arriving by ambulance entered through a different entrance specifically for ambulances. They were booked in by the ambulance staff at a reception desk before progressing to see a nurse co-ordinator who triaged the patient into the appropriate area (unless the patient required immediate access to the resuscitation bay).

# Urgent and emergency services

- The trust used a recognised triage system in the 'minors' area. Using categories one, two, three and four. This is documented on the ED card and IT system as 'target time'
- Once triaged, patients received an initial assessment by a doctor. Investigations that would assist with diagnosis and treatment were undertaken. For example, blood samples were taken, electrocardiograms (ECG) carried out, analgesia prescribed and x-rays ordered.
- Guidance issued by the College of Emergency Medicine (CEM) states a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. During the inspection the records we examined informed us that the target was met for nine out of eleven patients notes we checked who arrived by ambulance. Those who walked in to the ED waited between five and 45 minutes for an initial assessment by the triage nurse.
- From April 2015 to December 2015 the time to treatment target was 60 minutes or less. The trust achieved this target.
- The emergency department was a designated trauma unit and provided care for all trauma patients. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest trauma centre, if their condition allowed them to travel directly. If not, they were stabilised at Harrogate District Hospital and either treated or transferred as their condition dictates. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department was served with a nearby open grassed area where the helicopter could land and a protocol was in place for the transfer of the patient into the emergency department.
- An escalation process was in place that gave staff actions for how to manage the department during periods of extreme pressure. We were told more frequent board rounds would take place and at times two triage nurses are used if the 'minors' flow is busy.
- In November 2015 an electronic dashboard was launched in the department which provided live information which included the triage category of the patient, the acuity was based on the triage category given.
- We were told a request to increase the number of qualified and unqualified nurses was supported by the Board in September 2015. This introduced some different shifts to target more staff to be on duty at the busiest periods, and ensured an emergency nurse practitioner would be available throughout the day and increased the number on Saturday and Sunday afternoons when the department was busy with patients requiring treatment for a minor illness or injury.
- The current establishment was 7.76 whole time equivalent (WTE) band 6 nurses, 22 WTE band 5 nurses and 4.7 WTE healthcare assistants. They were over established by 0.2 band 5 nurses and under established by 0.2 healthcare assistants. The band 5 nurses rotated between A&E, medicine, intensive care and orthopaedic wards. Spending a period of time working in each area. This helped recruitment and development of band 5 nurses.
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, we saw displayed for each shift the actual versus planned numbers of nursing staff on duty.
- On the days of our visit, the actual numbers of registered and unregistered nurses on duty did match the planned numbers. The department had the skill mix and flexibility of the staff on duty that they were able to deploy themselves as demand and workload dictated across the different parts of the department.
- During an unannounced visit the following week the off duty revealed out of eight early shifts two were short staffed and four had higher than planned staff. All the late shifts had lower than planned staffing and the night shifts were fully staffed apart from one night. Two night shifts had an additional registered nurse for the full night rather than a twilight shift finishing at midnight. One person had sick leave for three shifts and another urgent leave. A substantive member of staff working as a bank nurse covered one shift.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this.

## Nursing staffing

- Staff told us that the department had been exploring opportunities to understand the acuity of patients that attend. General trends had suggested that acuity was increasing whilst attendance numbers were slightly down the proportion of patients admitted to hospital had increased.

# Urgent and emergency services

Staff told us that there were three registered children's nurses in the department and staff without a paediatric qualification were encouraged to complete the 'Child in Emergency Department' module at a local university.

- Staff told us that they could escalate concerns about staffing levels and would receive a response from management.
- The department was overseen by a modern matron who provided managerial support, and clinical support when necessary.
- The department did not use agency nurses. Bank nurses were used. The same bank nurses were re-booked providing familiarity to the department and many of the bank nurses were substantive staff.
- We were told recruitment was timely and there were no issues in filling nursing vacancies.
- Nursing and medical handover occurred at the beginning of each shift and there was a board round at least three times a day, more often when the department was busy. A board round involves a discussion with the multidisciplinary team regarding patients. We observed a board round which was led by the nurse coordinator and included both medical and nursing staff.

## Medical staffing

- We examined the medical staffing rota and talked with consultants and junior doctors. Medical cover was patient demand driven so that at busy times there was more medical cover. Rotas were complex and varied on a day-to-day basis. Junior doctor start and finish times fluctuated throughout the day.
- Within the department 26% of the medical staff were of consultant grade this was higher than the England average of 23%. They also had a higher percentage of middle grade and registrars, 60% compared to 52% the England average. However, proportions of junior doctors were noticeably lower than the England average at 14% compared to 24% England average.
- According to the Royal College of Emergency Medicine (RCEM) (2015), an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend.
- There were six whole time equivalent (WTE) A&E consultants employed by the trust and no current vacancies. This is therefore, below the RCEM recommendations.

- There were eight WTE middle grades. Four had substantive posts and four were long-term locum posts. There was a plan for 10 middle grades to be in post in June/July 2016. There were 10 junior doctor posts.
- Consultant rotas demonstrated that a consultant presence in the department was between 8.30 am to 8pm Monday to Friday, and for a minimum of six hours on a Saturday and Sunday. Outside these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available in the department.
- A paediatric registrar and on call paediatrician provided paediatric cover if needed. One of the consultants had sub-speciality training in paediatric emergency medicine.

## Major incident awareness and training

- The trust had a major incident policy, this was accessible to staff on the trust intranet.
- Staff had an understanding of their roles and responsibilities with regard to any major incidents.
- There was a designated store for major incident equipment that contained specialist suits, which staff was trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- Staff had undertaken training and practice that included practice in wearing the protective suits and resusitating a tent to use for contaminated casualties.
- Staff had received training on how to care for someone who may have symptoms of Ebola.
- The department could be locked down easily to ensure the safety of patients should the need arise.

# Urgent and emergency services

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



- We rated the emergency department as good for effective because :
- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the 'Royal College of Emergency Medicine (RCEM)', the 'National Institute of Clinical Effectiveness (NICE)' and the 'Resuscitation Council UK'.
- The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients.
- Staff were supported through a process of meaningful appraisal. Furthermore, there were systems in place for ensuring that staff who were newly appointed to the department were supported and that their competency was assessed to ensure they had the skills and knowledge to safely care for patients presenting to the emergency department.
- There was evidence of multidisciplinary working and staff understood their responsibilities in obtaining consent. Staff were able to demonstrate a good understanding of the Mental Health Act 2005. Patients had comprehensive mental health assessments and treatment, and people who were subject to the Mental Health Act (MHA) had their rights protected and staff had regard to the MHA Code of Practice. Staff used Fraser competency principles when assessing capacity and obtaining consent from children.
- The department offered a 24-hour seven-day service however; some services were available out of hours as an on call service. The trust was working towards the delivery of sustaining seven-day services. This would involve implementation of new models of care, and integrating networks across both health and social care.
- However:
- The department was not meeting the target for screening for dementia.
- Documentation of pain scores was low.

- Patient nutritional and hydration needs were not documented or assessed.

### Evidence-based care and treatment

- There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the RCEM's clinical standards for emergency departments.
- The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments.
- As a result of audit findings, we were told how the department continually improved pathways and guidance. For example, working with the mental health assessment team to provide assessments within one hour and a recent implementation of a mental health section 136-assessment facility within the hospital.
- Care pathways had been established for conditions such as stroke, hypoglycaemia and sepsis to promote early treatment and improve patient outcomes
- Guidelines were easily accessible on the trust intranet page and there were paper copies of pathways. There was no review dates on the pathways we viewed. Junior doctors were able to demonstrate ease of access and found them clear and easy to use.
- Junior doctors attended weekly teaching sessions to ensure they were up to date with evidence-based practice..

### Pain relief

- A pain score tool was used to assess if a patient had pain. Pain was scored as zero for no pain up to 10 for severe pain.
- We reviewed 14 sets of adult patients' notes for the completion of pain scores. Only three records had documented the patient pain score.
- Patients told us staff asked about their pain, nearly all of those patients who had pain said they were treated quickly. However, one patient informed us that the triage nurse had not treated them for pain during the initial assessment.
- According to the CQC A&E survey the trust scored the same as similar trusts in the response to patients feeling staff did all they could to help control pain.
- There was no recent audit of pain scores.

### Nutrition and hydration

# Urgent and emergency services

- Patients were offered food and drinks. Snack boxes were available 24 hours a day. Hot food was available from the hospital canteen if requested.
- We witnessed a nurse assisting a patient to eat during our inspection.
- There was no set mealtime regime.
- We noted that staff did not record in the patients' records whether as part of a 'comfort round' food and drink had been given or offered to patients, therefore, staff could not see if a patient had eaten or drank whilst in the department.
- In the hospital entrance, there was a shop and café, which sold hot and cold drinks plus food.
- The RCEM audit for fitting child the one indicator that was lower than the England quartile was regarding discharged patients with written safety information however, the sample size for this indicator is low. The one indicator in the upper England quartile was the recording of clinical information with an eye witness history recorded.
- The RCEM audit for mental health six indicators out of eight were in the lower England quartile.
- The department closely monitored its performance against a range of clinical indicators and presented a monthly report in a dashboard format. This presented a detailed and balanced view of the care delivered by the emergency department. It also reflected the experience and safety of the patients and the effectiveness of the care they received. This included ambulance handover times, time to treatment, four-hour breaches and attendance rates.

## Patient outcomes

- From April 2015 to December 2015 the unplanned re-attendance rate to the emergency department within seven days of discharge was consistently better than the England average and below the threshold of 5%, scoring on average 2.70%
- To ensure optimal clinical outcomes, The RCEM) has a range of evidence based clinical standards to which all emergency departments should aspire. The emergency department had participated in a number of audits to benchmark their performance against the RCEM standards such as 'the initial management of the fitting child', asthma in children, mental health and the severe sepsis and septic shock audit.
- Compliance to the treatment of severe sepsis had improved. In the RCEM audit 2013/14 for severe sepsis and septic shock four out of 12 indicators were in the upper England quartile. They were below in one indicator, which was administering antibiotics within one hour. An action plan was in place which included ongoing training of medical staff. Audit findings were shared at the ED Care Quality Meetings and posters were displayed the staff room. A sepsis-screening sticker was introduced to identify all patients with a high early warning score.
- In the RCEM audit for asthma in children 2013/14, seven out of 16 indicators were in the lower England quartile. In January 2016, an audit showed an improvement of observations of vital signs in children.
- In the consultant sign off RCEM audit one indicator was lower than the England quartile 'the consultant see the patient' and one in the upper England quartile 'ST4 or more senior doctor discussed with the patient'.

## Competent staff

- Medical and nursing staff had an annual appraisal and most staff spoke positively about the process.
- Information received showed that 33.3% of staff were appraised between April 2015 and September 2015. When we spoke with the Matron, we were told 19 out of 76 appraisals were overdue however; plans were in place for completing all appraisals by March 2016.
- Senior nurses were responsible for undertaking their team appraisals. These were divided and as a result a senior nurse was responsible in appraising four staff.
- New nursing staff received emergency department specific competency based training. A mentor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- We were told doctors' appraisals were up to date and staff were reminded by the workforce development and medical coordinators when their appraisal was due.

## Multidisciplinary working

- We observed good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency department.
- Care was delivered in a co-ordinated way using a number of different care pathways between the emergency department and the clinical assessment ward where acute medical patients are nursed.

# Urgent and emergency services

- Clinical nurse specialists came to the department to provide clinical expertise and review patients (if needed) and they would see patients on the clinical assessment ward.
- The mental health team was based on the hospital site providing timely assessment to patients with mental health needs.
- There was a fast response team which provided assessment for patients who were to be discharged. This team included a physiotherapist and occupational therapist.

## Seven-day services

- The emergency department had x-ray facilities in the centre of the department which could be accessed 24 hours, seven days a week. Out of hours a radiographer would be on call from 8pm. An outside company 'nighthawk' reported on scans out of hours. The doctors said there had been no delays in the reporting of scans or x-rays. A recent review of radiology services suggested a 24 hour seven day a week service, recruitment was needed to support this.
- Consultant rotas demonstrated that a consultant presence in the department was between 8.30 am to 8pm Monday to Friday, and for a minimum of six hours on a Saturday and Sunday. Outside these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available in the department.
- There was availability of pharmacy and physiotherapy services seven days a week and 'out of hours' an on call service was provided.
- There was seven-day access to pathology services.
- The trust had a working group and had undertaken a gap analysis in relation to the seven-day standards. We were told that throughout 2015/16 the trust would focus on the delivery of sustainable seven-day services. This will involve implementation of new models of care, the development of greater clinical alliances and networks across health and social care to deliver services that are more integrated.

## Access to information

- Patient records were in paper format. Following discharge or transfer to the ward the patient record was scanned into an electronic system. The paper record was stored for two months in a secure place. A copy of the paper record was sent to the ward.
- In the department at the coordinators station, there were electronic screens that displayed the status and waiting times of all patients in the department.
- Previous medical records were kept off-site. These could be requested.
- By using the trust's intranet, staff had access to relevant guidance and policies.
- A GP letter was generated from the IT system. Medical secretaries print off the letters and send them to the patients GP. If the GP's use a system which links with the hospital system (EMIS) the discharge letters are sent electronically.

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

- Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.
- Doctors gained written consent from patients who required sedation.
- Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment. Staff used Gillick competency principles when assessing capacity, decision making and obtaining consent from children. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

**Are urgent and emergency services caring?**

# Urgent and emergency services

Good



We rated caring as good because:

- The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.
- Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in the decisions about their care and treatment. Care was person-centred and staff were observed to provide care which maintained the dignity and privacy of patients.

## Compassionate care

- We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed.
- We observed a number of interactions between staff and patients and relatives. Staff were always polite, respectful and professional in their approach.
- We spoke to seven patients and five relatives who all praised the care they had received. All described how they were treated with care, dignity and respect.
- The department conducted a patient experience survey over a two week period in July 2015. The views of 54 patients were sought and questions were asked regarding communication, dignity, and the flow of their journey through the department. The majority of the comments were positive. There were recommendations made as a result of the survey. Such as staff to introduce themselves to patients by name and to encourage patients to ask questions about their care
- The friends and family test results between August 2014 and October 2015 demonstrated that higher than England average of patients would recommend services at Harrogate A&E. However, the response rate to this survey was low.
- In the CQC A&E survey (2014) most caring related questions scored about the same as other trusts, however, seven questions scored better than other trusts.

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

- Patients told us staff ensured they understood medical terminology and literature was given about their condition when required.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.
- Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for.

## Emotional support

- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the multi-faith chaplaincy service.
- The spiritual needs of patients are provided by a 24-hour chaplaincy support that provided sacramental care in the trust chapels and at the bedside and through supporting patients at the end of life.

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

Good



We rated the emergency department as good for responsive because:

- The service had systems and processes in place to facilitate the flow of patients through the department.
- The department was generally achieving the target of 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival.
- The time to treatment for patients was better than the national target.
- Patients' complaints were managed in line with trust policy and feedback was given to staff. Although the emergency care service had 'out grown', the current size of the department as the number of patients, equipment and consumables had increased, staff flexed the use of the department to accommodate the individual needs of patients.

However:

# Urgent and emergency services

- Paediatric facilities were limited and the department had no separate waiting area, the paediatric cubicle was often used for adults leaving paediatrics to be nursed in an adult cubicle.
- There was no specific guidance for the care of patients with a learning disability and screening for dementia patients was not always completed.

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

- The management of the department were aware of the changing demand on services. We were told as part of the unplanned care clinical transformation programme, a working group was looking at ensuring people who attend the emergency department or other urgent care services received rapid assessment and/or admission by speciality teams and would only be admitted in an acute bed when necessary.
- Projects were ongoing which included looking at integrating the ED and the GP out of hours service, the integration of IT systems, improving triage and flow in the department and looking at alternative pathways to improve access to appropriate alternative urgent care.
- We were as told plans to expand the emergency department were in discussion as current space was limited and the amount of equipment and consumables had increased over the years.
- Within the waiting room there were a number of notices which provided key useful information to patients and visitors about the service. There was a TV screen which displayed a 'welcome to the department' screen and explained the procedure of the department.
- A notice had the waiting time and there were notices with infection prevention and cleanliness scores displayed.
- The IT system had a flagging system. This included identifying patients with dementia and a learning disability. A patient or their carer consent was gained for the flag to be put on the IT system.
- Staff told us they did not have any specific guidance to assist them on how to support patients with a learning disability. They told us they would encourage their carer to stay with the patient to help alleviate any anxieties the patient may have. A 'VIP' card had been introduced which contained medical and personal information which was used for patients with a learning disability. During the time of inspection we did not see a patient with a learning disability.
- There was no specific 'dementia friendly' cubicle, however there were some modifications such as the toilet door in the waiting room had a red surround enabling the toilet to be visibly identified. A box was available which contained reminiscent objects such as a ration book and old pictures. This was used to reduce patients' anxieties of being in an unfamiliar place. A staff member told us it was a helpful tool and many patients enjoyed looking through the items. 'Twiddlemuffs' were available, which are knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached that patients with dementia can twiddle in their hands. Patients with dementia often have restless hands and like something to keep them occupied. The Twiddlemuffs provide a source of visual, tactile and sensory stimulation at the same time as keeping hands snug and warm.
- The 'Butterfly Scheme' was implemented, which at a glance creates discreet identification via the Butterfly symbol for patients who have dementia-related memory impairment and wish staff to be aware of it. We did not see evidence of this in use as we did not see a patient with dementia during our inspection.
- A target of 90% of all patients over 75 years old should be screened for dementia. Results of an audit in January 2016 showed 62% of patients in this category were screened. Screening questions were printed on the A&E card of all over 75 patients to service as a prompt for medical staff. Out of the 25 sets of notes of over 75 year olds, we found none of the dementia screening questions were completed
- A specialised bariatric trolley was available and accessibility to a hoist and bariatric wheelchair if needed.

## Meeting people's individual needs

- Disabled toilets and baby change facilities were available in the waiting room. Wheelchairs were accessible however, the door leading into the department from the main entrance did not have automatic opening and during the inspection we noticed people found accessing difficult if they had limited mobility, were in a wheel chair or using crutches.
- The reception area had a designated hearing loop.

# Urgent and emergency services

- A range of information leaflets were available for patients to help them manage their condition after discharge. Leaflets were available in English only.
- Interpreting and translation services were available. These could be either face to face or by telephone.
- There was a relative's room that had access to a telephone. Hot and cold drinks were offered and available on request.
- There was no separate paediatric area in the emergency department. The waiting room was shared with adults. Although the department had decorated one cubicle suitable for children, this was often accompanied by an adult, leaving children to be treated in an adult cubicle.
- The mental health team was based within hospital providing a service seven days a week service 24 hours per day.

## Access and flow

- The Department of Health's standard for emergency departments is to admit, transfer or discharge patients within four hours of arrival. Between October 2015 and the end of December 2015 the percentage of patients achieving this target was 95.4%. This was better than the England average.
- The median amount of time people could expect to spend in the emergency department before being discharged, admitted or transferred was 2 hours 54 minutes which is better than the England average
- The College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The median waiting time to receiving treatment for patients in the emergency department was 57 minutes.
- Once a decision to admit had been made, there had been no reported breaches of patients waiting more than 12 hours in the emergency department.
- The national average for the percentage of patients who leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait), was between 2% and 3%. The emergency department at Harrogate was 2.85%, this was better than the threshold of less than 5%.
- The emergency department aimed to ensure patients who arrived by ambulance were kept waiting for no

more than 15 minutes before patients are handed over to the care in the department. This was achieved for 94.5% of patients, which is better than the England average.

- Black breaches occur when the time from an ambulance's arrival to the patient being formally handed over to the department is longer than 60 minutes. The emergency department had two black breaches between April 2015 and December 2015. These occurred on the same day when the ED was particularly busy and were due to lack of cubicles.
- During the inspection, we observed flow of patients and reviewed current information on waiting times. We observed the time patients waited in the waiting room. The longest the patients waited was 40 minutes.
- We observed four ambulance handovers. Care was handed over within five to 34 minutes.
- We reviewed the notes for 13 patients who had arrived by ambulance. Time to initial assessment was between two and 23 minutes, with the average time being 11 minutes.
- We observed the flow of children who had attended the department. We spoke with the parents of a child who was seen two minutes of arriving by ambulance. We reviewed seven children's notes, which showed they were assessed within two and 33 minutes; the average time was 15 minutes.
- The bed management team observed flow within the emergency department and meetings took place at least twice a day (more frequently if needed) to understand the bed situation to enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- There was an escalation policy. This provided guidance on when and how to implement the escalation policy, to ensure safe working when the department was full or the hospital bed state was preventing flow of patients through the department.
- Patients had direct access to the clinical assessment ward (known as CAT) and the ambulatory care ward (known as CATT) by a GP referral.

## Learning from complaints and concerns

- Between November 2015 and January 2016 there were five complaints made. The themes were associated with staff attitude and communication.

# Urgent and emergency services

- Staff told us they were aware of how to deal with complaints. We were told doctors would look at the complaints, which involved medical staff or medical issues, and the matron would deal with complaints related to nurses or nursing care.
- Feedback was given to staff face to face. Any lessons learnt were discussed in the monthly Quality of Care meeting. An example of this was a complaint about inadequate pain relief and the need to record pain scores, introduce intentional nursing rounds and board rounds. Leaflets and posters were available and information was provided on the trust website on how to raise a concern and how to contact the patient experience team.
- Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.
- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke to complained about the department.

## Are urgent and emergency services well-led?

Good



We rated well led in the emergency department as good because:

- Staff were engaged in the vision and future development of the department.
- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes.
- There was strong leadership and management. The patients' voice was seen as important and the department took part in patient experience surveys.
- There was a strong supportive culture of openness, transparency and honesty. Staff were proud of working in the department.

However:

- There was poor record keeping and lack of auditing of patient records.

## Vision and strategy for this service

- The emergency department was part of the urgent and cancer care directorate.
- The directorate had a business plan that included a redesign of emergency and urgent care services. This would aim to prevent admission wherever appropriate to do and promote self-care.
- Senior staff told us the vision would be better integration with primary care services, which would include working alongside the GP out of hours service.
- A future expansion of the emergency department would allow more space and integration with the clinical assessment team (CAT) providing an urgent care centre.
- Work had begun in developing the workforce and the introduction of the advanced nurse practitioner role.

## Governance, risk management and quality measurement

- A governance system was in place and the agenda items of the care quality group included discussions of incidents, complaints and lessons to be learnt.
- A monthly senior leadership team meeting took place that discussed finance, performance data, changes to clinical practice and audit activity. Staff were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. Both these meetings fed into trust wide governance meetings.
- The department risk register was available and was continually under review to ensure it reflected current risks relevant to the operational effectiveness of the department. Eighteen risks were recorded on the register at the time of our inspection. Each risk was graded, dependent on severity. There were four low risks, eight moderate risks and six high risks. A lead officer was assigned to each risk and descriptions of key controls to mitigate risks were given. Examples of the high risk were failure to meet the four hour standard and poor patient experience due to staffing issues and flow through the department.
- There was lack of auditing of patient records.

## Leadership and culture of service

- The emergency department had a clear management structure at both directorate and departmental level.

# Urgent and emergency services

- The nursing team was established with experienced staff who provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability.
- The medical team had responsibility for audits in the department. Staff told us there was a strong educational resource provided by the senior doctors.
- From our discussions with staff, the leadership was strong, supportive and staff felt they were listened to. There was confidence and respect in the management and staff told us they were proud to work in the hospital.
- Staff commented that the Chief Executive and managers were visible and approachable
- All the staff we spoke with told us it was a good place to work.
- The team appeared to be efficient and teamwork was evident.
- Staff described the culture as open and transparent.

## Public and staff engagement

- The department used a combination of methods as an approach to understanding the experience of patients.







The trust took part in the national Friends and Family initiative and the department conducted a telephone survey of patients' experiences of the emergency department in July 2015.

- The trust results of the NHS staff survey were in the top 20% for the last five consecutive years.
- Staff said they felt involved in the development of the service and there was opportunities in relation to training, development and being link nurses in areas of interest to them.

## Innovation, improvement and sustainability

- The directorate had a business plan and had action plans in place to improve and sustain the urgent and emergency care service.
- As part of the unplanned care clinical transformation team, an urgent care and admissions avoidance working group was set up which were working on a number of projects to improve the service.
- The emergency department was shortlisted for the excellence in accident and emergency care award, which was part of the CHKS annual top hospitals programme (CHKS is a leading provider of healthcare intelligence and quality improvement services.)

# Medical care (including older people's care)

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

## Information about the service

Harrogate District Hospital is part of Harrogate and District NHS Foundation Trust and provides acute medical services for NHS patients.

Between July 2014 and June 2015, there were approximately 22,300 medical episodes of care carried out in the trust. Day cases accounted for 54% of all episodes with emergency admissions at 45% and elective admissions at 1%.

Medical services were managed within the integrated care directorate. Harrogate District Hospital provided medical care in six medical wards, the Clinical Assessment Treatment and Triage Unit (CATT) which included the Clinical Assessment Team (CAT), Fountains Acute Medical Unit (AMU) which included a four bedded Coronary Care Unit (CCU), Oakdale Ward (stroke/neurology/oncology/haematology) which included a three bedded Hyper Acute Stroke Unit (HASU), Byland and Jervaulx Wards (elderly care) and Granby Ward (respiratory/endocrinology).

Medical services covers a number of different specialties, which included general medicine, care of the elderly, cardiology, respiratory medicine, diabetology, gastroenterology and stroke care. In addition, it provides cancer services at the Sir Robert Ogden Macmillan Centre and neuro-rehabilitation services for adults at the Lascelles Unit.

During the inspection we looked at 24 patient records, spoke with 26 patients and relatives, and 47 staff including doctors, nurses, therapists, care support

workers, ward managers, matrons, administrative assistants and student nurses. We visited all six wards, the Sir Robert Ogden Macmillan Centre, the Lascelles Unit, the Endoscopy Unit, the Medical Day Unit and the Cardiac Catheter Laboratory.

We attended a number of focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI) on Jervaulx Ward. SOFI is a specific way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust.

Harrogate District Hospital was last inspected in November 2013. This inspection was part of a pilot scheme for a new system of inspections. The hospital was not rated but the inspection report found that Harrogate District Hospital provided care that was safe, effective, caring, responsive and well led.

# Medical care (including older people's care)

## Summary of findings

Overall, we rated medical care services as good because:

Patients were treated with dignity and respect and told us staff were very kind to everyone. There were consistently high scores in the Friends and Family Test Scores for patients who would recommend the service. Some medical wards regularly achieved 100%. Patients told us they felt well informed and included in decisions about their care. There was good emotional support particularly within the Robert Ogden Centre.

Services were effective. Protocols and policies based on current evidence were available for staff on the ward and on the intranet. We found local guidelines based on the National Institute for Health and Care Excellence (NICE) guidelines. There were good examples of multidisciplinary working. Nursing and therapy staff told us that there were good training opportunities available to them and nurses were well supported in completing their revalidation. However, junior doctors told us that work pressure was affecting their training as they were not having enough opportunities to learn and were not having regular supervision. Staff we spoke to had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

We found services to be responsive. Access to services was good with cancer waiting times data showing good performance. A redesign project was underway which aimed to improve patient flow and enhance the patient experience within acute medical admissions. Discharge liaison nurses facilitated the timely discharge of complex patients. We found some good examples of individual patients needs being met. Staff were aware of the policy for managing concerns and complaints and where to find it on the intranet.

The medical care services were well led. The senior management team for medicine were clear on their greatest risks and we saw this clearly documented on the directorate risk register. Control measures were in place to reduce the level of risk. Staff often saw senior managers, especially the chief nurse who was on the wards regularly and staff said was approachable. Staff spoke highly of their managers and told us they felt well

supported and listened to. The trust vision and values were well known. We found good morale amongst staff and they told us they were proud of their hospital and the care they delivered to patients.

However;

We found medical care services to require improvement for safety. Although wards appeared clean, we observed some poor infection control practices on several wards we visited. Doors to isolation rooms were often left open and staff did not always observe good hand hygiene and correct use of personal protective equipment. We found several issues with medicines. Hypo-boxes were not always checked according to the policy and the contents of the box were not always complete. One injection was found to be out of date on the resuscitation trolley on one ward and we found three cylinders of oxygen which were out of date and not stored safely on one ward. We also discovered medicines left unattended on the nurse's station on Fountains AMU. Nurse staffing was an issue however, the trust had recognised this and had taken measures to minimise the risk to patients.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



We rated medical care services as requires improvement for safe because;

- Although wards appeared clean, we observed some poor infection control practices on several wards we visited. Doors to isolation rooms were often left open and staff did not always observe good hand hygiene and correct use of personal protective equipment.
- We found several issues with medicines. Hypo-boxes, which were used to treat patients with low blood sugar, were not always checked according to the policy and the contents of the box were not always complete. One injection on a resuscitation trolley was out of date and we found three cylinders of oxygen on the Lascelles unit which were out of date and not stored safely. We discovered medicines left unattended on the nurse's station on Fountains AMU.
- Nurse staffing was an issue however, the trust had recognised this and had taken measures to minimise the risk to patients.

However;

- Staff knew how to report incidents and we saw evidence of good feedback and learning from incidents. Staff had a very good understanding of duty of candour.
- Work had been undertaken by the trust to reduce the number of falls. Staff had introduced safety huddles on wards to discuss patients at risk of falling and identify any actions to reduce the risk. For example, sensor mats were being trialled on the elderly care wards.
- There was good compliance with mandatory training in medicine. For all staff groups within this core service, the percentage of compliance ranged between 75% and 100%. This was within the trust target of 75%-95%.

### Incidents

- Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were no never events reported in medical services between January 2015 and December 2015.

- Serious incidents are incidents that require further investigation and reporting. There were 37 serious incidents reported for medicine between January 2015 and December 2015; 21 were pressure ulcers, 15 were falls with harm and there was one delay in treatment.
- Serious incidents were all investigated. We looked at examples of incidents, which had been investigated and found that staff had completed a thorough Root Cause Analysis and formed an action plan to prevent or reduce the likelihood of reoccurrence.
- Arrangements were in place to ensure medicines incidents were reported, recorded and investigated through the trust governance arrangements. The Medicines Safety Officer described how incidents were analysed and how learning was disseminated across the trust. This process could also be seen in the minutes of the Medicines Safety Review Group and the Area Prescribing Committee.
- Staff understood how to report incidents using the electronic reporting system. They confirmed that feedback was received and said that learning from incidents was shared across all teams.
- Incidents were discussed at monthly quality care meetings on Byland and Jervaulx wards. A ward manager told us about an incident when a patient with diabetes had not had their blood sugars tested. The diabetes specialist nurse had attended the meeting to discuss the importance of this with staff.
- Staff we spoke with had a very good understanding of the Duty of Candour. They were aware of the importance of being open and honest with patients about any mistakes in their care that had resulted in moderate or significant harm.

### Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), and catheter associated urinary tract infections (CUTIs). Between the dates of September 2014 and September 2015, staff reported 38 pressure ulcers, 18 falls with harm and two CUTIs in medical services.
- We saw local safety thermometer information displayed on quality and safety boards on all the wards we visited and in the Lascelles unit. Boards displayed a pressure ulcer and falls safety cross calendar, with each day of

# Medical care (including older people's care)

the month marked with a cross if any harm had occurred. For example, Oakdale ward had no pressure ulcers and one fall recorded for February 2015. The Lascelles unit had no grade three pressure ulcers since July 2015.

- Work had been undertaken by the trust to reduce the number of falls. Staff had introduced safety huddles on wards to discuss patients at risk of falling and identify actions to reduce the risk. For example, sensor mats were being trialled on the elderly care wards. Falls had reduced from an average of two per week to just over one per week.
- Reducing pressure ulcers was a priority for the trust. The SSKIN care bundle had been introduced which included five simple steps to prevent pressure ulcers. Tissue viability nurses had provided training to nurses and care support workers in ulcer prevention.

## Cleanliness, infection control and hygiene

- Personal protective equipment including aprons and gloves, and alcohol hand gel were available at the entrance to and throughout the wards we visited. Handwashing facilities were also available.
- Patients with infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. diff) were barrier nursed in side rooms. We observed on Fountains AMU, Granby, Byland and Jervaulx ward that, although there was a standard isolation sign on side room doors, several doors were left wide open. We asked staff why the doors were open and were told this was because patients were at risk of falling however; there was no documentation to show that a risk assessment had been carried out. One member of staff said the doors should be closed but could not explain why they had been left open. We found the same issue when we made an unannounced inspection of these wards on 10 February 2016. This was not a good example of infection prevention and control.
- Staff told us that if a patient had a C. diff infection, the door to the side room would always be kept closed. We checked one side room with a patient with C. difficile and found that the door was closed.
- There were not enough isolation rooms for all patients positively identified as carrying MRSA. Staff told us that the infection control nurses advised them which patients were at lower risk of passing on an infection to other patients and could be cared for in the bays.
- Hand hygiene was audited monthly. We looked at the results for Byland and Jervaulx ward from July 2015 to December 2015, which showed 100% compliance for all months apart from September on Byland at 90%, and July on Jervaulx at 95%. Despite these high scores, we observed that some staff did not always wash their hands prior to or following contact with a patient.
- We saw a member of the domestic staff with a plastic apron on go in and out of an isolation room to remove waste without wearing gloves, then proceed to the pantry and then into a patient bay with the same apron on.
- We witnessed administration staff entering wards without using the hand gel provided at the entrance.
- Information supplied by the trust showed there had been no cases of MRSA bacteraemia since September 2013, however there had been an increase in cases of Clostridium Difficile (C. difficile) compared to the previous year. We saw the results of an audit undertaken by the infection prevention and control team for all patients in hospital with an active infection. The audit monitored compliance against the key elements of the C. diff control policy. Results for April to September 2015 showed compliance was between 91% and 100% with the exception of Fountains AMU in August which was 88%.
- Each ward displayed infection control information on their quality and safety board. Oakdale ward had more than 90 days since the last Clostridium Difficile infection had been acquired on the ward and more than 800 days since the last bloodstream acquired MRSA infection.
- Staff completed infection prevention and control training as part of their mandatory training. Information provided by the trust showed that compliance for teams within this core service was between 75% and 100%, which was within the trust target.
- Staff we observed during the inspection followed the uniform policy and had clear name badges.
- The equipment we looked at was clean and had labels attached with the date it had last been cleaned. The exceptions to this were some items on the resuscitation trolley, which were dusty.
- All reusable equipment in the endoscopy unit was decontaminated by the sterile services department. There was a colour coded labelling system to distinguish between clean and dirty equipment.

# Medical care (including older people's care)

- Porters told us about using different trolleys to separate the transfer of clinical waste and linen. We observed these trolleys in use during the inspection.
- We looked at the results of the patient-led assessments of the care environment (PLACE). The hospital achieved a cleanliness score of 99.14% in 2015, which was higher than the national average of 97.5%.

## Environment and equipment

- Most areas we visited were clean, tidy and well organised.
- The Sir Robert Ogden Macmillan Centre, which opened in 2014, was a state of the art facility. We found it was extremely clean, tidy and well organised and it had a calm atmosphere.
- The Cardiac Catheter Laboratory was a six bedded admission and recovery unit for day cases. The lab performed coronary angiograms, pacemaker implantation and transoesophageal echoes. The area was fairly cramped with a small waiting area and filing cabinets in the corridors.
- An external company was responsible for portable appliance testing and calibrating the equipment. The equipment we checked was within the testing date and had servicing stickers attached, which were also within date. The exception to this was when we checked equipment for emergency use and found that on two wards equipment had exceeded the portable appliance testing date.
- The equipment library supplied equipment to patients on the wards. Staff ordered equipment by phone, and then it was allocated to the patient. Following use the equipment was collected, decontaminated and stored at the library.
- We saw that sharps were safely managed and disposed of in line with health and safety regulations. Sharps bins were correctly labelled and dated.
- There was a lack of storage in some areas and bathrooms were being used to store equipment. These rooms were not in use therefore, there was minimal impact on patient care. Staff acknowledged that this was not ideal but told us this was the only option if they were to keep corridors clear.
- Two porters we interviewed told us that some of the trolleys were old and needed replacing. They said some of them were difficult to manoeuvre.
- Medicines records were completed using an Electronic Prescribing and Medicines Administration (EPMA) system. This system was used effectively by nursing and pharmacy staff to administer and record medicines, and for medicines reconciliation. We observed how the system was used by the nurse in charge to check medicines were being administered at the correct times.
- Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Stock balance checks were performed regularly in line with the trust policy in all the wards we visited.
- Pharmacists and technicians provided a medicines reconciliation and discharge service across all medical wards.
- We checked medicines for emergency use on the resuscitation trollies and found these were in date with the exception of Granby ward where we found an injection, which was out of date. This was pointed out to the ward manager at the time and was rectified immediately.
- The wards had dedicated hypo-boxes, which were used to treat patients with low blood sugar. These were not always checked according to the policy and the contents of the box were not always complete. For example, on CATT Ward, one item was stored in the fridge and not in the box, and on the Cardiac Care Unit one item did not state the date removed from the fridge therefore it could not be guaranteed as safe for administration. We checked the hypo-boxes again on the unannounced inspection on 10 February and found that they were all in order.
- We discovered medication left unattended on the nurse's station on Fountains AMU. This was brought to the attention of the nurse in charge who locked it away securely.
- The storage and monitoring of medicines were was not always managed according to the trust policy. We observed on two wards that the fridge monitoring record was not the form specified in the trust policy and maximum and minimum temperatures had not been recorded. This was rectified during our visit.
- We identified one patient who was self-administering medicines. The trust had a self-administration policy but this was not being followed. As a result, there was no robust assessment or evidence to demonstrate who had assessed suitability to self-administer.

## Medicines

# Medical care (including older people's care)

- At the Lascelles Unit, we found oxygen cylinders stored in an unlocked room. Three of the cylinders were out of date, one by more than a year. This was brought to the attention of the manager at the time and to the trust during the inspection. The trust took action to rectify this immediately and produced an action plan to prevent this happening in future. We also noted that four cylinders were not restrained. There was a risk of a cylinder falling over which could injure someone or damage could be caused to the top of the cylinder resulting in a leak and potential risk of explosion.

## Records

- We reviewed 24 sets of patient records and found that overall they were completed well, in line with professional standards. We saw comprehensive risk assessments of patients' needs and care plans in place to manage the risks. Diagnosis and management plans were well documented and nursing assessments were complete.
- Records were stored securely in lockable units apart from some wards such as CATT and Fountains AMU. On these wards, records were stored in open trollies, which were not lockable. We asked a ward sister about this and were told that it was so staff could have quick access to records. She said the records were kept next to the nurse's station and there was always a member of staff present to ensure that they were not accessed inappropriately.
- We saw personal patient information and test results, left open on computer screens at the nurse station on Fountains AMU on two occasions.

## Safeguarding

- The chief nurse was the trust safeguarding lead. There was also a designated senior nurse and doctor for adult safeguarding.
- Staff we spoke to with were aware of the reporting mechanism for safeguarding issues. They knew whom to contact if they needed advice.
- Compliance with safeguarding training was good. In this service, there was 100% compliance with safeguarding awareness training and between 75% and 100% for level 1 adult safeguarding. Teams all met or exceeded the trust target of 75% - 95%.

## Mandatory training

- There was a trust mandatory training policy in place, which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and others.
- For each training element staff groups were identified and the frequency of each training element. Employees had a "personal training account" which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.
- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.
- There was good compliance with mandatory training in medicine. For all staff groups within this core service, the percentage of compliance ranged between 75% and 100%. This was within the trust target of 75%-95%. Compliance at The Lascelles Unit was 90%.
- Doctors told us that they were often asked to cover gaps in the medical rota and therefore not always released to attend their mandatory training.

## Assessing and responding to patient risk

- The trust used a National Early Warning Score (NEWS) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care.
- Nurses and care support workers recorded patient observations at the bedside and entered them onto an electronic system (patient track). If the NEWS score was three or above, indicating a patient was deteriorating,

# Medical care (including older people's care)

the system was set up to automatically bleep medical staff. This enabled the patient to be attended to swiftly. Depending on level of the NEWS score, medical staff of different grades and experience were bleeped.

- We saw patient risk assessments completed in care records including falls, pressure areas, nutrition and venous thromboembolism. These were completed thoroughly in the 24 records we looked at with the exception two falls risk assessments, which were incomplete.
- A critical care outreach team provided support to medical and nursing staff on the wards when caring for deteriorating patients.

## Nursing staffing

- At the time of the inspection, there were approximately 40 registered nurse vacancies across the trust, mainly in acute medical and elderly care wards.
- The trust used the 'safer nursing care tool' as recommended by the National Institute for Health and Care Excellence (NICE) which calculates safe nurse staffing levels based on patients' level of sickness and dependency.
- Nurse vacancies and staffing levels were on the trust risk register and there was an action plan to reduce the risk.
- Nurse staffing levels were particularly low on the elderly care wards, Byland and Jervaulx. To mitigate the risk to patients, managers were covering vacant shifts with current staff working additional hours or moving staff from other wards to cover for an agreed period.
- During our visit one member of staff, who was temporarily working on Byland ward, told us she had decided to stay there on a permanent basis as she had enjoyed working on the ward.
- We looked at the staffing rotas for the previous 3 weeks on Fountains AMU and found that on 10 days out of 21, the actual staffing levels did not meet the planned staffing levels. In most cases, they were short of one registered nurse for one of the shifts.
- When we visited Oakdale ward, actual staffing met the planned level. We were told that staff were often moved from Oakdale to cover other wards, which were short of staff.
- The Lascelles unit had 12 patient beds. There were 10 beds in use as a decision had been made to temporarily close two beds, due to low staffing levels. On the day on our inspection, planned staffing levels to care for patients in 10 beds were met. The unit were planning to re-open the remaining two beds once they had filled their nurse vacancies.
- On an unannounced visit on 10 February 2016, the actual staffing levels on Jervaulx and Byland wards were below the planned level. Jervaulx was one nurse short on the early shift and Byland was one nurse short on both the early and late shift. Additional care support workers had been allocated to these shifts and were over the planned level.
- We looked at nurse staffing fill rates. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved. In January 2016 the fill rate for medical wards during the day were, Fountains AMU 96% nurses and 121% care support workers, CATT 97% nurses and 107% care support workers, Granby 105% nurses and 128% care support workers, Byland 89% nurses and 139% care support workers, Jervaulx 84% nurses and 145% care support workers, Oakdale 96% nurses and 109% care support workers and Lascelles Unit 91% nurses and 108% care support workers.,
- The trust had over-recruited to the care support worker role, to support the short fall in qualified nurses. We saw this reflected in the fill rates and in the staffing numbers during our visit.
- The trust had introduced an incentive to encourage staff to work additional shifts. The trust would pay staff a bonus of £200 if they worked three extra shifts.
- Staff from the NHS bank also covered vacant shifts and we found that often the ward manager was counted in the nursing numbers.
- On some occasions when staffing levels were low, we heard call bells ringing for up to 10 minutes before they were answered.
- Staffing levels were monitored and managed by the matrons who visited each ward daily. Information collected by the matrons was discussed at the hospital flow meetings, which were held at 10.30am and 2.30pm each day.

# Medical care (including older people's care)

- There was an ongoing recruitment campaign. The trust had recently held several job fairs, which resulted in jobs offers being made to student nurses on qualifying. In the meantime the trust were keeping in touch with the students on a regular basis and had sent them a Christmas card and organised a 'curry night'.
- Formal handovers took place twice a day. We observed three nurse handovers and found these to be systematic and thorough. Printed handover sheets were circulated and each patient was discussed in detail. This included information on risks, reason for admission, nursing needs, social situation and whether a Do Not Attempt CPR order was in place.
- Names and photographs of the nurse leaders, such as the matron and ward manager, were displayed on a notice board at the entrance to each ward.

## Medical staffing

- There were approximately 78 whole time equivalent medical staff. Of these 36% were consultants, 7% middle career, 28% registrars and 29% juniors doctors. The percentage of consultant cover was similar to the England average and the percentage of junior doctors was higher than the England average.
- There were 38 junior doctors on the medical on call rota. During the day, Monday to Friday, there were 16 junior doctors and four registrars. In addition, three junior doctors and two registrars were on call.
- A resident acute physician was available Monday to Friday 8.00am to 8.00pm. All wards had consultants available on site for specialty input, Monday to Friday 9.00am to 5.00pm.
- During the week, there was a daily ward round on the Coronary Care Unit (CCU) conducted by a consultant cardiologist. There was no ward round on Saturday or Sundays however any newly admitted patients would be seen by the consultant of the day.
- We were told that one consultant was on call 24 hours a day. At weekends, the consultant on call carried out morning and evening ward rounds to review newly admitted patients. A second on call physician carried out a ward round on Saturday and Sunday for any medical patient on the wards requiring a review.
- One registrar and two junior doctors provided medical cover at night. At weekends during the day, two registrars and three junior doctors provided medical

cover. Junior doctors at the focus group told us this did not feel safe. One junior and one doctor said he would not recommend the service to his friends and family at the weekend.

- Junior doctors told us that they could not always be released for training due to workload pressure.
- We were told that site co-ordinators overnight have the responsibility to balance workloads between teams, with the ability to redeploy medical staff as necessary to meet demand.
- Medical handovers occurred twice a day at 9.00am and 9.00pm. The medical rota allowed for a 30 minute overlap of day and night staff. We observed a 9.00am handover on CATT ward, which appeared well established and thorough. All new patients admitted overnight were discussed in detail.
- Most junior doctors we spoke with felt well supported by their consultant.
- The trust had developed the Advanced Clinical Practitioner (ACP) model to fill gaps in the registrar and junior doctor rota. Eight ACPs had commenced in January 2015 and were due to complete their training in September 2016. They were based in the emergency department, on the acute wards and on the elderly care wards.

## Major incident awareness and training

- The trust had a major incident plan, which was available for staff on the trust intranet. The plan gave an overview of the Trust's response to a major incident and gave details of the role of key staff should this occur. Staff we spoke to had an awareness of the plan and knew where to find it.
- Training in major incident plan familiarisation and major incident room familiarisation was available and had been attended by key staff within the trust, which included the management team for integrated care.
- The trust had winter pressures escalation plans in place. The Physiotherapy gym on Granby ward had six escalation beds and would be used initially. If further beds were needed Swaledale ward could be opened, which had 12 beds. In addition, four beds could be opened in the day room on Wensleydale ward and six beds on CATT ward.

## Are medical care services effective?

# Medical care (including older people's care)

Good



We rated medical care services as good for effective because;

- Protocols and policies based on current evidence were available for staff on the ward and on the intranet. We found local guidelines based on the National Institute for Health and Care Excellence (NICE) guidelines.
- There were good examples of multidisciplinary working. We observed a multidisciplinary team meeting and saw evidence of input from the multidisciplinary team documented in patient's notes.
- Nursing and therapy staff told us that there were good training opportunities available to them. Nurses told us that they had good support for completing their revalidation from managers. However, junior doctors told us that work pressure was affecting their training as they were not having enough opportunities to learn and were not having regular supervision
- Staff we spoke to with had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff we observed sought verbal consent prior to providing care and treatment.

## Evidence-based care and treatment

- Protocols and policies based on current evidence were available for staff on the ward and on the intranet.
- The local guidelines for treatment of patients with Chronic Obstructive Pulmonary Disease (COPD) were based on the National Institute for Health and Care Excellence (NICE) guideline CG101.
- Ward managers undertook local audits such as hand hygiene and documentation audits. The results were shared with staff at team meetings and were displayed on ward notice boards and in staff areas.
- The endoscopy unit had a programme of 35 audits. Some audits were a requirement for the JAG accreditation and some were required by the trust.
- The trust used a sepsis screening tool, which identified if a patient needed urgent intravenous antibiotics with the aim of the antibiotics being administered to the patient within an hour of presentation. One junior doctor told us the sepsis tool was useful in picking up sepsis in

patients early. However, we saw that on one occasion this had not been implemented correctly which led to a three hour delay in the patient receiving antibiotic therapy.

- The sepsis screening tool was being audited. We saw the results of an audit that had been carried out between April to June 2015 and showed that 40% of patients had received intravenous antibiotics within an hour of presentation, against a target of 100%. An action plan had been formed to raise awareness of sepsis management however; three junior doctors and two nurses we spoke to on Fountains AMU said they were not aware of the audit.
- Medicines management was routinely audited across the trust and included medicines reconciliation, safe and secure storage of medicines, controlled drugs, and pharmacy intervention monitoring. Audit results were disseminated through the appropriate groups and action plans were prepared and acted on.
- Trust policies were regularly reviewed and covered all aspects of medicines management. These were accessible via the hospital intranet to all staff.

## Pain relief

- Staff assessed and recorded patient pain using the trust's pain scoring system.
- We were told there was a pain assessment tool specifically for patients with cognitive impairment.
- Patients were given their medicines in a timely way, as prescribed, including pain relief.
- We spoke with 26 patients during the inspection and all said their pain relief had been addressed. When asked about pain relief one patient said he had been in a lot of pain and definitely had pain relief, he just had to ask.
- At the Sir Robert Ogden Macmillan Centre, we saw robust pain assessments completed and patients could be referred directly to the pain management team.
- Some patients told us that even if they were not in pain the nurses would check on them regularly in case there was any change.

## Nutrition and hydration

- In the patient-led assessments of the care environment (PLACE) audit, the hospital scored 93.29% for food and hydration, which was higher than the national average of 88.49%.

# Medical care (including older people's care)

- We saw in patients notes that the Malnutrition Universal Screening Tool (MUST) was used to carry out nutritional risk assessments. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.
- Nutritional assistants were available to help patients identified as at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Input from a dietician was available if required.
- Patients with special dietary requirements such as those requiring soft diets were catered for.
- The hospital used a red tray system to identify patients who needed help with meals or their dietary intake monitoring.
- Patients we spoke with were generally happy with the food and drinks provided during their stay. One patient told us the food was fantastic, especially the soft/pureed food, and that it looked like a meal. Another patient said the food was good and but the portions were large. He said he had requested small portions but did not always get them.

## Patient outcomes

- The endoscopy unit at Harrogate District Hospital had achieved Joint Advisory Group (JAG) accreditation on GI Endoscopy. There were plans to move to a new purpose built unit, which would increase their capacity from two treatments suites to five.
- In the Stroke Sentinel National Audit Programme (SSNAP), Harrogate District Hospital achieved an overall score of D (on scale of A – E, with E being the worst) for July – September 2015 admissions. For both team and patient centred indicators, standards by discharge were rated highest and speech and language therapy was rated as worst.
- The Myocardial Ischaemia National Audit Project (MINAP) audit for this trust is better than the England average for two out of the three indicators for 2013-2014.
- Performance in the National Diabetes Inpatient Audit (2013) was mixed with the hospital performing better than the England average in ten areas and worse in ten. Based on audit results the trust had formed an action plan to improve insulin safety and reduce severe hypoglycaemia. The trust also took part in a national audit for Diabetic ketoacidosis (DKA).

- There was a lower risk of readmission for both elective and non-elective patients at Harrogate District Hospital compared to the England average with the exception of cardiology for non-elective, which was slightly higher risk of readmission than the England average.

## Competent staff

- Staff we spoke to told us they had completed their annual appraisal within the last 12 months. However, information supplied by the trust showed that appraisal rates varied from 100% for medical and administration staff in cancer services to 40% for staff in the heart centre.
- A therapist on Oakdale ward told us that she provided regular supervision for junior staff and had peer supervision with her colleagues monthly.
- We spoke with a band six nurse on the Coronary Care Unit (CCU) whose role was to provide support and education to nursing staff on the unit. Competency based training was delivered using a competency pack and each nurse was signed off once they had reached the required level of competency.
- Nursing and therapy staff told us there were good training opportunities available to them.
- Nursing staff told us they had good support for completing their revalidation from managers.
- A care support worker told us she had completed a four day induction before starting her role. Another care support worker was being supported to undertake nurse training through the Open University.
- Junior doctors told us work pressure was affecting their training as they were not having enough opportunities to learn and were not having regular supervision. We saw this highlighted in a report from the Deanery. The trust had recognised the issue and put in place an action plan to improve the situation.

## Multidisciplinary working

- There were good examples of multidisciplinary working.
- Oakdale ward provided neurology and stroke rehabilitation to patients who were cared for by a Multidisciplinary Team (MDT), which included doctors, nurses, care support workers, physiotherapists, occupational therapists, dieticians, nutritional assistants and specialist nurses.

# Medical care (including older people's care)

- We oversaw a MDT meeting on Jervaulx ward, which included the nurse in charge, consultant, physiotherapist, discharge liaison nurse and student nurse. The purpose of the meeting was to discuss discharge planning for patients on the ward.
- We saw evidence of input from the multidisciplinary team documented in patient's notes.
- Discharge liaison nurses attended MDT meetings to facilitate the safe and timely discharge of patients.
- There was good access to psychiatric input from the Acute Hospital Liaison Service which was provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). The team were based in the Briary Unit within Harrogate District Hospital. The senior sister on CATT Ward told us they had a good working relationship with the team.

## Seven-day services

- There was one bed within the Hyper Acute Stroke Unit (HASU), which was for patients needing thrombolysis. There was a stroke thrombolysis rota and four consultants with skills in thrombolysis covered the rota between 8.00am and 8.00pm, Monday to Friday and 8.00am to 2.00pm, Saturday and Sunday. Outside of these hours, there was a regional rota with Bradford, Calderdale & Huddersfield Trusts utilising Telemedicine and working remotely.
- The ward-based clinical pharmacy service was available between the hours of 8.30am to 5.30pm, Monday to Friday. There was a limited ward-based clinical pharmacy service at weekends between the hours of 9.00am and 2.00pm. Outside of these hours, an on-call service was provided. The main dispensary is open between the hours of 8.30am and 7pm Monday to Friday and 9am to 2pm at weekends.
- Gastroenterology consultants were onsite at the weekend and there was a 24 hour/seven days a week on call gastrointestinal (GI) bleed rota. Five consultants were on the rota. Patients with an acute GI bleed out of hours were taken to theatre as theatre teams had received endoscopy training.
- The endoscopy unit provided services Monday to Saturday, 8.00am to 7.00pm. It was also open on Sundays however; this ran on a voluntary basis for staff. There was a 24 hour emergency access number for patients who needed advice following a procedure.

- Computerised Tomography (CT) scanning was available Monday to Friday, 7.45am to 6.30pm and on Saturdays, 8.30am to 4.30pm. Outside of these hours, a radiographer was on call. If called in, the radiographer was required to be on site within 30 minutes. We were concerned that patients with a suspected stroke may have a delay in receiving a CT scan out of hours. Time to scanning was also an area where the trust performed poorly in the Stroke Sentinel National Audit Programme (SSNAP).
- A physiotherapist was available on call over the weekend on Oakdale ward.
- There were four side rooms on Oakdale ward for oncology patients. A named nurse held a bleep between the hours of 6.00pm and 8.00am for patients who needed advice following chemotherapy treatment at the Sir Robert Ogden Macmillan Centre.

## Access to information

- Staff had access to blood results and x-rays using an electronic results service.
- Relevant policies and guidelines were available electronically to staff via the trust intranet.

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

- All staff we observed sought verbal consent prior to providing care and treatment.
- Mental Capacity Act training was available via an e-learning course for qualified and unqualified staff. There was also a full day dementia awareness training day, which incorporated the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff we spoke to had a good understanding of MCA and DoLS.
- A ward sister told us there was a good working relationship with the local authority in relation to DoLS requests.
- Oakdale ward had made 11 DoLS applications. These were required for patients needing to wear mittens in order to prevent them pulling out their feeding tubes.
- Staff could tell us about best interest meetings they had been involved in for patients who lacked capacity. We saw that best interest flowcharts were available for staff to refer to if needed.

## Are medical care services caring?

# Medical care (including older people's care)

Good



We rated medical care services as good for caring because;

- Patients were treated with dignity and respect and said staff were very kind to everyone.
- We saw some individual examples of staff demonstrating great empathy and kindness.
- There were consistently high scores in the Friends and Family Test Scores for patients who would recommend the service. Some medical wards regularly achieved 100%.
- Patients felt well informed and included in decisions about their care.
- There was good emotional support particularly within the Robert Ogden Centre.

## Compassionate care

- This trust had a response rate of 46.7% in the Friends and Family Test of between August 2014 and July 2015. This was the same as the England average. Scores from patients who would recommend the service were high with some medical wards regularly achieving 100%.
- In the 2014 Cancer patient experience survey results for inpatient stay, 88% of patients said they were always treated with respect and dignity by staff. This was better than the 84% England average.
- We heard staff communicating with patients in a kind and caring manner. Patients were treated with respect and their privacy and dignity was preserved.
- Staff working in the Sir Robert Ogden Macmillan Centre clearly enjoyed their work and this was evident in the manner in which they provided care and emotional support to their patients.
- We carried out a short observational framework inspection (SOFI) on Jervaulx ward and saw good interactions between staff and patients. Patients responded positively to staff and it was clear from the patient's facial expressions that they enjoyed this interaction. Staff talked to patients regularly to see if they needed anything and not just when there was a specific task to perform. We thought the physiotherapist had a good rapport with patients.
- A patient in the Lascelles unit had been receiving therapy for a neurological disorder and one of his goals

was to write his name. During our visit, he achieved this. It was clear how delighted the staff were for him and one member of staff said she would bring him a valentine card so he could write his name on it for his wife. We thought this was very caring.

- We saw one nurse showing great empathy to a patient requiring medicines being administered via a Percutaneous Endoscopic Gastrostomy (PEG) tube. The nurse took great care to reassure the patient about what she was doing and explained about each medicine. She also explained about the flushes being given after each medicine.
- We spoke to three patients on Jervaulx ward who all said they were happy with their care and that staff were very helpful and kind to everyone.
- Some patients told us that when the nurses were busy it could take a while for them to answer their call bells.
- On one ward, we witnessed a lack of privacy in that a deceased patient was being attended to in a side room and the door was left ajar.
- We looked at the results of the patient-led assessments of the care environment (PLACE). The trust achieved a privacy and dignity score of 79% in 2015. This was worse than the national average of 86%.

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

- Patients we spoke with felt well informed and included in decisions about their care.
- One patient said she had not understood some of the information given to her when she was first admitted due to her illness, but her daughter helped her to understand.
- We observed staff explaining medicines to each individual patient and time was taken to ensure patients understood what was being administered.
- A member of staff in the Sir Robert Ogden Macmillan Centre explained the process to a patient having chemotherapy for the first time. We thought the way this was done was outstanding. The explanation was thorough and the patient was given time to ask any questions. It was done in a caring and compassionate way.
- We saw evidence in patient records that patients and their relatives had been involved in making decisions about their care and treatment.

## Emotional support

# Medical care (including older people's care)

- There was a cancer information, wellbeing and benefits service available within Sir Robert Ogden Macmillan Centre. The service offered support and information on all aspects of cancer including benefits and welfare for patients and carers. It also provided access to complementary therapies, palliative, social and psych-emotional support services.
- A patient told us about the support he had received from the cancer psychologist at the Robert Ogden Centre, which he said 'was a godsend'.
- Access to psychiatric input was provided by the Acute Hospital Liaison Service, which was based within the hospital on Rowan ward.
- A chaplaincy service was available to provide holistic care for patients and support for relatives and carers. Chaplains were available Monday to Friday, 8.30am to 4.30pm and there was always a Chaplain on call.

## Are medical care services responsive?

Good



We rated medical care services as good for responsive because;

- Access to services was good. Cancer waiting times data showed good performance and a redesign project was underway, which aimed to improve patient flow and enhance the patient experience within acute medical admissions.
- Discharge liaison nurses facilitated the timely discharge of complex patients. This included patients with delayed discharges. The nurses liaised closely with social services, care managers and family/carers regarding support on discharge and attended best interest meetings for patients who lacked mental capacity.
- We found some good examples of individual patients needs being met. Reasonable adjustments could be made for patients with a learning disability and patients with dementia had an "all about me form completed".
- Staff were aware of the policy for managing concerns and complaints and how to find it on the intranet. Staff said they tried to resolve minor complaints at source to prevent them escalating to formal complaints.

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

- The respiratory team worked with GPs and practice nurses to launch new guidelines and a treatment pathway for Chronic Obstructive Pulmonary Disease (COPD). A new formulary had been developed in consultation with Harrogate and Rural District Clinical Commissioning Group.
- Some services for patients with cancer were in the process of being repatriated to the Sir Robert Ogden Macmillan Cancer Centre from Leeds. This would mean less travelling time for patients living in Harrogate accessing these services.

## Access and flow

- There were no mixed sex breaches reported for Harrogate District Hospital.
- Cancer waiting times data for December 2015 showed a good performance with 97.91% of patients being seen by a specialist within 14 days of referral and 100% of patients receiving their first treatment within 31 days of diagnosis. Both figures were better than the England average.
- The percentage referral to treatment time within 18 weeks was better than the England average during the period April 2013 – August 2015. The only two specialties not meeting the 90% standard were neurology and thoracic medicine. However, both had less than five pathways per month therefore, percentages were based on small numbers.
- Information regarding bed moves between November 2014 and October 2015, indicated that across medical services for Harrogate Hospital, 78% of patients had no moves, 15% were moved once during their stay, 5% were moved twice, 1% three times and 1% of patients were moved 4 or more times. This showed an improvement on the number of moves reported in the previous year.
- A redesign project was underway which aimed to improve patient flow and enhance the patient experience within acute medical admissions. The project known as 'FLIP' commenced in October 2015 and was designed in three phases. It was in phase two at the time of our visit. The project involved the redesign and integration of the CATT Ward and the Clinical Assessment Team (CAT) which provided Ambulatory Care. The CAT team was located in a corridor adjoining the CATT ward, which allowed ease of access for staff and flow of patients between the two areas. All admissions from the Emergency Department or GPs

# Medical care (including older people's care)

were admitted to the CATT ward and seen by the acute physician. They were provided with a plan of care prior to either discharge home or transfer to a medical ward. Patients requiring a bed normally stayed on the unit for 24 to 72 hours. Patients attending for ambulatory care with the CAT team were triaged and provided with treatment and could be sent to the CATT ward if they needed to be admitted. The benefits of the project were already being seen. Despite a 30% increase in non-elective in-patient activity within general medicine, the percentage bed occupancy had decreased from October 2015 to January 2016 compared to the previous year. Managers attributed the fact that the hospital had not needed to open up the 12 bedded winter pressures escalation ward to the success of the project.

- A patient flow meeting was held twice a day on CATT ward at 10.00am and 2.15pm and was led by the nurse in charge. The bed manager and the nurse in charge for all other medical wards attended. A white board was used to identify beds currently available and patients who were planned to be discharged later that day. This gave the nurse in charge of CATT ward an overview of which wards could accept patients who needed to be transferred to a specialist ward.
- There were 15 medical outliers at the time of our visit. A medical outlier is a patient admitted to a ward different from the internal medicine wards. We found medical outliers on three surgical wards. We checked the medical notes of all outlying patients and found that they had been allocated an appropriate consultant and had been visited daily by the consultant apart from two patients who had been missed at the weekend.
- Hospital flow meetings, led by the bed manager, were held twice daily at 10.30am and 2.30pm. Matrons, workforce co-ordinators, the duty manager, site co-ordinators and discharge liaison nurses attended the meeting. Bed availability, staffing levels and infection control issues were discussed at these meetings. The decision to open up escalation beds would also be discussed at this meeting if necessary.
- Discharge liaison nurses facilitated the timely discharge of complex patients. This included patients with delayed discharges. The nurses liaised closely with social services, care managers and family/carers regarding support on discharge and attended best interest meetings for patients who lacked mental capacity.

- We spoke with two patients about their discharge planning. One patient told us this had been discussed with her and that she could go home when she was able to go up and down the stairs. Another patient said he was up to date with his discharge plan.
- We spoke with the diabetes specialist nurses who demonstrated how they used information from the Electronic Prescribing and Medicines Administration (EPMA) system to monitor patients' blood sugar readings and insulin doses. If a patient had a blood sugar reading of less than four or more than 15, a specialist nurse would proactively visit them. This enabled the team to target those patients early who required a review and allowed interventions to be made before referrals were received. This also helped to streamline the team's workflow. We thought this was extremely responsive.
- The endoscopy unit was running on more than full capacity and had a year on year increase in the number of procedures it carried out. The unit opened at weekends to keep up with the demand however, staff told us that it was not always possible to meet the two-week wait target. A new unit with increased capacity was being designed and building was planned to commence later in 2016.
- For the period July 2014 to June 2015 the average length of stay for medical patients at Harrogate District Hospital for all elective admissions was longer than the England average, particularly in cardiology. For all non-electives, the length of stay was similar to the England average though in geriatric medicine it was longer.

## Meeting people's individual needs

- Patients receiving cancer treatment at Harrogate District Hospital were able to receive free parking for the duration of their treatment.
- The trust had a named nurse for learning disability (LD). An LD flag was used to identify patients with a learning disability, which could be added to the patient's electronic record with their consent or as a best interest decision by their family/carers. A list of inpatients with an LD flag was circulated to the named nurse daily.
- Reasonable adjustments could be made for patients with a learning disability such as the use of communication books, bringing in items from home, free use of television and open visiting for carers.

# Medical care (including older people's care)

- Additional staff called 'specials' were used to look after patients requiring one to one care.
- There was a flagging system to identify patients with dementia on the electronic recording system. The trust was also reintroducing the butterfly scheme, which placed a picture of a butterfly on the board next to the bed of patients with dementia.
- There was no specialist nurse for dementia, however a matron who was an older persons champion had the responsibility to lead and improve dementia care within the trust. The Head of Nursing for integrated care was the deputy chair of the dementia working group and was leading work on dementia across the organisation with the clinical lead.
- Patients with a diagnosis of dementia had an 'all about me' form completed. This allowed staff to get to know the person's likes, dislikes and interests in order to provide patient centred care.
- We observed 'pets as therapy' visits on the wards. Research has shown that therapeutic visits from dogs can provide comfort and companionship to patients in hospital and relieve anxiety and stress.
- Medical patients with mental health conditions were assessed using a mental health risk assessment tool. If a patient was referred to mental health services, they were given an information booklet.
- Translation services were available via a telephone service; alternatively face to face interpreters could be arranged were necessary. Leaflets and patient information were emailed to the interpreter service and were translated into the preferred language and returned within five working days.
- Information for patients was available in large print, audio and braille.

## Learning from complaints and concerns

- Staff were aware of the policy for managing concerns and complaints and how to find it on the intranet.
- Staff said they aimed to resolve minor complaints at source to prevent them escalating to formal complaints.
- We did not observe any information leaflets or posters displayed informing for patients on how to complain if they were unhappy with the care they received.
- A patient we spoke with told us she knew how to complain if she needed to. She said she would find a senior member of staff but she had no reason to

complain at present. Another patient said that he knew how to complain to the Patient Advice and Liaison Service (PALS) if he wanted to, but he had no confidence in them.

## Are medical care services well-led?

Good



We rated medical care services as good for well led because;

- Staff we spoke with were aware of the trust values, 'Respectful, Passionate, Responsible' and the vision of 'excellence every time'.
- The senior management team for medicine were clear on their greatest risks and we saw this clearly documented on the directorate risk register. Control measures were in place to reduce the level of risk.
- Staff said that senior managers were often seen, especially the chief nurse who was on the wards regularly and was approachable. Staff spoke highly of their managers and told us they felt well supported and listened to.
- We found a good morale amongst staff who told us they were proud of their hospital and the care they delivered to patients. Staff said they would recommend the hospital to their own friends and family.
- We saw some good examples of service improvement and redesign.

## Vision and strategy for this service

- Medical care services sat within the integrated care directorate. The directorate were in the process of developing an elderly care strategy.
- The unit manager at the Sir Robert Ogden Macmillan Centre had a clear vision for the service and this was shared with staff.
- Trust values were displayed in visible areas of the wards we visited. We saw a 'this is us' poster displayed on a notice boards which set out the vision, strategic objectives, annual goals, mission, values and first principle for the trust.
- Senior managers had developed several business cases to increase the staffing infrastructure within CATT, dermatology and gastroenterology.

# Medical care (including older people's care)

- Staff we spoke with were aware of the trust values, 'Respectful, Passionate, Responsible' and the vision of 'excellence every time'.
- CATT ward displayed their own philosophy on what patients could expect when they visited.

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

- The senior management team for medicine were clear on their greatest risks and we saw this clearly documented on the directorate risk register. Control measures were in place to reduce the level of risk.
- Each ward or department had its own risk register and the highest risks were escalated onto the directorate risk register. Risks scoring 12 or above would be escalated onto the corporate risk register.
- Ward managers were able to tell us about their risks and what action was being taken to mitigate them. One example was the risk of falls to patients on the elderly wards. Ward managers were able to tell us what was being done to reduce this risk.
- Integrated care board meeting were held monthly and fed information into the senior management team meetings.
- Matrons carried out daily ward assurance checks and weekly matron assurance audits.

## **Leadership of service**

- The integrated care directorate was led by a clinical director supported by an operational director and a deputy clinical director. A head of nursing was attached to the directorate.
- Staff said that senior managers were often seen, especially the chief nurse who was on the wards regularly and was approachable.
- We thought the unit manager at the Sir Robert Ogden Macmillan Centre was inspirational. She was clearly proud of her staff, the unit and the services provided to patients.
- Matrons visited the wards they were responsible for daily to complete ward checks and support ward managers to deal with any current issues.
- Matrons had recently changed their work pattern to ensure there was a matron on duty from 8.00am to 8.00pm during the week and 9.00am to 5.00pm at weekends.

- There were opportunities for leadership development. A leadership programme was available for matrons and ward managers. We spoke to one ward manager who had completed the programme and had found it very useful.
- Ward managers told us they received good support from their matrons and would see them at least once a day.
- Staff spoke highly of their managers told us they felt well supported and listened to.
- In the 2015 NHS staff survey the trust scored 3.87 for having support from immediate managers. This was better than the average score of 3.72 for trusts of a similar type.

## **Culture within the service**

- Staff we spoke with were proud of their services. Most staff had worked at the trust for many years and they knew each other well. They told us there was good teamwork on the wards.
- We found staff to be pleasant and welcoming in all areas we visited.
- Nursing staff were aware there were issues with staffing and did not like being moved to other wards. However, they were optimistic the situation was short term and that things would improve.
- Staff said there was an open and honest culture and they felt listened to.

## **Public engagement**

- The trust participated in the NHS Friends and Family Test (FFT). This provides information on whether patients are happy with the service provided, or where improvements are needed.
- The trust had a Patient Voice Group who met monthly. The group consisted of 15 lay members and a trust governor. Members of the group visited wards to speak to patients and carers about their hospital experience. They reported their findings to the trust with recommendations to improve services for patients. We saw examples of reports produced by the group and evidence of the trusts response.
- We saw examples of how the trust responded to patient experience feedback. This was displayed on notice boards in areas we visited. One example was patients being transferred to the main hospital from the Sir Robert Ogden Macmillan Centre (SROMC) said they

# Medical care (including older people's care)

experienced discomfort due to poor weather conditions. In response to this, the trust had introduced the use of a taxi service to transfer patients comfortably from the SROMC to the main hospital.

- Staff at the SROMC produced a quarterly newsletter for patients and carers. The newsletter contained useful information about the services offered at the centre as well as contact information for a variety of support groups.
- Patients and staff had been involved in the design of a new endoscopy unit. Staff told us further public consultation was planned once the architect's designs were complete.
- The trust had over 550 volunteers carrying out a variety of duties at the hospital. These included meeting and greeting patients and visitors at the main reception, helping patients with meals and activities and fundraising.

## Staff engagement







- Results from the 2015 NHS staff survey showed that the overall indicator of staff engagement for the trust was 3.92 which is better than average when compared with other with trusts of a similar type. It was also an improvement on the score the previous year, which was 3.83.
- The staff friends and family test results for quarter two 2015/16 showed 90% of staff were likely or extremely likely to recommend the trust for care and treatment compared to the national average of 79%. Sixty six percent of staff were likely or extremely likely to recommend the trust as a place to work compared to a national average of 62%.
- We found a good morale amongst staff and they told us they were proud of their hospital and the care they delivered to patients. Staff said they would recommend the hospital to their own friends and family.
- Staff said they were encouraged and supported to access training and development. They felt invested in and valued.

- Staff working in the Sir Robert Ogden Macmillan Centre were able to access psychological support and complimentary therapies. Managers had introduced this as they recognised the psychological impact of working in an acute oncology service.
- Staff on Oakdale Ward told us the chief nurse and the head of nursing for the integrated care directorate had visited the ward to discuss staffing issues with them. They explained why it was necessary to move staff from Oakdale on a temporary basis to cover other wards, which were short of staff. Staff said that although they were still not happy with being moved around they appreciated the visit and understood the reasons why this was necessary.
- Staff said managers had encouraged them to be open and honest during the inspection by the Care Quality Commission.
- Staff sickness rates were lower than the England average.

## Innovation, improvement and sustainability

- A service improvement project had led to the redesign of acute admissions and assessment pathway. This was known as the 'FLIP project'. The project involved the redesign and integration of the CATT Ward and the CAT team who provided Ambulatory Care and aimed to improve patient flow and enhance the patient experience within acute medical admissions. The benefits of the project were already being seen. Despite a 30% increase in non-elective in-patient activity within general medicine, the percentage bed occupancy had decreased from October 2015 to January 2016 compared to the previous year. Managers attributed the fact that the hospital had not needed to open up the 12 bedded winter pressures escalation ward to the success of the project.
- The trust had worked with the Improvement Academy to find ways of reducing patient harm. An improvement programme was in place, which aimed to reduce the number of falls and pressure ulcers by 50%.

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

## Information about the service

Harrogate hospital is part of the Harrogate Hospitals NHS Foundation Trust. The surgical department provides a range of surgical services for the population of Harrogate and the surrounding areas

The hospital provides elective and non-elective treatments for ear, nose and throat surgery, general surgery, breast surgery, trauma and orthopaedics and urology. The surgical wards had 113 inpatient beds, day case beds and access to 10 private patient beds.

Between July 2014 and June 2015, the surgical department carried out 22,121 surgical spells. Sixty-six percent of procedures were carried out as a day case with 20% emergency admissions and 14% elective admissions. General surgery had the biggest percentage of admissions at 46%, Trauma and orthopaedics 28% and Urology 12%.

We ask the same five questions of all the services we inspect: are they safe, effective, caring, responsive to people's needs and well led?

During our inspection, we spoke with 65 members of staff including ward clerks, nurses, doctors, domestics and Allied health professionals, 37 patients and five relatives. We visited all surgical wards, theatres, and day theatre unit. We reviewed 25 sets of records. We observed care and treatment and reviewed a range of performance information about the surgical department.

## Summary of findings

We rated surgical services at Harrogate hospital as good overall because:

Staff protected patients from avoidable harm and abuse, openness and transparency was encouraged. There was a holistic approach to assessing, planning and delivering care and treatment to patients who use the services. All wards used an early warning scoring system for the management of deteriorating patients.

The safe use of innovative approaches to care was encouraged; teams were encouraged to work collaboratively. Staff were able to meet the needs of patients' through the way services were organised and delivered. For example, the directorate working with geographical partners and clinical alliances to improve access to services.

Patient's access to pain relief and nutrition was good and performance outcomes post-surgery were mainly better than the England average.

Patients were respected and valued as individuals, feedback from patients was positive. We observed positive interactions between staff and patients during the inspection. Staff were proud of the level of care they delivered and wanted to improve the lives of the patients they cared for.

Senior managers had a clear statement of vision for the service. The directorate and wards had quality priorities

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identified. The majority of staff we spoke with were positive about the management team and clinical leaders. Staff on the wards worked well together with respect for other specialities.

At times staffing levels did fall below established levels, but the trust were actively recruiting to posts and taking action to improve staffing levels through improvements in the skill mix of staff.

However, we had concerns over the effectiveness of the five steps for safer surgery. During the inspection, we observed nine procedures where the world health organisation WHO safety checklist was used, we noted compliance with six checklist requirements and non-compliance with three. One of the non-compliance practices we witnessed was stating the instrument count was complete, prior to it actually been undertaken.

Access for staff to appraisals required improvement as only 52.3% of staff had received an appraisal.

## Are surgery services safe?

Requires improvement



We rated surgical services at Harrogate hospital as requires improvement for safe because:

- We had concerns over the effectiveness of the five steps for safer surgery; during the inspection, we observed nine procedures where the world health organisation WHO safety checklist was used we noted compliance with six checklist requirements and non-compliance with three. One of the non-compliance practices we witnessed was stating the instrument count was complete, prior to it actually been undertaken.

However;

- At times staffing levels did fall below established levels, but the trust were actively recruiting to posts and taking action to improve staffing levels through improvements in the skill mix of staff.
- Staff knew the process for reporting and investigating incidents using the trust reporting system. The majority of staff we spoke with said they received feedback from incidents reported; lessons learned from incidents were communicated with staff on a consistent basis.
- All wards used an early warning scoring system for the management of deteriorating patients.

## Incidents

- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. No never events had been declared within the surgical department. A previous never event had occurred prior to the reporting period and changes in practice had occurred for example; staff were now documenting the size of prosthesis used on a whiteboard during the operation.
- Serious incidents are incidents that require further investigation and reporting. Fifteen serious incidents (SI) were reported in the surgical department during the reporting period, January 2015 to November 2015. Themes included pressure ulcer development and slips, trips and falls resulting in fractures. We reviewed

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two serious incident reports and noted a detailed investigation with recommendations and learning identified. Action plans were available for the incidents; however, some of the actions were overdue.

- The department reported and investigated incidents using a national computer system. We reviewed incident data supplied to us by the trust which showed surgical wards reported 266 incidents January 2015 to January 2016. Reported incidents showed the top three categories of incidents reported was themes of falls both day and night (90 reports). Category 2 or 3 pressure ulcer acquisition (37 reports) and 31 reports of inadequate staff for workload. Incidents reported in day and main theatres were patient identifier not on each sheet 44 reports and others including equipment being unsuitable for procedure, lack of availability and faults and breakages.
- Moderate harm and above incidents were shared at a trust wide meeting attendance included the Medical director, Chief Nurse, and Chief operating officer.
- Senior nursing and medical staff reviewed the incidents reported daily and analysed the data to identify trends, monitor actions and learning.
- Nursing and medical staff we spoke with were all aware of the reporting system and staff could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. Staff we spoke to were all aware of the top three incidents. The majority of staff we spoke with said the received feedback following completion of incident forms.
- Staff we spoke with told us that learning from incidents was shared throughout the department through team meetings, safety briefings and attendance and minutes of directorate meetings. We reviewed documentation from Farndale ward meeting (January 2016) and noted that shared learning from a recent RCA was discussed; these minutes were displayed in the clinical areas. Staff meeting minutes from theatre (February 2016) did not document any shared learning or themes from RCA. Examples of shared learning throughout the department were the introduction of movement indicator mats to help prevent falls and positioning equipment to prevent pressure damage.

## Duty of Candour

- The majority of staff we spoke with were all aware of duty of candour requirements and described it as being “open and honest” when incidents occurred. Staff

provided us with examples of when they used duty of candour, for example delays in the operating theatre and patient cancellations. Records of duty of candour discussions were stored on the central incident reporting system.

- We reviewed two serious incident investigation reports and duty of candour discussions, we saw documentation of the discussion, as part of the investigation, however, on one of the two reports we reviewed there had been a five-month delay in informing the patient of the incident. Following the inspection, we were told by the trust that a clinical decision was taken to delay informing the patient until the specialist centre had completed the definitive treatment required and the patient had subsequently recovered from a complication of surgery. For the other incident the patient had been informed as soon as the incident was recognised.
- From RCA reports we reviewed we saw that family liaison officers were appointed for the patient involved in serious incidents to improve communication.

## Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and ‘harm free care’. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), and catheter associated urinary tract infections (CAUTIs).
- In the reporting period, September 2014 to September 2015 there had been an increase in pressure ulcer grade two, three or four development on average two were recorded every month per 100 patients surveyed 11 in total in the year. As a result of the increase the department had begun a trial of new positioning equipment to prevent pressure ulcer damage. In the same reporting period, the surgical department reported three falls with harm and no catheter related urinary tract infections were CAUTI reported.
- Venous thrombolysis (blood clots) assessments were carried out within the trust and year to date (end of quarter three) we reviewed showed 98.1% of patients received the appropriate assessment of risks.

## Cleanliness, infection control and hygiene

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- Infection prevention and control information was visible in all wards and patients' area, this included information on number of days since last clostridium difficile (C.difficile) infection and Methicillin resistant staphylococcus aureus (MRSA).
- Wards and departments we visited were visually clean and we observed staff washing their hands, using hand gel between patients and staff complying with 'bare below the elbow' policies.
- Hand hygiene audit data we reviewed showed 100% compliance April to September 2015. During the inspection, we saw hand hygiene compliance data displayed on ward corridors. We noted good availability of alcohol gel and soap dispensers we reviewed were all in working order.
- The trust had a policy for Methicillin resistant staphylococcus aureus (MRSA) screening and all emergency and elective patients undergoing surgery and procedures fitting the national criteria were tested for MRSA. We reviewed compliance rates with screening and noted 86.2% compliance to 91% compliance May to July 2015.
- The trust had reported zero cases of hospital acquired Methicillin resistant staphylococcus aureus (MRSA) and 20 reported cases of hospital acquired clostridium difficile (codify). In the reporting period April to December 2015, this was eight cases above the agreed threshold.
- Wensleydale ward (elective orthopaedic ward) was not ring-fenced for elective only patients as per best practice recommendations. The ward had systems in place to isolate people awaiting elective surgery pre-operatively from people requiring emergency surgery, however staff were not able to be segregated.
- During the inspection, we observed compliance with IPC policies for example rooms were available for the isolation of infectious patients and patients requiring isolation, were isolated. Staff were required to complete an incident form for patients requiring isolation, but unable to be isolated within two hours, we saw evidence of the failure to isolate incidents reported.
- Matron monthly standards assurance framework reviewed infection prevention and control compliance including trust dress code, MRSA screening and commode cleanliness, results we reviewed from these audits showed good levels of compliance.
- Environmental cleaning schedules were available and displayed in public areas. We reviewed patient led

assessment of the care environment (PLACE) results and noted 99.1% vs. a national average of 97.6%. During the inspection, the department was visually clean. Domestic staff we spoke with said they felt part of the clinical team and were aware of the audit scores for their area.

- Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use. Commodes we reviewed were visually clean and labelled correctly.
- The infection prevention and control (IPC) team delivered training both face to face and via e learning. IPC training compliance rates for the surgical department were 90% with a trust target of 75-95%.
- Wards and departments had link nurses for infection prevention and control, these staff carried out IPC audits and they had received extra training in Infection Prevention and Control.
- Within the theatre environment decontamination of laryngoscope handles occurred by wiping with a detergent wipe, we did not observe and staff did not tell us that disinfection or sterilisation of any handles occurred. The Association of Anaesthetists of Great Britain and Ireland 2008, recommends, "Laryngoscope handles can become contaminated with blood and micro-organisms and they should be washed/ disinfected and if suitable sterilised after every use, they also state that handles of knurled laryngoscopes cannot be reliably cleaned manually if covered in blood or body fluids". The Medical and healthcare products Regulatory Agency released an alert in 2011 outlining that failure to decontaminate a laryngoscope handle between patients had led to a patient's death.

## Environment and equipment

- The ward corridors appeared cluttered with equipment, on Nidderdale ward, chairs and a computer table were stored in front of a fire exit. The inspection team reported this to the trust during the inspection, and the trust took immediate action. We saw corridors within the pre-operative assessment area used as storage areas for trollies and equipment. No preparation rooms were available within the theatre environment; and we observed electrical items, sterile sets and single use equipment stored in theatre corridors.
- In most areas visited resuscitation equipment was, recorded as checked and equipment stored was within expiry date. The Matron Monthly standards assurance

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framework checked the condition and cleanliness of resuscitation equipment, these audits recorded evidence of compliance with the standards November 2015 to January 2016.

- We reviewed safety checks of four anaesthetic machines, one showed recording of checks undertaken on a daily basis, and three showed absences in daily checking records, when we discussed the absence in checks with staff, staff we spoke with acknowledged the need for daily checks. The Association of Anaesthetists of Great Britain and Ireland (2012) recommend a pre-use check of the anaesthetic equipment. We informed the theatre management team of these concerns at the time of inspection.
- There were adequate stocks of equipment and we saw evidence of stock rotation.
- Minutes of trust meetings we reviewed highlighted concerns over a lack of repair to theatres, during the inspection orthopaedic staff highlighted concerns over air flow in theatre three, during the inspection work was being carried out on the air handling system, we reviewed pre and post work air testing certification and noted compliance.
- Staff we spoke with highlighted concerns about equipment repairs/ replacement; they told us that equipment sent for repair or new equipment authorised for purchase had been subject to delays.

## Medicines

- On surgical wards, medicines were stored, prescribed and administered appropriately. Controlled drugs were stored, accurate records were maintained and staff performed daily balance checks regularly in line with the trust policy on the five wards we visited. Access to medicines was restricted to authorised staff.
- Within theatres, drug cupboards were unlocked whilst the unit was open. Emergency drugs were stored on an unlocked trolley within the day surgery unit; however, this area was restricted to authorised staff. Staff within theatres maintained accurate records.
- We observed patients being administered their medicines in a timely way, as prescribed, including pain relief.
- Emergency medicines were readily available, and staff completed regular checks as per trust policy. The wards had dedicated Hypo-boxes, which contained medicines used to treat low blood sugar. We observed these had

been checked regularly according to policy but found one medicine, which did not state the date removed from the fridge and therefore it could not be guaranteed as safe for administration.

- Staff recorded administered of medicines using the Electronic Prescribing and Medicines Administration (EPMA) system. The nursing and pharmacy staff used EPMA to complete medicines rounds and medicines reconciliation effectively.
- Medicines fridges were secure; however, staff on two wards we visited did not always record fridge temperatures according to the trust policy, recording of maximum and minimum temperatures did not always occur consistently. Staff rectified this during our visit. Staff in theatres accurately recorded fridge temperatures.
- The pharmacy provided a medicines reconciliation service across the surgery wards. Pharmacists worked within the pre-assessment service for elective surgical patients. We saw that this service meant that patients were prescribed their medicines in a timely manner and the information was accurately documented at the point of admission. We observed that on the day reviewed 100% of patients had completed medicines reconciliation documented within 24 hours of admission.
- The Matron Monthly standards assurance framework reviewed medicines management including controlled drugs management and storage of medicines we noted a good level of compliance with these standards.

## Records

- Paper records were available for each patient that attended the department; the trust had recently implemented a national computer programme for some patient records; however, paper based medical and nursing records were still in use.
- We reviewed 25 sets of medical and nursing care records whilst on site and on the majority of occasions, these were accurately completed. Staff used black ink, legible handwriting and documentation occurred at the time of the review, or administration of medication as per compliance with trust policy and professional standards.
- Patient's records were stored in trolleys near the nurse station; on all areas visited, these were unlocked.
- The department used risk assessments for falls, pressure damage prevention and records we reviewed

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showed that on the majority of occasions these were accurately completed. Completion of venous thromboembolism (VTE) assessment was noted to be 98% for quarter three 2015 trust compliance rates were equal or above 96%.

## Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by yearly safeguarding refresher training. We reviewed safeguarding training compliance rates for the elective care directorate were 90% with a trust target of 75-95%. Level two safeguarding compliance was 88% and level three safeguarding compliance was 48%.
- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Staff we spoke with were able to describe their roles in relation to the need to report and take action as required when they identified safeguarding issues.

## Mandatory training

- There was a trust mandatory training policy in place, which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act, deprivation of liberty safeguards (DoLS) and others.
- For each training element staff groups were identified and the frequency of each training element. Employees had a “personal training account” which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.
- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the Trust identifying that they would have been on track to meet trajectory. Figures below 75% were red or amber dependent on the percentage. Training compliance, data we reviewed for substantive staff, working on the surgical wards and theatres showed 86% compliance for mandatory and essential skills training.

- During the inspection, we reviewed mandatory training records displayed on surgical wards. Data for January 2016 showed that on Wensleydale ward out of 31 staff training records reviewed, 19 staff members had training that was overdue. The average number of overdue training modules per staff member was 3.7 modules. Numbers of overdue training ranged from 11 types of training for one member of staff to one type of training for five staff.
- New staff received a corporate and a departmental induction, which included some aspects of their mandatory training.
- Staff we spoke with told us that the trust had recently linked attendance at mandatory training with incremental increases on the nursing staff pay scale; senior nursing staff we spoke with told us that this link had improved attendance at mandatory training.

## Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) tool; the surgical areas used a computerised programme for recording and monitoring the NEWS scores. This allowed the staff on the ward to electronically record patient observations, with trigger levels to generate automatic alerts, to the medical staff of acutely ill patients. This scoring system supported the process for early recognition of patients who were becoming unwell. Some medical staff spoke with us about problems with the systems for example; bleeping medical staff when acuity changes from zero to one, and bleeping for patient changes when at the end of life. We discussed this with senior nurses and other medical staff who explained that medical staff were able to change the patient parameters and if doctors had not changed the patient's parameters, it would bleep inappropriately. The NEWS Escalation pathway included actions required if responders did not respond in a required timescale.
- The hospital undertakes the five steps to safer surgery procedures and audit including the World Health Organisation (WHO) safety checklist, the hospital demonstrated compliance with the safety checklist via an audit of surgical patients medical notes. Two audits had been carried out in 2015 reviewing the use of WHO checklists, Poor compliance was noted in August 2015 all elements complete (8%), individual compliance sign in (47%), time out (85%) and sign out (47%). Reminders about the need to improve compliance was sent to staff

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in 2015, and a re-audit in December 2015 showed improved compliance to 64% individual compliance was sign in (86%), time out (95%) and sign out (71%). During the inspection we observed nine WHO checklists being completed, we noted compliance with six WHO checklists and non-compliance with three. One of the non-compliance practices identified was the instrument count which was communicated as complete, however this was still taking place. During the inspection, several staff including the senior management team told us there was ongoing work to improve the use of the WHO checklists. The Deputy Medical Director had responsibility for improving the use of the WHO checklists via implementation of the National Safety Standards for Invasive procedures (NATSSIPs) 2015 safety standards. Post the inspection, the trust told us that a proposal for improvement and implementation was due at the elective board February 2016.

- During the inspection the theatre suite used a paper checklist to record swab used during surgery, this record was stored in the patient notes. It is acknowledged by the inspection team that although no law exists dictating what system or method is used within the perioperative environment for recording swab counts, the Association for Perioperative Practice (AFPP) 2012; recommend provision of a dry wipe count board, which is permanently fixed to the theatre wall. We reviewed the trust operating theatre swab, instrument and needle count procedure and noted that this recommended recording on a paper checklist, however did also recommend writing on a white board any swab placed inside a cavity. This document had no date of approval or made reference to AFPP guidance.
- Access to advice and treatment post discharge was available via a ward attender's clinic run on one of the surgical wards; patients could access this service via referral from clinical practitioners.
- During the inspection on Farndale ward, we observed staff moving patients who they had identified as requiring increased observation to beds nearer the nurse station to allow increased observation.

## Nursing staffing

- The trust used the safer nursing care tool to assess nursing staff required per department, per shift. The last acuity undertaken at the trust was in August 2015 and included a review of the inpatient surgical wards. This study assessed patients care needs over 24 hour period.

- We saw displayed on each ward, the planned and actual staffing levels. When the actual staffing levels dropped below the planned level, the trust had recently introduces a new escalation/flow chart for staffing shortages which required highlighting to senior nursing staff. The matron assessed the individual situation against the situation in the trust, and made a decision about deployment of additional resources. A further development was the introduction of an on-call weekend Matron role with responsibility for staff support and allocation.
- Prior to the inspection, December 2015 surgical wards apart from day shifts on Farndale and Wensleydale wards had achieved greater than 97% average fill rate for registered nursing staff. Due to registered nurse vacancies Wensleydale ward staffing levels were being assessed on a shift-by-shift basis to ensure the planned staffing levels matched to the needs of the patients.
- We reviewed duty rosters for the previous three months and on Wensleydale ward, out of 63 registered nurse shifts reviewed, registered nurse staffing levels fell below the established level required on 13 occasions; the ward had allocated an extra support worker to assist with patient cares on 12 of the 13 occasions. We were concerned that during an overnight period registered nurse to patient ratios were higher than the trust required (one RN to 14 patients). Senior nursing staff we spoke with acknowledged that the ward required additional registered nurses on nights; this issue was highlighted within the risk register as being insufficient when trauma patients were admitted to this area or returned from theatre. The last documented date of review in August 2015, during the inspection staffing levels remained at two registered nurses planned overnight. The matron we spoke with was developing a business case for additional night registered nurses however did not have a timescale for implementation of three registered nurses.
- Staffing rostered we reviewed on Farndale ward showed that out of 63 shifts reviewed, actual staffing levels fell below established levels on two occasions. Three qualified nurses working on Farndale ward we spoke with said that due to the staffing levels they were working above their allocated hours and "they couldn't remember the last time they went home on time."
- At the time of the inspection, surgical wards and departments had 148.9 WTE established registered nursing post and 90.8 unqualified nurses. We reviewed

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vacancy rates and this showed 10.79 registered nurse WTE vacancies on surgical wards and 4 vacancies in theatres. Levels of vacancies per area ranged from less than one to four WTE vacancies.

- The nurse in charge of the wards we visited were all counted in the registered nurse on duty numbers, senior nurses we spoke with commented that this can increase the pressure on other registered nurses, as they have to oversee the group of patients the nurse in charge had been allocated to.
- Patients requiring extra levels of supervision were allocated 1:1 supervision, records we reviewed on Farndale ward showed that, in one week in January 2016 the ward had been short of 1:1 supervision on 10 occasions. Agency staff often supplied this supervision. A recent development was the plan to employ 1:1 supervisory staff on Farndale ward. Farndale ward would then support other areas requiring 1:1 supervision. Benefits of this system was increased competence for staff providing support to patients and increased support for staff working in this role.
- The department used bank and agency staff to improve staffing levels we reviewed staffing levels for bank and agency staff and noted a 3.6% bank/agency usage. A local induction checklist was available on the wards to provide induction to new agency members of staff.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and we saw that this delivered away from the patients to ensure confidentiality. Discussion included the patient's clinical condition, safety risks for patients such as infection prevention and control, falls, pressure area requirements and timings of patient observations. and care needs. Discussion held was professional and appropriate and the inspection team noted positive interactions amongst the nursing team. Nutritional support staff were able to access handover information to update about new nutritional information.

## Surgical staffing

- We examined the medical staffing rota and talked with consultants, middle grade and junior doctors. Medical cover was available on-site 24 hours a day. Consultants were available 24hrs, with on-call cover provided evenings and at weekends.
- We found that the medical skill mix was similar to the England average at Consultant level at 39% (England

average 41%). Middle career level was higher than England average at 29% (England average 11%). Registrar level was lower than England average at 20% (England average 37%). Junior doctor at were the same at 12% (England average 12%).

- Medical staff we spoke with us about the level of support of senior medical staff as being good both on the telephone and in person. They told us about busy on-call periods overnight and weekends.
- Out of hours, there was a three-tier surgical cover available. Junior doctors were available on site on a 24-hour basis. Middle grade doctor cover was available on site until 20.00pm and on-call access available over night. Consultants were available on a 24-hour basis. Staff we spoke with talked amount with immediate and reliable access to support by middle grade doctors or above consultants.
- Ward rounds were conducted daily and recent general surgery recruitment had enabled the development of a "consultant of the day"; this would ensure that all patients saw a consultant on the day of dmission.
- Junior doctors had dedicated morning and evening handover times with comprehensive written handover sheets. We witnessed a surgical handover and noted effective discussion about the clinical care of surgical patients and agreement for patient management plans. Junior medical staff we spoke with, talked about the on-call over night and weekend periods as being busy, with a heavy workload, however they did feel that they were supported and that senior medical staff were available as required.

## Major incident awareness and training

- The trust had a major incident plan and business continuity plans. This was available to staff on the trust intranet.
- Staff we spoke to had an awareness and understanding of their roles in major incidents. Should a major incident be declared a dedicated area was available with in surgery to use as a decant area for emergency admissions.
- Staff had received training and practical sessions on how to care for someone who may have symptoms of Ebola.
- The senior management team told us that no recent practical or table top exercises had been undertaken involving surgical services.

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## Are surgery services effective?

Good



We rated surgical services at Harrogate hospital as good for effective because:

- There was a holistic approach to assessing, planning and delivering care and treatment to patients who use the services.
- The safe use of innovative approaches to care was encouraged; teams were encouraged to work collaboratively.
- Patient's access to pain relief and nutrition was good and performance outcomes post-surgery were mainly better than the England average.

However;

- During the inspection, we were concerned that only 52.3% of staff had received an appraisal.

### Evidence-based care and treatment

- We found that patient treatment was based on national guidance from the National Institute for health and care Excellence (NICE), the Association of Anaesthetics, and the Royal College of Surgeons. For example patient consent, venous thromboembolism assessment and enhanced recovery pathways. We saw evidence of discussion in accordance with National Confidential Enquiry into Patient Outcome and death (NCEPOD) guidelines.
- Policies were stored on the trust intranet and wards and departments were discouraged from storing hard copies of policies to ensure the most up to version of the policy was in use.
- A range of standardised, documented pathways and agreed care plans were in place across surgery. Examples of these include enhanced recovery for orthopaedic patients, fractured neck of femur and hip and knee replacement pathways.
- The outcome of the Bowel Cancer Audit in 2014 showed the trust to be better than the England average for three indicators.
- Performance in the Lung cancer audit showed that the trust performed better than the England average for two indicators.

- We reviewed data for the management of fractured neck of femur this showed that in 2015, 90.4% of patients with attendance to the emergency department with a fractured neck of femur were admitted to orthopaedic care within 4 hours this was much better than England average performance of 46.1%.
- Surgical services had an audit programme and a range of local audits being carried out for example, anaesthetic emergencies, antibiotic usage and management of sepsis audits.
- The orthopaedic department invited patients to attend joint schools pre-operatively to provide information about the operation and improve patient outcomes.

### Pain relief

- We observed patients being offered pain relief. Patients we spoke with said they had regularly been offered pain relief, and following administration staff had checked that their pain relief had been effective.
- Staff used a pain score tool to assess patient's pain levels; staff recorded the assessment on the patient records computer system. Staff we spoke with were knowledgeable about pain scoring for patients living with dementia and were able to give examples of when it was used.
- We found that the department used local infiltration and spinal anaesthetics for major surgery to assist with pain relief post-operatively, which improved patient comfort. Staff we spoke with in the recovery department spoke with us about a pain management audit undertaken by the specialist pain team the results had led to a change in the type of pain relief offered to patients postoperatively.
- The introduction of the electronic patient observation system provided improved pain assessments, as this question was a mandatory field on the observation assessment.
- The wards and departments used a bespoke Harrogate friends and family feedback questionnaire, questions included questions about pain control, pain relief offered, timescale for administration and effectiveness of pain relief.

### Nutrition and hydration

- We saw patients offered drinks, food and snacks. The trust employed nutritional assistants these staff assisted patients with choosing meals, feeding and identifying

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patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. The trust offered an extensive patient snack menu; savoury, sweet, high calorie and soft diet options were available.

- Nutritional support staff we spoke with were very knowledgeable about the effects of malnutrition on patients outcomes for example, lack of wound healing, low energy and mood swings. Support staff prepared toast to order on the patient's breakfast round so it was fresh for patients. They were also knowledgeable about the stages of thickening agents required for patients requiring thickened fluids or a special diet.
- Staff recorded nutritional needs and assessment in patient notes and the support staff had a nutritional board detailing the nutritional needs of the patient. Dieticians and nutritional staff had also developed pictorial charts for menu choices, thickening agent and special diets to aid people with reading difficulties or whose first language was not English.
- Patients had access to fresh water where appropriate and fluid balance charts we reviewed were accurately completed. Fluid balance charts had recently changed from paper based recording to electronic and staff had received training in how to complete the charts.
- Nutritional staff identified any patients at risk of malnutrition through collaboration and discussion with nursing staff, patients and families.
- The department used MUST nutritional risks assessments documentation we reviewed showed accurate completion, nutritional assessments the matron monthly assurance framework audited compliance with the assessment.
- Patients we reviewed were fasted pre-operatively for the minimum time possible; patients were able to have sips of water until two hours before the operation.

## Patient outcomes

- The trust standardised relative risk readmission rates for elective and non-elective surgery were better than the England average for all types of surgery.
- The National Bowel Cancer Audit (2014) showed better than England average results for three indicators, including cases discussed at MDT meeting, seen by clinical nurse specialist and CT scan reporting. Laparoscopic surgery was attempted on 77.9% of occasions higher than the England average of 54.8%.
- The Lung Cancer Audit (2014) results showed the percentage of patients receiving surgery (12.0%) was

lower than the England average of 15.1%. However, the trust discussed a higher number of patients in the MDT (98.0%) than England average (95.6%) and a higher number of patients were receiving CT before bronchoscopy in the trust (95.1%) England average (91.2%).

- The trust participated in the National Hip Fracture Audit. Findings from the 2015 report showed that the trust was performing better than the England average for six out of the eight indicators. Performance against falls assessment was the same as the England average 96.1%. Performance was worse than England average on pre-operative assessment by geriatrician 69.2% trust average, 85.3% England average; however, this had improved from 44.4% in 2014. Following recent RCA, the trauma and orthopaedics wards had trialled movement indicator pads to prevent falls and new pressure relieving devices to prevent pressure sore acquisition. The senior management team confirmed approval of the business case for the purchase of the movement indicator pads.
- We found that the National Emergency Laparotomy Organisational Audit 2014 showed that seven of the 28 measures were not available including an emergency surgical unit. For the 2015 patient audit, the trust scored green in four out of 11 outcome measures; five scored amber and two scored red including consultant surgeon review within 12 hours of emergency admission and assessment by a specialist in medicine for care of older person. We reviewed the trust action plan on the audit; and although risks and timescales were identified, it was unclear what actual action had been taken on the two outcome measures scoring red. Post the inspection the trust confirmed that two business cases had been approved to recruit two new consultants to allow compliance with the outcome measures.
- Patient reported outcome measures (PROMs) showed that the trust performed similar to the England average for all measures.
- The department monitored their performance against a range of clinical indicators via an integrated performance dashboard. This data included referral to treatment times and cancer treatment targets. Performance data was discussed within elective care board meetings.
- We reviewed the trust trauma unit peer review report this highlighted three areas of concern including no trauma management guidelines, no funding agreed for

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the TARN coordinator role and no multi-disciplinary forum in place to review morbidity or mortality. An action plan was available and on review, one of the actions was closed, as it had not been clear at the time of inspection the role the trauma co-ordinator carried out.

- Staff carried out inspections of patient's skin and assessments of the risks to patients developing pressure ulcers was documented in patients notes. Patients comfort rounds (contact rounds) were conducted every two hours, the frequency of these assessments would vary in response to the needs of the patient for example if the patient were at risk of falls or requiring additional observations these would increase to every 30 or 60 minutes.

## Competent staff

- We found that 53.2% (January 2016) of staff (excluding administrative and clerical staff) within the surgical department had an up to date appraisal. Appraisal records we reviewed could not be broken down further to individual ward level. On Littondale ward, data we reviewed showed that out of approximately 40 nursing staff appraisals required to be undertaken, 21 were due at the time of inspection. On Harlow ward, 100% of staff had received an appraisal. Medical staff we spoke with all told us that they had received an appraisal.
- New staff working in orthopaedics had a supernumerary period within the first weeks in post, during this time staff spent time with the physiotherapists, theatres, pre-assessment and joint school to improve clinical knowledge and competence.
- An induction pack with competency-based training was available on the orthopaedic wards; competency records were available and signed by an appropriate person for example patient movement competencies were assessed and signed by the physiotherapist. On all surgical wards staff using infusion devices had to pass specific competencies prior to using, ward managers held a list of staff authorised and used this list when planning duty rosters.
- Nutritional support staff had undertaken in-house training with the dieticians; they had spent time shadowing the dieticians and have monthly training meetings.
- All new clinical support staff recently employed had received training, the care certificate programme was used this programme takes 12 weeks to complete and

has written and clinical competencies. Senior nurses or qualified therapist, signed competences as required. Sessions included on the programme were Infection prevention and control, palliative care, safeguarding, mental capacity act and deprivation of liberty assessments.

- Clinical support workers we spoke with had been undertaking patient observations until the introduction of the electronic system, they had not received the training to allow them to complete electronic observations so at the time of the inspection were not undertaking patient observations.
- Newly qualified and junior nurses were able to go on a rotation and work in the intensive therapy unit for a period, to increase knowledge and confidence in caring for critical ill and deteriorating patients.

## Multidisciplinary working

- There were established multi-disciplinary team (MDT) meetings for all cancer pathways. These MDTs included nurse specialists, surgeons, anaesthetists and radiologists.
- The trauma and orthopaedic department worked collaboratively with a range of disciplines to maximise patient outcomes. An Oroth-geriatrician provided ward cover on the trauma and orthopaedic wards.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients if needed.
- Farndale ward employed a discharge co-ordinator to facilitate discharges; staff spoke with us positively about this role and the difference it made to patients and relatives.

## Seven-day services

- On-site medical cover was available 24 hours a day; junior doctors provided this. Senior medical cover from middle grade doctors and Consultant cover was available on-site for approximately 12 hours a day and on-call cover was available on a weekend and evening, in line with professional standards.
- Daily ward rounds with medical staff took place for all patients. Patients were seen on admission at weekends by medical staff and then reviewed by senior medical staff in line with professional standards.
- The department had access to, diagnostics and radiology services 24 hours, seven days a week, to

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support clinical decision-making. Access to occupational therapy was available Monday to Friday and physiotherapy services were available six days a week with on-call access available on a Sunday.

- Pharmacy staff were available on site between the hours of 08.30am to 5.30pm, Monday to Friday. There was a limited ward-based clinical pharmacy service at weekends between the hours of 09.00am and 2.00pm. Outside of these hours, an on-call service was provided. Orthopaedic consultants had access to dedicated trauma lists five days a week and then shared the emergency list with other surgical specialities on a weekend. We witnessed clinical discussions to prioritise patients requiring emergency surgery.

## Access to information

- The computerised programme recorded patient observations, acuity and patient alerts. These alerts informed the staff about issues of concern. All substantive members of staff had access to computerised records; bank members of staff did not have access.
- Senior nursing staff told us that due to the training required to implement the computerised programme, they had noticed increased pressure placed on registered nurses, as they were the first to receive training.
- Staff used electronic handover reports, reports we looked at were detailed and contained relative information about the patient, for example an electronic butterfly indicating a patient living with dementia.
- Electronic discharge summaries we reviewed were of good standard, contained relative information; staff completed these summaries in a timely manner and contained actions for the GP. Three copies were made of the discharge letter one for the GP, one for patient records and one for the patient. The pressure area status of the patient on discharge was also included. There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- We saw screensavers on computers that shared information and key messages for staff, on infection prevention and control, resuscitation and case note tracking.

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

- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Nursing and medical staff obtained consent via both verbal and non-verbal routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives. We observed clinical staff obtaining consent from patients, before undertaking clinical procedures.
- Where patients lacked capacity to make their own decisions, staff we spoke with told us they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Where this was not possible, staff had to make best interest decisions to enable lifesaving treatment to proceed. Documentation of these decisions was available within the care records.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records for the department showed 89% of staff within the elective care directorate had undertaken mental capacity training against a trust target of 75-95%. Deprivation of Liberty Safeguards training had been completed by 92% of staff working within the elective care directorate. The trust was unable to provide data for specific ward areas or staff groups.
- A trust wide audit of consent had been carried out in June 2015 this indicated that all patients audited including patients within surgical department who responded to the audit “felt fully informed about the consent process and were satisfied with the consent process overall”. Recommendations contained in the report were to assess the quality of the record of consent for patients who lacked capacity, investigation of training programmes to allow specialist nurses and junior medical staff to obtain consent and review of consent leaflets used within the trust.

## Are surgery services caring?

Outstanding



We rated surgical services at Harrogate hospital as outstanding for caring because:

- Staff respected patient's wishes and they valued and treated patients as individuals.

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- Feedback from all patients we spoke with was consistently positive, and patients told us that the care they received exceed their expectations.
- We observed positive interactions between staff and patients during the inspection.
- Staff were highly motivated and inspired to deliver high quality care, and promote patients dignity. They were proud of the level of care they delivered and wanted to improve the lives of the patients they cared for.
- Patient's emotional and social needs were embedded in their care and treatment, and patients were seen as active partners in their care.

## Compassionate care

- We spoke to 37 patients and five relatives, in every surgical ward and department. During the inspection, we observed genuine positive interactions between patients and staff. Feedback we received from patients was consistently good and patients told us that the care they received exceed their expectations.
- Patient- led assessments of the care environment (PLACE) scoring for the trust showed that the trust scored lower than England average on privacy dignity and well-being (79%) England average 86%, and Dementia care (60%) England average 74.5%.
- The NHS Friends and Family test (FFT) is a satisfaction survey that measures' satisfaction with the healthcare the patient has received. It is noted that the response rate was 40.5% better than the England average at 35.5%. There was also a better than England average response rate on Wenselydale (52%) and Farndale (44%) wards. A high proportion of patients (94.8%) would recommend the service. Patients friends and family feedback we reviewed for Littondale ward showed that patients had said "the care was top notch", "would advise anyone to come to Littondale ward" and that "staff should be applauded"
- Patients on the wards we visited appeared happy and calm; all patients we spoke with were positive and complimentary about the staff. They described the staff as "lovely", "caring", wonderful and excellent". Whilst on the wards call bells were only ringing for short periods.
- Staff treated patients with privacy and dignity. We observed staff closing curtains/doors whilst delivering personal care. Within the theatre environment and pre-assessment, staff separated male and female patients during pre-operative period and we observed staff covering patients with blankets to maintain privacy

and dignity. The Matron monthly standards assurance framework reviewed patient's privacy and dignity and we noted compliance with the audits. November 2015 to January 2016.

- We observed highly motivated staff, inspired to deliver high quality care, and promote patients dignity. Staff described the level of care they delivered as "outstanding" and said they were "proud" of the level of care they delivered. They said they took time to care and listened and talked to patients. Staff valued patients as partners in their care.
- Care we observed being delivered was very patient centred and individualised, staff looked genuinely happy whilst caring for patients, interactions we heard with patients or discussions about patients between staff were positive and respectful.
- The majority of staff we spoke with talked about wanting to make life better for patients. Staff gave us examples of patient centred care such as allowing a surgical patient who had been in hospital a long time dog visit them, using adult colouring books, knitting and playing cards with patients especially for patients having 1:1 supervision to provide distractions. They also gave examples of buying patients magazines when they did not have any visitors.
- Staff showed empathy when administering medicines and spent time with patients explaining what the medicines were and why they were required.
- We reviewed comments received by the trust from patients on one occasion a patient attended clinic on the wrong day for pre-assessment, rather than send the patient home, the pre assessment clinic ensured the assessment occurred. Other comments were about the professionalism of staff and the reassurance staff provided during surgery.
- We witnessed password in use to ensure patients confidentiality when they were speaking to a patient's family member lived away from the hospital. We witnessed a senior nurse breaking bad news over the telephone this news was broken in a compassionate, knowledgeable and empathetic manner. Time was given by the member of staff for questions that the relative had.

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

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- All patients we spoke with said they were fully involved in their care decisions. This included discussion of the risks and benefits of treatment. They said they knew who to approach if they had issues regarding their care, and they felt able to ask questions.
- Patients we spoke with told us they had opportunities to speak with the consultant in charge of their care. Patients also said that staff kept them informed, explained why tests and scans were required and did their best to keep patients reassured.
- Patients we spoke with were all aware of their discharge arrangements and actions required prior to discharge occurring.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.

## Emotional support

- A multi-faith chaplaincy service was available within the trust and during the inspection, we saw three different chaplains visiting surgical ward areas.
- Clinical nurse specialists were available within surgery and provided support to patients following breaking bad news, continuing treatment and care.
- Patients that have had a prolonged length of stay following either elective or emergency surgery are invited to a post-discharge critical care outpatient clinic appointment.
- Clinical nurse specialists were available to provide advice and support to patients following their cancer diagnosis.
- Clinical nurse specialists were able to refer to a oncology Psychologist.

## Are surgery services responsive?

Good



We rated surgical services at Harrogate hospital as good for responsive because:

- Patients' needs were met through the way services were organised and delivered for example the directorate working with geographical partners and clinical alliances to improve access to services.
- Waiting times, delays and cancellations were minimal and managed appropriately.

- Staff used the lessons learned from patient complaints to improve clinical practice.

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

- The directorate had recently begun working with neighbouring NHS trusts to provide satellite surgical services for patients away from the Harrogate hospital site, for example pre-assessment clinics and endoscopy lists.
- Clinical partnerships and alliances had been developed allowing Harrogate to provide services at Harrogate hospital, for example ear, nose and throat and urology alliances.
- The surgical department worked in partnership with local providers to deliver the bowel cancer screening, one noticeable improvement was the introduction of a remote endoscopy service to improve the timeliness and access to treatment for patients in the geographical area.
- Pre-assessment clinics were available evenings and on Saturdays. A trial of off-site pre-operative assessment clinics had been running throughout the last year, a business case had been developed to establish the off-site clinics permanently.

## Meeting people's individual needs

- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available within the department if required and disabled toilets were available.
- The department reviewed patients' needs on admission, or during pre-assessment in regards to hearing difficulties, staff we spoke with gave examples of when sign language had been used and were knowledgeable about where to access.
- Translation services were available for people whose first language was not English. Leaflets and diet information was printed in different languages if required.
- Specific information for nursing patients with learning disabilities was available on the internet. A lead nurse for learning disabilities was available within the trust, the staff working on the wards were aware of how to contact the lead nurse. Families of patients with learning disabilities are encouraged to stay with the patient pre and post operatively on the day surgery unit.

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- The department used the butterfly scheme to support people living with dementia, a blue butterfly was available on patient notes, handover information and on patient boards to indicate the patient was diagnosed dementia, a white butterfly was available to indicate the patient did not have a diagnosis of dementia; however was at times showing delirium.
- There were close links between specialist nurses and ward staff to ensure continuity of care and support for patients.
- There was good access to the surgical areas. There were lifts available in each area and rooms on Farndale wards were equipped with hoists and were large enough to accommodate disabled people in wheelchairs.

## Access and flow

- Theatre usage had remained consistently above 79% for day surgery and above 90% for main theatres August to October 2015. Elective theatre lists were available Monday to Saturday and emergency theatre lists were available seven days a week. Access to emergency theatres was available 24 hours a day; however, orthopaedic trauma and general surgery shared the theatre access overnight and at weekends.
- The overall number of cancellations was lower 0.3% than the England average (0.8%) April 2013 to June 2015. The trust cancelled 90 patients' operations for non-clinical reasons February 2015 to January 2016 and 49 patients for non-clinical reasons including cancellation by the patient. All patients cancelled were booked for surgery within the 28 days from the cancellation as per the target.
- Pre-assessment services including blood tests and screening was organised to take place as near as possible to the time of listing to prepare the patient adequately for operation.
- The trust consistently achieved the national referral to treatment standards (RTT) for patients admitted for treatment within 18 weeks of referral during 2015/16 to date. Data submitted by the trust to NHS England for the period April 2015 to December 2015 showed that the average incomplete pathways performance during this period was 95.6%, above the 92% national standard. General surgery met the standard in all 9 months with an average performance of 94.5% (standard 92%). The average for Ear nose and throat surgery was 95.1% (standard 92%). Urology reported an average of 98.2% (standard 92%) and Ophthalmology an average of 97.3% (standard 92%). Trauma and orthopaedics were the only speciality which did not meet the 92% standard with an average of 91.3% during the April to December 2015 period, with performance below the 92% standard in three out of nine months. The senior management team were aware of the reasons for this performance for example the changes in the national pathway and had a recovery plan in place to meet the standard.
- We reviewed compliance with the cancer standard and noted that they were held within the trust within another directorate, not the surgical services group. The year to date performance data was better than the England average in all performance measures. Data we reviewed from December 2015 showed that the 14-day standard was met 96.6% better than the England average (93%). The trust had consistently met this standard since January 2014. The department had met the 31-day standard consistently since April 2013; YTD data 99.5% better than England average (96%). The 62-day standard had consistently been met apart from one slight decrease in September 2015; current performance was 90% better than the England average (85%).
- The current length of stay data showed that the trust performed better (three days) than the England average of 3.3 days for all types of elective admissions. Non-elective admission performance was slightly worse (5.4 days) than England average 5.2 days stay. However, trust performance in non-elective trauma and orthopaedic length of stay was better 7.9 days than the England average of 8.7 days July 2014 to June 2015.
- To improve patient flow, pre-assessment clinic admitted most of the elective patient admissions. Patients walked to theatre and allocated a bed once the operation was complete. This gave ward staff enough time to discharge patients and prepare for the admission.
- Overall activity within the day surgical unit had increased. A review had been carried out by the trust of day surgery capacity and changes had been put in place to improve flow and met the increased demand, this included allocation of trolley space post-procedure and checklists. This ensures trolley space was used effectively throughout the day.
- Farndale and Wensleydale wards had approximately two or three medical patients located on them (medical

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outliers). Staff we spoke with told us that this was a frequent occurrence, however they were isolated away from the orthopaedic patients in separate side rooms or bays.

- An escalation area was available on Wensleydale ward, this area was used during periods of increased bed occupancy. This area could take four patients it was equipped with access to oxygen and suction. An agreement was in place with the site co-ordinators that this area did not open if extra staff were not available. The escalation area was not in use during the inspection.

## Learning from complaints and concerns

- There were 132 complaints received within the elective care board 2014/2015. Surgical wards and departments received 67 complaints October 2014 to December 2015. The top three complaints were associated with all aspects of clinical treatment (35), staff attitude (11) and communication issues (10).
- Data shared with us by the trust showed the directorate had a response rate of 70%. The directorate had detailed actions taken as a result of complaints received these included monitoring of the individuals highlighted in the complaint to ensure discussion held at the appraisal and the inclusion of a patient story at the governance group.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.
- Complaints themes were shared with staff individually and via safety briefs and ward meetings.
- Staff talked to us about changes in practice that had occurred post a complaint, for example, the use of compression bandaging and a lack of skin inspection on admission. Further training had been carried out post this complaint and staff were now aware to remove compression bandaging on admission to assess a patients skin. Post a delayed cancer diagnosis investigation a new patient pathway was developed.
- The trust had a process that addressed both formal and informal complaints that arose via the Patient Advocacy and Liaison Service (PALS).
- We reviewed 10 complaints letters and investigation response letters to complaints; these included an

apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements. The trust also answered questions in the complaint response clearly with a summary of what happened, why this happened and what should have happened and action the trust would take. These responses made it clear to the people making the complaint what the standard should have been and made the responses very easy to read and understand.

## Are surgery services well-led?

Good



We rated surgical services at Harrogate hospital as good for well-led because:

- The leadership, governance and culture promote the delivery of high quality patient-centred care. The senior leadership team were new in post, however, with clinical leads had improved the leadership within the directorate.
- Senior managers had a clear statement of vision for the service was available for the directorate and wards had quality priorities identified.
- Safe innovation was encouraged and new sustainable models of care were being explored.
- The majority of staff we spoke with were positive about the management team and clinical leaders. Staff on the wards worked well together with respect for other specialities.

## Vision and strategy for this service

- The elective care directorate including surgery had a vision to improve patient flow and become a centre of excellence for the care of the frail elderly; they monitored success with this vision via performance data on numbers of discharges before midday, numbers of transfers and numbers of cancelled appointments. The directorate monitored success with the frail elderly vision by reviewing admission rates and length of stay for patients over 75 years and numbers of dementia screening undertaken. Surgical services specifically had a vision to increase partnership working with clinics provided in the neighbouring area, by providing clinics

# Surgery

for other organisations, the trust was able to increase income and employ an additional general surgeon. This improved emergency access to consultants and additional evening ward rounds.

- Staff we spoke with working in the clinical areas, were not aware of the directorate vision and strategy, however they were able to articulate the values of the trust. All wards we visited had quality priorities identified. These were on display within wards and departments and matched the elective care directorate vision, for example, improving communications, patient experience and a centre for excellence.
- We saw the trust values displayed in visible areas of the wards and departments.
- The trust worked in partnership with other trusts to improve financial sustainability, patient outcomes and access to services for example providing clinics for patients outside of the trust and providing the national bowel cancer screening service.
- We reviewed the elective care directorate, business plan; which set out how the directorate would support the delivery of care to patients and deliver improvements in the trust. Quality objectives identified matched the trust vision for 2015/2016.

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

- The surgical department including theatres was part of the elective care directorate. The directorate held monthly elective board meetings, we reviewed three sets of board meeting minutes and noted brief documentation of discussions of governance, quality and financial issues, success and feedback and performance.
- An intergraded performance dashboard monitored performance data within the directorate. We observed evidence of discussion of the report at the board meeting.
- The elective care board discussed all of the business cases received by the board and the clinical leads and management team spoke highly of the process for prioritising the business cases.
- Individual ward and department risk register were available these were reviewed along with issue logs which were issues identified by the wards and departments but were not deemed as risks. The risks and issues contained within the registers reflected current risks relevant to the operational effectiveness of

the department. These were graded red, amber and green. However; Wensleydale risk register was not documented as being reviewed since April 2015, one of the risks on Nidderdale wards action plan added in May 2013 had been reviewed in September 2015 however severity of the risks had not decreased in the September 2015 review despite mitigating actions being put in place. The theatres risks register had been reviewed in November 2015 however, of the 12 risks identified on the registered nine remained the same risk as when first identified, two of the items remained the same as when identified in 2012. Following the inspection, the trust highlighted to us a new process of review and discussion of risk registers that was due to be introduced; meetings were to be held quarterly.

## **Leadership of service**

- The clinical director and operational director were new appointments to the elective care directorate senior management team. Clinical leads, matrons and general manager for surgical departments supported the senior management team.
- The elective care board held their meetings monthly on alternate days to allow at least 50% of the clinical leads attendance, of the minutes of the meetings we reviewed good attendance was noted from clinical leads.
- The trust executive management team carried out patient safety walk rounds; staff working on the wards we visited spoke highly of the leadership and visibility of the chief executive.
- From our discussions with staff, they described the surgical leadership team and ward managers as open and approachable all staff said they felt listened too and felt able to raise concerns. There was confidence and respect in the management team.
- We received mixed reports of the effectiveness of leadership within theatres, staff did not attend team meetings and poor staff morale had been previously in identified main theatres. The department had been working with the human resources department to improve staff morale. The senior management team were aware of the issues in theatre, and the elective board meeting had discussed this issue.
- Minutes of department manager meetings we reviewed showed discussion and information sharing of issues within the trust such as the introduction of 1:1 staff, HR and finance updates.

# Surgery

- The wards had rotational senior nurse posts allowing qualified registered nurses to chance to work at a higher grade for a period. Staff we spoke with working in these roles were positive about the experience and were grateful for the opportunity they also said it improved succession planning.
- The matrons undertook patient safety checklists on the surgical wards daily; this checklist included reviewing staffing levels, patient acuity and dependency, patient admissions and discharge due, medical staffing and any other issues affecting patient care.
- Matrons had recently started to work weekends. Staff who worked at a weekend told us that that the extra tier of nursing support was positive. Information we reviewed about this role detailed that this role was to improve communication with patients and relatives at a weekend as senior nursing staff were available to speak to patients and relatives with concerns.
- The surgical areas acknowledged that recruitment and retention of newly qualified nurses was difficult and the trust had taken positive measures in encouraging staff to choose to work at Harrogate, they had arranged social nights, sending Christmas cards and letters welcoming new starters to Harrogate .

## Culture within the service

- At ward level, we found that staff worked together and there was respect across specialities and across disciplines.
- We found the culture in the surgical wards was open and positive. Staff we spoke with described the culture as good, open, cohesive and they said they enjoyed coming to work. Staff we spoke with said they felt valued in their role.
- Staff spoke about their colleagues in a positive and respectful manner.
- Staff spoke with us about feeling able to raise concerns and feeling listened too, and staff believed that the trust would take action on concerns raised.
- Staff spoke positively about the services they provided to patients and were proud of working for the trust.

## Public engagement

- The NHS Friends and family (FFT) showed a response rate at ward level as 40.5%. It is noted that the response rate was better than the England average at 35.5%.

- Wards had access to “You said we did boards” these boards detailed actions taken from comments received in patients feedback, during this inspection all boards we saw contained positive comments, such as staff being caring, helpful and supportive.

## Staff engagement

- Each ward held ward meetings we saw evidence of these being minute and displayed in staff areas for staff to read if they had not attended.
- Staff working for the trust spoke with us about a daily newsletter for staff highlighted issues within the trust, staff could provide information for this newsletter.
- Department managers spoke with us about an “open door policy” for staff to discuss issues with them.

## Innovation, improvement and sustainability

- The percutaneous tibial nerve stimulation (PTNS) for bowel incontinence service had won an award in 2014 for development of the PTNS service and recognition of the high standards of individual patient care provided.
- The orthopaedic department had recently introduced a joint therapy and orthopaedic hand and wrist clinic; this clinic had seen a reduction in patient attendances into hospital with hand injuries. The vision was to make this clinic therapist led in the future.
- The urology department had implemented haematuria outreach clinics to improve patient’s access to services.
- A plastic surgery service had been development in alliance with another local provider.
- Surgical services had developed advanced nurse practitioner roles in Ophthalmology.
- The surgical department had developed pre-operative assessment clinics, in offsite locations.
- One notable practice was the employment of a band two-support worker in day theatres to the role of stores person. In six months, this member of staff had saved half of their salary through stock rotation and lean thinking.
- The partnerships with other providers to provide surgical services in other provider building by Harrogate staff were improving access to surgical services in the geographical area.

# Critical care

Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Outstanding	☆
Well-led	Good	●
Overall	Outstanding	☆

## Information about the service

Harrogate and District NHS Foundation Trust provided critical care services at Harrogate District Hospital. The elective care directorate managed the service.

The critical care unit had ten bed spaces, four of the bed spaces were single side rooms, which meant the unit had capacity to isolate patients who had acquired infectious diseases as well as ensuring single sex accommodation. It was staffed with five registered nurses to care for three Level 3 patients (who require advanced respiratory support or a minimum of two organ support) and four Level 2 patients (who require pre-operative optimisation, extended post-operative care or single organ support). Staffing and capacity on the unit was managed flexibly to meet the demand.

Intensive care national audit and research centre (ICNARC) data published in September 2015 showed that between 1 April 2014 and 31 March 2015 there were 462 admissions with an average age of 64 years. Sixty nine percent of patients were non-surgical, 23% emergency surgical and 8% elective surgical. The average length of stay on the unit was five days.

A critical care outreach team provided a supportive role to the wards medical and nursing staff when caring for deteriorating patients and support to patients discharged from critical care. The team was available seven days a week from 9am to 10pm. Between April and December 2015, the critical care outreach team responded to 700 ward referrals and followed up all patients who were discharged from the critical care unit.

The critical care service was part of the North Yorkshire and Humberside Critical Care Network.

We spoke with one patient, one relative and 24 members of staff. We observed staff deliver care and looked at five patient records and six medication charts. We observed nursing and multidisciplinary handovers. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

# Critical care

## Summary of findings

We rated critical care as outstanding because:

People's individual needs were central to the planning and delivery of critical care services and the management team worked with leads in the trust to plan service delivery. The service engaged patients and the public to plan and improve critical care services.

Access to care was managed to take account of people's need. The unit's bed occupancy was mainly lower than the England average and the delayed discharge and out of hours discharge rates were much better than similar units and the national average.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs. For example, patients who staff knew had a traumatic experience in critical care were seen by the nurse and clinical psychologist in the supporting intensive therapy unit patients (situp) service. Patient diaries and a follow up clinic formed part of the rehabilitation after critical illness service.

There was clear nursing and medical leadership on the unit and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively. It was clear that staff had confidence in the leadership and there were high levels of staff engagement and satisfaction. We observed a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other's opinions.

Staff considered patients' individual preferences and were motivated and inspired by leaders to deliver person-centred, holistic care. Patients received psychological support from specialist staff during and following their critical care stay to help them cope emotionally with their care and treatment. Feedback from patients and relatives was continually positive about all aspects of their care. Staff had been nominated for awards for their patient care.

The service had a good track record in safety and had provided 100% harm-free care between September 2014 and September 2015. Systems and processes in infection control, medicines management, patient

records and the monitoring, assessing and responding to risk were reliable and appropriate to keep patients safe. Staffing levels and skill mix were planned and reviewed to keep people safe at all times.

Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence-based guidance, standards, best practice and legislation.

However,

The service did not meet all the recommendations in the Guidelines for the Provision of Intensive Care Services (2015), for example, a lack of a supernumerary nurse, aspects of the medical staffing arrangements and the percentage of post-registration qualification for critical care nurses on the unit.

# Critical care

## Are critical care services safe?

Good



We rated safe as good because;

- The service showed a good track record in safety. There had been no never events, two serious incidents and a low number of incidents reported. Staff understood their responsibilities to raise concerns and report incidents.
- The unit had provided 100% harm free care on the day it was recorded between September 2014 and September 2015.
- Systems and processes in infection control, medicines management, patient records and the monitoring, assessing and responding to risk were reliable and appropriate to keep patients safe.
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times.
- The number of staff in the service that had completed mandatory training was above the trust's target range.

However,

- At the time of the inspection medical and nurse staffing was not yet in line with the Guidelines for the Provision of Intensive Care Services (2015). For example, care was not always led by a consultant in intensive care medicine and there was no supernumerary nurse coordinator.

### Incidents

- 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. There had been no never events between October 2014 and September 2015.
- There had been two serious incidents reported between January and December 2015, both grade three pressure ulcers (PU). The trust investigated serious incidents using a root cause analysis process. We reviewed one of the investigations and the PU was found to be unavoidable. However, recommendations from the investigation were to review the information staff gave to relatives about PU and to trial a new skin inspection

record to prompt staff in describing pressure areas. We saw evidence of completed skin inspection records in the patient records we reviewed, which demonstrated that lessons had been learnt from incidents.

- Twenty three incidents had been reported between August 2015 and January 2016, 74% of these were graded as no harm, 13% as low harm and 13% as moderate harm. Themes of the incidents were skin and pressure damage, falls and escalating the pieces equipment that had not been serviced by the due date.
- Incidents were reported on an electronic system. Staff were aware of what to report as an incident and how to report it. Most staff told us they received limited feedback on an individual basis from incidents they had reported.
- Senior staff investigated incidents and shared information from this at staff meetings. A senior member of staff gave an example of a new process that had been introduced on the unit following an incident when a patient had experienced a delay waiting for a swallow assessment.
- The clinical lead confirmed that every death on the unit was discussed at the trust-wide morbidity and mortality meeting. A consultant intensivist attended the meeting.
- The unit held a quarterly meeting where consultants reviewed mortality from the Intensive care national audit and research centre (ICNARC) data and investigated any unexpected deaths. There was no critical care specific multi-professional mortality review group in place at the time of our inspection.

### Duty of Candour

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm.
- Staff were aware of the importance of the Duty of Candour and of being open and honest regarding patient care.
- The serious incident investigation we reviewed had evidence of compliance with the Duty of Candour.
- The trust provided an information leaflet outlining the principles of the Duty of Candour to all staff and a Duty of Candour toolkit was available to staff on the intranet.

### Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and

# Critical care

analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism (VTE).

- The unit displayed safety thermometer information visible to staff and visitors.
- Data from September 2014 to September 2015 showed 100% harm free care on the day the data was recorded.

## Cleanliness, infection control and hygiene

- All areas on the unit were clean and tidy. Infection control information was displayed to visitors prior to entering the unit.
- The trust provided information on national specification cleanliness scores; the unit achieved 100% compliance in quarters one and two of 2015/16. The unit achieved 99.6% compliance in quarter two of 2015/16 in the internal patient environment action team audit.
- Equipment was visibly clean and was labelled with the date it had been cleaned.
- The sluice was clean and tidy; we checked two bed pans and one commode. They were all clean and labelled with the date and time they had been cleaned.
- ICNARC data showed the unit had three unit acquired Methicillin resistant Staphylococcus Aureus (MRSA) infection between April 2014 and June 2015.
- ICNARC data showed the unit had not had a unit acquired Clostridium difficile (C.difficile) infection between April 2014 and June 2015. Information provided by the trust prior to the inspection showed there had been one case of a unit acquired C.difficile infection in December 2015. We reviewed the root cause analysis, this was deemed to be an unavoidable case. The infection prevention and control team had completed training on the unit as recommended in the investigation's action plan.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Staff completed eight infection prevention and control audits each month, for example, commodes, hand hygiene, catheter care and saving lives. The results were displayed on the unit. The results of all of the audits over the last six months apart from one were over 90% compliance. Catheter care achieved 60% compliance in November and December 2015; this had improved to 70% in January 2016.

- The unit had achieved number one quality assurance in saving lives audit in May to June 2015, and excellent saving lives audit compliance in July to September 2015.
- Information provided by the trust showed 90% of staff had completed infection prevention and control training. This was within the trust's own target range of 75% to 95%.
- Domestic staff who worked on the unit were trained in cleaning high risk areas. They completed a daily checklist which included records for flushing taps to prevent Legionella; this was returned to the domestic supervisor weekly. The checklist we viewed on the unit was completed for the three days up to the time of inspection.
- Sink cleaning checklists were available at all sinks and completed twice daily.
- The unit had two side rooms with facilities for respiratory isolation.

## Environment and equipment

- The unit was secure; access was by an intercom.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- The environment and equipment was standardised. For procedures such as central venous catheter and chest drain insertions, staff set up standardised boxes.
- Staff checked the defibrillator and other emergency equipment daily. Records for this were complete.
- We checked 44 pieces of equipment, for example, bedside equipment, consumables, oxygen ports and suction, 35 of them were within the service date. Senior staff told us the trust had recently changed the equipment maintenance contract and the company were working through a backlog. We saw evidence on the incident reporting system that staff had escalated the equipment that was out of service date. Staff checked the oxygen and suction was working as part of their bedside safety checks.
- The transfer trolley equipment checklist was complete and the equipment was within the service date.
- We raised concerns to the unit manager regarding the storage of a number of pieces of sharp equipment, for

# Critical care

example, blood glucose needles, suture cutters and intravenous cannulas on open shelves on the corridor of the unit. The unit manager addressed this immediately and the equipment was removed and stored elsewhere.

- At the time of inspection there was not a complete, up to date record of equipment training. The practice development sister was collecting the information to create an up to date record, however, there was not a confirmed timescale for the completion of this work.

## Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored appropriately.
- We reviewed six electronic medication records, they were all complete and in line with national and trust guidance.
- The critical care outreach team worked within trust policies and patient group directions (where prescription medicine can be supplied to patients without a prescription under certain conditions) to administer pain relief, oxygen and nebulisers. The patient group directions were in date.
- Information provided by the trust showed 95% of nurses had completed medicines management antibiotic stewardship training. This was within the trust's own target range of 75% to 95%.
- Information provided by the trust showed 58% of nurses on the unit had completed medicines management for hospital based nurses training. This was below the trust's own target range of 75% to 95%.
- The trust's antimicrobial pharmacist completed bimonthly Antibiotic Prudent Prescribing Indicator audits using data obtained from the electronic prescribing system. Results were not available for the critical care unit specifically; however, the elective care directorate achieved 44% compliance in October and 29% compliance in December 2015. The expected performance was 100%. The information provided by the trust showed the trust wide results only and not an action plan.

## Records

- Records were stored securely and all components of the record were in one place.
- We reviewed five sets of records. They were all accurate, complete and in line with NICE CG50: acutely ill patients in hospital: recognition and response to acute illness in adults in hospital and professional GMC and NMC standards.
- Staff completed a discharge summary that went with the patient to the ward on discharge from the critical care unit.

## Safeguarding

- Staff were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Information provided by the trust showed 100% of staff on the unit had completed safeguarding adults awareness training and 100% of nurses on the unit had completed safeguarding adults responder training. This was above the trust's own target range of 75% to 95%.
- Information provided by the trust showed that 89% of nurses and 67% of additional clinical services staff on the unit had completed safeguarding adults Level 1 training. This was below the trust's own target range of 75% to 95%.
- Information provided by the trust showed that 100% of nurses and administrative staff and 33% of additional clinical services staff on the unit had completed safeguarding children Level 1 training.
- Information provided by the trust showed that 97% of nurses and 33% of additional clinical services staff on the unit had completed safeguarding children Level 2 training.

## Mandatory training

- Mandatory training was available through face to face and e-Learning sessions. Staff told us they were given time to attend to complete this.
- At the time of inspection there was not a complete, up to date record of mandatory training available on the unit. The practice development sister was collecting the information to create an up to date record. However, there was not a confirmed timescale for the completion of this work.

# Critical care

- Information provided by the trust showed that 96% of critical care staff and 97% of critical care outreach staff had completed mandatory training. This was above the trust's own target range of 75% to 95%.

## Assessing and responding to patient risk

- The trust used a recognised national early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- Staff used an electronic system to record patient observations, calculate NEWS and alert clinicians in-line with the policy for the escalation of adult inpatient care.
- The critical care outreach team was available seven days a week from 9am to 10pm. The team consisted of senior nurses who were supported by a consultant intensivist for two sessions a week. They reviewed: discharges from ITU within 24 hours of transfer to the ward, any patient with a NEWS score of 7 or more and any patient that staff had concerns about.
- Medical staff told us they had a high regard for the service provided by the critical care outreach team and there was support from clinical staff for the service to be available 24 hours a day. The critical care outreach team gave us examples of patients whose care would have benefitted from out of hours review by the team.
- Information provided by the trust showed that, between April and December 2015, the critical care outreach team responded to 700 ward referrals.
- The critical care unit did not accept paediatric admissions, the anaesthetists would attend a paediatric referral in the emergency department or on the ward. So that staff were working in as familiar an environment as possible, the anaesthetists would transfer the child to theatre recovery if ongoing management was required while waiting for the dedicated intensive care transport service for children.
- Records included risk assessments for VTE, pressure areas and nutrition. Staff had completed all apart from one of the assessments in the five records we reviewed.
- Staff were aware of the risk assessment they would complete if they needed to use any form of restraint, for example, mittens to maintain a patient's safety.
- At the beginning of their shift we observed staff completing bedside safety checks.

## Nurse staffing

- Nurse staffing met the Guidelines for the Provision of Intensive Care Services (2015) minimum requirements of a one to one nurse to patient ratio for Level 3 patients and a one to two nurses to patient ratio for Level 2 patients.
- The unit was staffed to five Level three beds with an establishment of 32.5 whole time equivalent (WTE) registered nurses. This met the Critical Care Network standard of six WTE registered nurses per Level 3 bed. The unit also had 2.4 WTE healthcare assistants.
- The unit displayed the planned and actual staffing figures. We reviewed the nursing rota for the four weeks prior to the inspection, the actual number of staff met the planned number for 90% of the shifts.
- The planned staffing figures did not include a supernumerary clinical co-ordinator. This did not meet the Guidelines for the Provision of Intensive Care Services (2015).
- Staff were moved from the unit when there was capacity to cover vacancies on the ward. The unit manager kept a record of this and staff reported that it was managed fairly by senior staff.
- Sickness in the service was around 5%. Senior staff managed sickness with support from the human resources and occupational health teams in line with trust policy.
- The use of bank and agency staff was less than 7% between May 2014 and March 2015. This met in the Guidelines for the Provision of Intensive Care Services (2015). We reviewed five completed induction and checklists used for agency staff.
- We observed a nursing handover. Clear, structured patient information was provided and any unit issues were discussed, for example, staff sickness, equipment or expected admissions.

## Medical staffing

- Critical care had a designated clinical lead consultant.
- The unit met the requirements of the Guidelines for the Provision of Intensive Care Services (2015) for medical staffing between Monday and Friday 8am to 6pm. Care was led by a consultant in intensive care medicine and the work pattern delivered continuity of care. Consultants led a daily ward round and the consultant to patient ratio did not exceed the recommended 1:8 to 1:15.

# Critical care

- One anaesthetic trainee doctor was based on the unit overnight who was supported by the on-site staff grade obstetric anaesthetist and the on-call consultant anaesthetist.
- Overnight and weekend medical cover did not meet the requirements of the Guidelines for the Provision of Intensive Care Services (2015) for medical staffing as care was not always led by a consultant in intensive care medicine. A business case was in progress to split the consultant rota to ensure 24 hour access to a consultant in intensive care medicine.
- We observed two multidisciplinary team handovers from the night doctor to the day team, which were structured and management plans were communicated effectively.

## Major incident awareness and training

- Senior staff clearly explained their continuity and major incident plans. The actions described were in line with the trust's major incident and continuity plans.
- Staff knew how to access the major incident and continuity plans on the intranet and on the unit.

## Are critical care services effective?

Good



We rated effective as good because;

- Care and treatment was planned and delivered in line with evidence based guidance, standards, best practice and legislation. For example, NICE guidance on rehabilitation after critical illness and the prevention, diagnosis and management of delirium.
- Patient outcomes were the same as or better than similar units. There was participation in national and local audits and evidence of actions that had been taken following the completion of audits.
- We observed patient centred multidisciplinary team working.
- Staff had an understanding of consent, the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLS). Training compliance in MCA was within the trust's target range.

However,

- There was a lack of dates on some of the policies and guidelines we reviewed.

- Only twenty four percent of nurses had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%.

## Evidence-based care and treatment

- The unit's policies, protocols and care bundles were based on guidance from NICE, the intensive care society and the faculty of intensive care medicine. Staff demonstrated awareness of the policies and knew where to access them.
- We reviewed eight policies and guidelines on the critical care intranet site, six of the documents did not have date of ratification or review date. Two of the documents did not contain any references. The two documents that had review dates on were both out of date. The policies and guidelines appeared to be based on best practice and evidence. The matron informed us the practice development sister planned to review all the policies and guidelines to ensure they were up to date. A timescale for this was not available at the time of the inspection.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The unit delivered care in line with NICE CG83 rehabilitation after critical illness. Staff had completed the rehabilitation short clinical assessment screening tool in the five records we reviewed.
- The supporting intensive therapy unit patients (situp) service was based on research of the psychological consequences of critical illness and a critical care admission.
- Staff used the stepped implementation of enhanced psychological care for conscious patients in ITU as a tool to screen patients and select those who would benefit from clinical psychology input. A post-traumatic stress disorder screening tool and hospital anxiety and depression questionnaire were sent with the follow up clinic invite to determine patients who would benefit from clinical psychology input.
- We saw evidence in the patient record that staff assessed patients regularly for delirium. This was in line with NICE CG103 delirium: prevention, diagnosis and management.
- The trust's tracheostomy care pathway, equipment boxes and resources were in line with National Tracheostomy Safety Project guidance.

# Critical care

- The clinical lead had produced guidance on the deprivation of liberty safeguards in critical care based on best practice and advice from the critical care network and the trust's legal team.

## Pain relief

- A pain specialist nurse visited the unit and reviewed patients who were receiving pain relief infusions. Staff referred other patients that would benefit from review.
- The unit had a pain link nurse who attended relevant trust meetings and training.
- Staff used the trust's pain score on patients who were awake. There was nowhere to record the score on the observation chart at the time of the inspection, however, the chart was being updated and the pain score would be included on the observation chart.
- We observed staff assessing pain and giving support to a patient who required pain relief.
- The patient told us that their pain was managed effectively and kept under control.

## Nutrition and hydration

- Staff assessed patients' nutritional and hydration needs daily and acted upon the findings.
- Staff clearly documented patients' fluid and nutritional intake in the patient record. There was evidence of review of fluid balance and nutrition daily on the ward round.
- We observed a standardised guideline for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietician was not available.
- Staff had access to a dietetic service, a dietitian visited the unit at least three times a week and staff could request a review of a patient. We were informed a speech and language therapist attended the unit when required.
- During the inspection one patient on the unit was able to drink. Water was available for the patient and within reach.

## Patient outcomes

- We reviewed the intensive care national audit and research centre (ICNARC) data from 1 April 2014 to 31 March 2015, the crude unit mortality was 14%. This was in line with the network average.

- For the period 2 April to 30 June 2015 the ICNARC (2013) model mortality ratio was 1.13 and the APACHE II (2013) mortality ratio was 1.11. This was in line with similar critical care units.
- There had been eleven early re-admissions between 1 April 2014 and 30 June 2015. This was two percent of all admissions and was in line with similar critical care units.
- The ICNARC data clerk and lead ICNARC consultant collated the ICNARC reports and reviewed individual cases, for example, unexpected mortality.
- The critical care outreach team had been involved in establishing a critical care outreach regional network forum. This meant they could begin to benchmark the service across the region.
- We reviewed an electronic copy of the service's registered audit activity. This included an audit on glycaemic control in critical care, an audit of compliance with NICE CG83: rehabilitation after critical illness audit that was due to be completed in December 2015 and a planned audit on the incidence of delirium and sedation practices was awaiting registration.
- The lead nurse in the critical care outreach team led the sepsis CQUIN audit with an ED consultant.
- The critical care outreach team collected data to audit the number of patients who would trigger a referral to the team out of hours, number of reviews and type of treatment they received to see if there was a need for an extension of the service. The data collection was ongoing at the time of the inspection.
- An audit of compliance with ventilated associated pneumonia care bundles was completed in 2014/15. The audit provided by the trust included results only and no action plan. Compliance with a sedation break was lowest at 68%, during the inspection we saw evidence in the patient record that a sedation break was considered daily.

## Competent staff

- Senior nursing staff had allocated responsibilities, these included completing appraisals, managing sickness and the rota. Nursing staff had link nurse roles, for example, infection prevention and control, pain and diabetes.
- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months.

# Critical care

However, information provided by the trust showed that between April and November 2015 0% of administrative staff, 23% of nurses and 67% of additional clinical services staff on the unit had received an appraisal.

- The unit had a practice development sister who was responsible for coordinating the education and training for nursing staff and students. This met the recommendations of the Guidelines for the Provision of Intensive Care Services (2015).
- Twenty four percent of nurses had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%.
- The practice development sister had introduced the national competency framework for adult critical care nurses as the first step towards meeting the post registration in critical care qualification recommendation. Staff told us time was a limiting factor in completing these, they felt the support from the practice development sister and teaching from the medical staff was good.
- We saw evidence that 89% of staff had been trained in the five priorities of end of life care.
- New members of nursing staff received an induction onto the unit and the practice development sister had introduced a preceptorship pack. Staff were allocated a mentor and had a supernumerary period of four weeks. The unit manager and practice development sister told us this was flexible depending on staff needs. A member of staff told us their supernumerary period was extended and they were supported by senior staff in this.
- The unit provided student nurse placements. A student nurse told us they received good support and opportunities for learning on the unit. Students had an induction pack, competencies and defined roles for their placement, for example, they would not be responsible for a patient's airway during repositioning.
- Opportunities were available for band five nurses to work in a band six development role for six months.
- Specific courses including simulation and transfer of the ventilated patient training was available for staff.
- The critical care outreach team delivered a number of training courses in the trust. These included immediate and advanced life support, recognition of the deteriorating patient, teamwork and human factors.

- Critical care outreach staff completed acute healthcare competencies with consultant anaesthetists, these included advanced clinical skills. Three members of the team had completed a post graduate advanced clinical assessment course at a local university.
- Junior medical staff told us they were well supported and received weekly dedicated teaching time. During the inspection we observed consultants using the ward round, multidisciplinary handover, procedures and interventions as teaching opportunities.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from human resources.

## Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during the inspection.
- The five records we reviewed had evidence of a consultant admission review and treatment plan.
- We observed two multidisciplinary handovers. The consultants sought input from all the professions when making management plans for patients. There was evidence of discussion between speciality teams, for example, doctors discussed the care of a patient with acute renal failure with the renal team and a cardiothoracic patient was transferred to a specialist centre.
- Physiotherapists treated patients on the unit twice a day. A dietician and pharmacist visited the unit regularly. Nurses told us they had access to speech and language therapy, specialist nurse in organ donation and other nurse specialists when required.
- We observed evidence of discharge planning during the multidisciplinary handover. Each profession handed over patient information verbally to the relevant professional prior to the patient leaving the unit. For example, the junior doctor contacted the junior doctor on the ward and the nurse gave the ward nurse a handover.

## Seven-day services

- A consultant intensivist or anaesthetist was available seven days a week and completed a ward round on Saturday and Sunday.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

# Critical care

- Specialist critical care physiotherapists provided treatment Monday to Friday. Patients received physiotherapy treatment at the weekend and an on-call service was available overnight.
- "The ward-based clinical pharmacy service was available between the hours of 8.30am to 5.30pm, Monday to Friday. There was a limited ward-based clinical pharmacy service at weekends between the hours of 9.00am and 2.00pm. Outside of these hours, an on-call service was provided. The main dispensary is open between the hours of 8.30 and 7pm Monday to Friday and 9am to 2pm at weekends."

## Access to information

- A resource file of policies and procedures was kept on the unit. This included information on tissue viability, critical care transfers, central venous catheters, blood transfusion and nutrition and dietetics.
- Staff were able to access blood results and x-rays using electronic results services.
- Staff completed a discharge document for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital. A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.
- The ward clerk reported no difficulty accessing or filing patient notes.
- The electronic patient observation system included flags to alert staff to specific patient needs, for example, learning disabilities, visual impairment, treatment limitation and do not attempt resuscitation decisions.
- The consultant wrote to a patient's GP after they had attended the follow up clinic and suggested any referrals that may be required.

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

- Staff demonstrated an understanding of consent, the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLS).
- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- Staff told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity. All staff knew how to access the MCA and DoLS flowchart and policies.

- We reviewed the records of two patients with learning disabilities, they included capacity assessments, family discussions, consideration of and referral to an independent mental capacity advocate and DoLS application when appropriate.
- Information provided by the trust showed 88% of nurses had completed mental capacity act training. This was within the trust's own target range of 75% to 95%.

## Are critical care services caring?

Outstanding



We rated caring as outstanding because;

- Staff considered patients individual preferences and were motivated and inspired by leaders to deliver person centred, holistic care.
- Feedback from patients and relatives was continually positive about all aspects of care which exceeded their expectations.
- All staff consistently communicated with both conscious and unconscious patients in a kind and compassionate way and that promoted their dignity and respected their privacy.
- There was a person centred culture, staff started a diary for patients in consultation with their relatives.
- Staff valued patients emotional needs and ensured they received psychological support from specialist staff during and following their critical care stay to help them cope with their care and treatment.
- Two members of staff had been nominated for awards for their patient care.

## Compassionate care

- The unit did not participate in the NHS Friends and Family Test because patients were infrequently discharged directly home.
- We reviewed 14 comments from 2015 to 2016 in the comments and suggestions book in the visitors' waiting room. They all featured excellent comments regarding the care and compassion shown by all the staff on the unit.
- The unit displayed many thank you cards from within the last six months from patients and relatives. All the cards contained excellent feedback regarding the compassionate care received on the unit.

# Critical care

- Staff told us they received good feedback about the care they received on the unit from patients at supporting intensive therapy unit patient (situp) visits, at the follow up clinic and through patient satisfaction surveys.
- We spoke with one patient and one relative. They were both positive regarding the care provided. They told us they or their relative were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- We observed staff treated patients with dignity and respect for their privacy. During all interventions, staff drew curtains around patients or closed the door to the side room. Patients were kept covered with sheets and blankets.
- All staff communicated in a kind and compassionate way with both conscious and unconscious patients.
- One patient on the unit was awake and able to use a call bell. It was placed within their reach and staff responded in a timely and respectful manner to the patient's requests.
- Staff sensitively managed conversations regarding a patient's condition, prognosis, care and treatment options.
- A member of nursing staff had been nominated for multiple awards for their compassionate care.
- A member of medical staff had won the trust doctor or dentist of the year award. Comments included; "a good patient advocate," "exceptional bedside manner with patients and family" and "goes above and beyond and puts the patient first."
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff told us they received training and a good level of support from the organ donation specialist nurse.
- Staff told us doctors discussed treatment with families and explained deteriorations or changes to treatment sensitively and compassionately. We observed a sensitive multidisciplinary discussion led by consultant about a patient who had deteriorated. The team considered the patient's family, next of kin and the patient's wishes as well as the treatment limitations that were already in place.

## Emotional support

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

- Nurses started a diary for patients in consultation with their relatives. Staff took an initial photograph of the patient on their first day on the unit and subsequently at regular intervals to show a timeline of important events of a patient's progress. During the patients stay on the unit, staff and relatives made entries in the diary. We were shown a diary from a patient who had attended the follow up clinic (with the patient's consent). There was input from members of the multidisciplinary team and relatives. The diary was emotional to read and excellent and compassionate care was obvious throughout.
- During our inspection we observed a chaplain visit the unit. Staff welcomed them and they visited a patient.
- Staff showed a good understanding of end of life care and explained how they would support families and speak to them regarding their preferences and try to meet these, for example, moving patients approaching the end of their life into a side room. Staff described a good working relationship with the palliative care team.
- The patient and relative we spoke to told us they had been kept informed of their treatment and progress and that they were involved in the decisions made by the medical team. They said staff communicated with them in a way they were able to understand.
- The unit had regular, substantive clinical psychology input. This service was infrequently found in similar units. Staff referred patients to the psychologist who they knew had a traumatic experience in critical care.
- The situp service was founded after a consultant requested one of the nurses to visit a patient who had been discharged from the unit who was scared to go to bed on the ward. The service has been running for between 18 months to two years. Last year staff visited
- A relative thought the visiting times on the unit were good, however, staff had submitted a suggestion to the box in the staffroom regarding open or extended visiting for close family.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- Staff from the situp service tried to visit patients on the ward between 2pm and 3pm so they were able to see their relatives too.

# Critical care

63 patients and provided emotional support and relaxation techniques. Staff received consistently positive feedback from patients, relatives and the ward staff.

## Are critical care services responsive?

Outstanding



We rated responsive as outstanding because;

- Services were tailored to meet people's individual needs which were central to the planning and delivery of critical care services. The management team worked with leads in the trust to plan service delivery.
- Access to care was managed to take account of peoples' need, between May 2013 and March 2015 the bed occupancy was mainly lower than the England average. The delayed discharge and out of hours discharge rates were much better than similar units and the national average.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs. For example, patients who staff knew had a traumatic experience in critical care were seen by the nurse and clinical psychologist in the supporting intensive therapy unit patients (situp) service. Patient diaries and a follow up clinic formed part of the Rehabilitation after critical illness service.
- The unit had a well-equipped and comfortable visitors' waiting room and overnight stay room.
- The service had not received any complaints in the last 12 months.

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

- The service worked with leads in the trust to plan service delivery. We saw evidence of this in the minutes of the trust wide critical care delivery group meetings.
- The service was actively involved in the regional critical care network.
- Critical care provision could be flexed to meet the differing needs of Level 2 and 3 patients, for example, an increase in Level 3 beds if required.

- Staff started a diary for any patient who was admitted to the unit acutely where the patient gave consent or where the multidisciplinary team in conjunction with family, agreed that it was in the patient's best interests to start a diary.
- Patients who had a critical care admission of three weeks or longer, patients who staff knew had a traumatic experience in critical care or patients who requested a visit were seen by the supporting intensive therapy unit patients (situp) service. A nurse and a clinical psychologist visited patients on the ward to clarify noises and events from patients' critical care stay and to talk through the transition from critical care to the ward.
- Staff held a bimonthly critical care follow up clinic in the out-patient department. The team consisted of a consultant, a senior nurse and a clinical psychologist. All level three patients were invited and the supporting intensive therapy unit patients (situp) service referred patients to the clinic. Patients were given an appointment within six months of discharge from critical care when possible and the attendance rate was more than 50%. Staff took patients who wanted to visit to the critical care unit at the end of their appointment.
- A visitors' waiting room was available in the entrance to the unit and was well equipped with seating, hot drinks, trust and charity information leaflets, a television and a games console. Staff used this room to also meet visitors in private. An overnight stay room was also available for visitors with washing facilities, a sofa bed and television.
- The unit did not have any bathroom facilities for patients. The visitors' bathroom facilities did not have call alarms in, patients who were able to complete personal care independently had to use wash bowls and commodes at their bedside.

### Meeting people's individual needs

- Staff told us they felt able to support patients with dementia and learning disabilities. We saw evidence that nursing care plans included assessment and interventions for patients with dementia, learning disabilities and delirium.
- The unit manager had ordered sound ear to monitor noise levels as patients had reported it was noisy on the

# Critical care

unit at night. Staff told us how they would reassure and try to orientate patients who appeared disorientated in their surroundings, for example, patients with delirium or dementia.

- The electronic patient observation system had a flag for patients who lived with dementia or learning disabilities. Staff knew how to contact the named nurse for learning disabilities.
- During the inspection there was a patient with learning disabilities admitted to the unit. The multidisciplinary team considered whether there were any capacity, safeguarding and DoLs issues relevant to the patient's care and treatment.
- Translation services were available to patients whose first language was not English. Most staff knew how to access the service but told us they did not need to use it regularly. Staff who did not know how to access the service told us they would speak to the nurse in charge or refer to the policy on the intranet.
- A clinical psychologist joined the critical care team in 2014 in response to patients in the follow up clinic reporting psychological problems. The psychologist was available for two sessions a week and treated patients from the follow up clinic in an outpatient clinic and reviewed patients on the unit or in the situp service.

## Access and flow

- The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient.
- Between May 2013 and March 2015 the bed occupancy was mainly lower than the England average.
- Data provided by the trust for 2015 showed:
  - there had been seven cancelled elective operations due to a lack of critical care capacity;
  - there had been no adult patients ventilated outside of critical care;
  - there had been no mixed sex accommodation breaches;
  - all patients had been admitted to the unit within four hours of referral. This was in line with Guidelines for the Provision of Intensive Care Services (2015).
- The ICNARC data from 1 April 2014 to 30 June 2015 showed the unit had transferred five patients due to

non-clinical reasons. This was not in line with Guidelines for the Provision of Intensive Care Services (2015), however, this was better than other units and below the network average.

- The ICNARC data from April to June 2015 showed there had been six delayed discharges and two out of hour's discharges to the ward. This was much lower than similar units and the national average.

## Learning from complaints and concerns

- Staff were aware of the policy for managing concerns and complaints and how to access it.
- The unit displayed information and leaflets on how to make a complaint.
- The service had not received any complaints in the last 12 months.

## Are critical care services well-led?

Good



We rated well-led as good because;

- There was clear nursing and medical leadership on the unit and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively. It was clear that staff had confidence in the leadership.
- There was a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other's opinions.
- There was an effective and comprehensive governance process in place to identify, understand and address current and future risks.
- There were high levels of staff engagement and satisfaction.
- The service engaged patients and the public to plan and improve critical care services.

However,

- The leadership team had a focus on achieving operational objectives which had not yet been translated into a credible strategy for critical care.

## Vision and strategy for this service

# Critical care

- The elective care directorate business plan (2015/16) set out quality objectives that were in line with the trust's accountability framework and the trust's vision.
- The clinical lead and matron were proud of the ICNARC data and shared a vision to build a high quality critical care that met the Guidelines for the Provision of Intensive Care Services (2015).
- The management team were keen to develop the culture of inter-professional working and to support the nursing staff to achieve a post registration qualification in critical care.
- Business cases had been completed for a supernumerary nurse in charge (Guidelines for the Provision of Intensive Care Services 2015) and for a dedicated level one surgical unit to meet the needs of the high risk surgical patient (National Confidential Enquiry into Patient Outcome and Death Knowing the Risk report). A business case was in progress for a fully split consultant rota ensuring twenty four hour access to a consultant in Intensive Care Medicine.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

## Governance, risk management and quality measurement

- The service held monthly quality of care risk meetings that included governance. We reviewed minutes from these meetings; patient safety, quality and patient experience, equipment and the risk register were some of the agenda items discussed.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded. The unit's risk register identified the following key risks: bed capacity, movement of staff to cover vacancies on the ward, lack of a supernumerary nurse in charge and delays in maintenance and upkeep of equipment. The risk register showed that controls were in place to mitigate these risks.
- The management team and senior staff were aware of the issues on the risk register and agreed they were representative of the risks they identified in the service.

- The unit manager attended directorate sisters meetings, these shared information across clinical specialities and included discussions around finance, governance, root cause analysis, recruitment and risks.

## Leadership of service

- The leadership team and senior staff were visible and approachable. There was clear nursing and medical leadership on the unit and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively.
- It was clear from our conversations, observations and data we reviewed that staff had confidence in the leadership at all levels. Staff reported feeling very supported by their teams and managers. There were high levels of staff satisfaction.
- Senior staff had completed the trust's leadership training and a master's level leadership module at a local university.
- The leadership team were extremely positive about the service and very proud of all the staff.
- Senior staff were aware of the impact on morale of staff moves to the ward. They had developed a written protocol for skills and expectations of critical care staff and when working on a ward.
- Junior medical staff told us they felt supported by consultants at all times.

## Culture within the service

- We found a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other's opinions.
- Staff told us they felt able to raise concerns about incidents poor care and safeguarding.
- Staff told us the senior nurses, matron, and consultants were all visible, supportive, and staff felt happy to discuss any issues with them.
- Staff told us the trust was a good place to work and they were most proud of the teamwork and the willingness to help and support each other.
- Junior medical staff told us they found the anaesthetic department more helpful than in other trusts they had worked in. They saw the consultants working with medical and surgical colleagues to improve patient care.

## Public engagement

# Critical care

- Patient comments and thank you cards were on display on the unit.
- Staff encouraged patients to complete the trust patient satisfaction survey on discharge from critical care. The responses were returned to the unit manager who read and responded to feedback. The trust did not collate or analyse the results of the survey.
- There was a comments and suggestions book in visitors' room. There were also two plaques in the visitor's room acknowledging donations that had been made in memory of former patients.
- Patient feedback from the follow up clinic was used to introduce changes on the unit, for example, protected sleep time was to be introduced and a sound ear to monitor noise levels had been ordered in response to patient feedback that the unit was noisy at night and the lights were not turned out until late.
- Staff from the follow up clinic displayed feedback from patients who attended the clinic on communication board in staffroom.







## Staff engagement

- Regular staff meetings were held. We saw evidence in the minutes that incidents, audits, policies, training, staffing and equipment were some of the topics discussed.
- There was a communication board in the staffroom displaying information about the risk register, equipment, training and competencies. There was also a communication book on the unit.
- A comments box for ideas and suggestions from staff was in the staff room. Staff told us the patient observation chart was put up in the staff room for staff to add suggestions of updates or changes to the chart.
- There was evidence that the leadership team listened to staff's ideas, for example, the situp service was introduced after a nurse reviewed one patient on the ward and asked why there wasn't a service for all patients.

## Innovation, improvement and sustainability

- Medical staff set up a virtual journal club. The online resource ensured all staff could engage with evidence based practice whether or not they were physically present at work. This work had been highlighted by the Faculty of Intensive Care Medicine and the trust was approached by the deanery to roll out the initiative to all trainees.
- Inter-professional simulation training sessions took place on the unit during the working day to allow all members of the multidisciplinary team to attend. These focussed on airway management and team working to improve patient safety. The work was presented at the Intensive Care Society State of the Art Conference 2015.
- The patient diary, supporting intensive therapy unit patients (situp), clinical psychology and follow up clinic services ensured patients received a high standard of rehabilitation during and following their critical care admission.
- The critical care outreach team worked with the local critical care network to set up a critical care outreach regional network forum to benchmark services and share best practice.
- Staff used an electronic system to record patient observations, calculate NEWS and alert clinicians in-line with the policy for the escalation of adult inpatient care. An audit on the response to the deteriorating patient was planned following the introduction of the system.
- The trust offered rotational posts to nurses, this gave staff experience of developing specialist and transferable skills across clinical areas such as surgery, emergency department and critical care. ED, ITU.

# Maternity and gynaecology

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

## Information about the service

Harrogate and District NHS Foundation Trust offered a full range of maternity and gynaecological services. The unit comprised an antenatal clinic (with six consulting rooms); maternal assessment centre (MAC); (a four bedded room and one side room; open Monday-Friday 8am-8pm ;). A delivery suite; (with 6 delivery rooms including a newly refurbished birthing poolroom) an Obstetric Theatre; (a recovery room, a four bedded observation ward ;) a bereavement room, and a combined 16 bed antenatal/postnatal ward. Antenatal and postnatal care was also provided in the community; in GP's surgeries, at home and in children's centres within the Harrogate, Knaresborough, Ripon and Yeadon/Otley areas. A consultant antenatal clinic was also available at Ripon Hospital, on alternate Tuesdays. A home birth service was available for low risk pregnancies.

Gynaecological services included Termination of Pregnancy (ToP) and an early pregnancy, gynaecological assessment unit (EPGAU), which operated seven days a week, 8.30am to 2.30pm. The female gynaecology ward provided in-patient treatment for a range of gynaecological conditions, female urology and general surgery patients were also admitted to this ward.

The maternity service delivered 1,834 babies between July 2014 and June 2015.

The stillbirth rate from April 2014 to March 2015 was seven and the number of early neonatal deaths for the same period was three. (A stillbirth is a baby born dead after 24 completed weeks of pregnancy.)

The service offered both medical and surgical termination of pregnancy. Between April 2014 and March 2015, there were 99 medical and 60 surgical terminations carried out. There were processes in place to ensure the sensitive disposal of pregnancy remains.

We inspected the maternity and gynaecology services, which included the EPGAU, gynaecology ward, antenatal clinic, antenatal day unit, antenatal/postnatal ward, the delivery suite, obstetric theatre and community midwifery service. We spoke with three women, who used the service and 57 staff. Including, midwives and community midwives, midwifery support workers, student midwives, ward clerks, ward domestics, doctors, anaesthetists, consultants and senior managers. We also held staff focus group meeting to hear their views of the service they provide. We observed care and treatment, inspected 15 sets of care records and we reviewed the trust's audits and performance data.

We reviewed information about the population of Harrogate and found it was one of the less deprived areas when compared to the England average. Teenage pregnancy (under 18 years of age) was 16.8%, compared to the England average of 34% and obese adults was 20.7%, compared to the England average of 24.2%.

# Maternity and gynaecology

## Summary of findings

Overall we rated this service as 'good' because:

Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff. Records relating to women's care were of a good standard. Risks to women were identified, monitored and managed to keep them safe. Records were kept secure in line with the data protection procedures.

Multidisciplinary working took place; Obstetricians and gynaecology and midwifery staff worked well as a cohesive team and supported each other in providing safe, well- led care. Women reported having their pain effectively managed and there were choices for managing pain.

Staff involved women in their care and treated them with compassion, kindness, dignity and respect.

The appointment times for patients booked into antenatal clinic and having the type of care they had planned, were meeting trust targets. Waiting times, delays and cancellations were minimal and women were kept informed of any disruption to their care or treatment. The trust was open and transparent in responding to complaints.

The trust had a vision and strategy that staff knew about. Staff were engaged, motivated, innovative and supported by their colleagues and line managers. However, some staff told us they did not always feel supported by senior management; they were not always visible.

The unit was meeting the nationally recommended birth to midwife ratio of 1:28. However we heard how although new staff had been recruited and in post, the unit was still experiencing staffing shortages and further recruitments were taking place. Consequently, the increase demand on the service was met by moving staff, between departments and the community. Managers informed us that all new staff would be in post and operational by April 2016.

However, medication training for community midwives was recorded at 29%. All staff must receive appropriate training necessary to carry out their duties. We found 18

(24%) out of 75 guidelines were out of date. Staff appraisal rates were 63.6% and not meeting the trust target of 75%. We also found worn wooden storage units were being used in delivery suite. The units could not be effectively cleaned and therefore were a risk to infection control. This was brought to the attention of the infection control nurse at the time of the inspection.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good



We rated maternity and gynaecology services for safe as good because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Systems were in place to protect patients from abuse and staff were aware of the procedures to follow.
- Records relating to women's care were of a good standard. Risks to women were identified, monitored and managed to keep them safe. Records were kept secure in line with the data protection procedures.
- The unit was meeting the nationally recommended birth to midwife ratio of 1:28. However, there had been some recent vacancies, which the trust was actively recruiting to. In the interim, any increased demand on the service was met by moving staff, between departments and the community. Managers informed us that all new staff would be in post and operational by April 2016.

However, we also found:

- Medication training for community midwives was 29%. All staff must receive appropriate training necessary to carry out their duties.
- We found worn wooden storage units were being used in delivery suite. The units could not be effectively cleaned and therefore a risk to infection control. This was brought to the attention of the infection control nurse at the time of the inspection.
- There was not always an appropriate sized cuff available for use with the blood pressure machine. Although there were alternative methods available to obtain a blood pressure recording, the trust should ensure variable sizes of blood pressure cuffs are available.

### Incidents

- There were no never events reported in maternity of gynaecology services between October 2014 and September 2015. Never events are serious, preventable patient safety incidents that should not occur if the available preventive measures are in place.

- Between November 2014 and September 2015, there were 671 incidents reported. Of these, 430 was reported as no harm caused, 61 reported as low harm, 25 as moderate harm and three were reported as severe harm caused.
- Common themes of incidents included complications of treatment for example, third and fourth degree tears and postpartum haemorrhage (a blood loss from the genital tract, within 24 hours of delivery of over 1500mls. This is the most common obstetric haemorrhage).
- Between March and May 2015, there were three unexpected intrauterine deaths, reported as serious incidents.
- A root cause analysis (RCA) had taken place in all three cases, which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons are learnt, to prevent the same incident occurring again. Action plans and recommendation summaries were shared with all staff.
- Staff were able to give examples of feedback received from the three incidents, and lessons learnt. A customised fetal growth chart had previously been introduced and helped in the early detection of restricted growth associated with poor outcomes, such as stillbirth and neonatal death. The trust had revisited the customised growth chart training to improve understanding and use of the screening tool.
- The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines recommend the use of customised antenatal growth charts. With the exception of those on maternity leave, all doctors, midwives in the antenatal clinic, community teams, and the antenatal sonographer had received one to one training.
- The risk management midwife sent out emails and memos to staff relating to incident themes and trends. There were daily team brief/updates at staff handovers, monthly newsletter and staff briefings taking place and we observed some of these during our inspection. The information also included risks, themes, trends and lessons learnt from incidents.
- Clinical practice issues were discussed at staff meetings and clinical supervision.
- Perinatal mortality and morbidity meetings were held and jointly attended by obstetric and paediatric staff. Serious cases, including stillbirths and neonatal deaths, were reviewed.

# Maternity and gynaecology

## Duty of Candour

- Duty of Candour (DOC) 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.
- Leaflets were sent to all staff explaining the DOC, briefings and training was held and it was included as part of the induction for all new staff.
- We saw an example of DOC, where a women's care had not gone according to plan. They had received an explanation from the consultant involved in their care and the Risk Midwife. A letter of apology was sent from the Chief Executive of the trust. This showed the trust was open and transparent with patients about their care and treatment when things went wrong.

## Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at patient harms such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- Data from the trust quality and safety dashboard showed maternity services had 100% harm free care from April 2015 to September 2015.

## Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and equipment had stickers on them, which showed they were clean.
- Quarterly cleanliness audits were completed for all wards and departments. For example, between May and August 2015, the antenatal department scored 97.3%, and gynaecology ward scored 95.8%.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of the ward and there was clear signage encouraging visitor and staff to wash their hands.
- Between April and September 2015, the staff hand hygiene audit result for delivery suite and the gynaecology ward was 100%. On the antenatal/postnatal ward, in April 2015, it was 89%, May 50%, and July and August 2015, the audit result was 100%

- The trust completed an audit of commode cleanliness. Within the maternity department and gynaecology ward, between April and September 2015, the audit showed 100% of commodes were clean.
- From August 2014 to August 2015, there had been no cases of either Methicillin-resistant Staphylococcus Aureus (MRSA) bacteria, or Clostridium difficile infections within maternity and gynaecology.
- The infection prevention and control team completed a Clostridium difficile high impact intervention audits. The audit monitored compliance against key elements of the Clostridium difficile control policy. Maternity and gynaecology services scored 100% every month from April 2015 to September 2015, with the exception of June 2015, when the gynaecology ward scored 98%.
- In two of the delivery suite rooms, worn, wooden units were in use as storage. The fabric of the units was not suitable for the environment and there was a risk to infection control as it could not, be effectively cleaned. We informed the trust infection control lead nurse at the time of the inspection, who confirmed they would address the issue.

## Environment and equipment

- Access to the gynaecology ward, combined antenatal and postnatal ward and delivery suite was via an intercom system. All staff needed swipe cards to access the unit.
- Refurbishment had taken place on the maternity unit. The refurbishment included a new maternity assessment centre for triage of pregnancy women, birthing pool-room and the decoration of corridors.
- All delivery rooms had ensuite facilities and a wet room.
- The unit had a separate room for bereavement and for women and their family, who were experiencing the loss of an infant.
- With the exception of missed ad hoc recordings, resuscitation and emergency equipment check were taking place in each area we inspected. This meant the equipment would be available in an emergency.
- Equipment was available to meet people's needs. For example, oxygen and cardiotocography (CTG) machines. (CTG machines are used during pregnancy to monitor both the foetal heart and the contractions of the uterus.)
- There were blood pressure recording machines available however; staff told us there was not always a selection of cuffs, available for use with the machine.

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The size of the cuff used would depend on the size of the person's arm. The unit did have alternative equipment, to be able to monitor a person's blood pressure in the absence of the appropriate cuff.

- On delivery suite, some of the Portable Appliance Testing (PAT) of electrical equipment was out of date. For example, the CTG machine should have been re-tested in June 2015 and the test had not taken place. However, whilst we were inspecting, the staff responsible for the checks attended the ward and the equipment was re-tested.

## Medicines

- Medicines were stored in locked cupboards and trolleys in all clinical areas.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All fridge temperatures were checked and recorded daily. We found there were no gaps in recording. Nurses and midwives told us they received support from the on-site pharmacist, when necessary.
- Records showed the administration of controlled drugs were subject to a second, independent check. After administration, the stock balance of an individual preparation was checked to confirm it was correct and the balance recorded.
- Records showed controlled drugs were checked in line with hospital policy.
- Electronic prescribing was taking place. There were processes in place to record all medications dispensed by midwives under the NICE guidance good practice guidelines.

## Records

- We inspected 15 sets of women's clinical record, which included one set of gynaecology records and medical notes. There was a good standard of record keeping.
- Some records were held electronically and some in paper format. When not in use data protection procedures were in place to keep records safe.
- Records showed each woman had a named midwife responsible for their care. Each record contained antenatal assessments and screening, and a clear pathway of care, which described what women should expect at each stage of their labour.
- The documentation included, a situation, background, assessment, recommendation (SBAR) transfer record;

which was used when handing over care between staff. The tool was used in maternity services where there may be multiple handovers between staff. It assists in improving communication, therefore helps in keeping patients safe.

- Risk assessments were completed and we saw they identified potential or actual risks.
- Staff told us record reviews had just started. They included the review of 20 sets of woman's records, by band 6 midwives. The review was to include the patient journey from the antenatal to the post-natal period.

## Safeguarding

- The trust had safeguarding adult and children policies. There was an environmental system in place for safeguarding mothers and babies. A daily check took place, to ensure it continued to work and therefore maintained security and safety.
- Risk assessments and pathways of care were in place to identify women and children at risk.
- The trust had a named midwife for safeguarding who was a resource for staff and who provided support for vulnerable women. They were responsible for managing child protection and domestic violence issues.
- Staff we spoke with told us they understood their responsibilities for identifying and reporting any concerns.
- Safeguarding training was mandatory. Training records for maternity and gynaecology services showed 57% of staff had completed safeguarding children level 3. However, 100% had completed safeguarding children level 4. Which meant those staff who had level 4 training had received a more advanced training package and were not required to also complete the level 3 training.
- The trust was developing the maternity guideline for female genital mutilation (FGM). In the interim, they were using the safeguarding children policy and procedures for FGM. The World Health Organisation (WHO) 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 procedure and action they would take in reporting. Between January to March 2015, there was one reported case. Since that date, there have been no cases to report.

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## Mandatory training

- There was a trust mandatory training policy, which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills. This included topics such as, safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act, and Deprivation of Liberty Safeguards (DoLS).
- For each training element staff groups were identified and the frequency of each training element. Employees had a “Personal training account” which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual, through to directorate and trust level.
- The compliance rates for the directorates/trust were set at 95% and rated as green if they were 75% or above. This was explained as the trust identifying they would have been on track to meet trajectory. Figures below 75% were rated as red or amber, dependent on the percentage.
- In women’s services the compliance for mandatory training ranged between 75 – 100%. The medicines management training for community-based nurses was 29% and therefore not yet meeting the trust trajectory rate of 75%..
- However, we were shown two staffs’ individual, electronic training accounts. They pointed out that although some of the training modules were showing as they were out of date, in some instances the training was not due for a couple of months, or they had attended training and their account had not been updated. One of the staff demonstrated that although their training in one topic was showing out of date, on the same computerised system, there was a certificate to show the training was completed.
- Some staff also reported they did not find the computerized electronic learning, easy to access. They told us they were able to access weekly support to help them with the process. Unfortunately, having the time to do this was not always achievable.
- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Obstetric Early Warning System (MOEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. All records we inspected contained completed MOEWS tools.
- The World Health Organisation (WHO) devised a safer surgery checklist, which included five steps that should be taken when a patient have an operation. A checklist had been adapted for obstetric procedures.
- The trust had completed an internal audit of compliance with the completion of the WHO checklist. The audit results (dated 14 August 2015,) showed the correct checklist version, had been used in seven out of the eight cases audited in the maternity unit. The audit recommended producing guidance on the use of the checklist and the implementation of a training programme for staff. Staff were aware of how to use the checklist. The five notes we inspected, where women had a caesarean section, the WHO checklist had been completed.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- 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.
- In May 2014, the trust completed an audit of 10 patient records, to look at the timeliness of the escalation process for deteriorating patients. The audit showed that all 10 patients had the correct observations undertaken and scores recorded.

## Midwifery staffing

- The ratio of midwives to births was 1:28.2 (35.46 per 1000 births) which was in line with national guidelines. The Safe Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG), recommend a ratio of one midwife to 28 births.
- The trust did not use an acuity tool to determine staffing levels. However, on a monthly basis, staffing levels were reviewed where they completed a trust-staffing template, the ‘Intrapartum Scorecard’ which showed the number of midwives per 1000 birth ratio.

## Assessing and responding to patient risk

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- The Intrapartum Scorecard is a tool for monitoring and improving patient safety in maternity units. Data collected using the scorecard can be used to:
  - Demonstrate staffing and activity levels on the labour ward which can then be used prospectively to inform planning of staffing and activity and/or escalation procedures;
  - retrospectively provide evidence of staffing levels, activity and any action taken to escalate a situation where necessary;
  - Support serious untoward incident investigations where information about these measures may contribute to the understanding of the situation at the time of the incident;
  - Provide a record of activity and staffing over a period of time and feed into the RCOG dashboard.
  - From October 2014 to September 2015, there were 63.8 whole -time equivalent (WTE) midwives (which included 3.9 WTE specialist midwives), and 12.8 WTE maternity support workers.
- In June 2015 to September 2015, data showed maternity services were slightly under the establishment for qualified staff. The number of planned qualified staff was 70.4 WTE and the actual number was 69.1 WTE. However, the actual number of unqualified staff was above the planned number. The number of planned unqualified staff was 13.4 WTE and the actual number was 13.8 WTE.
- The number of shifts 'filled' on the maternity wards for registered midwives from July 2015 to October 2015, ranged from 86% - 93% for days and from 99% - 101% for night shifts. The number of shifts 'filled' on the maternity wards for care staff from July 2015 to October 2015, ranged from 103% - 158% for day shifts and from 158% - 183% for night shifts.
- Information from the trust stated that women had a named midwife who was responsible for their care. Women confirmed this at the time of inspection.
- There was an escalation policy to address staffing shortfalls. We heard how the delivery suite, midwife coordinator had an overview of the unit. Changes were made where needed to ensure there was sufficient staff to meet patient needs. This may have included the support from a supervisor of midwives or the on-call community staff.
- We heard how although new staff had been recruited and in post, the unit was still experiencing staffing shortages and on several occasions had used the escalation policy. New staff had been recruited and working in the unit, some were on induction, and therefore supernumerary.
- Staffing levels were displayed on the delivery suite and ward corridors. There was a correlation on most days between planned and actual staffing numbers. In some instances, there was new staff in post and they were extra to the displayed figures and therefore supernumerary. On one of the days of our inspection, we saw two staff were supernumerary.
- However, during our inspection, one of the managers informed us about the workload the previous evening. They said their unit had been quiet, therefore they had one of their staff work in another area where they were busy. On another occasion, a member of staff went home ill and another phoned in sick. The remainder of the staff, including the Risk Midwife, discussed the workload, and covered the shift.
- During our inspection, we also heard how a delivery suite coordinator had not followed the escalation policy correctly. A community midwife had been requested to attend the unit, and the Supervisor of Midwives (SoM) was not notified, as per procedure. Consequently, the incident of not following procedure was reported and for investigation.
- The Professional Advisory Panel (PAP) met weekly and reviewed monthly, staff movement within the unit as part of on-going monitoring of safe staffing levels. This included when the escalation policy was used. Information from that group was then discussed at the Maternity Risk Management Group; the Risk Midwife, Consultant Gynaecologist and Obstetrician and senior managers from each area within women's services, were part of that group. Therefore, all managers of the service were aware of the risks and concerns within the unit.
- We saw a handover taking place from night to day staff on the antenatal/ postnatal ward and separately on delivery suite. The form used, contained information about learning, and updated within the service. Clear comprehensive information was provided in both instances. Information was included about staffing levels, and the number and dependency levels of women and where appropriate, their babies.
- Ward staff reported the delivery suite co-ordinators telephoned and visited the ward for updates and they felt supported by the process.

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- Staff reported, on occasions when labour ward had been busy, they had been moved from the ante/postnatal ward. The labour ward co-ordinator told us in the first instance they would take staff from the ward, but if the ward was busy they would ask the community midwives to assist with cover.
- From October 2014 to September 2015, trust incident reporting data showed there were 31 incidents relating to staffing; all of these were rated as not causing any harm. Of these, 16 were when community midwives were requested to work in delivery suite.
- Between June and September 2015, the maternity dashboard showed there were three occasions in July 2015, when staff moved within the unit and one in September 2015. During the same period, the escalation policy was implemented twice in June 2015, and for the same period, two women were not able to have a planned home birth.
- Labour ward staff told us, staff had retired in December 2015, and they were aware the vacant posts were advertised. Midwives and Health Care Assistants were also on induction, worked supernumerary and therefore not included in the numbers. The staff told us the trust used bank staff from NHSP to cover gaps in the rota and many of these employees already worked at the unit. They also told us, lists were provided each month with extra paid shifts for staff to cover. The member of staff confirmed the duty rota for the following month did not have many vacant shifts to cover.
- During the inspection, a senior manager told us that staffing levels from November 2015 to January 2016 were 'tight' due to retirement and maternity leave. Several vacant staff posts across the organisation had been filled and further vacant posts were advertised. For example, band six, 1.6WTE midwife posts were currently out to advertisement. They told us, by April 2016, they hoped to have a full establishment of staff.
- The antenatal manager was also the screening coordinator and worked 37.5hrs per week. In addition there was a deputy screening coordinator, 7.5 hours a week.
- Community midwives had a caseload of 1:80/100, which was in line with national guidance.
- The trust did not audit records to show what percent of women received one to one care in labour. However, women told us they had received one to one care in labour and staff had recorded this in the care records we inspected.

## Medical staffing

- The CQC data pack showed there were 26% (20 whole time equivalent (WTE)) consultants employed by the trust, compared to the England average of 35%. Twenty-eight percent, middle grade staff, 36% registrars and 10% junior doctors. This compared with the England average of 8% middle grade doctors, 50% registrars and 7% junior doctors.
- From July 2014 to June 2015, the weekly consultant cover on the labour ward was 44hours.
- Trust information stated there was a designated consultant presence on delivery suite Monday - Friday 08.00 - 16.30h. The consultants provided this on a sessional basis, ensuring that there was always a consultant designated, even when there was unplanned or planned leave.
- We saw on the maternity risk register, dated May 2014, showed there was a gap in Consultant Obstetrician staffing levels. The information had been reviewed in March 2015, and showed the risk had been reduced.
- One of the consultant obstetricians said that sometimes they needed to 'act down' due to shortages in the junior staff rota.
- At weekends and on bank holidays the on-call consultant attended at 8am and carried out a ward round. Out of hours, the on-call consultant was required to attend within 30 minutes when needed. There were guidelines, (Medical Staffing on the Delivery Suite) that detailed the circumstances in which the consultant on-call would be required to attend.
- There was a second on-call resident doctor (and this role was in place at all times). This doctor had to have at least two years' experience in obstetrics and gynaecology and have a minimum of level three specialist training (ST3).
- The unit was staffed by three specialty trainees (ST3 or above), four full-time specialty doctors and one part-time specialty doctor. The second on call shifts, were from 8am – 8.30pm and 8pm - 8.30am, with a built in 30 minute handover period. There was also a first on-call resident doctor at all times. Foundation 2 (F2) doctors, General Practice Vocational Trainees Specialists, (GPVTS) and Obstetrics and Gynaecology Specialty trainee's year 1 – 2, covered this role. The shift pattern matched that of the second on call rota. The first on-call could be 'called' for support in an obstetric emergency and required to attend immediately.

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- From July 2014 to March 2015, the use of medical locums ranged from 1.3% to 14.4%.
- We discussed the medical staffing with the Clinical Director for delivery suite and elective care. They told us there were six consultants, currently five of whom were covering a six-person rota.
- Daily antenatal and postnatal ward rounds took place daily in line with current guidance and staff reported consultants were contactable when required.
- We observed a medical handover on labour ward. It was comprehensive and involved a multidisciplinary team of staff. The staff used a prepopulated template, which contained contact telephone numbers such as, doctors/ anaesthetists on-call, haematology, biochemistry and extension numbers of theatre bookings, wards, delivery suite and departments. It also contained information about the diagnosis of patients in the hospital, any procedures outstanding, clinical information and management. The form gave a clear indication of which patients were in the unit, the medical condition of those patients, and the workload of the staff. This helped ensure patients were safe.
- At the morning handover, a case conference takes place and individual cases discussed in detail with the multidisciplinary group of staff.
- The trust identified on their risk register in June 2014, that guidelines were out of date and there was a lack of capacity to update them. In January 2015, the risk remained on the register as 'low,' and a guideline group was established. The update of the guidelines was being monitored through the Maternity Risk Management Group (MRMG). At our inspection, 18 (24%) out of 75 guidelines on the intranet, had exceeded their date of review and as such were out of date.
- We found patient outcomes were monitored using the maternity dashboard. Two of the outcomes were above the trust target, they related to third degree tears and post-partum haemorrhage (PPH).

However, we also found:

- Staff had the skills, knowledge and experience to do their job.
- Multidisciplinary working took place; Obstetricians and gynaecology and midwifery staff worked well as a cohesive team and supported each other in providing safe, well- led care.
- Women reported having their pain effectively managed and there were choices for managing pain.
- Women were offered support to feed their baby's, and food and drinks were always available for mothers.
- Consent to care and treatment is obtained in line with legislation and guidance.

## Major incident awareness and training

- There was a major incident plan, which outlined the roles and responsibilities of staff in each area.
- Midwives attended skills and drills training each year. (Yorkshire, Emergency Training (YMET)) The training was attended by multi professional staff and included scenario based on maternal and neonatal emergencies. In January 2016, 79% of midwives and 75% of medical staff had training.

## Are maternity and gynaecology services effective?

Requires improvement



We rated maternity and gynaecology services for effective as requires improvement because:

- Staff appraisal rates were 63.6% and not meeting the trust target of 75%. All staff must have annual appraisals.

## Evidence-based care and treatment

- In December 2015, maternity services undertook an audit of intrapartum monitoring, comparing current practices of monitoring in labour against the National Institute for Health and Care Excellence (NICE) guidelines. An action plan showed the current labour guidelines were not in line with NICE guidance and there had been changes in interpretation of CTG's. Action plans from the audit included; writing new guidelines, update the CTG e-learning package and deliver training to all staff. A re-audit was to take place following the training and implementation of new documentation. This showed ongoing compliance and monitoring had been identified.
- We inspected three guidelines on the trust website relating to gynaecology. These included, the Criteria for all health professionals to refer patient to early

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pregnancy assessment, the Management of early pregnancy complications, and Intramuscular policy for ectopic pregnancy. The review dates were 30 November 2017, 1 January 2018, and 30 April 2016, respectively.

- The general, patient information leaflets were in date, with the exception of, 'Day Surgery general information,' and 'Inpatient general information.' The review dates were 31 December 2012 and 31 December 2012, respectively.
- In the women's unit, 18 patient information leaflets we inspected were in date. However, when we inspected the maternity guidelines staff accessed via the intranet, 18 (24%) out of 75 were not in date. These included, the 'Emergency department, guidelines for pregnant and recently delivered women' and 'Diabetes in pregnancy.' The review dates of these guidelines were 26 September 2014, and 30 September 2013, respectively. Several of the 18 guidelines that were not in date, had a review date of 2015.
- On 27 June 2014, the trust risk register identified, a number of maternity guidelines were out of date and there was a lack of capacity to update them. In January 2015, the trust updated the register. A guidelines group was established and progress was monitored through the Maternity Risk Management Group (MRMG). Minutes of the monthly MRMG meetings, dated April, June and December 2015, showed guidelines were being updated and ratified.
- In September 2013, The NHS Litigation Authority Clinical Negligence Scheme for trusts (CNST) undertook an assessment of maternity clinical risk management standards. The service was assessed against five standards including, clinical care, high-risk conditions, organisation, communication, postnatal, and new-born care. The maternity service was compliant with 47 out of the 50 criterion and achieved level two status. The assessment found that risk management processes, were well embedded; there was a systematic approach for delivering specialist training to staff and parents had postnatal support in cases of poor outcomes for the new born. Areas of non-compliance included, approved documentation to describe the management of venous thromboembolism (VTE).
- In December 2015, an obstetrics and gynaecology, (all health care professional staff) training session took place. This was to update staff in the use on VTE assessments and audits, which had taken place. Further VTE training had been arranged for March 2016. All nine-care records we inspected for VTE risk assessment contained correctly completed documentation.
- In January 2015, the trust completed an audit to assess the compliance of prescribing antibiotics, following either a termination of pregnancy (TOP) or surgical management of a miscarriage (SMM). They audited compliance against NICE and RCOG guidelines. The guidance stated all women having a surgical TOP/SMM should be prescribed antibiotics prophylactically. The audit reviewed 25 patients and found overall compliance was poor. Prophylactic antibiotics, had been prescribed to 56% of these patients. Minutes from the March 2015, antimicrobial prescribing subgroup showed there was a problem accessing the surgical prophylaxis guidelines in theatre. This was because the laminated posters had been removed from the anaesthetic room, on advice of infection control. The action from this was the group would look into making the guidelines more prominent on the intranet. The annual audit programme 2015/16 showed, the trust were on target for repeating the audit this year.
- Obstetrics and gynaecology services audited the prescribing of prophylaxis antibiotics and appropriate treatment of wound infections, following a Lower Segment Caesarean Section (LSCS). The audit found the number of patient who received appropriate prophylaxis was 97%. This was an improvement from 71% in 2011. The audit made some recommendations, including educating doctors and theatre staff on the antimicrobial policy for SMM and surgical TOP and ensuring all patients have a chlamydia test prior to a surgical TOP or SMM. The trust's audit programme showed they were 'on course' for completing the re-audit in these areas.
- In September 2015, a screening programme, quality assurance report was completed for the trust in conjunction with NHS screening quality assurance services. The aim of the report was to review the standards in antenatal and new-born screening to ensure people have access to a high quality service. The review team identified no immediate concerns. Areas of good practice were identified. These included promotion of early access to maternity services via on online self-referral for women. They also noted, the service had comprehensive antenatal and postnatal care guidelines along with antenatal and new born

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screening specific guidelines. A number of recommendations were made and included, a formal contingency plan in the absence of an antenatal and new born screening coordinator. At the inspection, we met the newly appointed antenatal and screening coordinator and the trust continued to address the action plans, relating to the other recommendations of the report.

## Pain relief

- We spoke to three women on the maternity unit; they said they had regular access to pain relief. Two of the women had received an epidural and both said they had received the epidural promptly with no delays.
- The percentage of women who had an epidural between April 2015 and November 2015 ranged from 18.8% to 25.7%
- Other forms of pain relief included Entonox, and a birthing pool was available.
- A hypnobirthing service had recently been introduced. This is an approach to birth that teaches breathing exercises, relaxation techniques and self - hypnosis. It aimed to help women approach their baby's birth with confidence and enabled them to remain calm and in control, whatever course their birth took.
- In all of the seven care records inspected, we found there was a recognised pain score assessment tool being used.

## Nutrition and hydration

- An infant feeding coordinator was responsible for training staff and ensuring compliance with United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit achieved accreditation in 2002.
- Women told us they were educated and supported with breastfeeding.
- Between April and June 2015, 84.7% of women following delivery were breast-feeding and this figure was similar to other trusts. Of these, 73.2% of women were breastfeeding on discharge from hospital.
- Women had advice on a healthy lifestyle, choices and nutrition; we saw information relating to this in the antenatal clinic and available in each area we visited.
- Meal times were protected which helped women to have their food undisturbed. Breakfast was self- service, consisted of cereals and toast, and was available

between 5.30 - 10am. Lunch was served at approximately, 12midday and the evening meal at 5pm. Women had a menu card with a choice of food, and these were completed each day.

- Beverages were encouraged and readily available throughout the unit.

## Patient outcomes

- The number of births between April 2015 and November 2015, at Harrogate and District NHS Foundation Trust was 1,321. Of these births, the percentage of normal vaginal deliveries ranged from 57.1% to 67.4%. This was in line with the national average of 60%.
- Data from the maternity quality dashboard showed between June and November 2015, the percentage of deliveries that required either forceps or Ventouse method of delivery, were within the trust targets.
- Emergency caesarean section rates were 15.8%, which was comparable with the England average of 15.2%. Elective caesarean section rates were 12.1%, which was slightly higher than the England average of 11%.
- Teenage pregnancy (under 18 years of age) rate was 16.8%, compared to the England average of 34%. From July 2014 to June 2015, the percentage of births to mothers under the age of 20 was 2.7%. This was below the England average of 3.7%. The percentage of births to mothers aged 20-34 was 71.5%, which was also below the England average of 75.8.
- The maternity service quality dashboard reported 51, third and fourth degree tears, between April 2015 and November 2015. This was above the trusts target of less than three a month. In December 2015, the rate of third and fourth degree tears reduced to 2.7% of deliveries. A review of each case had taken place and an audit was taking place to help determine the cause. The Professional, Advisory Panel (PAP) and the Quality Risk Management Group (QRMG), attended by the Risk Midwife, were monitoring this issue. The data was included on the Maternity Dashboard and monitored by the Trust Board.
- The rate of post-partum haemorrhage (PPH) of greater than 1.5 litres between April 2015 and November 2015 was 48. This was against the trust target of less than two a month.
- The Clinical Governance report, Quarter 2 July to September 2015, stated the incidence of PPH had been identified as a consistently high reported clinical incident. It also stated that there was an uncertainty

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whether the form used to report the incident, had been completed correctly, leading to an under reporting of incidents. An audit of cases by a Supervisor of Midwives (SoM) and Risk Management Midwife, found no clearly identifiable cause. A subsequent audit from October 2014 to March 2015, suggested an incidence of 3.6% of all deliveries. The QRMG meeting minutes, in December 2015, showed the PPH rates were discussed as remaining a highly reported clinical incident. The Consultant, Gynaecologist and Obstetrician on the group, stated they thought staff were now better at recognising a PPH, and there was no immediate need for a further audit at this time. At the supervisors of midwives meeting dated August 2015, they had agreed actions the delivery suite coordinators would take to help reduce the incidence of PPH and emergency management should it take place. [SK1]The incidents would continue to be monitored.

- Between July 2015 and October 2015, there were four maternity admissions to the intensive care unit (ICU)/ high dependency unit (HDU). This was within target for the trust.
- Between April 2014 and March 2015, 159 termination of pregnancy (ToP) were carried out. Of these 99 were medical and 60 were surgical terminations of pregnancy.
- The stillbirth rate from April 2014 to March 2015 was seven and the number of early neonatal deaths for the same period was three. (A stillbirth is a baby born dead after 24 completed weeks of pregnancy.)

## Competent staff

- Midwives had statutory supervision of their practice and confirmed they had access to a supervisor of midwives for advice and support 24 hours a day.
- Newly qualified staff had a named Supervisor of Midwives (SoM), a preceptorship programme; this provided the staff with support and a framework to develop competencies. They worked as supernumerary for a period in time.
- The supervisor to midwife ratio was 1:15 and this was in line with the national guidance of 1:15.
- Between April 2015 to January 2016, trust data showed 63.6% to 75% of staff had received an appraisal. Some staff told us they had received an appraisal and were up to date. However, other staff told us they were a little behind appraising their staff. For example, the community midwifery manager said that although they

were a little behind appraising their staff, dates were in place to address this. Other staff were relatively new in post and had not had their appraisal yet. Managers told us they had not had the time to bring all their staff up to date with their appraisals.

- The consultant obstetricians provided support and mentorship for junior doctors.
- Medical staff were up to date with their revalidations. Doctors who wish to keep their licence to practise in the have to demonstrate to their regulating body the General Medical Council (GMC) normally every 5 years – that they are fit to practise and up to date, by complying with the relevant professional standards.
- Gynaecology nurses had additional training and maintained competencies for their role.
- There were midwives with special interest. These included safeguarding, neonatal screening, practice development. In addition, there was a risk management midwife and an infant feeding coordinator.

## Multidisciplinary working

- Multidisciplinary working took place across the unit and staff were encouraged to provide an integrated approach to the services provided. An example of this was staff attended joint meeting such as, the Professional, Advisory Panel (PAP), the Maternity Risk Management Group (MRMG) and the Maternity Service Forum. The multidisciplinary team included all senior managers, heads of services, specialist midwives, and in some meetings patient representatives, trust governors.
- Staff told us how the Consultant Obstetricians and gynaecology and midwifery staff worked well as a cohesive team and supported each other in providing safe, well- led care.
- Protocols were in place for transfer of patients to other trusts when specialist treatment or care was required. We saw this in practice during our inspection. The consultant spoke with the accepting consultant and arranged the transfer. A letter written and the handover was thorough.
- Community midwives had a base next to the antenatal clinic and communication between those two teams worked well. Processes were in place for the community midwives to follow up patients who had missed antenatal appointments.
- Clinicians worked closely with GPs and social services when dealing with safeguarding concerns, such as child protection.

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- The Public Health midwife and Targeted Youth Support advisor worked in partnership with other agencies in Harrogate to deliver a joint approach to care for pregnant teenagers and teenage parents. Bumps2Babes was a package of care which provided antenatal care and information/advice sessions including, information about lifestyles, labour/delivery, infant feeding and other health related information.
- The trust was part of the Harrogate Health Transformation Board, in providing better health, in Harrogate and the rural areas.
- The Early Pregnancy Unit (EPAU) with the exception of Saturday was open six days a week, 9am to 2.30pm. Scans were available each day as the staff on the EPAU, were qualified to scan.
- The maternity assessment unit (MAU) was open Monday to Friday 8am to 8pm and outside these hours, women were requested to contact delivery suite.
- Community midwives provide routine services daily between 9 am – 5pm and contacted out of hours by the on call system for emergencies

## Seven-day services

- From July 2014 to June 2015, the average number of hours per week consultant cover on the labour ward was 44hours. This complied with the Royal College of Obstetricians & Gynaecologists best practice standard for consultant labour ward cover.
- The unit was staffed by three specialty trainees, four full-time specialty doctors and one part-time specialty doctor. The second on call shifts, were from 8am to 8.30pm and 8pm - 8.30am, with a built in 30 minute handover period.
- Staff reported consultants were contactable when required and this included out of hours and weekends.
- At weekends and on bank holidays the on-call consultant attended at 8am and carried out a ward round. Out of hours, the on-call consultant was required to attend within 30 minutes when needed. There were guidelines, (Medical Staffing on the Delivery Suite) that detailed the circumstances in which the consultant on-call would be required to attend.
- A team of specialist registrars and doctors contributed to a rota to provide onsite medical cover for each 24-hour period.
- Routine Obstetric theatre sessions took place in the main hospital theatre, three times a week. A separate theatre was also available in the delivery suite, for emergency maternity cases. We observed the use of the delivery suite theatre during our inspection and the process/ procedure was appropriately actioned by staff.
- A dedicated theatre team and obstetric anaesthetist provided 24 hours a day, seven days per week cover. The anaesthetist had an emergency 'bleep' and number, specifically used for emergency labour ward cases.
- Patients who used the services had access to informative literature. This included, smoking cessation classes and leaflets, active birth classes, breastfeeding support, and information about antenatal scan.
- Copies of patient's delivery summary were sent to their GP and health visitor to inform them of the outcome of the birth episode. Electronic discharge letters were used and we heard how this had helped improve communication to GPs.
- We spoke with community midwifery staff who told us they had regular contact with health visiting services and GPs.
- The unit had developed its own Facebook page in July 2015, for women who used the service. It provided feedback and was a forum of information on maternity services. The Facebook page was also used to exchange information between midwives and women as a way to improve communication.
- The maternal health record had coloured inserts relating to different types of information. This would have assisted women and staff when using the records. For example, a pink form was used to identify the antenatal VTE assessment; a yellow form was used to advertise interactive educational maternity classes and red for home birth coffee afternoons. .

## Access to information

## Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards(DoLS)

- Records reviewed showed women were consented appropriately and correctly for surgical procedures. Records for consent to surgical or medical termination of pregnancy (ToP) were in line with the Abortion

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Regulations 1991 and the Department of Health guidance, in reference to the Royal College of Obstetrician and Gynaecologists Guidelines (RCOG): The Care of Women Requesting Induced Abortion (2011).

- We found the midwives understood the purpose of the MCA (2005) and the Children's Act 1989 and 2004.
- Information provided by the trust confirmed 28 maternity staff had completed MCA and DoLS awareness training and six had attended a Masterclass. The trust was currently drafting a new training needs analysis and would identify which staff needed the training.
- Staff knew about Gillick competency assessments of children and young people. These were used to check whether these patients had the maturity to make decisions about their treatment.

## Are maternity and gynaecology services caring?

Good



We rated maternity and gynaecology services as good for caring because:

- Staff involved women in their care and treated them with compassion, kindness, dignity and respect. When in labour, women were encouraged to bring their birthing partners with them, and they were made to feel welcome.
- Women were involved in decisions about their care and felt supported by staff. Results from the 2015, CQC survey showed in three out of nineteen questions asked, the trust scored better when compared with other trusts. They scored about the same compared with other trusts for the remaining sixteen questions. The information showed women's partners were involved as much as they wanted during labour and were given appropriate advice and support.
- There was a midwife with a special interest in the care of the bereaved and procedures in place to support parents in cases of stillbirth or neonatal death.
- A chaplaincy service provided support to women and their partners following pregnancy loss. When requested they assisted with arrangements conduct a funeral service.

- Support groups contact details, such as counselling and screening services were available to assist women and their families.

However, we also found:

- On the Early Pregnancy Assessment Unit (EPAU), the communal waiting room which was shared with general patients, could potentially compromise a patient's privacy and be seen as insensitive to their needs.

## Compassionate care

- As part of our inspection, we observed care being delivered and listened to staff speaking to patients and relatives on the telephone. They were supportive and sensitive to their needs.
- The trust had 152 responses to the CQC maternity service survey in 2015. Harrogate maternity scored better in comparison to other trusts for the care women received during labour and birth, and the care they received in hospital after birth.
- In September 2015, the NHS Friends and Family Test results showed: a relatively low response rate of 26.7%. However, the responses were positive and 98.5% would recommend the service. One hundred percent of community postnatal patients would recommend the service.
- The NHS Choices website had one response in November 2015, relating to the maternity services at Harrogate. They rated the service as five stars and said their partner had received brilliant care and aftercare. They had been present at the birth; their partner had been supported with breastfeeding and advice, and the staff were kind.
- The trust had recently introduced a Harrogate Maternity mums and midwives Facebook page, where they received and responded to feedback.
- We spoke with three women on the antenatal/postnatal ward; all spoke positively about their experience and the care they had received. They told us that midwives responded promptly when requested for assistance and advice; they ensured patients were comfortable.
- When in labour, women were encouraged to bring their birthing partners with them, and they were made to feel welcome.
- We saw letters/cards of appreciation and positive comments about people's experience of the unit.

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- Patients who completed CQC 'share your experience' forms prior to inspection told us, staff were caring and they felt they were treated with dignity and respect.
- Gynaecological services included Termination of Pregnancy (ToP) and an early pregnancy, assessment unit (EPAU). The female gynaecology ward provided in-patient treatment for a range of gynaecological conditions. Female urology and general surgery patients were also admitted to this ward.
- The EPAU was a nurse led unit, with consultant supervision. The staff were qualified and competent in their area of work; they were enthusiastic about the service and care they provided. They were also sensitive to the needs of the patient's in their care.
- The waiting room/dayroom was at the entrance to the ward and used by EPAU and the general ward patients. There was a small quiet room, used for sensitive meetings. Staff gave examples of how they maintained patient privacy and dignity and be sensitive to their needs. They tried to ensure they met patients at the ward door, when an appointment made to attend the EPAU.
- Staff also said they tried to ensure their patients did not sit in the communal sitting area with other patients from the general ward. However, as this was not always possible, the use of combined sitting areas, could potentially compromise a patients privacy and be seen as insensitive to their needs.

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

- Women told us they had been involved in decisions about their choice of birth and felt supported by staff. Records showed staff discussed birth options and a plan at booking and during the antenatal.
- Information about the unit was available on the trust intranet to help inform and involve women in their care. For examples, there was information relating to care (pathways) they should expect to receive during their pregnancy.
- Results from the 2015, CQC Maternity Service Survey showed in three out of nineteen questions asked, the trust scored better when compared with other trusts. They scored about the same compared with other trusts for the remaining sixteen questions.

For example they scored:

- 9.6 out of 10, for partner's involvement and being involved as much as they wanted.
- 9.2 out of 10, for being given appropriate advice and support. These results were similar to other trusts.

## Emotional support

- There was a midwife with a special interest in the care of the bereaved and procedures in place to support parents in cases of stillbirth or neonatal death.
- Several staff had received bereavement training, and support provided by the Stillbirth and Neonatal Death Charity (SANDS). SANDS is a charity providing support for bereaved parents and their families. Staff who previously looked after a women who suffered bereavement, attended their annual memorial service.
- There was a separate bereavement room within the unit, so women and their families experiencing pregnancy loss had privacy.
- There were effective and confidential processes for women attending the pregnancy advisory service. Staff supported women to make informed choices about their termination of pregnancy options. Specialist gynaecology nurses undertake a holistic needs assessment, which ensured the emotional needs of women prior to surgery.
- Staff sensitively supported women experiencing pregnancy loss, in their choice about disposal of foetal/placental tissue.
- A chaplaincy service provided support to women and their partners following pregnancy loss. When requested they assisted with arrangements and conduct a funeral service.
- The trust website provided a list and contact details of support groups to assist women and their families, these included: Sick cell and Thalassaemia Association of Counsellors, UK Thalassaemia society, The NHS New-born Screening Programme, and information relating to antenatal results and choices.

## Are maternity and gynaecology services responsive?

Good



We rated maternity and gynaecology services as good for responsive because:

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- The appointment times for patients booking into antenatal clinic and having the type of care they wished planned, were meeting trust targets.
- Waiting times, delays and cancellations were minimal and people were kept informed of any disruption to their care or treatment.
- The needs of different people were taken into account when planning and delivering the service.
- Staff were aware of the diverse needs of the women they cared for and there were arrangements in place to support individuals with complex needs,
- The trust was open and transparent in responding to complaints.

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

- The maternity team had worked on developing outreach services to provide a full maternity pathway to women out of area, who chose Harrogate District Hospital to have their baby. This had enabled outreach clinics to be established in Yeadon and Otley, with further work being undertaken, to explore potential opportunities in North and East of Ripon. This strategy would enable the trust to increase the number of deliveries in Harrogate and support the increase in consultant Obstetrician/Gynaecology numbers.
- The Trust was planning to increase the number of births to approximately 2,500 per annum; it also planned to employ an additional two Obstetric Consultants within the next five years. This was to ensure that the service continued to be sustainable in the longer term.
- Two additional midwives were recruited to support the maternity service in 2014/15; and a further midwife appointment to be made in 2015/16, as the number of births increased.
- A senior midwife held a Pregnancy and Birth Revisited clinic and they supported women in planning subsequent and current pregnancies.
- Hypnobirthing sessions were available for women, run by midwives who were accredited by the Hypnobirthing Association. This initiative was to promote normality and improve the patient experience during labour/delivery; it is an effective and recognised coping mechanism for women in labour.

- A consultant obstetrician and gynaecologist held a 'one stop shop' Uro-Gynae. clinic (joint provision with Physiotherapy). It included a comprehensive and sensitive service in the follow up care of women who had experienced a third degree tear.
- Community midwives were committed to home births and provided care for women in labour at home, as long as their pregnancy and previous medical history were risk free.
- In order to keep babies with their mothers on the postnatal ward, the staff provided transitional care. Transitional care was an area where babies who needed a little more nursing care and monitoring could stay with their mum rather than go to the Special Care Baby Unit. This meant mum could continue to be the main carer of their baby.

## Access and flow

- Between January 2014 and June 2015, the maternity unit had not closed.
- We saw bed occupancy for the previous 12 months was lower than the England average.
- The percentage of patients booked into antenatal clinics within 12 weeks 6 days was between 94.7 to 100% between April 2015 and October 2015. This was meeting the trust target of more than 90%
- The trust were also meeting their target for patients having the type of care they wished to receive; planned by 12 weeks of pregnancy.
- Triage of patients took place in the Maternity Assessment Centre, Monday to Friday 8am to 8pm, outside of these hours women were asked to contact labour ward.
- In September 2015, one woman had their induction delayed by 24 hours due to increased activity on labour ward.

## Meeting people's individual needs

- All staff were aware of the diverse needs of the patients they cared for.
- Staff told us they had access to a translation service for patients whose first language was not English; this included a telephone or face-to-face service.
- Staff told us texting services were used for women with a hearing impairment.
- There was a network of midwives and consultants with lead roles and special interests in areas such as public

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health, teenage pregnancy, substance misuse and/or mental health issues, bereavement, safeguarding, infant feeding, safeguarding, antenatal screening, practice development, and risk management.

- There were arrangements to support individuals with complex needs, with access to clinical specialists and medical expertise.
- Hypnobirthing sessions were available was to promote normality and improve the patient experience during labour/delivery.
- Following pregnancy loss or termination women were offered a choice in the disposal of the pregnancy remains. They were also offered support with funeral arrangements.
- A chaplaincy service was available 24 hours a day.

## Learning from complaints and concerns

- The service had a system in place for handling complaints and concerns and staff were aware of the procedure to follow.
- A complaints management report published in February 2015, showed there were effective support systems and processes in place for the management of complaints. This included a policy and procedures, leadership and accountability. At the time of the report, 84% of staff had attended a complaints training workshop.
- From September 2014 to September 2015, there were three concerns/complaints relating to gynaecology inpatient stay. In maternity services for the same period, there were eight; one related to the antenatal clinic, three in delivery suite; three on the antenatal/postnatal ward and one in the community. There were no themes were identified however action had been taken where appropriate, in response to concerns and complaints. For example, in one case a patient had questioned if an anaesthetic had caused them to have a miscarriage. A meeting was arranged with the patient and the consultant to discuss the concerns.
- We saw an example of a letter in response to the outcome of a complaint. The trust had apologised and had included an apology when their reply was not within the agreed timeframe for response.
- Complaints were discussed at the Maternity Risk Management Group meetings and learning disseminated to staff through bulletins, updates and meetings.

## Are maternity and gynaecology services well-led?

Good



We rated maternity and gynaecology services as good for well-led because:

- The trust had a vision and strategy that staff knew about.
- There were clear lines of responsibility and reporting to board level.
- A register was used for recording key risks, actions taken to mitigate the risks, which were regularly reviewed.
- The service actively sought the views of women and their families.
- Staff were engaged, motivated, innovative and supported by their colleagues and line managers. However, some staff told us they did not always feel supported by senior management; they were not always visible.

## Vision and strategy for this service

- There was a strategic business plan for women's services, and managers were clear about the risks, areas for development, and vision of the service.
- Staff, patients, service users and their carers had helped to inform and develop the trust values and behavioural framework.
- Staff were enthusiastic in their roles and proud to be part of the obstetrics and gynaecology team.

## Governance, risk management and quality measurement

- Staff were aware of the governance arrangements in place and who to report risks. We saw from minutes of meetings that risks, complaints, incidents and litigations were discussed and actions shared through the weekly monthly Maternity Service Forum.
- The governance arrangements ensured the board was aware of risks and was able to monitor progress against action plans.
- Trust wide and service wide risk registers were in place and regularly reviewed.

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- Managers and matrons were aware of the risks in their areas and knew how to escalate risks through the organisation when needed.
- This included the out of date guidelines and the lack of capacity to update them. The update of the guidelines was being monitored through the Maternity Risk Management Group (MRMG).
- Staff were aware of the Duty of Candour (DOC) and about being open when things went wrong. Leaflets were sent to all staff explaining the DOC, briefings and training was held and it was included as part of the induction for all new staff.
- The service had completed a gap analysis following the publication of the Kirkup report (2015). Following the analysis, an action plan was written which included timescales and updates as to when the actions had been addressed.

## Leadership of service

- There were clear lines of responsibility and reporting to board level of which the Head of Midwifery, Nursing, Elective Care Directorate (HoM, Non-Executive Directors) had access.
- A Consultant and Clinical Lead, and a Consultant and Clinical Director, Elective Care were the lead consultants for the service. They worked closely with the HoM, NED.
- The minutes of the MRMG and the MSF showed both the Consultants and HoM attended each meeting. This showed their commitment to ensure they were aware of the risks of the organisation, monitor actions and progress and report to the trust board. It also showed they were visible in meeting with the staff.
- Each midwives had a named SoM; the trust achieved a SoM ratio of less than 1:15 every month between May 2015 and September 2015. This was in line with national guidance.
- The labour ward had a rota of midwife coordinators and senior staff.
- Staff were engaged, motivated, innovative and supported by their colleagues and line managers. However, some staff told us the HoM and Matron were not always visible and therefore they did not always feel supported.

## Culture within the service

- Morale was good in most areas and staff were positive and enthusiastic about their roles and responsibilities.

- Staff said they enjoyed working at the unit and their immediate managers and peers supported them.
- Staff said they could raise concerns and felt listened to. They talked about a positive culture in which staff received open, non-judgemental feedback relating to when things had gone wrong and not according to plan.
- Staff were motivated, supported by the trust to improve and deliver services and this was evident in how services had been developed. For example, the Hypnotherapy service.
- Feedback from staff included, it is a "Happy place to work." The culture and ward environment has improved over the last month." I had "Great support to return to work following a long absence." "I feel we can contribute and our ideas are listened to."

## Public engagement

- The service actively sought the views of women and their families. A ward/delivery suite, in-patient information booklet had been developed in liaison with people who used the service and staff. It provided important information for patients, and helped to make their stay more comfortable. The booklet contained important information such as, mealtime arrangements, breast feeding advice and support.
- The trust had introduced a Facebook page in July 2015, for women who used the service. It provided feedback and was a forum of information on maternity services. The Facebook was also used to exchange information between midwives and women as a way to improve communication
- The service had developed a trust website, virtual tour of the unit. It included information on the importance of security. It also orientated women and their partners to the environment. This could help them feel relaxed and promote a positive experience for the women and their family.
- Antenatal classes and coffee mornings were promoted. An invitation to these was distributed in the women antenatal notes during their visits.

## Staff engagement

- The outcome of the NHS staff survey 2015 was positive. The results had improved since the 2014 survey. The findings showed, 69% of staff, would recommend the organisation as a place to work, compared to 58% of

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other trust; 3.63% of staff felt valued and 3.87 felt supported by their immediate manager. This compared with other trusts as 3.42% and 3.72% respectively. All indicators from the results of the survey were positive.

- The General Medical Council, National Training Scheme Survey results were in the expected range of responses.
- The trust had developed a 'Maternity book'. A social media closed environment where midwives and medical staff could discuss and exchange ideas, information, and good practice points and evidenced based information. The team had been shortlisted for the Royal College of Midwives (RCM) Midwifery Service of the year award in recognition of this work.
- The majority of staff spoken with felt engaged with the organisation and were able to share examples of how they had been involved in making improvements to the service.
- Clinical staff were aware of revalidation regarding meeting the requirements of the Nursing and Midwifery Council.
- Staff had developed the ward/unit handover sheet. In addition to discussing patient care, the sheet contained update information for staff. This included, learning from incidents and changes to practice. Information was added to the sheet, as staff needed updating; it remained current for two weeks. The sheet was signed by the staff, as confirmation they had been read and then removed from circulation after two weeks.
- Monthly briefing helped keep staff up to date with events across the trust; Staff talked about monthly team/ site meetings where incidents, learning, training, and changes were discussed. We saw minutes of the monthly managers meetings and the meetings were well attended by manager from women's services across the trust.
- The trust had an annual awards ceremony; staff were recognised for good practice, innovations and contribution to the service.

## Innovation, improvement and sustainability

- The trust was shortlisted for the Royal Collage of Midwifery of the Year Award, for use of social media: They had introduced a Facebook page in July 2015, for women who used the service. It provided feedback and was a forum of information on maternity services. The Facebook was also used to exchange information between midwives and women, as a way to improve communication.
- The trust had developed a 'Maternity book'. A social media closed environment where midwives and medical staff can discuss and exchange ideas, information, good practice points and evidenced based information. The team had been shortlisted for the Royal College of Midwives (RCM) Midwifery Service of the year award in recognition of this work.
- A ward/delivery suite, in -patient information booklet had been produced. It provided important information for patients, and helped to make their stay more comfortable. The booklet contained important information such as, thanking them for choosing the hospital, meal times, breast feeding advice and support.
- Hypnobirthing sessions were available for women. This initiative was to promote normality and improve the patient experience during labour/delivery; it is an effective and recognised coping mechanism for women in labour.
- The maternity unit initiated a refurbishment project. The refurbishment included the development of an antenatal triage unit, upgrade to bathroom facilities, and the purchase and installation of a new birthing pool.
- NHS England had been working towards reducing stillbirths and early neonatal deaths; - Saving Babies in North England (SaBiNE) project. The trust achieved funding for joint work with the Perinatal Institute, to help embed element 2 of the care bundle, into maternity services.

# Services for children and young people

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

## Information about the service

Children and young people's services were located at Harrogate District Hospital, with a small number of children's outpatient appointments also offered at the Wetherby Health Centre. The service saw around 3,000 children and young people per year, with the majority being classed as emergency admissions. In addition, around 9000 new children and young people were seen in the trust's outpatient clinics alongside 16,000 follow up appointments. These were split between dedicated children's outpatient appointments and appointments where children and young people were on adult appointment lists so that they had access to specialist services (for example, in ophthalmology).

The service consisted of the Woodlands ward (the ward), the special care baby unit (SCBU) and children's outpatients. In addition, children and young people were seen and treated in A&E, day surgery, and theatres. Non-specialist paediatric surgery was undertaken by general surgeons, with all specialist paediatric surgery being undertaken away from the trust.

The ward contained 17 beds and up to six day case beds. These numbers included a dedicated high dependency (HDU) bed. The ward accepted patients for elective surgery, alongside emergency admissions via A&E, ambulatory patients attending A&E, and patients attending from GP services. SCBU consisted of seven cot areas and provided special care to babies born at over 32 weeks of gestation and that did not require ventilator support. The children's outpatient department consisted of four clinic rooms and provided appointments across a range of specialties.

During the course of our inspection we visited the ward, SCBU, children's outpatients, A&E, day surgery and theatres. We spoke to 17 staff members, ten parents of young children using the service, two young people and reviewed nine sets of medical records.

# Services for children and young people

## Summary of findings

We rated services for children and young people as requires improvement because:

The senior leadership group had only been in post for a relatively short period. This meant that there had not yet been time for the service to develop a comprehensive vision and strategy for children's services within the trust. Governance structures were in place, but further work was required to re-establish ward meetings and to establish engagement with staff groups and with the public.

Nurse staffing was not planned in accordance with recognised acuity tools and was not compliant with safe staffing guidance. Staff told us that this had impacted on the reporting of incidents, with staff feeling that incidents were under reported due to staffing pressures. Children and young people attending for surgery or via A&E were not always cared for in a suitable environment. Children who were placed on adult surgery lists were also not treated in accordance with national guidance. The trust understood this issue and plans were being developed to increase paediatric day surgery provision. No formal risk assessment had been carried out to consider the needs of children and young people who attended the ward with mental health needs and staff had not received training to support them in these situations. Staff had identified that there were shortfalls in training and had arranged training with a local NHS trust. The trust had not met its target for staff receiving appropriate levels of safeguarding training in accordance with national standards. Staff were achieving targets for mandatory training overall.

Cleanliness and infection control audits showed good performance by children and young people's services. We saw that staff were able to manage pain effectively and nutritional needs of patients were met. We also saw good examples of multidisciplinary working and information sharing with GPs. Care was appropriately recorded in the medical records, but we found that records contained limited evidence of the child's voice being recorded. Records were also not always stored securely. We saw that staff adhered to evidenced based practice when providing direct patient care and the service was accredited by external schemes, such as the

UNICEF baby friendly initiative. Children and young people could access inpatient services at any time. Clinical staffing was appropriate with medical cover on site at all times and consultant support available via a consultant of the week system. Pharmacy advice and support was also available seven days a week. Appropriate policies and procedures were in place to consider consent and we noted good consent practices in place. The trust faced a challenge in staff receiving up to date appraisals and ensuring all staff received clinical supervision and had appropriate training to care for children and young people. The trust was aware of these challenges and this was due to be addressed by the new leadership team.

Services were planned to identify the needs of the local population. Children and young people attending services were routinely seen in dedicated ward and outpatient areas for the majority of the care they received. The trust had identified the needs of the local population and was acting on these to improve access to services, such as plans to create a paediatric assessment unit. Good facilities were available to parents wishing to stay with their children and clear pathways were in place for children and young people to attend the service via A&E or through GP contact with the ward.

Staff told us that they previously felt that there was a lack of senior leadership within the service. However, they were positive about the new service and trust level leadership and felt that this would lead to improvements in services for children and young people.

# Services for children and young people

## Are services for children and young people safe?

Requires improvement



We rated the safe domain as requires improvement because:

- Nurse staffing was not planned in accordance with recognised acuity tools and was not compliant with safe staffing guidance. Staff told us that this had impacted on the reporting of incidents, with staff feeling that incidents were under reported due to staffing pressures. Children and young people in theatre were not cared for by nurses with paediatric training.
- The service had not met its target for staff receiving appropriate levels of safeguarding training in accordance with national standards. Staff were achieving targets for mandatory training. No formal risk assessment had been carried out to consider the needs of children and young people who attended the ward with mental health needs and staff had not received training to support them in these situations.
- Children and young people were not always cared for in a suitable environment.
- Children who were placed on adult surgery lists were also not treated in accordance with national guidance.
- We observed that records were completed appropriately, but that they contained limited evidence of the child's voice being recorded. Records were not always stored securely.

However, we found that:

- Clinical staffing was appropriate with medical cover on site at all times and consultant support available via a consultant of the week system.
- Cleanliness and infection control audits showed good performance by children and young people's services.
- Staff were aware of the trust's major incident policy and were confident of where to seek advice.

### Incidents

- The service reported 111 incidents between October 2014 and September 2015. The majority of these incidents were recorded as no or low harm. One incident was recorded as causing moderate harm to a

patient. The most common theme in incidents was in relation to medicines. This appeared on the services risk register, but mitigating action had not been identified on the risk register.

- Incidents reported by staff also highlighted low staffing levels on the ward and difficulties in dealing with children and young people who had mental health needs. Both of these issues also appeared on the services risk register.
- The service reported no serious incidents and no never events between October 2014 and September 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- Staff were aware of how to report incidents using the trust's online system. Staff could explain the kinds of incidents that would be reported and told us that they sometimes received feedback from their managers about the outcome of incident investigations. Feedback from incidents was provided via a range of means, from face to face meetings, e-mails and team meetings.
- Staff told us they felt the number of incidents on the ward was underreported due to a lack of time to complete incident forms. Staff told us that they would still complete forms for 'serious' incidents (such as medication errors), but they would not routinely report other issues (such as a shortage of staff).
- The trust explained that an information leaflet outlining the principles of the Duty of Candour was circulated to all staff in June 2015 and that training was also now given during trust induction for new starters. Separate learning was also provided during advanced risk management training and via the e-learning package for investigations of incidents, complaints and claims.
- The majority of junior staff we spoke with had an understanding of the principles behind the Duty of Candour and described this as being 'open and honest'. Senior staff understood the duty and the requirements in regard to notifying patients/relatives and undertaking investigations.
- The service staff attended a variety of meetings in which morbidity and mortality issues were discussed, this included neonatal morbidity and mortality meetings, paediatric clinical governance meetings and the trust wide mortality review group.

### Cleanliness, infection control and hygiene

# Services for children and young people

- Training figures provided by the trust showed that 94% of paediatric nurses and 86% of SCBU nurses had undergone infection control training. In addition, 80% of additional clinical services staff caring for children and 100% of additional clinical services staff on SCBU had completed this training. This was against a trust target of 75-95%.
- We saw that the service regularly achieved 100% in infection control audits between January and December 2015.
- The trust carried out reviews of ward cleanliness using the NHS national specifications for cleanliness. In 2015, the ward scored of 98.9% in quarter one and 100% in quarter two. The SCBU achieved a score of 100% in both quarters.
- The ward and SCBU used a daily matron checklist that was completed by matron and covered a range of issues, including staffing, occupancy and incidents. The audit had been adapted from one used on adult wards. The trust told us that the new paediatric matron was in the process of adapting the checklist to ensure that this was more focused to paediatric patients.
- The ward and SCBU had achieved 100% compliance with the screening of non-elective patients deemed to be at risk of MRSA between May and August 2015.
- Clinical areas were visibly clean and clear of clutter. We saw evidence of regular cleaning audits taking place, including daily checks of utility rooms, clinic areas, toilets and water filters in SCBU.
- We saw that staff used 'I am clean' stickers to denote equipment that had been cleaned. We saw that seven of ten pieces of equipment we checked had these stickers completed, with a date of cleaning and signature. Three pieces of equipment had the sticker in place, but no indication of when it had been cleaned.
- The service had two infection control link nurses that assisted in sharing learning and developing practice among the nursing staff.
- Hand gel was available to staff and visitors on entering clinical areas and outside of individual rooms and bays. Information was on display to request staff and visitors to sanitize their hands.
- Posters were in place on the entrance to the ward/SCBU area requesting that visitors do not attend if they had been unwell within the last 48 hours. This was to control the spread of any infection.
- We saw that personal protective equipment was available to staff and that this was appropriately used

when providing patient care. Staff told us that side rooms would also be used to barrier nurse patients who had an infectious disease. During our unannounced inspection we saw that some glove and apron dispensers were empty and had not been replaced.

- In the 2015 CQC children's survey, the service performed about the same as other trusts concerning responses provided by carers and children about whether the ward environment was clean.

## Environment and equipment

- Patient Environment Action Team (PEAT) is an annual assessment of inpatient healthcare sites in England with 10 or more inpatient beds. The ward had undergone an assessment in quarter two of 2015/2016 and achieved a score of 98.5%.
- The SCBU was compliant with bed spacing and equipment requirements under British Association of Perinatal Medicine and Health Building Note guidance (09-03). We saw that there was appropriate space within the cot areas to allow free movement of staff for clinical interventions.
- The risk register for the service identified that there was a risk of harm to patients as an incubator used in urgent patient transfers was no longer supported by the manufacturers. Staff told us that charity fundraising had taken place and that a new incubator was now funded.
- The ward used an interactive whiteboard to track patients. This allowed staff a central point of access to identify patients in each area of the ward and their current status. The ward had also been provided with four electronic tablets to aid in electronic prescribing. Staff told us that three of these units did not work and the remaining unit was slow. Staff said that this had been reported. Instead, we observed staff using the main computer at the nurses' station to record drug administration.
- We checked paediatric resuscitation equipment on SCBU and the ward. These contained appropriate drugs and equipment and had been checked in line with trust policies.
- Separate male and female toilets were available on the ward. We saw that pull chords in toilets and bathrooms had been secured with plastic coverings to remove the risk of these acting as a ligature.
- The ward and SCBU were child friendly areas. SCBU had a family room that could be used as a play room for older siblings and an area for them to bond with their

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new sibling. The ward was conscious of child safety, with items such as hand gel and exit buttons for doors set higher up the wall to avoid children being able to use them. The children's outpatient area was brightly decorated with books, toys and an interactive computer projection on the floor. Some areas of the outpatient and ward area (such as door frames in outpatients and the food service area on the ward) were tired, with scuff marks and damage to paintwork. In outpatients, we were told that a project to renovate the area was underway. This would include a new clinic room, painting and a large mural for the waiting area.

- The ward had a designated indoor and outdoor play area. This was well stocked with entertainment equipment and toys. The external play area was secured by security card access and had a high metal fence surrounding it to avoid children being able to leave the play area by another way.
- We asked staff if any formal ligature risk assessment had taken place, in light of concerns expressed in the risk register about the increasing number of attendances by children and young people with mental health needs due to a lack of regional facilities. We were told that no formal risk assessment had taken place and that there was no designated area where children and young people with mental health needs were treated. Staff told us that these patients would be nursed in side rooms if one to one support was available. If not, they had been nursed in one of the open four bedded bays on the ward. When this happened, staff told us that other children were also nursed in those bays at the same time. We observed that equipment was available within side rooms and bays (such as tubing and curtains) which were ligature risks. There was also a risk to other children and young people being nursed alongside these patients with a challenging presentation.
- The trust ran one paediatric day surgery list every four weeks. When this took place an area of the day surgery unit was separated off to allow a separate area for children and young people to undergo surgery. This included separate waiting, operating and recovery areas.
- When placed on adult theatre lists children and young people were required to wait in the general waiting area (with a chaperone from the ward), were anaesthetised in the same area as adults, and were recovered in shared recovery bays with adults, with a curtain separating them. However, there was a risk that children

in recovery would be able to see adult patients being transported and recovered. This process was not in line with Royal College on Anaesthetist standards (Standards for Children's Surgery, 2013) or Royal College of Nursing guidance.

- The trust had changed its equipment provider in July 2015. At this time it was identified that a number of pieces of equipment throughout the trust had not been appropriately checked and serviced. The trust told us that they had been working to ensure that equipment was properly serviced and had identified high risk equipment for urgent attention. As of November 2015, there were 1325 pieces of equipment outside of their service period. We spoke with staff in the service who told us that they had no specific equipment issues that caused them concern and that they could contact estates to ensure that any urgent repairs were completed in a timely way.
- In the 2015 CQC children's survey, the service performed about the same as other trusts concerning responses provided by carers and children about whether appropriate equipment was available on the ward and whether children and young people felt safe.
- We saw that the fridge used for storage of milk on SCBU had its temperature regularly checked and monitored.

## Medicines

- Training data provided by the trust showed that 88% of paediatric nurses and 93% of SCBU nurses had undergone training in antibiotic stewardship. The figures for medicines management training were lower, with 63% of paediatric nurses and 71% of SCBU nurse having complete this training. This was against a trust target of 75-95%.
- The trust carried out three monthly inspection and audit of controlled drugs via its pharmacy department. The most recent audit available at the time of our inspection was from April to June 2015. This identified that weekly checks of liquid controlled drugs had not been completed on the ward and that the ward was not checking and recording daily fridge temperatures. The audit said that pharmacy had asked for the need for these checks to be completed and for this guidance to be cascaded to staff.
- At the time of our inspection, we checked the recording and monitoring of controlled drugs and fridge temperatures on the ward and on SCBU. We saw no

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issues in how drugs were monitored or recorded and saw evidence that regular monitoring and reconciliation of controlled drugs and medicines fridges was taking place.

- The service used the trust's e-prescribing system. This allowed staff to accurately record and monitor medications via the electronic system. The system took account of any medication allergies and would not allow staff to prescribe these medications.
- A risk of medication errors due to delays in uploading information to the electronic prescribing system appeared on the service risk register. No mitigating action had been identified to tackle the issue.
- Medications were secured in locked fridges and controlled drugs were stored securely in locked cabinets.
- Staff told us that no FP10 prescription pads were available to staff.
- Staff within the service did not use patient group directives (PGDs) to provide medication. PGDs are written instructions for the supply or administration of medicines to groups of patients. Instead, medications were prescribed by the advanced nurse practitioner or clinical staff.

## Records

- The children and young people's service was using paper records at the time of our inspection. The service had not yet been incorporated into the trust's electronic record system. Work was ongoing to roll this system out to the service later in 2016.
- We reviewed nine sets of patient records during our inspection. All the records we reviewed had appropriate documentation completed, including assessment forms, care plans and discharge documentation. We saw that entries were appropriately signed, dated and were legible. We saw that there were no specific tools to assist staff on the ward with the assessment of paediatric pain, pressure ulcers or nutrition and hydration. This information was contained within the general documentation. Staff told us that these tools were in development.
- The records we reviewed did not reflect the child's voice in delivering care. We saw limited examples of the child's voice being reflected in comments within the medical and nursing records we reviewed, such as the child's preferences for care or recording how they had been engaged with to reach decisions.

- We saw that records on SCBU and the ward were not always stored securely. On SCBU a record trolley was located near the nurses' station. This was unlocked and there was potential for records to be accessed by unauthorised persons if staff were not present at the nursing station. On the ward, a large basket of records was placed opposite the nurse's station. Again, this could have been accessed by unauthorised persons. A parent told us that they had raised concerns about how these records were stored, but that no action had been taken.
- The trust carried out an annual audit of record keeping across all services, including children and young people. In 2015, the trust reviewed 203 records with 1663 separate entries being considered. This looked at 12 key pieces of information (including whether entries were dated, timed, in chronological order and recorded allergy information). This produced an average score of 90% across all the key questions.
- The annual audit also looked separately at the standard of documentation for patients with learning disabilities. In 2015, the trust reviewed eight records and 59 entries. This produced an average score of 86 %.

## Safeguarding

- Intercollegiate guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, March 2014) states that all clinical staff working with children, young people and/or their parents should undergo appropriate safeguarding training. Nursing and care worker compliance with the required levels of safeguarding training had not been achieved throughout the service. This meant that there was a risk that staff looking after children did not have appropriate training to identify and address safeguarding concerns.
- Data provided by the trust showed that 94% of paediatric nurses and 90% of additional clinical services staff had completed safeguarding children Level 1 training. On SCBU, 100% of SCBU nurses and 50% of additional clinical nursing staff had completed this training.
- Training data for safeguarding children Level 3 compliance was lower and was below the trust target of 75-95% compliance. Thirty eight percent of paediatric nurses and 50% of additional clinical service workers had completed this training. On SCBU, 71% of SCBU nurses and 0% of additional clinical service workers had undergone this training.

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- Data provided by the trust showed that 19 of 25 medical staff (76%) within the service had up to date children's Level 3 safeguarding training.
  - Training data provided by the trust showed that on average staff within the service had achieved 88.5% compliance with staff undergoing appropriate safeguarding adults training.
  - The safeguarding children's team consisted of child protection nurses, looked after children staff, paediatric liaison nurses and administrative staff. Individual staff groups met quarterly to discuss issues, as well as attending a quarterly meeting of all the specialties.
  - The trust had an appropriate policy in place with regard to safeguarding children. This included advice and guidance for staff on the safeguarding process, as well as key contacts. Advice was included on areas such as fabricated or induced illness and female genital mutilation.
  - Staff told us that they would be reliant on other agencies informing them of whether a child was subject to a child protection plan. If this was known to the trust, it would be recorded in the documentation. If not, they would expect contact from community services or social services to confirm this.
  - The trust had a policy in place a policy and procedure for vulnerable and missing patients. This included guidance on what to do if a child was found to be missing, including reference to the child protection policy, search requirements, and key contacts (including the Police).
  - Staff on the SCBU had begun to undergo formal safeguarding supervision. Management had undergone training to provide supervision and a formal log was kept to record safeguarding supervision of staff. Supervision had not yet begun on the ward or in outpatient areas.
  - The trust had an access policy in place for patients that did not attend planned clinic appointments. This policy included appropriate guidance on how to raise concerns if children under 16 years did not attend for planned appointments.
  - Entry to the ward and SCBU area was controlled by a security pass system and monitored by CCTV. Visitors had to use an intercom to gain access.
- mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act, the deprivation of liberty safeguards (DoLS) and others.
- For each training element staff groups were identified and the frequency of each training element. Employees had a "Personal training account" which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
  - Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.
  - The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the Trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.
  - Data provided by the trust from 1 February 2015 showed that overall staff within the children's service and on SCBU were achieving targets for statutory and mandatory training modules. Against a target of 75-95%, staff on the ward were achieving 91% compliance, staff on SCBU and paediatric medical staff were achieving 99% compliance, and staff in paediatric outpatients were achieving 100% compliance.
  - Staff told us that they could access mandatory training via an electronic system, with some training offered as face to face sessions. Staff received electronic updates when training was due to be completed so that they could book on to the appropriate course.
  - Staff told us that they did not receive dedicated time to attend mandatory training sessions. Instead, staff undertook training within the working day as and when this was possible.

## Assessing and responding to patient risk

- The trust used the paediatric advanced warning score (PAWS) tool to assess patient risk. The trust was moving to incorporate PAWS into its online software. This system ensured complete observations sets, accurate risk calculations, alerting in-line with escalation pathways and real-time visibility of alerts and responses. We were told that this would be online from May 2016.

## Mandatory training

- There was a trust mandatory training policy in place which referenced 30 statutory training requirements,

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- Staff told us that no early warning risk assessment tool was in use on the SCBU. Instead, staff told us that they would use their skill and training through being qualified in specialty. Nursing staff told us that they did support the introduction of a neonatal early warning risk assessment tool and that this had been raised with clinical leads.
- Data provided by the trust showed that 14 of 17 identified nursing staff had completed new-born basic/intermediate life support training; 16 of 22 had completed paediatric intermediate life support training.
- The trust resuscitation policy required annual local paediatric advanced life support training for relevant staff. Data provided by the trust showed that one of three identified nurses and 19 of 25 had completed paediatric advanced life support training. The service risk register identified that there was a shortage of staff who had undertaken advanced life support training and the trust was exploring how to fill the training gap, including introducing this as part of new staff training.
- The trust had neonatal and paediatric specific resuscitation teams. Staff could access support from these teams throughout the hospital via dialling 2222 and requesting the appropriate team to attend.
- The SCBU and the ward had 'red buttons' by bed sides that could be pressed to summon emergency assistance from colleagues. This identified the area in question and we saw that the use of the 'red button' was audited on a monthly basis.
- On-site support was available for patients with diabetes between Monday-Friday via a specialist diabetes team. This included amongst other staff a nurse and a consultant. Out of hours access was available to specialist advice for diabetic children. Staff could access telephone advice and support from regional specialist centres under the Yorkshire and Humber children's diabetes escalation policy. This provided guidance on escalation and transfer needs for unwell children and young people.
- During our unannounced inspection of the ward, we noted that there were no medications to deal with a hypoglycaemic attack on the resuscitation trolley. These were stored separately in the nurses' station and there was a folder on the shelf under the box containing instructions on how to manage a child who was having a hypoglycaemic attack. Not all the equipment or

medicines required for this were in the box at the time of our inspection and some equipment and medicines were out of date. We brought this to the attention of senior staff who said that they would resolve the issue.

- Staff could access support from children and adolescent mental health services (CAMHS) for children and young people with mental health needs between Monday-Friday from another trust. There was no weekend provision for CAMHS support. Staff told us that they could access the adult psychiatric team if they required urgent support over the weekend.
- The trust used the EMBRACE transport network within Yorkshire and the Humber to assist in stabilising and transferring patients who required higher levels of care. If EMBRACE were unavailable, the trust confirmed that they would continue to care for the patient with support from anaesthetists until an Embrace team was available, or if the patient could not safely wait for an Embrace team, then the trust would transfer the patient in accordance with EMBRACE guidance. All staff told us that they found the service to be timely, supportive and easy to access.
- The trust used a 'red band' system to identify children and young people with allergies. A red wrist band was provided to these patients to provide a visual aid to staff about allergies and to ensure that this was checked against the medical record.
- We observed two handovers, one on SCBU and one on the ward. These were well structured and we saw that specific patient risks were clearly documented and handed over to staff coming onto shift.

## Nursing staffing

- Data provided by the trust showed that the service employed 24.7 FTE staff nurses, 2.9 FTE nursing sisters, 2.7 FTE specialist nurses and 1.0 FTE band seven ward manager.
- A paediatric matron had started in post approximately three weeks prior to our inspection. Before this, the role had fallen to a matron from adult services, with no specific paediatric matron having been in post for some years.
- At the time of our inspection, senior staff told us that the ward employed 2.8 FTE band six nurses and 15.37 band 5 nurses. Of these, three band 5 nurses were on

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maternity leave, with one new FTE nurse and two band 5 nurses working 23 hours a week recruited to post. In addition, four newly qualified nurses had been recruited to join the ward from September 2016.

- SCBU employed 0.9 FTE band six staff, 10.65 FTE band five staff. From these figures, one band five was on long term sickness and one 0.6 FTE staff member was on maternity leave. SCBU was recruiting an additional band five staff member.
- The trust provided us with data on the fill rate against the trust's planned levels for nursing staff between July and October 2015. In relation to the ward, this showed that 96.8% of day shift staffing was achieved 97.5% of night shift staffing. On the SCBU, data was only provided for day shift staffing. This showed that 96.8% staffing was achieved.
- The sickness rates for nursing staff were 8.2% (433.7 days) on the ward and 4.3% (201 days) on the SCBU.
- The trust provided us with data on the use of nurse agency staff in children's services. This showed that on average between May 2014 and March 2015, 2.1% of shifts on the ward were covered by agency staff and 4.6% of shifts on the SCBU. Staff also told us that shifts on the ward had also been covered by nurses from SCBU (who are not paediatric trained) and adult nurses where staff shortages had been found. When this occurred, senior staff told us that they tried to ensure that SCBU nurses cared for younger children and adult nurses looked after older young people.
- The trust did not use an acuity tool to determine staffing levels within the service. Senior staff told us that the establishment for SCBU was 2:1 registered nurses to nursery nurse, whilst the establishment on the ward was 3:1 registered nurses and clinical support worker. Senior staff were not aware of how this establishment level was decided on by the trust or whether any specific safer staffing tool had been used to calculate this establishment.
- Staff told us that the service was short of nursing staff and we looked at rosters to see if staffing on the ward met safe staffing levels as recommended by the Royal College of Nursing (Guidance on Safe Nurse Staffing Levels in the UK, 2010). We saw that an establishment of three qualified nurses was not always in line with this guidance and that staff were routinely caring for more children than the guidance recommended. The

guidance suggests that there should be a child to nurse ratio of 3:1 for children under two, 4:1 for children over two during the day, and 5:1 for children over two during the night.

- In addition, guidance suggests that there should be a 2:1 ratio of child to nurse when children and young people are receiving high dependency care. At the time of the inspection, we were told that additional nurse staffing was not made available for the HDU bed and this was not routinely monitored to see if additional staffing had been required.
- Data provided by the trust showed examples of shifts where the ward establishment of 3:1 was still in place to care for nine children under two, plus six children over two. We also reviewed paper rosters for nurse staff which showed that night time staffing for one week in January 2016 showed that only two qualified nurses were on the night shift on three of seven nights.
- During our unannounced inspection we saw that planned staffing was 3:1 for the early shift, 3:1 for the day shift, and 2:1 for the night shift. The actual staffing displayed showed that the ward was not at establishment, with staffing of 3:1, 1:1 and 2:1.
- In addition to children identified in these figures as being admitted to the ward, staff also attended to the needs of children attending the ward for follow up advice, ambulatory patients from A&E, and patients attending from GP services. Staff were also expected to accompany paediatric patients to theatre when being taken to, and returning from, surgery. Staff told us that this meant that the ward could reach capacity. When this occurred, staff told us that no additional staffing cover was available and that the ward did not close. This meant that there was a risk that staffing levels on the ward were unsafe and we saw examples of incidents reported on the electronic system by staff to identify when shifts were short of qualified professionals.
- The SCBU did not have a supernumerary nurse coordinator rostered on shift as recommended by Department of Health best practice guidance (2009). This meant that staff taking breaks did not leave the SCBU when only two nurses were available on shift in order to ensure that two nursing staff remained on the SCBU at all times.
- Staff on SCBU told us that some patients were provided with continuous positive airway pressure (CPAP) treatment. The British Association of Perinatal Medicine (Service Standards for Hospitals Providing Neonatal

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Care, 2010) identifies that where CPAP is provided care escalates from 'special care' to 'high dependency' care. This changes the guidance on recommended staffing levels from 1:4 babies to staff, to 1:2 babies to staff. Where CPAP was provided additional staff were not rostered to ensure that safe staffing levels could be maintained.

- On dedicated children's day surgery days, staff on the ward told us that they were rostered to day surgery to ensure a paediatric presence in the waiting areas. Staff told us that there would routinely be two or three nurses to care for a list of upwards of twenty patients. Staff told us that they felt that this left them stretched and described the day surgery experience as noisy and overly busy for children and young people.

## Other staffing

- The service employed 7.3 FTE care support workers, 2.8 FTE nursery nurses, and 0.65 play support worker.
- The trust provided us with data on the actual vs planned staffing levels for allied health professionals operating within the service. This was averaged over a four month period between June to September 2015. During this period actual staffing levels were below the planned level (13.4 FTE planned versus 13.2 FTE achieved).
- There was a lack of play support available for children attending on the ward. The play specialist worked 30 hours per week and split time between the ward and clinics for MRI and blood taking. There was no provision of play support in A&E or for children and young people attending most outpatient appointments. This National Service Framework for Children's Services (2004) identified that play specialists should be available to children attending hospital services.

## Medical staffing

- The service employed 21 WTE medical staff. This was broken down into 27% consultant cover, 17% middle career (at least three years at senior house officer or a higher grade), 42% registrar cover, and 14% junior doctor cover. The service had a lower percentage for consultant cover than the England average (35%), but higher junior doctor cover compared to the England average (14%).

- The trust provided us with data to show the number of shifts covered by locum medical staff between April 2014 and March 2015. This showed that on average 8.21% of shifts during this period were staffed by locum clinicians.
- Consultant on site cover provided 8.30am -5.30pm each week day. A consultant was available specifically to ward areas during this time via a consultant of the week system and then on-call from home (contactable via switchboard) covering the 24 hour period 7 days per week. At weekends a consultant paediatrician was on site Saturday and Sunday morning. Registrar's provided on site cover 24 hours a day. In addition, between Monday and Friday 8.30am-3.30pm there were three doctors in training on site. After this time, one of these doctors was in the hospital at all times.
- No designated medical cover was provided for A&E. Staff told us that the onsite paediatric clinicians would be called to attend A&E in the case of a paediatric emergency. Any ambulatory paediatric patients, were sent to the ward for treatment.

## Major incident awareness and training

- The trust had a major incident policy in place. This included 'action cards' to assist staff in taking appropriate emergency steps and included reference to the needs of children. This was in reference to ensuring staff were aware to identify any paediatric needs and to signpost staff to seeking paediatric support from ward and clinical staff.
- Staff were aware that the trust had a major incident policy and could explain where to locate this on the intranet or within their department.
- Senior staff we spoke with had not developed service specific plans to respond to specific seasonal paediatric needs, such as bronchiolitis.

## Are services for children and young people effective?

Good



We rated effective as good because:

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- We saw that staff adhered to evidenced based practice when providing direct patient care and the service was accredited by external schemes, such as the UNICEF baby friendly initiative.
- We saw that staff were able to manage pain effectively and nutritional needs of patients were met. We also saw good examples of multidisciplinary working and information sharing with GPs.
- Children and young people could access inpatient services at any time and seven day access was available to consultant clinicians and pharmacy advice.
- Appropriate policies and procedures were in place to consider consent and we noted good consent practices in place.

However, we found that:

- The trust faced a challenge in staff receiving up to date appraisals and ensuring all staff received clinical supervision and had appropriate training to care for children and young people. The trust was aware of these challenges and this was due to be addressed by the new leadership team.

## Evidence-based care and treatment

- We saw that staff provided care and treatment in accordance with trust policies and relevant national guidance.
- Examples of this included staff adhering to the trust infection control policy and transitional arrangements for children with diabetes in line with NICE guidance (NG18 - Diabetes (type 1 and type 2) in children and young people: diagnosis and management).
- The trust was accredited under the UNICEF Baby Friendly initiative. The trust also used the BLISS baby charter to consider the care provided to premature and sick babies. A BLISS champion attended the SCBU at regular intervals to provide a link to BLISS services.
- The trust used wider guidance and professional publications to assist in the development of policies. Examples of this included the admission criteria to the SCBU taking account of NHS Litigation Authority maternity standards and the policy on neonatal intubation referencing and directing staff towards supporting academic articles.
- The service had an audit programme in place for PAWS scoring, paediatric cannulas, chaperones in clinic, and a ward review audit. At the time of our inspection the results of these audits were not yet available.

- The majority of the policies available to us on the trust intranet were in date. A minority of policies on the trust intranet were beyond their review dates. Examples of this included the children's surgical services policy (2014) and PAWS and escalation policy (January 2015). This meant that there was a risk that some policies did not reflect current best practice.

## Pain relief

- We saw that children and young people were prescribed appropriate pain relief and this was clearly documented in their medical records.
- We observed staff interacting with children and young people to discuss their pain. We saw that these discussions, as well as consideration of non-verbal pain indicators, were considered and recorded in the medical records.
- There was no acute paediatric pain team at the trust. Staff told us that they could access support from the adult pain team when required.
- The trust did not have a specific paediatric pain tool in place that allowed for a uniform assessment of pain. Senior staff told us that this was in development.

## Nutrition and hydration

- The records we reviewed showed that assessments of nutrition and hydration were appropriately completed. Fluid balance charts were also complete. There was no specific tool used to assist staff in considering the nutritional needs of children and young people. Senior staff told us that this was in development.
- The ward had protected meal times between 11.45am and 12.30pm.
- Specialist diets were available on request from the catering department (such as gluten free or halal). Staff told us that these were easy to order when needed.
- Nutrition and hydration formed a key part of the handover on SCBU. Staff offered feeding support and education to mothers. The child's weight and fluid intake were regularly monitored to identify where additional support may be needed.
- Staff, young people and parents told us that they were disappointed in the food available on the ward. They told us that this was often similar on a day to day basis with little menu choice available for children and young people.

## Patient outcomes

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- The service did not report any emergency readmissions after elective admission among patients' in the under one age group between June 2014 and May 2015.
- The readmission rates within two days of discharge for non-elective children under one year old was higher than the England average (4.3 compared to 3.3). We raised this with staff and they told us that this was linked to premature discharges from the maternity service, with children then being readmitted to the SCBU. The readmission rates for children and young people aged one year to 17 years was the same as the England average (2.7).
- The service provided data on the rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes. The data spanned February 2014 to January 2015 and showed that readmission rates were lower than the England average (16.3% compared to 16.8%) for children and young people aged one to 17 years with asthma. However, only eight patients were subject to multiple admissions during this time. For epilepsy and diabetes, there were no multiple readmissions reported.
- The service took part in the 2013/2014 paediatric diabetes audit to look at HbA1c levels. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The service scored worse than the England and Wales average for the share of patients with HbA1c less than 7.5% (9.9% at the trust compared to 18.5%) and about the same for median HbA1c levels (72 mmol/mol).
- The trust had not previously participated in the National Paediatric Asthma Audit. At the time of our inspection, the trust was collecting data to participate in the next audit round.
- The trust was not an outlier in any of the categories considered in the national epilepsy 12 audit in November 2014. Patient satisfaction was below the national average of 88%, with the trust scoring 80%.
- Staff told us that the appraisal process was helpful and useful to them, with opportunities to listen to feedback as well as be involved in identifying areas for development.
- Staff were supported to engage in further education and training. An example of this was a junior staff member who was being supported through further education with a view to the trust supporting an application to nurse training.
- Clinicians had access to a weekly training session provided by the consultant colleagues.
- Nursing staff did not undergo formal clinical supervision to record and discuss areas of practice. Senior staff told us that this was something they were going to introduce.
- Theatre and recovery staff caring for children did not have specific paediatric training and senior staff told us that there was no paediatric anaesthetist available. The trust instead relied on its own anaesthetists who had an interest in paediatric anaesthesia. Staff told us that theatre staff and anaesthetists maintained their competency by treating paediatric patients regularly via the specific day surgery list, and the patients added to other lists. The trust offered non-specialist paediatric surgery, which was undertaken by adult surgeons. All specialist paediatric surgery was undertaken in Leeds.
- In the 2015 CQC children's survey, the service performed about the same as other trusts concerning responses provided by parents and carers about how competent they felt the staff were caring for their child.

## Multidisciplinary (MDT) working

- We saw good examples of MDT working during our inspection. Clinical staff told us that they could attend various MDT forums within the trust, such as in A&E, critical care and wider care group meetings. This provided an opportunity for children's and young people's services to feed in concerns and take on comments from other specialties.
- Paediatric consultants covered both acute and community services. This ensured that they had an overview of a child's clinical pathway and had strong working relationships with both acute and community services.
- We observed an MDT meeting on the ward which was attended by clinical staff, nursing staff, pharmacy staff, and microbiology. Also present was a liaison school nurse to ensure that input and learning was from

## Competent staff

- At the time of our inspection, data provided by the trust showed that to the year to date 38.8% of staff had received an appraisal. This was against a trust target of 75-95%. For the last completed year, (2014/2015) 64.3% had received an appraisal.

# Services for children and young people

community colleagues. Staff told us that therapy services would also routinely attend if there were patients on the ward that were receiving therapy intervention.

- Staff worked closely with paediatric physiotherapy, occupational therapy, and speech and language teams to ensure that all needs were met during week days. Staff said that they could contact these teams and would routinely expect a response on the same day. Paediatric physiotherapy, occupational therapy and speech and language services were provided in conjunction with the community services, with staff serving both the hospital and community areas.
- Agreements were in place for staff to access support and guidance from other regional centres if they were unable to obtain on site advice. Examples of this included access to the Yorkshire and Humber diabetes network, attendance at the Yorkshire and Humber neonatal network and the EMBRACE transport system.

## Seven-day services

- Access to SCBU and the ward was available 24 hours, seven days a week. The ward took attendances from A&E and out of hours GP services at any time.
- The children and young people's outpatient department was open 7.30am-5.00pm, Monday to Friday.
- The service could access paediatric physiotherapy, occupational therapy and speech and language therapy during office hours Monday-Friday. No paediatric services were available at the weekend. Staff could access emergency physiotherapy support from the adult physiotherapy team out of hours.
- Consultant cover was available on site from 8:30am -5:30pm each week day. A consultant was available specifically to ward areas during this time via a consultant of the week system and then on-call from home (contactable via switchboard) covering the 24 hour period 7 days per week. Consultant ward rounds also took place on Saturday and Sunday mornings.
- The main pharmacy department was open 8.30am -6.45pm Monday to Friday and 9am to 2pm Saturdays, Sundays and Bank Holidays. The outpatient pharmacy was open 8.30am-5.30pm Monday to Friday. At other times the department was supported by an on call pharmacist. A medicines information service also operated from 9am-5pm Monday to Friday where staff could call to ask questions.

## Access to information

- The service provided electronic access for GPs to raise questions and concerns. They could submit questions electronically that would be considered and responded to by the consultant of the week. Clinical staff told us that GPs could also contact the service via telephone to seek advice. This was with a view to reducing unnecessary admissions to the trust.
- SCBU used an electronic system to prepare discharge correspondence for GPs. This was a patient data management system that ensured that all the necessary information was communicated to GPs on discharge.
- Discharge letters for GPs were sent directly from the ward. These were typed by the ward clerk and posted out. We were told that this would routinely happen within 24-48 hours of a patient being discharged from the ward.
- Posters were displayed on the ward advising families that details about their child's admission could be shared with health visiting or school nursing services.
- The trust told us that Personal Child Health Record (PCHR) were used by staff. All parents of babies were given a PCHR when they were discharged. Recognised growth charts were also contained within the health records.

## Consent

- We saw that consent was appropriately documented in the records we reviewed. Staff were also able to give examples of where Gillick competence had been considered in allowing a 16 year old to consent to their own treatment.
- Staff were aware of the consent needs for looked after children. They explained that they would request that the appropriate person from social services attend the ward in person to discuss treatment and sign off a consent form.
- Staff told us that they could seek support from the safeguarding team if they had any concerns about capacity or issues surrounding the consent process.
- The trust had an up to date policy in place with regard to taking patient consent. This included detailed guidance on the assessment and meaning of Gillick competence in children and young people.
- The trust had a specific policy in place to assist staff and families in reaching decisions about paediatric limitation of treatment orders.

# Services for children and young people

- All nursing staff within the service had completed Mental Capacity Act 2005 training. This allowed staff to consider issues around the capacity of parents and older patients in reaching decision around treatment.

## Are services for children and young people caring?

Good



We rated caring as good because:

- We observed staff delivering compassionate care to children, young people, and their families. This included staff of all grades engaging with young patients to make them feel at ease and explaining medical procedures to parents and young people in a clear and compassionate way.
- Parents told us that they felt engaged in their child's care and we saw that staff provided education to parents (such as infant life support and baby massage) to help parents feel comfortable with their child's health needs and encourage involvement in their care.
- All parents and young people we spoke with felt that their emotional needs were supported by staff.
- An on-site chaplaincy service was available and we saw that that details were offered on a variety of support groups for parents, children and young people with different medical needs.

### Compassionate care

- We observed nursing, medical and therapy staff providing compassionate care to children and young people. We saw that staff spoke with children and young people on an appropriate level to make them feel comfortable, such as engaging a young child in conversation about their new shoes while performing an examination.
- The SCBU offered visiting to parents and siblings at any time of the day. Grandparents were encouraged to visit between noon and 7pm. The ward offered visiting at any time for immediate family and parents with visiting hours for other visitors between 2pm-4pm and 6-8pm.
- The trust offered a 50% discount on car parking for visitors to SCBU and the ward.

- The ward had cot beds available for parents in side rooms to allow them to spend the night with their children. Parents told us that staff were caring and ensured that their needs were met (such as providing hot drinks) whenever they could.
- In the 2015 CQC children's survey, the service performed about the same as other trusts in regard to responses provided by carers and children about staff providing compassionate care, such as offering children privacy, staff introducing themselves, and whether carers felt that their child was well looked after.
- The children's service did not take part in the Friends and Family test. This meant that feedback was not routinely gathered on patient experience. The new matron in post explained that she would be introducing this into children and young people's services.

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

- The trust had developed training to teach parents skills to help care for their babies. This included a course on how to tube feed, paediatric life support skills, and practical skills, such as baby massage and breast milk advice. This encouraged and facilitated parents to be more involved in their baby's care.
- We saw medical and nursing staff communicate with young children and their parents in a caring manner. This included engaging young children in conversation about how they felt and their interests, as well as engaging parents in discussions around their child's health needs. All parents we spoke to felt that staff had fully explained and engaged them in the care of their child.
- Information leaflets were available to parents, explaining various different illnesses and courses of treatment. This information was not available in an easy read, or child friendly format. This meant that children did not have access to information they could read to help them understand about their treatment.
- We saw staff fully explaining care and treatment they were going to deliver to children and their families. Parents told us that they had been involved in their child's care and understood the care being provided.
- Staff told us that older children could discuss their health needs with staff without parents or relatives being present. Staff understood that older children and

# Services for children and young people

young people may have matters they did not wish to discuss when parents were present. Staff could facilitate these discussions outside of parental visiting or in private areas away from parents and relatives.

- In the 2015 CQC children's survey, the service performed about the same as other trusts in regard to responses provided by carers about their involvement in their child's care, such as whether they were kept up to date about care, had the opportunity to ask questions, and were told about aftercare arrangements on discharge.

## Emotional support

- The trust provided a Christian chaplaincy service with a 24 hour on call service. A chapel was available for worship and quiet reflection. At the time of our inspection, no multi-faith prayer room was available, so the chapel was being used for multi-faith worship. The trust explained that their local population was a majority Christian, but that the trust had contacts within local faith communities who could provide support and advice as the need arose.
- The SCBU displayed information on local support groups on its notice boards and within its patient information leaflet. This included details of local groups supporting families and babies, a 'twins club' for parents who had a multiple birth and the national child trust.
- The ward displayed a large information poster supplied by North Yorkshire County Council. This set out a full range of parent and child groups in the local area, including dates and venues when they were running. Activities included play groups, parent support groups and drop in health sessions.
- The service had access to CAMHS via an arrangement with a local mental health trust. This meant that the service could request psychological support from qualified staff between Monday to Friday.
- All parents we spoke to felt that their emotional needs, and those of their children, had been taken into account by staff. Examples of this included staff provided a single bed with cot sides for a parent to sleep in with their sick young child, as this was how they were used to sleeping at home.

## Are services for children and young people responsive?

Good



We rated responsive as good because:

- Services were planned to identify the needs of the local population. Children and young people attending services were routinely seen in dedicated ward and outpatient areas for the majority of the care they received.
- The trust had identified the needs of the local population and was acting on these to improve access to services, such as plans to create a paediatric assessment unit.
- Good facilities were available to parents wishing to stay with their children and clear pathways were in place for children and young people to attend the service via A&E or through GP contact with the ward.
- The service received low levels of complaints and had begun trialling ways to collect feedback from children and young people about the service they received.

However we found that:

- Staff had identified that there were shortfalls in training for meeting the needs of children and young people with mental health needs and had arranged training with a local NHS trust.
- The trust was not compliant with national guidance in relation to children being seen on adult surgery lists, but plans were being put together to increase paediatric day surgery provision.

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

- Services were planned to meet the needs of the local population in regard to the availability and access to children and young people's services at the trust.
- At the time of our inspection, the ward had 17 inpatient beds (including a high dependency bed) and a four bedded day case area. The service had a business case approved to turn its day case beds into a six bedded assessment unit with trolleys. Work on this was due to begin shortly after our inspection. Staff told us that they were hopeful that this would reduce the number of unnecessary admissions to the ward and provide a timelier service for children and young people.

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- SCBU had seven level one cots. SCBU had space for ten cots, but we were told that only seven were used routinely, with some flexibility to extend to eight cots if there was ever demand. Staff on SCBU told us that they would provide CPAP treatment to babies who were stable or seen to be clinically improving if this helped to provide care locally for parents.
- There were dedicated paediatric outpatient clinics in general surgery, urology and orthopaedic sub-specialities. Outreach clinics were also provided at the Wetherby Health Centre.
- Children and young people in elective surgical lists were seen in a dedicated nurse-led paediatric pre-assessment clinic by an advanced nurse practitioner and play specialist. Approximately 50% of elective cases were completed on a four weekly dedicated paediatric day case unit day, staffed by paediatric nurses. The remainder of elective cases were treated on the day surgery unit on mixed adult/paediatric lists. The trust offered non-specialist paediatric surgery, which was undertaken by general surgeons. All specialist paediatric surgery was undertaken in Leeds.
- There was no capability for general anaesthetic to be provided to children requiring MRI scanning. Given this, the trust had a service level agreement with another trust to see these patients. To help reduce the number of children requiring anaesthesia, the play specialist within the service ran an MRI clinic to let children 'practice' ahead of their scans. We were told that this had been successful in reducing the number of children who had to travel out of area.
- Parents with babies on SCBU had access to two fully equipped, refurbished bedrooms including double beds and kitchen facilities. In addition to this, from December 2015, two of the SCBU rooms had a single bed so that mothers could stay with their baby at the cot side and not be separated. Cot beds were also available on the ward to allow parents to stay with their children.
- A parking discount of 50% was available for parents visiting children and young people on the ward of on SCBU.
- The hospital television service was free for children and young people until 7pm. After this time, they had to pay for access.
- Senior staff told us that they were putting together a business case to offer a second paediatric day surgery day every month. It was hoped that this would reduce pressure on the current day surgery day and help to avoid children and young people being placed on adult lists.
- Some specialities had begun to develop transition pathways for adolescent patients. We were told that access to these services was variable. In diabetes, a clear pathway existed with support from adult services and joint clinics. However, in specialties such as epilepsy no such clinics were currently in place. Senior staff told us that this was something the trust was working on to ensure a clear transition pathway for all adolescent patients.
- The Paediatric Diabetes Multi-disciplinary team (PDMDT) was a multi-professional group serving the population of Harrogate and the surrounding district area. The service supported children aged 0 to 18 years old as part of the Yorkshire and Humber Children and Young People's Diabetes (CYPD) network. The team consisted of a consultant paediatrician with a special interest in Diabetes, a paediatric diabetes specialist nurse, a paediatric diabetes specialist dietitian and administrative support.
- Open visiting times were available for immediate family on the ward and SCBU and the trust had offered discounted parking for people visiting the children and young people's service.

## Access and flow

- Clear pathways were in place for children and young people to attend the trust. Guidance was also in place for staff to aide in identifying children and young people that required more specialist care and arrangements were in place with local trust's and transport agencies to ensure that children and young people could access the right care at the right time.
- Between July 2014 and June 2015, the service saw 2,860 children and young people as admitted patients. This was broken down between emergency admissions (94%), day case (4%), and elective (1%).
- Data provided by the trust for January to December 2016 also showed that the trust had 9,203 new children's outpatients appointments and 16,123 follow up appointments.
- Approximately 800 patients aged from two to 16 years underwent surgery each year at the trust. The majority are elective day cases in the following specialities: ENT,

# Services for children and young people

community dental, maxillofacial, general surgery, orthopaedics and ophthalmology. Patients were a minimum of 2 years old and 15kg (10kg for minor procedures e.g. grommets) in order to undergo surgery.

- The median length of stay for children under one year old in an elective admission was one day. For all other types of admission (elective one year old to 17 years old and non-elective admissions) was zero days. This is lower than the England average for non-elective care.
- The service recorded data under the clinical classification system (CCS) to record the nature of emergency admissions to the trust. This showed that the percentage of children under one year old, and children and young people aged one year to 17 years, seen as for common medical problems was broadly in line with national averages. Some conditions were seen and treated more frequently by the trust. For example, acute and chronic infection in patients aged one year to 17 years was 7.3% compared to 3.9% nationally and viral infections in children under 1 year old was 10.3% compared to 7.4% nationally.
- Cancellation rates for the children's outpatient service stood at 9.6% of appointments cancelled by the trust and 9.9% cancelled by patients for new appointments. For follow up appointments, these figures dropped to 3.2% and 8.9% respectively.
- The percentage of appointments where children did not attend stood at 7% for new appointments and 15% for follow up appointments.
- Between April 2015 and the time of our inspection, 64 children had required transport out of the trust so that care could be continued at another NHS provider. The majority of these transfers concerned children less than one year old who needed access to higher level care.
- Between April 2015 and the time of our inspection, 289 young people had been cared for on wards' outside of the children and young people's service. The National Service Framework for Children says that children should not be cared for on adult wards, but on wards that are appropriate for their age and stage of development. The majority of these patients were 16 or 17 years old. Staff told us that it was likely that they would be on adult care pathways and staff told us that they took account of the young person's individual needs and maturity before reaching a decision on whether they could be cared for on an adult ward. Four

15 year old's had also been cared for on adult wards in this period; three of these were discharged the same day they attended, with one staying on a ward overnight.

## Meeting people's individual needs

- Staff had access to telephone interpretation services 24 hours a day. Staff told us that face-to-face interpretation could be booked in advance when required. There was also a service to allow staff to send documentation to the translation service. This took around five days to complete.
- There was no supply of foreign language patient information leaflets in the areas we visited and the staff we spoke to were not aware of how these could be accessed.
- There was an on call rota for a child and adolescent mental health psychiatrist via another trust. Staff had access to a referral flowchart and contact details were available to access services via a referral document. Services were available Monday-Friday. At the weekend, staff told us that they instead had to contact adult psychiatric services.
- At the time of our inspection, staff had not undergone training to help them meet the needs of children and young people attending the service with mental health needs. Staff told us that they did not feel confident in dealing with these situations. Senior staff told us that a basic training session was taking place the week following our inspection and they would identify the staff's further training needs.
- There was a learning disability link nurse within the trust. They were available for one day per week. Outside of these hours' staff were unable to access specific support or advice for caring with patients with learning disability issues. Staff told us that they could attempt to contact colleagues in specialist school nursing for assistance if this was necessary.
- At the time of our inspection, there was no specific paediatric assessment unit at the trust. Children attended the ward via A&E or GP services. Staff told us that ambulatory children that attended the trust would routinely attend the ward directly for care and treatment. The service had a business case approved to turn four day case beds on the ward into a six trolley assessment unit with trolleys. Work on this was due to begin shortly after our inspection

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- Staff told us that where possible children were placed at the top theatre operating lists when they were on mixed lists with adults. However, this was not always possible (for example, where adults on the list had complex health needs). During our unannounced inspection we saw that three children were on an adult list and were to be seen third, fourth and fifth. We were not provided with any information as to why this was the case.
- The SCBU had two cot beds that could be provided to parents to sleep in with their babies in private cubicles on the SCBU. Parents also had access to two parent's rooms a short distance from the unit. These provided double beds, televisions and washing facilities should parents wish to stay with their child. There was also a day room away from the ward that parents could use. Staff told us that these rooms were often used as part of the discharge planning process to allow parents a chance to spend time with their child away from the SCBU, but within easy reach of assistance if needed via an emergency call buzzer.
- The SCBU had a small room on the ward that provided a safe environment for younger siblings, with toys and games, where parents could take babies to interact with their siblings. The room could also be used by mother's to breast feed their babies, and could be made private by closing a blind or using portable privacy curtains within the room.
- In the 2015 CQC children's survey, the service performed about the same as other trusts concerning responses provided by parents and carers about the facilities available to them. It performed better than the England average concerning the availability of hot drink facilities. We saw signs informing parents that they could take hot drinks onto the ward and SCBU area, with guidance to add some cold water or milk to drinks to reduce their temperature and avoid the risk of scalding if a drink was spilt.

## Learning from complaints and concerns

- The number of complaints received by the trust had risen from 215 in 2013/2014 to 265 in 2014/2015. The ward received eight complaints between September 2014 and September 2015 and outpatients received one complaint. There was no particular trends or themes within these complaints.
- Information leaflets were available to parents attending the service outlining the complaint process and

encouraging parents to feedback any concerns they may have. No leaflets were available in an easy read or child friendly format to encourage children to raise any concerns with staff.

- The ward had recently installed a tool to help children feedback about their care. This included boxes where coloured counters (red or green) could be added to show if whether the child enjoyed aspects of their stay. The play worker who had recently installed the tool told us that she hoped to begin collecting feedback to identify positive and negatives about children's experiences on the ward.

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

Requires improvement



We rated well-led as requires improvement because:

- The senior leadership group had only been in post for a relatively short period. This meant that there had not yet been time for the service to develop a comprehensive vision and strategy for children's services within the trust.
- Work was required to re-establish ward meetings and to establish engagement with staff groups and with the public to help drive improvements and contribute to service decisions.
- Staff told us that they previously felt that there was a lack of senior leadership within the service.
- The service did not have a nominated executive and non-executive lead for children at board level in line with the National Framework.

However, we found that:

- Staff were positive about the new service and trust level leadership and felt that this would lead to improvements in services for children and young people.
- Governance structures were in place

## Vision and strategy for this service

# Services for children and young people

- Senior staff we spoke to identified a number of areas where they sought to develop the service, such as the new children's assessment area planned for the ward. They said that this vision had been supported by Board level leaders.
- At the time of our inspection senior leadership had only been in place for a relatively short period of time; the clinical lead, ward sister, and children's outpatient lead had been in post around twelve months or less, and the paediatric matron had been in post for three weeks. This meant that there had not been an opportunity for a clear forward vision or strategy to be discussed or implemented.
- Staff we spoke with were unable to describe any service specific vision or strategy. They were confident that this would be developed now that new senior leadership could be embedded in the service.
- Staff were aware of the wider trust vision and values and could describe these and how they related to their practice.

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

- Senior staff told us that they had a good link to the trust board and felt valued as a service.
- Monthly meetings took place on SCBU and a meeting took place around twice a month between the outpatient sister and matron. The ward did not have regularly scheduled meetings. Staff told us that this was due to how busy staff had been and that they had explored other ways of keeping staff up to date. This had included posters and e-mail. Senior staff told us that they were in the process of reintroducing regular team meetings.
- Senior staff attended a monthly governance meeting within the service. Feedback from this was fed into the monthly quality care meetings with more senior trust staff via the clinical lead.
- The service kept an up to date risk register which identified areas of concerns, and for most areas, identified suitable mitigating actions to address risk.
- The trust's quality and governance group last received the annual safeguarding children report in July 2015. The chief nurse acted as the safeguarding lead for the trust and sat on the safeguarding children's group. The safeguarding children's team reported also to this group on a bi-monthly basis. The group consisted of the chief nurse, deputy chief nurse, lead clinicians, senior

managers, named safeguarding and looked after children professionals, and representatives from trust human resource and workforce development. The group met to take forward the development, implementation, management and evaluation of safeguarding children services and practice.

- The safeguarding risk register identified that the administrator for the Harrogate area was on a career break. This was considered a risk to safeguarding issues being reported and recorded in a timely manner. Mitigating action had been put in place to ensure that other staff were available to cover these duties and recruitment to an interim post was taking place.
- The trust did not have a designated executive or non-executive lead for children and young people. Instead, the trust told us that all board members shared this responsibility. This was not in line with guidance under the National Service Framework for Children.

## **Leadership of service**

- Staff told us that there had previously been a lack of leadership within the service, specifically in relation to nursing leadership. This was due to no specific paediatric matron being in post for around seven years prior to the recent appointment. During this period children and young people's services were covered by other matrons from adult specialties.
- Staff told us that this meant that the needs of the children's and young people's service were not always understood or addressed. Many of the examples we were given by staff to support this related to the understanding of nurse staffing needs in paediatric services.
- Staff were confident and positive about the new nurse leadership now available within the service. They told us that they felt that this was a positive step and that they had confidence in the new leadership of the service.
- Staff had confidence in the new Board level leadership from the Chief Executive and chief nurse. They felt that this had coincided with a push to improve services and they felt confident in senior leaders to deliver change.
- Medical staff we spoke with felt confident in the clinical leadership of the service. The consultant of the week system also ensured that a senior member of staff was available to provide senior clinical leadership if required.

## **Culture within the service**

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- The trust performed within the expected range for responses to the General Medical Council (GMC) National Training Scheme Survey 2015.
- The trust had an appropriate and up to date policy in place concerning whistleblowing. Staff in the service told us that they would be comfortable in raising concerns with senior staff.
- The latest staff friends and family test data (July 2015) received 276 responses across the trust. The majority of staff said that they would be likely to recommend the trust as a place to work (99).
- All staff we spoke with felt supported by their colleagues and immediate line managers. We saw some examples of interworking between SCBU and the ward (such as SCBU staff being utilised to cover staff shortages). However, there were no joint team meetings or shared facilities (such as staff rooms) to encourage a closer link between the services.

## Public engagement

- The service gathered feedback from children and young people via the trust patient voice group in October 2015. The service spoke with nine children and young people and gathered their views on the service, including their views on access, communication from staff, and the hospital environment. This produced a range of recommendations across the service, including for example including facilities for older children on the ward.
- The SCBU carried out a parent satisfaction survey. Results from April to October 2015 showed that from 25 completed questionnaires, 24 parents said that they were 'very satisfied' with the service.
- The SCU displayed parent feedback on the service and the actions they had taken in response. Examples of this included breastfeeding mothers complaining that they had to leave the unit to get food. In response, the SCBU had begun to order meals for parents on the ward's food trolley. This meant that parents no longer had to leave the SCBU.

- The SCBU carried out a parent survey. Between April and October 2015, results from the survey showed that 21 parents used the overnight accommodation facilities. Of these, six said that they were excellent, 11 said that they were very good, three found them average, and one found them fair.







## Staff engagement

- Staff told us that they were kept up to date with developments and improvements being made by the trust via internal e-mail and notifications.
- Staff were encouraged to take part in the staff friends and family test in order to provide feedback to the trust.
- Staff could not provide us with any further specific examples of where they had been engaged by the trust to take their views or opinions on ideas to improve trust services.

## Innovation, improvement and sustainability

- The trust was involved in a scheme to encourage parents to donate excess breast milk. This was then provided to other neonatal units via a network approach and was sent for pasteurising offsite. The SCBU also used donated milk when mothers were finding it difficult to express breast milk or breast feed their baby.
- The service had developed an MRI clinic via its play worker. This allowed children an appointment with the play worker to experience the MRI environment before the scan took place. This included the use of a play tunnel and playing MRI sounds to children. This had been successful in ensuring that fewer children required sedation ahead of MRI scanning.
- The ward stock room had begun to list the price of equipment on labels. Staff explained that this helped to focus them on the cost of the equipment they were using and allowed them to become more aware of the effect of waste and to consider cost saving measures.

# End of life care

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

## Information about the service

There was a well-established service level agreement between a local hospice and Harrogate and District NHS Foundation Trust for the provision of specialist palliative care services which described how the services provided by the trust and the hospice worked together. This agreement had expired, however the practice continued, including the honorary contracts and governance arrangements. The specialist palliative care team visited patients on wards, in outpatient departments at the acute hospital, in nursing/ residential homes and in patients' homes in Harrogate and the surrounding district. They also work closely with all other services offered by the local Hospice.

Specialist palliative care consultants, including those working at the hospice, were employed by the trust. The specialist palliative care clinical nurse specialists (CNS), the supportive care CNS and the team's administrator were employed by the hospice and provided care to the patients in Harrogate District Hospital via the service level agreement. The supportive care CNS provided support, training and service development to improve end of life care within the hospital environment. At the time of the inspection, the supportive care CNS was on sick leave. There were no nursing staff employed by the trust who worked on the wards with a specific remit for palliative/end of life care.

Staff based in the community and the hospital could access advice and support from the specialist palliative care nursing team.

The trust also provides care for people at the end of life in Ripon Community Hospital where there are two beds on Trinity ward used for this purpose. Patients and staff at Ripon Community Hospital have access to the service provided by the hospice on the same basis as Harrogate District Hospital.

This inspection report focuses on the end of life services patients receive on the acute hospital wards at Harrogate District Hospital. Details of the end of life service provided at Ripon Community Hospital are reported within the Community Health In-patients Services inspection report.

The total number of patients who died at Harrogate District Hospital Foundation Trust was 679 from April 2014 to March 2015. Of that number a total of 211 patients were referred for specialist palliative care advice. There were 166 patients referred to the specialist palliative care service who had a diagnosis of cancer (79%) and 45 (21%) who had a non-cancer diagnosis.

During our inspection we visited five wards; spoke with 12 patients, six relatives and six members of staff. We reviewed eight sets of patient records.

# End of life care

## Summary of findings

The end of life care services were rated good overall. We rated the service as good for safe, effective, caring and well-led. We rated responsiveness as requires improvement.

We found patients received compassionate and understanding care on all the wards at the hospital and from the hospital chaplaincy service.

There was a strong culture of incident reporting. Staff knew how to report incidents and there was feedback and learning from incidents. Staff had a good understanding of the duty of candour and apologised when things went wrong.

The trust participated in the National Care of the Dying Audit of hospitals. The 2015 results showed that staff recognised that the patient would probably die in the coming hours or days in 96% of cases. The care of the patient was discussed with a nominated person important to the patient in 87% of cases and 69% of patients received a holistic assessment and care plan in the last 24 hours of life. The audit results for 2014 indicated that the trust scored better than the England average for eight out of 10 clinical indicators and three out of seven of the organisational indicators.

The trust had produced new guidance for staff that was based on up to date evidence and national guidelines. There were multi-disciplinary team (MDT) meetings in place. A care planning process had been developed and was being used based on current national guidance. Staff could access evidence based guidelines for symptom management. Equipment was available promptly from the equipment library when requested.

There were senior Board level executive and non-executive leads in place and an end of life steering group. The trust recognised the importance of improving their approach to end of life care by establishing the 'Rethinking Priorities Programme'. This was a development programme which involved consultant medical staff evaluating some of the most challenging aspects of providing a high quality service to patients approaching the end of life.

The trust was working with their local clinical commissioning group (CCG) and community teams to develop a five year strategic plan for end of life care. Progress developing the strategy was slower than planned and was not completed in February 2016, when we inspected. However, in the absence of an agreed local strategy the trust had developed a care of the dying adult and bereavement policy.

However,

The service level agreement with the local hospice to provide specialist palliative care clinical nurse specialists (CNS), the supportive care CNS had expired. Specialist face to face palliative care was only available Monday-Friday which was not meeting the national guidance of a seven day service. There was 24 hour specialist palliative care telephone advice available from an on call palliative medicine consultant in the region, who could be contacted via the local hospice. Care for people at the end of their life was not part of the trust's mandatory training.

The trust were unable to fully measure the quality of the service provided or measure improvements because they did not collect quality information such as recording the preferred place of care for patients. The trust recognised this and planned to develop quality measures.

Facilities in the mortuary required improvement and updating; the drainage and floor covering in the mortuary was old and appeared dirty with poor facilities for viewing and arrangements for transferring patients from the ward. The mortuary's facilities for accommodating bariatric patients were limited as they could only accommodate patients up to a certain size. There was limited access to the mortuary at weekends for relatives. Porters were trained to transfer bodies to the mortuary but were not mortuary technicians so were not able to prepare the body for viewing. This relied on the trained mortuary staff being available and they only worked Monday to Friday although there were some on call facilities.

# End of life care

We found a large number of historical autopsy post mortem reports stored in the mortuary, some of which dated back to 1970. This breached the NHS Code of Practice, which states that these records should have been destroyed once they are 30 years old.

## Are end of life care services safe?

Good



Overall we rated these services as good for safe because:

- There was a strong culture of incident reporting. Staff knew how to raise incidents and there was feedback and learning from incidents. Staff had a good understanding of duty of candour and apologised when things went wrong.
- There was an escalation pathway for staff to follow when the patient's condition deteriorated.
- There were specialist palliative care CNSs, supportive care CNS contracted through an agreement with the local hospice. Advice was also provided by staff from a local hospice.
- The trust had introduced individualised end of life care planning to replace the Liverpool care pathway. Staff had been trained but the trust was relaunching the new approach because audits showed it was not being fully followed on the wards.

However we also found that:

- The trust was one of only 18% of trusts nationally that did not provide mandatory end of life training.
- We found a large number of historical autopsy post mortem reports stored in the mortuary, some of which dated back to 1970. This breached the NHS Code of Practice, which states that these records should be destroyed once they are 30 years old.
- The level of consultant medical cover was less than national guidance recommended for the size of population served by the trust. National guidance indicates 1.6 consultants or 16 clinical sessions was required for cancer patients for the size of population served by the trust.

## Incidents

- There were no never events and no serious incidents reported in the period April 2014 to March 2015 for patients on the end of life care pathway. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Other lower grade incidents were reported and acted upon. We saw an example of action the trust had taken

# End of life care

following an incident reported by mortuary staff. An implantable cardiac defibrillator device had not been removed following the death of a patient. As a result of this the trust had updated guidance for assessing and caring for patients at the end of life: there was a section reminding staff to de-activate these with a link to the trust's policy.

- Arrangements were in place to ensure medicines' incidents were reported, recorded and investigated. The medicines safety officer described how incidents were analysed and learning disseminated across the trust.
- A mortality and morbidity group met monthly to review the care provided to patients who had died. The care patients received in the last days of life was discussed to identify ways of improving the care provided. There was an action to record the involvement of palliative care specialists as part of the mortality review.
- Staff had a good understanding of the NHS's policy on duty of candour.
- We saw reference in one person's records that showed a senior nurse had contacted their relatives to inform them the person had fallen on the ward. The nurse had contacted the family in accordance with the trust's duty of candour policy. The duty of candour requires health organisations, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, to notify the relevant person that the incident has occurred and provide reasonable support to the relevant person in relation to the incident and offer an apology.

## Medicines

- There were protocols in place for the prescription of medications for patients for the following symptoms: pain, agitation, breathing difficulties and nausea.
- The ward based clinical pharmacy service was available between the hours of 8.30am to 6.45pm Monday to Friday with a limited service between the hours of 9am to 2pm on Saturday and Sunday. Outside of these hours, an on call service was provided.
- An anticipatory medicines protocol was in place. These were medicines a patient might need in the last few days of life. It provided staff with information about prescribing the appropriate medicines in sufficient quantities and allowed carers and community staff to source a supply of the appropriate medicines in the community if the patient was discharged. The protocol was accessed by staff on the trust's computer system.

- Nursing staff told us medical staff organised anticipatory medicines for patients approaching the end of life. This meant staff on the ward had the medicines they needed if a patient's condition deteriorated or if they experienced particular symptoms.
- Community staff told us families sometime had difficulty obtaining medicines for relatives particularly out of hours. Not all pharmacies stocked the medicines patients' needed. The trust had identified the importance of ensuring patients were discharged with sufficient supplies of the medicines they needed and were working with pharmacies and GPs to improve access to the medicines required. Families living in rural areas had to travel extensive distances on occasions to obtain the medicines a patient required.

## Records

- An audit of general nursing notes was undertaken in March-April 2015. The audit looked at 20 sets of in-patient case notes per ward and 10 nursing entries per set of notes and included priorities of care for end of life patients. An action plan was developed to address the issues identified. Nursing staff were reminded of the importance of completing all aspects of the nursing documentation and this would be monitored by the monthly sisters' meetings.
- A case note audit was undertaken to determine if the five priorities of care were being followed from the national guidance, 'Priorities of Care for the Dying Person' and whether the care plans for the last days of life were being used. The results of the audit were used to inform a staff training programme. There were 750 staff recorded within their 'End of life care focus around the five priorities for care of the dying person monitoring report' who had received training in the five priorities of care. As a result of the audit, the trust also planned to re-launch the recently developed care plan for people approaching the end of life.
- We reviewed eight people's care plans, which included examples of the care plans developed following a multi-disciplinary team (MDT) assessment for individualised care plan for last days of life. These showed which staff had been involved in discussing the patient's care, a record of the information provided to the patient and their carers, any concerns identified, the patients' wishes regarding future decisions for example if they did not wish to be admitted to hospital or wished to make an advanced decision to refuse further

# End of life care

treatment. We found most of these records contained information about discussions with patients about their wishes at the end of life and with relatives. However, we also found examples where there was little or no record of discussions with the patient or relative or a formal record that the patient was in the last days of life.

Nursing staff told us medical staff were good at discussing the care of dying patients with relatives but they did not always record the information in the person's records.

- When it was recognised a patient was in the last hours or days of life this was recorded.
- The records contained information about referrals to the palliative care team for advice.
- Do not attempt pulmonary resuscitation notices had been completed for five patients. The need for anticipatory medicines was recorded for the key symptoms that may develop at the end of life. In keeping with national guidance, there was evidence that most patients were assessed frequently five or more times in the final 24 hours of life.
- We found a large number of historical autopsy post mortem reports stored in the mortuary, some of which dated back to 1970. This breached the NHS Code of Practice which states that these records should be destroyed once they are 30 years old. These records were stored in a filing cabinet and some in a locked cupboard. The mortuary manager told us they were not aware of any plans to relocate these records.

## Mandatory training

- There was a trust mandatory training policy in place, which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act 2005 and the deprivation of liberty safeguards (DoLS).
- For each training element, staff groups were identified and the frequency of each training element. Employees had a personal training account, which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.

- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.
- Care for people at the end of life was not part of the trust's mandatory training programme. The trust participated in the National Care of the Dying Audit of hospitals 2014 which indicated that the trust was one of 18% of trusts nationally who did not provide mandatory end of life training. The Trust had recognised a gap in training and had prioritised and delivered the training of 750 staff in recognising the five Priorities of Care for the Dying Person at end of life. One of the areas audited related to communication skills training for care in the last days of life for medical and nursing staff. The results of the audit showed medical and nursing staff had not received this training in the period April 2014 to March 2015.
- Four staff we spoke with told us they had completed training in safeguarding. They were aware of the different forms of abuse and how to report any concerns.

## Assessing and responding to patient risk

- The trust used a National Early Warning Score (NEWS) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care.
- Nurses and care support workers recorded patient observations at the bedside and entered them onto an electronic system (Patientrack). If the NEWS score was three or above, indicating a patient was deteriorating, the system was set up to automatically bleep medical staff. This enabled the patient to be attended to swiftly. Depending on the level of the NEWS score, medical staff of different grades and experience were bleeped.
- All the care plans we looked at contained risk assessments for nutrition and hydration and tissue viability.
- Staff carried out safety rounds every two hours for patients assessed as being at risk.
- There was an escalation procedure staff could follow if the patient's symptoms worsened significantly.

# End of life care

- Staff caring for patients were encouraged to seek specialist advice from the specialist palliative care team if symptom control was difficult or if they had any questions about the end of life care plan.

## Nursing staffing

- The specialist palliative care CNSs, supportive care CNS and the team's administrator were employed by a local hospice and provided care to the patients in Harrogate District Hospital via a service level agreement.
- Ward staff cared for people at the end of life and worked closely with the specialist palliative care team employed by the hospice to ensure patients received the appropriate care. .
- Staff based in the community and the hospital accessed advice and support from the specialist palliative care nursing team employed by the local hospice.
- Patients received end of life care from the general ward staff.
- Nurse staffing on some of the wards, especially care of the elderly wards, was an issue. This might have impacted on the care of patients who were receiving end of life care. However, the trust had recognised this and had taken measures to minimise the risk to patients.
- Matrons monitored staffing levels twice a day. Staff were re-deployed to other wards and bank staff were used to cover gaps in nursing staff rotas.
- The trust had also recruited healthcare support workers to increase overall staffing levels on the wards and there was an ongoing recruitment campaign to recruit nursing staff.

## Medical staffing

- The Trust employed 0.5WTE specialist palliative care consultant and 0.53 WTE specialist palliative care doctor contracted to work on the hospital site. This meant that the Trust had combined specialist palliative care medical staffing of 1.03WTE. The level of medical cover was less than the national guidance recommended for the size of the population served by the hospital. National guidance indicates the hospital should have 1.6 WTE doctors for patients requiring specialist palliative care. Figures provided by the trust indicated cancer patients accounted for approximately 80% of patients who were referred to the Specialist Palliative Care Team.

- The service had a business plan to increase the level of consultant cover and had advertised a part time post providing three sessions (0.3) for the hospital and two sessions for the hospice. The trust had not been able to recruit to the post. A further business case had been developed to increase the trust sessions and in conjunction with the hospice, to introduce a number of community sessions. At the time of inspection the trust were still considering the business case.
- The NICE End of life care for adults quality standard (updated 2013) states that palliative care services should ensure provision to: Visit and assess people approaching the end of life face-to-face in any setting between 09.00 and 17.00, 7 days a week and; provide specialist palliative care advice at any time of day or night, which may include telephone advice.. The Trust partially achieved this by a face-to-face service provided 9am to 5pm Monday to Friday and out of hours and weekends via the on call palliative care consultant in the region. The national care of the dying in hospital audit results showed that Harrogate District Hospital provided face-to-face services on weekdays only. This was similar to the majority of other hospitals nationally (73%) compared with 21% of sites which had access to face-to-face palliative care services seven days per week.

## Other staffing

- There was a mortuary manager and an anatomical technical practitioner (ATP) who worked alongside consultant pathologists.
- There was a team of 44 porters who worked across the trust. Approximately eight porters were involved in end of life care. They were responsible for handling deceased patients and transferring them to the hospital mortuary via the concealment trolley. Another four porters were trained, which meant there were sufficient staff to provide the transport service 24 hours a day seven days a week. The charge-hand and deputy charge-hand porters were trained to prepare deceased patients for relatives to view out of hours.

## Major incident awareness and training

- There were major incident plans in place which included increasing the capacity of the mortuary arrangements in the event of a major incident and arrangements for staff to be called in if necessary in such an event.

# End of life care

## Are end of life care services effective?

Good



Overall we rated this services as good for effective because:

- The trust had produced new guidance for staff which was based on up to date evidence and national guidelines. Staff could access these to plan end of life care, including evidence based guidelines for symptom management.
- Patients had access to pain relief in a timely manner
- Equipment was available from the equipment library promptly when requested.
- Nursing staff were required to maintain evidence of their competence and practice for using syringe drivers as part of their professional practice portfolio.
- The trust participated in the national care of the dying in hospitals audit and in 2014 had scored higher than the England average for eight out of 10 clinical indicators and three out of seven of the organisational indicators. Since the inspection, the 2015 results were published which were better than the England average for the cases reviewed as part of the clinical audit. However, the organisational audit was worse than other trusts in England.
- There were weekly specialist palliative care multi-disciplinary team (MDT) meetings to discuss the care of patients in hospital and the community.

However,;

- The drainage and floor covering in the mortuary required improvement. The mortuary floor was old and appeared dirty. The floor in the main mortuary areas was cleaned daily and deep cleaned monthly. We also found the mortuary viewing area was poorly lit and in need of re-decoration.
- The mortuary had no facilities in place for accommodating bariatric patients. . An agreement was in place to transfer a patient to a neighbouring trust if required and this contingency had been used on one occasion. The trust had developed plans for addressing this which relied on capital funds being available.
- The trust were unable to fully measure the quality of the service provided or measure improvements because they did not collect some key pieces of information for

measuring service quality. This included, for example, recording the preferred place of end of life care for patients. Managers told us the trust recognised this and planned to develop quality measures.

## Evidence-based care and treatment

- In response to the 2013 review of the Liverpool Care pathway, the trust had produced new guidance for staff which was based on up to date evidence and national guidelines.
- The new guidance referenced, 'Priorities of Care for the Dying Person' (2014) from the Leadership Alliance for the Care of Dying People (LACDP). The LACDP consisted of a coalition of 21 national organisations who worked together to develop guidance on end of life care. The LACDP was formed to review the evidence on end of life care, patients, carers and clinical professionals and make recommendations about new standards of care. It also referenced, 'More Care, Less Pathway: An Independent Review of the Liverpool Care Pathway' (2013)
- The service was no longer using the Liverpool care pathway. All NHS trusts had been required to replace the use of the Liverpool care pathway with individual care plans by July 2014.
- Community and hospital staff told us they could access the Trust's guidance to plan end of life care following the above guidance. This meant they could follow procedures of what nursing actions to take.
- Care plan templates had been developed for end of life care patients that were based on guidance. The source of the guidance used to inform the plan was included at the back of the document.
- A case note audit was undertaken to determine if the five priorities of care were being followed from the national guidance 'Priorities of Care for the Dying Person' and whether the care plans for the last days of life were being used. The results of the audit were used to inform a staff training programme. There were 750 staff who had received training in the five priorities of care. As a result of the audit, the trust also planned to re-launch the recently developed care plan for people approaching the end of life.
- The trust's care of the dying adult and bereavement policy provided staff with guidance on advanced

# End of life care

decisions to refuse treatment (ADRT). These are decisions that allowed patients to refuse specified medical treatment for a time in the future when they may be too unwell to consent or refuse treatment.

- The trust had developed a hospital policy using evidence-based guidance produced by the national institute for care excellence (NICE) for intravenous fluid therapy in adults in hospital. The trust's guidelines focused on the use of subcutaneous fluids (sub cut fluids) to provide an effective means of controlling hydration and symptom control for patients who were unable to take or absorb fluids.

## Pain relief

- The trust's guidance on caring for patients at the end of life contained procedures for assessing the pain patients experienced. The guidance contained recommendations for the dosage and frequency of medicines that could be prescribed. There was also guidance on the use of sub-cutaneous medicines if the patient was unable to swallow medicines and the use of analgesic patches. There were alerts for staff to look out for signs of toxicity.
- We saw four examples of pain management plans that had been completed. These contained information about the medicines, which had been prescribed for regular use together with prescribed anticipatory medicines that could be used if a patient's condition deteriorated.
- There was pain assessment tools included in patients' care plans. Patients were asked to rate the level of pain they experienced on a scale of one to ten. Patients who had difficulty giving a numerical value to the level of pain they experienced could indicate the severity of pain by pointing to a sad or smiley face. This meant the service had systems in place for assessing pain for a range of patients with different needs.
- We looked at patient notes and found that patients had access to pain relief in a timely manner.
- We saw these records all contained pain assessments which were completed as part of their patient observations.
- A relative told us staff had recognised and dealt with symptoms promptly although pain had initially been difficult to control.
- The trust had developed a policy and programme for training relatives to assist patients with subcutaneous medications.

## Equipment and Environment

- Syringe drivers and other medical equipment patients needed were obtained from the 'equipment library'. This was a department in the hospital that held a store of equipment staff could access when required.
- There was a programme of rolling training for the use of some pieces of equipment; the ward sister was notified about staff requiring update training. Staff in the equipment library also provided ward staff with training, for example, in using syringe drivers. The trust developed a policy in April 2015 for the use of syringe drivers. This specified that registered professionals must undertake the trust's syringe driver training annually and the McKinley T34 e-learning module. The training was followed by a period of supervised practice and competency assessment. Nursing staff were required to maintain evidence of their competence and practice as part of their professional practice portfolio.
- Staff in the hospital and staff working in the community told us the equipment library provided an excellent service ensuring equipment was safe and accessible when required even at weekends and holidays. We were told that in hospital equipment was available within a couple of hours of a request.
- Syringe drivers were located in district nursing bases in the community and community staff could obtain equipment out of hours from the equipment library. This meant equipment was available to support patients being discharged from hospital.
- The multi-faith chaplaincy centre was located close to the front entrance of the hospital. The centre had a room which could be used as a prayer room.
- We saw the results of audits undertaken every three months in the mortuary. The audits checked a range of health and safety and infection control procedures were being followed for example waste disposal.
- However when we visited the mortuary we found that the drainage and floor covering in the mortuary required improvement. The mortuary floor was old and appeared dirty. The floor in the main mortuary areas was cleaned daily and deep cleaned monthly. We also found the mortuary viewing area was poorly lit and in need of re-decoration. The trust had acknowledged the area needed to be improved. It had been highlighted on a number of occasions but there was no date set for the work required to be carried out.

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- Nursing and portering staff told us the concealment trolley was not discreet.
- The mortuary's facilities for the accommodation of bariatric patients were limited. The size of the fridges and methods used had been identified on the risk register. Multiple staff were used to slide patients (charge hand porters involved) and there was a dynamic risk assessment of individual cases performed which could have involved referral to another mortuary facility if necessary. An agreement was in place with a neighbouring trust to transfer a patient and this contingency had been used on one occasion. The trust had developed plans for addressing this which relied on capital funds being made available.
- Staff told us there was a shortage of single rooms for people approaching the end of life. They said they struggled to balance the needs of people at the end of life with single rooms required for people with an infection. Patients who were at a lower risk of passing on infection were nursed in bays with staff following infection control procedures as far as possible.

## Nutrition and hydration

- The assessment and care plan guidance developed by the trust contained a section on supporting patients' nutrition and hydration needs. This described the importance of encouraging patients to eat and drink for as long as possible.
- There was guidance on clinically assisted hydration and clinically assisted nutrition. We saw examples of nutritional and hydration assessments which had been completed by staff.
- The results of the national care of the dying in hospitals (2014) showed that the trust was better than other trusts at assessing patients' nutritional needs. There was 62% of patients who had their nutritional needs assessed compared with 39% nationally. The same audit showed 72% of patients had their hydration needs assessed compared with 48% nationally.
- The national care of the dying audit recommended that decisions about the use of CAN (Clinically assisted nutrition) and CAH (clinically assisted hydration) were taken by a senior experienced clinician supported by a multidisciplinary team.
- The trust had developed a protocol for the use of sub cutaneous fluids. The trust recognised this was as an

issue, and plans were being put in place to provide this as part of the service. This included developing a competency check and training for injections to be given.

- We saw guidelines developed in September 2015 by the trust to support people at risk of dehydration in the final days of life. The guidelines covered a range of circumstances which might require clinical intervention, for example, if a patient experienced acute dehydration or was unable to drink normally. The trust's policy was based on a set of guidelines developed by the local hospice.
- Staff told us the most effective way of ensuring people were not at risk of dehydration and weight loss was to encourage them to eat the foods they like when they felt able to eat. They said they were able to provide clinical assistance with subcutaneous fluids in some cases but they preferred to encourage patients to eat a normal diet wherever possible.
- Special diets and prescribed food supplements were available for patients if required.

## Patient outcomes

- The trust participated in the national care of the dying in hospitals audit. This compares the trust with 131 trusts nationally (90% of the trusts eligible to contribute). By participating in this audit, the trust receives an analysis of how services compare with other similar organisations on a range of clinical and organisational indicators.
- The 2015 survey results were not available when we inspected but were subsequently published which showed that the trust was better than the England average for the cases reviewed as part of the clinical audit. However, the organisational audit was worse than other trusts in England. In the 2015 National Care of the Dying Audit, the categories had changed from previous audits. The trust submitted audit results for five clinical indicators. The results showed that staff recognised that the patient would probably die in the coming hours or days in 96% of the 45 cases data was submitted for. The care of the patient had been discussed with a nominated person important to the patient in 87% of cases. There was documented evidence that the patient was given an opportunity to have concerns listened to in 91% of cases and 69% of patients received a holistic assessment and care plan in the last 24 hours of life.

# End of life care

- The results of the national care of the dying in hospital audit showed staff at the trust performed better than other trusts for reviewing the care provided for patients approaching the end of life; 53% of patients had their care reviewed in the last hours and days of life compared with 50% in other trusts participating in the audit.
- We saw the results of an audit of patients admitted with neutropenic sepsis. The national institute for health and care excellence (NICE) recommended that patients with neutropenic sepsis were given antibiotics within 60 minutes of attending hospital. The audit showed 87% of patients received antibiotics within 60 minutes which was a 13% improvement on 74% in the 2014 audit. The audit identified the actions required to increase compliance with the standard.
- The results from the national care of the dying in hospital audit 2014 highlighted that the number of patients whose care was supported by a framework of care for the last hours or days of life was 84% for the trust compared with 48% nationally. The trust performed significantly better than other organisations on this indicator.
- As part of the information submitted to the national care of the dying audit the trust had reviewed five sets of case notes to establish why patients did not die in their preferred place of care. The results showed that four people had died before they could be transferred and one person was too ill to be transferred.
- The trust reviewed a proportion of cases after death to identify the level of compliance with the trust's policies and the quality of care provided. The national care of the dying in hospitals audit 2014 showed the trust reviewed the care of 61% of cases after death compared with trusts nationally who reviewed 56% of cases.
- The trust had developed an action plan based on the results of the national care of the dying audit. The trust's action plan set out their response to the eight key areas of the audit. The first recommendation was for hospitals to provide a face-to-face specialist palliative care service from at least 9am to 5pm, seven days per week, to support the care of dying patients. The action plan recorded the current levels of access to palliative care but there were no specific timescales for improving this.
- The results of the 2014 national care of the dying audit showed the trust performed better than many other organisations on continuing education, training and audit for care of the dying, protocols promoting patient

privacy, dignity and respect, up to and including after the death of the patient and formal feedback processes regarding bereaved relatives/friends views of care delivery.

- The trust were unable to fully measure the quality of the service provided or measure improvements because they did not collect some key pieces of information for measuring service quality. This included, for example, recording the preferred place of end of life care for patients. Managers told us the trust recognised this and planned to develop quality measures.

## Competent staff

- A national care of the dying audit recommendation related to education and training in the care of the dying, which should be mandatory for all staff caring for dying patients. This included communication skills training, skills training for supporting families and those close to dying patients. The trust had provided five priorities of end of life care training for 750 nursing and care staff. However, end of life care training was not included as mandatory training for all staff.
- Nursing staff told us there was a range of training opportunities staff could access for improving the quality of care provided for patients at the end of life. They said the palliative care team provided intensive ward based training in the five priorities of care.
- Staff on the wards could contact the CNSs or doctor in the specialist palliative care team to access advice on caring for patients. The specialist palliative care team, CNSs and doctor also contacted the wards to check on patients and to speak with relatives when they visited or at home offering information, advice and support. Within the CNS team there were nurses linked to the wards; we observed them proactively contacting their wards to offer their support.
- Care staff received end of life training as part of their induction.
- Foundation Year 1 doctors received end of life training as part of their induction.
- A monthly one hour education session for end of life care and symptom control had recently been introduced which was open to all trust staff.
- Nursing staff had yearly training on the use of syringe drivers. We saw records of staff who had received training. Training dates were planned for staff who had not completed the training.

# End of life care

- On one ward staff showed us the excellence award they had received from the end of life development practitioner in October 2015. The award recognised that 85% of staff on that ward had completed end of life care training based on the five priorities for care of the dying person.
- The chief nurse told us they had re-developed the palliative care facilitator role into the supportive palliative care nurse role. The role was not fully developed. Staff told us they had valued the previous facilitator's role and were concerned about the breadth of the new role across hospital and community services.
- Mortuary staff had completed the Institute of Public Health diploma and the certificate of anatomical pathology.
- Charge hands porters received additional training annually in the processes for transferring deceased patients to the mortuary with input from the mortuary manager and the chaplaincy. Training in bereavement support was also provided.
- Staff on Trinity ward at Ripon Community Hospital attended end of life care training and accessed training provided by a local hospice. Staff on this ward had access to one dedicated member of the specialist palliative care team who provided advice and undertook the local training. All the nursing staff caring for people at the end of life on Trinity ward were trained to use syringe pumps.
- To help staff listen and respond to patients or carers who are distressed, six staff were attending SAGE & THYME® communication skills "train the trainer" sessions in February 2016. This would then be rolled out across the trust from February 2016 onwards. (The SAGE & THYME® model was developed by South Manchester NHS Foundation Trust. Its purpose was an aide-mémoire to train all grades of staff on how to listen and respond to patients or carers who were distressed or concerned).
- The trust had also developed a senior clinicians' development programme. The trust was encouraging senior clinicians to be fully involved with end of life care making it a routine part of their practice. The training focused on meaning of end of life, improving the management of end of life care, advance care planning, prognostic indicators, and advanced decisions to refuse treatment and how to communicate in the most sensitive way to the patient that they were dying.

- Chaplaincy staff completed end of life training twice a year. We saw a copy of the training programme which covered bereavement, grief and loss. The chaplaincy team visited the wards daily to identify people who may need their support.

## Multidisciplinary working

- Guidance developed for patients approaching the end of life instructed staff to organise a multidisciplinary assessment (MDT). An MDT required the involvement of a senior member of the patient's medical team and a qualified nurse responsible for co-ordinating the patient's care. The purpose of the MDT assessment was to consider whether the patient might be in the last hours or days of life or if the patient's deterioration could be reversed, for example, because it was caused by the medication they were receiving. The MDT discussion should also take account of the patient's wishes before a decision was made about developing an end of life care plan or a plan to address the reversible causes of the patient's deterioration.
- The end of life care planning guidance also required staff to organise a multi-disciplinary reassessment and review of the patient's care plan if the patient's condition improved or concerns were raised by the patient carers or staff about the current plan.
- There were weekly specialist palliative care multi-disciplinary team (MDT) meetings to discuss the care of patients in hospital and the community. The team was made up of a range of professionals including consultants in palliative medicine, specialist palliative care CNSs, pharmacy staff, and hospice staff including a physiotherapist, an occupational therapist, chaplaincy, a social worker and day therapy nurse.
- The care of people who were dying was discussed daily by medical staff. There were weekly continuing professional development meetings for medical staff. Annually, a consultant in palliative medicine has led one of these sessions. We observed medical and nursing staff discussing one person's condition to assess if the patient would benefit from continuing treatment. They agreed to discuss the person's condition with the person's relatives before reaching a conclusion.
- Medical staff on the wards worked closely with the specialist palliative care team and referred patients as soon as patients were recognised as approaching the

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last days of life. Medical staff were able to obtain advice from this palliative care team before speaking with the patient or their relatives and completing DNACPR documentation.

- An audit of written communication to GPs following an in hospital death in general surgery patients had been completed and the results presented.
- Staff said some medical staff preferred to obtain advice from the palliative care team before speaking with the patient or their relatives and completing DNACPR documentation.

## Seven-day services

- NICE End of life care for adults quality standard, published (updated 2013) stated that palliative care services should ensure provision to: visit and assess people approaching the end of life face-to-face in any setting between 9AM and 5PM, seven days a week and; provide specialist palliative care advice at any time of day or night, which may include telephone advice. Referrals to the specialist palliative care team could be made from 8am-6pm Monday to Friday with non face-to-face on weekends. Outside of these hours specialist palliative care telephone advice, for professionals, could be obtained by contacting a hospice. Advice was provided either by the hospice's inpatient team or the palliative medicine consultant on call in the region dependent upon the complexity of advice required. Staff told us access to the specialist palliative care team seven days a week would be an improvement.
- The chaplaincy service was accessible twenty-four hours a day, seven days a week. Chaplains were available on weekdays and at weekends.
- Mortuary staff had a 24 hour, 365 days a year cover for the transporting of patients. The manager told us they were on call on a year round basis.

## Access to information

- The service was not using a specific electronic palliative care co-ordination system (EPaCCS). These are information systems which enable information about patient preferences to be recorded and shared with other professionals involved in providing care at the end of life, for example the ambulance service or other hospitals in the area. The hospital was not able to share information with the community teams who were employed by trust. However, community staff used the

same computer system as GPs and the specialist palliative care team. This meant information about patients' needs in the community was shared. The trust had identified there was a risk not all information was being effectively shared. The trust was planning to implement a system (EPaCCs), which enabled information about patients to be shared between different groups of healthcare professionals.

- Patients' do not resuscitate documents could be transferred between the hospital and the community but this required the document being sent or taken by the patient.
- Wards used care plans as a reference tool to help them deliver care and treatment for end of life care patients that were based on national guidance.

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

- An audit of 'do not attempt cardio-pulmonary resuscitation (DNACPR) notices was carried out in August 2015. The audit found the notices were included in 56% of the record reviewed. There were 33 cases where a DNACPR was not present, 12 of which were deemed appropriate for having no DNACPR in place and the remaining 21 cases should have had the DNACPR considered. The audit identified the need to improve awareness especially for junior doctors.
- The audit also highlighted that DNACPRs completed in the community were recorded on to the SystemOne computer system, which staff in the hospital could not access.
- We examined seven completed DNACPR notices and found these had all been effectively completed. This included the sections which recorded whether the patient lacked the mental capacity to make an informed decision. Discussions with relatives were recorded in five sets of patient notes.
- Best interest meetings were held for patients who had learning disabilities. We saw evidence of best interest meetings for a patient on Littondale ward.
- The trust's revised guidelines for the multi-disciplinary assessment and individualised care plan contained information and guidance for staff on the importance of completing do not resuscitate documentation. Staff were directed to the trust's policy which could be accessed via the trust's intranet. Care plan guidance also prompted staff about things to consider if a patient was unable to make decisions because they lacked the

# End of life care

mental capacity. Staff were offered further guidance and information about the Mental Capacity Act 2005, how decisions in the patient's best interests should be made and recorded using advice and guidance on the trust intranet or by contacting an independent capacity advocate (IMCA).

- Staff were familiar with the need to consider patients' mental capacity if they suffered from a mental health condition such as dementia. The nurse we spoke with said they usually raised any concerns about a patient's mental capacity with medical staff who would arrange for the patient to be assessed.
- The trust now provided information about the process as part of the induction programme. The resuscitation team were providing training for specialist nurses in decision-making and 20 nurses had already been trained.

## Are end of life care services caring?

Good



Overall we rated these services as good for caring because:

- There was evidence of compassionate and understanding care on all the wards at the hospital.
- Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- Patient's spiritual and emotional needs were assessed as part of the services end of life care planning process. Relatives we spoke with said they felt really well supported by the ward team who kept them updated about their relative's condition. They said they were involved and felt they were being consulted.
- Patients' privacy and dignity was respected and staff did not interrupt whilst care was being provided.
- The trust surveyed relatives' views following bereavement to identify areas for improvement.
- The hospital chaplaincy service provided a caring, responsive and effective service for patients, family and friends.

However,

- We observed grieving relatives in a corridor outside one of the wards. When we asked staff about this they said there was a lack of quiet, private areas on the wards where relatives could grieve in privacy.

## Compassionate care

- There was evidence of compassionate and understanding care on all the wards at the hospital. Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- We spoke with one person's relatives who told us the care staff provided was 'fabulous'. They said all grades and types of staff were attentive and looked after the whole family when they visited. The patient's relative told us "I have been able to stay on the ward for the last 10 days". We spoke with another relative on Granby ward who had stayed overnight. They told us there were no facilities for relatives but staff had offered accommodation on an adjacent ward.
- We observed grieving relatives in a corridor outside one of the wards. When we asked staff about this they said there was a lack of quiet, private areas on the wards where relatives could grieve in privacy.
- Ward staff used a system of placing a clothes peg on the curtains around a patient's bed to indicate staff were providing care for patients. This ensured patients' privacy and dignity was respected and staff did not interrupt whilst care was being provided.
- Staff on general wards told us they prioritised care for people approaching the end of life. They said they tried to ensure they were provided with a private side room to provide them and their families with privacy.
- The trust was sending out bereavement surveys to relatives after someone had died. The survey had started in November 2015. We saw the results of a bereavement survey the trust had recently undertaken. There had been seven responses. Comments were mostly positive. One person responded saying, "I couldn't fault the care and attention given to me and my family while (my relative) was in hospital and after their death. The support from the chaplaincy team was also excellent. Another person said, "When I came to the general office the next day to collect belongings and the death certificate I was made to wait a long time and I was made to feel like an unexpected burden."
- Nursing staff told us if a patient died at the week-end relatives were unable to view until Monday. They told us relatives found this distressing and they felt this did not offer people a compassionate experience.

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

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- The trust participated in the National Cancer Patient Experience Survey in 2014 (the 2015 results were not published at the time of our inspection) and was in the top 20% of trusts in England for the following questions;
- staff giving information about support groups and financial help,
- patient definitely involved in decisions about care and treatment
- patient given the right amount of information about condition and treatment
- the family definitely given all information needed to help care at home.
- The trust was not in the bottom 20% of trusts in England for any of results.
- We saw an example of medical staff involving a patient's family in their care. The family lived abroad, were aware their relative was approaching the end of life and had visited them in hospital. Medical staff had contacted them to keep them involved.
- We spoke with a relative who was staying at the hospital. They said they felt really well supported by the ward team who kept them updated about their relative's condition. They said they were involved and felt they were being consulted.
- The trust had prepared a booklet for the family and friends of people in the last days of life. The booklet encouraged friends and relatives to record questions and suggestions in the booklet to discuss with staff. The booklet provide information about recognising someone was in the last days or weeks of life, the trust's approach to medicines, how staff would support patients with eating and drinking, if they suffered from breathlessness or restlessness and what would happen if the person's heart stopped.

## Emotional support

- Patients' spiritual and emotional needs were assessed as part of the service's end of life care planning process. Staff identified what was important to patients for example their wishes, feelings, culture, faith and values.
- Information about accessing the chaplaincy team was available and staff were encouraged to let the team know about all patients being supported in the last days of life.
- The trust's risk register highlighted the risk of patients and their families not accessing the hospital chaplaincy team because staff did not always make the team aware

of patients who might need their support. The trust's care plan for the in last days of life prompted staff to consider peoples' needs and the service had been promoted at education events with limited success. Actions to improve access included the publication and promotion of a revised spiritual, religious and pastoral care policy, end of life care study days and chaplains participating in breaking bad news alongside nursing colleagues.

- A relative told us they had spoken to the palliative care doctor and the chaplain and felt they had all their questions answered. They said the atmosphere on the ward was pleasant and although staff were really busy they always had time for patients at the end of life and their relatives. They said "staff are cheerful and sensitive to what's happening, not morbid." The said staff offered warm drinks and parking was free which they really appreciated.
- Patients and relatives told us they chaplaincy service provided emotional and psychological support. Other relatives told us the chaplain visited daily and they felt really well supported.
- One member of staff told us patients' pet dogs were able to visit them.

## Are end of life care services responsive?

Requires improvement



Overall we rated these services as requires improvement for responsive because:

- The trust did not achieve the standard for seven day access to face to face specialist support for end of life care.
- It was not possible for staff to identify everyone who might benefit from palliative care team support because of work pressures in the hospital and the limited palliative care cover available.
- There was limited access to the mortuary at weekends for relatives. Porters were trained to transfer bodies to the mortuary but were not mortuary technicians so were not able to prepare the body for viewing. This relied on the trained mortuary staff being available and they only worked Monday to Friday with an on call rota for out of hours. We were told that the charge-hand and

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deputy charge-hand porters were trained to prepare the deceased for relatives to view out of hours. However, these staffing levels did not provide sufficient coverage out of hours.

- There was no locally agreed service plan in place for end of life care with commissioners.

However, we found examples of good practice which included:

- Care plan templates had been developed for end of life care patients that were based on national guidance which provided each patient with an individualised plan based on their needs.
- A fast response team in the community worked closely with the hospital discharge team to support people who wished to be discharged. The team were able to provide care for up to 48 hours until a support package was in place.
- The trust provided relevant information to patients and their carers for them to review to understand their treatment options and care.
- The trust had adopted the swan logo to promote heightened dignity, respect and compassion for the dying person and their significant others, at the end of life and after death. The swan logo was to be included on all relevant documentation and a memory box was being developed for families.
- A bereavement room was set aside for General Office staff to speak to relatives and for the collection of the death certificate and patient belongings

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

- The trust had identified the lack of access to specialist palliative care consultants as a high risk to delivering care on the service's risk register. We were told the lack of medical cover for the wards meant not all patients who would benefit from specialist palliative care advice received it.
- Additionally staff told us it was not currently possible to identify everyone who might benefit from palliative care team support because of work pressures in the hospital and the limited palliative care cover available. This was further evidenced by the trust's review of staff's knowledge in identifying the 'Five priorities of care for the dying person'; only 10% of staff could identify the five priorities of care prior to training. This had increased to 73% following training.

- The trust and local clinical commissioning group (CCG) had been discussing the care provided for end of life patients. The CCG was responsible for commissioning health services on behalf of the local population. At the time of our inspection there was no agreement in place between the trust and the CCG about the care which should be provided for patients approaching the end of life.
- The trust was developing the use of the swan symbol on information for people at the end of life. The swan scheme has been developed nationally to be used on documentation or hospital signs to indicate end of life and bereavement. The trust had secured charitable funding to extend the use of the swan symbol to a range of documents relating to death and bereavement.
- A multidisciplinary group was looking at improving end of life care for haematology and oncology patients.

## Meeting people's individual needs

- Care plan templates had been developed for end of life care patients that were based on guidance. These plans stated that each patient must have an individualised plan based on their needs and that the content should be discussed openly with the person and the people who were important to them. The plan was based around the five priorities of: recognising, involving, planning, communication and support. The plan identified the triggers for organising a full multi-disciplinary assessment if the persons' needs were complex. The plans contained information about hydration, medication, spiritual needs, pain and other symptoms. The plan required staff to provide a written description of patients' needs; there were no tick boxes on the plan.
- Ward staff told us they discussed the person's preferred place of care with them when a decision had been made that the patient would not benefit from further active treatment. They described how they could apply for 'fast track' funding to enable nursing care to be provided at home if required.
- The trust provided us with the results of a hospital SPCT response time audit, which was undertaken in June 2014. There were 19 patients referred to the SPCT that month, three were for level 1 advice. Of the remaining 16, all patients were seen, or an appropriate staff member contacted, within one working day of the referred being received,

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- A rapid discharge service was available for patients who wished to return home for the final days of life. The discharge planning team worked closely with the community nursing team to ensure patients could be cared for at home if this was their preferred place of care. They said it was also sometimes difficult to put care packages in place to allow people to return home because of the difficulty in obtaining care staff in the community.
- There was a problem with rapid discharge at the weekend because the team did not work weekends and so patients were in hospital an additional two to three days. In the EOLC Steering Group Meeting minutes for July 2015 it stated there were still no care packages in place in the hospital and the Fast Response Team were still providing this care. This was having an impact on the responsiveness of the service as the number of patients was increasing.
- The trust had identified several risks relating to the quality of care provided generally to patients with a learning disability and patients with dementia and plans were in place to address these.
- An email was sent out to wards alerting staff when a patient with a learning disability was admitted. This enabled staff to consider what adjustments were needed to provide care which was appropriate to meet the patient's needs.
- The trust also used the butterfly system to signify when a patient who was living with dementia so staff could more easily identify and adjust the care provided.
- We reviewed the care of one person who had a learning disability. We found all the relevant assessments had been completed to ensure the person received the care they needed. A deprivation of liberty authorisation had been obtained to provide care in the person's best interests and a DNACPR notice was in place. The records contained a document which described the reasonable adjustments which had been made for the person following a discussion with the person's relatives. The discussions medical staff had with the person's relatives were fully documented. We noted however that there was no discussion about the person's treatment if they began to deteriorate, but staff had arranged for them to visit the hospice.
- The trust provided relevant information to patients and their carers for them to review to understand their treatment options and care. There was a resource box for end of life care which contained helpful information for staff to give to patients and their relatives. They were able to provide targeted information which met the person and their families' needs.
- An information leaflet had been developed for patients who were prescribed strong opioid medications. These described the type of medications which could be prescribed, their effect and possible side effects.
- Information provided for friends and family described how the service managed patients' symptoms using medicines to control sickness, breathlessness and anxiety if they occurred. The leaflet described the role an electronic syringe driver could play in controlling patients' symptoms.
- The trust had developed documents they used to inform families about the care provided to patients at the end of life. The documents included 'Information about last days of life', 'Services in the hospital while you stay with your loved one' and 'Guidance for bereaved relatives.'
- The hospital was introducing comfort boxes to support relatives staying with patients that included a toothbrush and toothpaste, a note pack and car parking pass.
- Staff in the mortuary were aware of families cultural traditions and were able to arrange for the release of a body in accordance with those traditions.
- There was limited access to the mortuary at weekends for relatives. Porters were trained to transfer bodies to the mortuary but were not mortuary technicians so were not able to prepare the body for viewing. This relied on the trained mortuary staff being available and they only worked Monday to Friday with an on call rota for out of hours. We were told that the charge-hand and deputy charge-hand porters were trained to prepare the deceased for relatives to view out of hours. However, these staffing levels did not provide sufficient coverage out of hours. Out of hours, the manager on call met bereaved families at the entrance to the hospital or on the ward and accompanied them to the mortuary.
- Relatives collected death certificates and belongings from the general office near the entrance to the hospital. A bereavement room was set aside for office staff to speak to relatives. The room provided a pleasant, private area for receiving their relative's effects.
- Staff were able to direct people to bereavement support organisations.

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## Access and flow

- The trust did not achieve the standard for access to specialist face-to-face support for end of life care.
- The trust had audited how long it took for hospital and community staff to access palliative care advice. The standards were set by the network specialist palliative care group (NSPGC). There were 48 community referrals to the team during the month of June 2014: 100% of patients were contacted within two working days of the referral being received and 94% of patients were seen within five working days.
- There were 19 patients referred to the specialist palliative care team in hospital during June 2014. three referrals were for level 1 advice. Of the remaining 16, all patients were seen, or an appropriate staff member contacted, within one working day of the referral being received. This meant patients were being seen within the standards set by the palliative care network.
- A fast response team in the community worked closely with the hospital discharge team to support people who wished to be discharged. The team were able to provide care for up to 48 hours until a support package was in place.
- There was no end of life facilitator in the trust. The post had been revised into a supportive palliative care nurse role. The facilitator role was primarily to enhance outcomes for patients. The supportive palliative care nurse post was designed to focus on improving the quality of life for people at the end of life working across the hospital and community services. Some staff expressed concerns the role was being extended to cover both hospital and community services.

## Learning from complaints and concerns

- Staff were aware of the policy for managing concerns and complaints and how to find it on the intranet.
- Staff said they aimed to resolve minor complaints at source to prevent them escalating to formal complaints. Staff we spoke with knew how to respond to a complaint. They knew where to access the complaint policy. They also would refer patients and their families to the patient experience team.
- We reviewed one complaint about end of life care. The trust had responded appropriately to the complaint.

They had kept the family informed about the progress of the complaint. They had also agreed to meet with the family to listen to their concerns and share the findings from the investigation into the complaint.

- On the risk register for the service it stated there was a risk that complaints regarding patient care during the last days or weeks of life are not captured by complaints team to ensure lessons are learnt and training can be provided. The patient experience team had received a copy of a report from the complaints Ombudsman which highlighted the need to identify poor experience so it could be improved.
- One of the complaints themes identified by risk management staff was pain relief during end of life care. We reviewed a complaint regarding end of life care and saw that lack of pain control was one of the issues raised.

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

Good



Overall we rated these services as good because:

- There were senior Board level executive and non-executive leads in place. The Chief Nurse was the executive lead for end of life care on the trust board.
- There were good relationships between the hospice and the trust although this needed strengthening and formalising.
- The trust was continuing to improve its approach to end of life care, for example, by undertaking the 'Rethinking Priorities Programme'; a development programme which involved consultant medical staff evaluating some of the most challenging aspects of providing a high quality service to patients approaching the end of life
- The trust was a vanguard trust. This was a nationally sponsored service improvement programme. As part of that programme the trust was developing new models of care for end of life care provision.

However, we found that:

- There was no strategic plan in place for end of life care in the Harrogate and Rural District commissioning area. Progress developing the strategy with other key stakeholders was slower than planned and was not

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completed when we inspected in February 2016. However, in the absence of an agreed local strategy the trust had developed a care of the dying adult and bereavement policy.

- The trust did not monitor if patients achieved their wish for preferred place of care or death. As this was not routinely identified, this information could not be used to improve or develop services.
- The service level agreement with the hospice to deliver palliative care had expired. However, the trust was in the process of moving into a Partnership Agreement.
- The responsibility for the palliative care service was split between two directorates. The trust had recognised the service could be organised more effectively to improve leadership and governance and this was being reviewed.

## Vision and strategy for this service

- The trust was working with their local clinical commissioning group (CCG) and community teams to develop a five year strategic plan for end of life care. A meeting was held in September 2015 to identify key areas to be included in the strategic plan; stakeholder representatives included GPs, district nurses, social care, voluntary sector, hospice specialist palliative care. There was a steering group in place with terms of reference. This group had completed a gap analysis in relation to the End of Life Care Strategy: New Ambitions and submitted this to the CCG in early January 2016.
- Progress developing the strategy with partners was slower than planned. The trust planned to complete the strategy by January 2016 but it was not completed when we inspected in February 2016.
- In the absence of an agreed local strategy the trust had developed a care of the dying adult and bereavement policy. This described how the trust would continue to develop care for patients at the end of life. The policy included plans for developing the knowledge and skills of staff, reviewing end of life and bereavement policies, developing the use of the swan symbol scheme, enabling staff to recognise care being provided for patients approaching the end of life and the development of rapid discharge for patients in the last days of life. This policy referenced the National Institute for Health and Clinical Excellence (NICE) Quality Standards for End of Life Care for Adults (2011).

- The trust was also planning to sign up to the national 'transforming end of life' care programme for acute hospitals programme.

## Governance, risk management and quality measurement

- The steering group reported to the trust's "Improving fundamental standards of care" group. The steering group had wide representation from throughout the trust and from a range of specialties.
- The end of life steering group was responsible for the improvement of end of life care delivered across all areas of the trust. The group's aims were described as ensuring the trust provided a person centred approach to end of life care and patients received supportive and palliative care to live as well as possible until they died. The group planned to review pathways across the acute and community settings to support patient choice, prevent delays in discharges through improved availability of equipment, medication and co-ordinated care provision. The group were also working on ways of monitoring the quality of service provided.
- The trust participated in national audits, such as the care of the dying audit. We saw there was an up to date action plan in place to address issues identified in the audit.
- The trust did not monitor if patients achieved their wish for preferred place of care or death. As this was not routinely identified, this information could not be used to improve or develop services.
- There was a risk register for end of life care, which included original and target risk assessments with controls. It identified risk to patient care of not providing the required level of direct specialist palliative care and ability to support improvement projects due to under resourced consultant provision. It stated that there was a lack of clarity regarding level of service commissioned. To mitigate the risk an updated business case was to be re-discussed at the organisational delivery group in January 2016; a job plan for additional 0.9wte consultant has been agreed with the Royal College. Supportive Care CNS role had been developed further and sits within the trust. The target was to increase from the 0.8wte CNSs to have 1.6wte CNS.

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- The mortuary care of bariatric patients was also on the risk register. Costs for refurbishment and creation of a bariatric scheme for the mortuary were to be identified, however clarity required regarding whether this would be prioritised was not clear.
- A senior staff member commented about the weaknesses in the commissioning of palliative care services. The trust had a block contract in place for district nurse community services that did not detail expectations of delivery.
- In addition, the service level agreement with the hospice to deliver palliative care had expired. The trust was in the process of moving into a Partnership Agreement during the time of the inspection. Although the service level agreement (SLA) had expired, the practice was maintained, including the honorary contracts and governance arrangements
- The director of integrated care told us they received reports on complaints and incidents. These were investigated by the trust's quality managers and they responded to complaints within 30 days.
- Following reports of delays in death certificates being made available for collection, internal audit were commissioned to undertake an audit regarding the whole death certification process.

## Leadership of service

- The trust met the recommendation to have a designated board member with specific responsibility for care of the dying and the board discussed the report of local audit annually.
- The chief nurse was the executive lead for end of life care on the Trust Board. The responsibility for the palliative care service was split over two directorates. The nursing staff were managed through the urgent, community and cancer care directorate and the medical staff were managed through the integrated care directorate. The director of urgent, community and cancer care told us the structure was being reviewed because the trust recognised there was a lack of clear governance structures with the nursing and medical staff working in/aligned to different directorates.
- The palliative care team worked across both the hospital and community settings. Both services cared for people in the last days of life however, they did not operate as an integrated team. There were no plans being developed to provide a more integrated service with more seamless pathways for patients.

- Managers told us relationships between the hospice and the trust were good but needed strengthening and formalising. The trust was committed to increasing awareness about end of life care planning and earlier referral to the palliative care team. The 'rethinking priorities' programme had been provided for some consultant medical staff aimed at raising the profile of end of life care and spreading good practice across directorates.
- Staff commented that the senior management were visible. There was also a daily email to keep everyone up to date generally with what was happening within the trust.

## Culture within the service

- We found an open and friendly staff culture at the hospital.
- Staff told us they felt valued by the trust and were able to raise issues or concerns. They felt the culture was open and supported staff.

## Public engagement

- The trust gathered the views of staff providing care throughout the hospital who cared for people approaching the end of life. The views were gathered using questionnaires distributed to staff via the Chief Executive's daily bulletin board. Staff could also attend drop in discussions within the hospital and a local GP surgery.
- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying Audit for Hospitals.
- A bereavement survey was in place. The outcomes of the survey helped to inform the educational plans for staff. The survey was sent out seven weeks after their relative's death to ask them to complete a questionnaire.

## Innovation, improvement and sustainability

- The trust was a vanguard trust. This was a nationally sponsored service improvement programme. As part of that programme the trust was developing new models of care for end of life care provision.
- The trust had developed end of life plans used by patients for recording information about their wishes at the end of life. The leaflet allowed patients to record






## End of life care

their thoughts about the care they wanted to receive and the things they did not want to happen. Patients could also record information about what was important to them for example pets or possessions.

- The trust had completed the 'Rethinking Priorities Programme'. This was a development programme which involved consultant medical staff evaluating the care provided to patients approaching the end of life. The programme addressed some of the most difficult issues medical staff faced for example identifying of patients in the last year of life was not always easy and the

challenges varied between specialties. The programme also covered difficulties in starting a conversation about aims of treatment and planning future care, how to improve communication between primary and secondary care when each may defer to the other and how senior clinicians could learn from their peers. The programme had successfully raised awareness of advanced care planning in stroke services and neurology, ceilings of care and recognising the last 12 months of life in urology.

# Outpatients and diagnostic imaging

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

## Information about the service

Harrogate and District NHS Foundation Trust (HDFT) provides a full range of outpatient and diagnostic imaging services. The service was last inspected by CQC in January 2014 and they found that patients received safe and effective care and treatment from the outpatients department. People reported positively on their experience as outpatients. We found the department was well-led.

Outpatients and diagnostic imaging included provision of clinics across all medical and surgical specialties. Services were provided from the main outpatients department at Harrogate district hospital (HDH), the Elmwood Day Hospital, the Medical Day Unit, The Sir Robert Ogden Macmillan Centre, the Diabetes Centre and the Cardiology Department.

Outpatient services were also provided from a number of outreach sites including, Ripon Community Hospital, Wetherby Health Centre, Yeadon Health Centre, Wharfedale Hospital in Otley, Airedale Hospital, Mowbray Square Health Centre in Harrogate, as well as a number of Leeds GP Practices including Street Lane, Rutland Lodge, Yeadon GPs and Chapeltown. There was a small x-ray department at Ripon hospital and ultrasound scanning was available at Wetherby and Yeadon health centres.

HDFT provided a wide range of diagnostic imaging services including plain film x ray, fluoroscopy, MRI, CT, Ultrasound and Nuclear Medicine.

Between July 2014 and June 2015, HDHFT outpatient department saw 269,918 patients.

Some outpatient pathology and radiology services were delivered in partnership with other trusts under service level agreements and partnership arrangements.

We inspected the main x-ray department at Harrogate hospital, A&E x-ray, x-ray and ultrasound at Ripon hospital, the main out patients department at Harrogate hospital, the Sir Robert Ogden centre, the Elmwood department and outpatients at Ripon hospital and Wetherby health centre.

During the inspection, we spoke with 36 patients and carers, and more than 50 staff, including volunteers. Staff we spoke with included senior managers, nurses, doctors, scientists, radiographers, healthcare assistants and administrative staff. We attended a number of focus groups and we observed staff deliver care in the departments we visited. We observed the radiology, laboratory and outpatient environments, checked equipment and looked at patient information and care records. We received 42 comments cards from service users about this service and we also reviewed performance information from, and about, the trust.

# Outpatients and diagnostic imaging

## Summary of findings

We judged outpatient and diagnostic services at Harrogate district hospitals NHS foundation trust as good for all of our key questions. We found that the services were safe, caring, responsive and well-led. Outpatients & diagnostic imaging services were inspected but not rated for effectiveness

Patients received safe care and staff were aware of the actions they should take in case of a major incident. Incidents were reported, investigated appropriately and lessons learned were shared with all staff. The cleanliness and hygiene in the departments was within acceptable standards, however, there were some areas at Ripon that were in need of re-decoration

Staff were aware of the various policies designed to protect vulnerable adults and children and we saw good examples of actions taken to address identified concerns. Patients were protected from receiving unsafe treatment as medical records were available 99% of the time and electronic records of diagnostic results, x-ray images and reports and correspondence were also available. There were sufficient staff to deliver services safely.

However, The WHO surgical safety checklist was not yet fully implemented in imaging areas, the phlebotomy room was not ideal for patients from an infection prevention, and control perspective as it contained stores and staff coats.

Care and treatment in outpatients and diagnostic imaging was evidence-based and performance targets were consistently met. The staff working in outpatients and diagnostic imaging departments were competent, received an annual appraisal and there was evidence of multidisciplinary working across teams and local networks. Nursing, imaging, and medical staff understood their roles and responsibility regarding consent and the application of the Mental Capacity Act. Staff undertook regular audits in imaging and pathology departments regarding quality assurance to check practice against national standards and action plans were put in place to make improvements when necessary

However, there were a number of pieces of equipment, which were ageing, and in need of replacement, this was particularly in the imaging services. There were a small number of local policies past their review date.

We observed staff in all areas treating patients with kindness and respect. Privacy and dignity was maintained at all times and we saw staff answering patients' questions patiently and cheerfully with a caring manner. Patients were very happy with their care and information from all professional groups. Patients told us they understood the information that was given to them and what was happening to them. Patients were given plenty of time to make informed choices and consider the possible side-effects of certain treatments. There was good emotional support for patients within the departments and staff were able to signpost patients to support groups and counselling services when necessary.

Services were planned around the needs of patients, there were many initiatives including virtual clinics, and nurse led services, which meant patients could easily access specialist advice and support. The trust was consistently exceeding its performance targets and England averages for referral to treatment times (RTT) and for diagnostic and cancer waits. The Trust was actively managing its waiting lists for both new and follow-up patients and there was a clear plan to reduce the numbers of ophthalmology patients awaiting review appointments. The trust had developed a number of one-stop services for patients and had well-embedded outreach services. The clinical assessment team, fast track systems and the rapid access clinics meant patients could access specialist assessment and diagnostics very quickly.

Staff worked hard to meet individual patient needs, concerns and complaints were taken seriously and staff and managers responded positively to patient feedback.

All services had clear vision and strategies, which were known to staff at all levels of the service. The services were visionary and innovative and there was a well-embedded culture of service improvement. Staff and members of the public were engaged in service improvements. There were clear governance structures and managers were clear about how they could escalate

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risks to senior managers and the executive team. Managers and staff had a good understanding of what risks their services faced and mitigated against these wherever possible. Staff recommended the trust as a good place to work and were happy for relatives to receive care there. There was a strong culture of learning and improvement and numerous examples of innovation, improvement and sustainability.

## Are outpatient and diagnostic imaging services safe?

Good



We rated the safety of outpatient and diagnostic imaging services as good because:

- There was good evidence that safety issues were identified and addressed, incidents were investigated appropriately and improvement actions implemented.
- Lessons learnt were shared with staff.
- Cleanliness and hygiene in the departments was within acceptable standards.
- Staff were aware of the various policies designed to protect vulnerable adults and children and we saw good examples of when actions had been taken to address concerns.
- Medical records were available 99% of the time and electronic records of diagnostic results, x-ray images reports and correspondence were always available.
- There were safe systems in place for storage and transport of records.
- Nursing staff numbers were sufficient and staff were able to work flexibly to meet the different demands of clinics and patients.

However:

- The WHO surgical safety checklist was not yet fully implemented in imaging areas but was rolling out.
- The phlebotomy room was not ideal for patients from an infection prevention and control perspective as it contained stores and staff coats.
- There were rusty handrails in the disabled toilets and a lack of non-touch taps on hand wash basins in Ripon outpatient and imaging areas which may pose a risk to infection prevention and control.

### Incidents

- There were no never events in this service between October 2014 and September 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.

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- During the same period, there was one serious incident in this service where a patient was not given appropriate follow up appointments for monitoring and treatment of their eye condition. The consequence for this particular patient was that there was no identified harm. However, there was potential for serious deterioration of eyesight in this situation.
- We saw that the trust informed the patient under duty of candour when the error was identified and that appropriate investigation and actions were taken to prevent future patients missing appointments.
- Outpatient areas reported 115 incidents during this time, 110 were low or no harm and four resulted in moderate harm. One patient received a blood test intended for another patient, one pathology test result for A&E was delayed, one patient's medication was not given and one member of staff sustained an injury at work.
- Radiology reported 83 incidents between October 2014 and September 2015 all but two of these were low or no harm incidents. Two incidents were moderate harm; both were members of staff who had sustained an injury at work.
- The trust reported three radiation incidents notified to CQC under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or to the Health and Safety Executive (HSE) under IRR99 requirements during 2015 and one further incident reported in 2016, which was still being investigated at the time of inspection.
- HDFT was not an 'outlier' with regard to the numbers of notifications or the type of errors in radiology. The radiation doses to patients arising from these errors were not significant and would not cause 'harm'.
- The incidents were investigated appropriately and the trust took action to share learning and reduce the risk of similar incidents occurring in the future. Where training or practice issues were highlighted, these were addressed.
- There was evidence that incidents graded as moderate or above were treated using duty of candour principles and patients were informed of the errors at the earliest possible time.
- An information leaflet outlining the principles of Duty of Candour was circulated to all staff in June 2015 and had subsequently been given to new starters.
- Most of the staff we spoke with understood the principles of duty of candour.
- Managers and consultants viewed duty of candour positively and were involved in responding to patients when incidents occurred.
- There was evidence of learning and changes to practice and pathways because of incidents. For example, staff in the Elmwood centre told us how an incident with a patient with a leg ulcer had led to improvements being made to documentation. Staff told us how the learning from this incident and changes made had been shared through the quality of care meeting.
- Staff were aware of how to report incidents using the electronic incident reporting system and how to escalate incidents to their line manager, or Radiological Protection Supervisor (RPS) as necessary.
- Radiology staff were aware of the need to report radiation incidents under IR(ME)R and routinely informed their RPS and Radiology Protection Advisor (RPA) if an incident occurred. In the case of equipment related incidents staff were aware of the need to also report to the HSE.
- Staff felt they were encouraged to report incidents and be open and honest with patients if they made a mistake or a patient suffered harm.
- The majority of staff we spoke with told us they received feedback from incidents through team meetings and learning points were discussed where appropriate. Outpatient and radiology staff we spoke with told us that any incidents were discussed informally at departmental meetings. We saw that incident report summaries, lessons learnt and outcomes were included in meeting minutes.
- Radiology staff gave examples of receiving feedback following incidents via these meetings and discussion of incidents was noted in the 'Medical Exposures' meeting minutes.
- We saw that serious incidents were investigated using root cause analysis methodology and the documentation of the incident, investigation and root causes was comprehensive, open and honest.
- A number of repetitive strain injuries (RSIs) among sonographers had led to changes in working patterns to reduce the number of hours spent on a single task. Some staff were also provided with some education regarding posture and movement and the department had subsequently seen a reduction in RSIs.

## Cleanliness, infection control and hygiene

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- The departments we visited at Harrogate and District General Hospital and Wetherby health centre were visibly clean and we saw evidence that waiting areas, utility rooms, clinic rooms and equipment were cleaned regularly.
- Rooms used for diagnostic imaging were decontaminated and cleaned after use and imaging equipment was cleaned and checked regularly. Couches were cleaned with detergent wipes between patients.
- We observed staff complying with “bare below the elbow” in clinical areas and hand hygiene policy. Soap and hand gel dispensers were readily available for staff, patients and visitors to use. Dispensers were clean and well stocked.
- Personal protective equipment (PPE) was readily available in all areas.
- Daily cleaning checklists were up to date in the main outpatients’ areas and the Robert Ogden centre in all rooms. The matron carried out regular walk through environmental checks with the domestic supervisor.
- The phlebotomy room was visibly clean but cluttered with stock. Staff lockers and coats on a coat rack were in the same room where patients were having blood taken.
- Phlebotomy staff told us that the ICP team did spot checks on staff hands in the department using the light box.
- Staff in all outpatient departments had access to blood spillage kits and were aware of what they needed to do should a spillage occur.
- There were posters on display asking visitors with flu-like or diarrhoea symptoms not to attend the wards and to encourage patients and public to use the hand gels provided.
- Monthly infection control audits in outpatient and diagnostic areas between April 2015 and September 2015 showed 100% compliance with hand hygiene and clean commodes in all but one area. The one exception was CDC therapists who scored 80% compliance with hand hygiene in September 2015. Areas where compliance with cleaning or intravenous (IV) insertion had fallen below 100% during the six month period all showed improvement and 100% compliance in September 2015.
- We saw in outpatient and imaging areas that audit results were fed back to staff through team meetings or were displayed on noticeboards for staff to see.
- A radiographer, two assistants and a nurse acted as infection prevention and control (IPC) links for the imaging department and at least one of them attended the monthly meetings to bring back relevant information for all staff within the department.
- Staff in imaging were aware of the five moments for hand hygiene and were aware of the processes to be followed when carrying out procedures on infectious patients.
- Infectious patients were usually flagged on the electronic request and the department arranged for them to be last on the list.
- Infectious patients attending ultrasound underwent their investigation on the transport trolley to reduce the amount of decontamination needed within the room. The radiography assistants decontaminated the rooms following use. Ultrasound probes were protected by disposable film when used on infectious patients.
- Infection prevention and control training compliance was good across all staff groups within outpatient areas. All areas had achieved at least 95% compliance with the exception of medical staff who had achieved 75% compliance. The trust year to date training target had been achieved by medical staff. All other areas had achieved or exceed the year-end target.
- We saw that waste was segregated and disposed of appropriately and there were safe processes in place for disposal of radioactive waste.
- We saw that equipment was labelled as clean following decontamination.
- We saw that disposable curtains were being used in outpatient and diagnostic imaging areas and were dated appropriately.
- We observed cleaning and replacement of equipment, according to policy, between procedures in the urology treatment area.
- We observed the following at Ripon hospital:
- At Ripon hospital there was a weekly cleaning chart for the x-ray department staff to complete. The cleaning record was only completed nine times during the 19-week period between 15 September 2015 and 29 January 2016.
- There was a laminated booklet with instructions for staff cleaning the department. However, the guidance was not dated and the cleaning product recommended for use was no longer being used by the trust.

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- The hand-washing sink in the x-ray room did not have non-touch taps or mixer taps. The sink in the staff kitchen also did not have mixer taps or non-touch taps.
- The staff fridge was not checked for temperature or any record of cleaning kept. The fridge appeared dirty.
- There was alcohol gel in the waiting room at Ripon hospital and there were posters on the walls with information about infection control.
- There were a few toys available in the waiting room but these looked grubby.
- Instrument trays for minor operations / procedures were sent from Ripon hospital to Harrogate hospital for cleaning and sterilisation.
- Keyboards in the reception, x-ray and consulting rooms at Ripon hospital were not covered and therefore not easy to clean.
- A lid on one of the storage boxes in the storeroom was very dusty, the room was also carpeted with boxes on the floor and a number of trolleys, which would make cleaning very challenging.
- There were six trolleys set up in the clinic room; however, only four of these had 'I am clean labels' that were dated and signed.
- Sharps boxes were dated and signed and were not overfilled.

## Environment and equipment

- The trust scored better than the England average for all indicators in the Patient-led assessments of the care environment (PLACE) audit. Cleanliness scored 100 against a national figure of 98, food scored 93 against a national figure of 88, facilities scored 94 against a national figure of 90, Privacy, dignity and wellbeing scored 90 against a national figure of 86.
- Internal Patient Environment Action Team Scores and National Specifications for Cleanliness Scores for Ripon outpatients and elective outpatients were 100% and 97% respectively. Dermatology and the heart centre scored 96% and 100% respectively
- In radiology we saw that hazardous fluids used for cleaning imaging plates and to remove artefacts (marks or imperfections) was stored appropriately in a locked box with the PPE needed for staff use. Staff were aware of the procedure and PPE needed to carry out this task safely.
- Spillage kits for radioactive materials were set up and ready for use in the nuclear medicine department and

any spills within nuclear medicine were reported to the Environment agency. Medicines and Healthcare products. Regulatory Agency (MHRA) inspections took place every two years.

- There was a named senior radiographer responsible for the servicing and repair of equipment and maintenance contracts were in place with manufacturers and other maintenance contractors. These contracts covered routine maintenance and emergency call out arrangements for each piece of equipment.
- Staff were concerned about the reliability of X-ray equipment in the emergency department as this was old. They reported that engineers were becoming less confident that future repairs would be possible as the equipment is no longer manufactured and replacement parts sometimes need to be reclaimed parts. Staff were aware that this was on the risk register.
- Although there were a number of imaging machines due for replacement these were all functioning safely. All equipment was regularly serviced and maintained and had quality assurance checks performed every two months. Each piece of imaging equipment also had an annual routine test by the Department of Medical Physics in Leeds who provided radiation protection advice (RPA).
- The drug storage fridges within the imaging department and outpatients were checked daily. We saw records that indicated this happened.
- We looked at stocks of drugs in fridges and cupboards and found them to be correctly stored and all within date.
- Imaging rooms had emergency call bells and oxygen was available. Paediatric and adult resuscitation trolleys were kept within the department. We saw evidence that resuscitation trolleys and anaphylaxis boxes were checked weekly and were checked and restocked after each use. If resuscitation trolleys were used out of hours the radiographers informed the bed manager who arranged for the trolley to be re-stocked immediately.
- There were three mobile x-ray machines situated at strategic points around the hospital for easy access when ward based x-rays were needed. The radiographer collected the machine nearest to the patient area to reduce time taken to locate and transfer the equipment to the patient's bedside. A protective apron was also stored with each machine.
- One of the mobile machines had a note on it regarding an intermittent fault 'not to use long prep as will not

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expose and fault with brake'. Discussion with the senior radiographer indicated the fault with the brake had been fixed but notice had not been removed and the reminder to staff regarding the prep time had meant there had been no exposure problems for around 12 months.

- We saw documentation that indicated all of the mobile x-ray machines were checked regularly.
- A defibrillator and facemasks were available at reception in the main outpatient area at Harrogate. The Elmwood centre accessed the resuscitation trolley from the nearby X-ray department. There was also an emergency pack within the department that contained airways and other basic equipment for gaining intravenous access and blood sampling. Emergency packs were checked monthly and after use.
- We looked at daily and weekly checklists of resuscitation equipment over the last six months and saw that these were carried out as stipulated and clearly documented.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protected patients against unnecessary exposure to harmful radiation.
- Staff wore dosimeters (an instrument for measuring the amount of radiation absorbed by somebody) to ensure that they were not exposed to high levels of radiation.
- There was clear and appropriate signage regarding hazards of radiation in the imaging department.
- We saw there were six fire extinguishers due a maintenance check in the main outpatient area.
- There were accessible toilets for wheelchair users in the Harrogate outpatient areas and these had handrails and call bells for patients to call for assistance.
- The urology clinic was cramped for space for notes and patients and had limited wheelchair access.
- Hoists were available to help move patients onto examination trolleys when needed.
- We saw that the Robert Ogden centre was a new, purpose built facility for cancer sufferers with excellent accessibility that offered a clean, modern and calm atmosphere for patients attending for outpatient appointments and treatments.
- At Ripon hospital, the out patients department was based on the first floor of the hospital and this could be accessed by either a flight of stairs or a lift. The door was locked at night with keypad access for the community teams that used the building out of hours.
- We saw that the main corridor in the outpatients at Ripon hospital was carpeted and in need of replacement. There was a replacement programme and the floors in the other clinic areas had recently been replaced.
- There were no mixer or non-touch taps in the patient toilets at Ripon hospital.
- The ultrasound and x-ray dept. were on the ground floor of the hospital down a short but steep slope.
- The patient toilet in this area was intended for disabled use but there was little space to manoeuvre a wheelchair and a narrow doorway. The toilet had a handrail on one side that could be raised up and down and a fixed handrail on the other wall. The fixed handrail was rusty. There was a call bell in the toilet and baby changing facilities. The room had very poor paintwork and the walls looked very shabby.
- The ultrasound room at Ripon hospital was very small and cramped, however managers were aware of this and there was plan to move into a larger room as another service was moving to the outpatient area.
- The environment in Ripon outpatients was in need of some updating and repair as flooring was uneven in some areas and this could pose a trip risk. Staff told us that work was underway to improve this
- The resuscitation trolley at Ripon was situated on the ward downstairs. If required this would take some time to collect or be brought to the outpatient department. There was no other equipment for resuscitation on the same floor or in the department.
- We saw a box of 1ml syringes that was out of date (October 2012). This was pointed out to staff in the outpatient area. Nursing staff were responsible for the stock control and ordering of supplies.
- The Radiology department did not have a rolling capital replacement plan. Bids were submitted annually for prioritisation. If successful, operational requirements or specifications are then prepared and equipment was evaluated to ensure the most appropriate equipment is purchased.
- Staff told us that some of the radiology equipment breaks down regularly and the gamma camera had

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been on the risk register for around 5 years. Staff reported that they were unable to get replacement parts for it and had to use springs from biro pens to replace springs within the machinery.

- All staff agreed there was an increased demand for services but equipment is not keeping up with the demand and that lack of modern equipment could negatively affect upon recruitment and retention of staff. In particular, there was an identified need for a second CT scanner.
- Capacity issues with MRI scanning have been addressed with purchase of a mobile scanner. At the time of our inspection this had been returned to the supplier due to a fault.
- Nurses and consultants in outpatients told us that although the department lacked space they had the facilities and equipment required to carry out their work.
- The consultant in the urology clinic told us they had new generation cystoscopy equipment, which had made diagnostic images much clearer.
- There was designated scoping equipment that staff took to the outreach centres, with them.
- We saw that equipment in outpatients such as phototherapy machines were regularly tested and calibrated.

## Medicines

- At Harrogate hospital and the outreach clinics drugs were stored securely and appropriately and the nurse on duty held the keys. When there was no nurse on duty the keys were kept in a locked cabinet.
- Drugs requiring refrigeration were kept in a locked fridge and nurses checked daily minimum and maximum temperatures. We saw documentation that indicated these checks were carried out every day. Nurses knew what action to take if the temperature exceeded the recommended range. It was noted that the fridge in the outreach clinic at Wetherby was outside of expected range.
- Contrast medium was stored appropriately in a warming cabinet and staff told us that the temperature of the cabinet was checked daily and that stock was rotated. However, there was no documentation of warming checks or stock rotation.
- Emergency drugs for treatment of reaction to contrast media and anaphylaxis were kept locked in the resuscitation trolley.

- Radiographers using patient group directives (PGDs) (a written instruction for the administration of medicines to groups of patients who may not be individually identified before presentation for treatment) could administer antispasmodics, local anaesthetic and contrast media.
- We looked at PGDs and found them to be in date. Staff underwent training and assessment of competence before being able to administer medicines and contrast media and the lead clinician in radiology held the signed competency assessment forms.
- We saw records of controlled drug audits that showed these medicines were stored safely and securely and that monitoring of stock levels and ordering was undertaken in all relevant areas.
- There was a dedicated outpatient pharmacy where patients could collect medicines prescribed at their consultation.
- Prescription pads were kept securely locked away and used prescriptions were signed for.
- At Ripon hospital, we saw that staff checked the drug fridge daily, but were using an out of date recording sheet and the minimum and maximum temperatures were not being recorded. Staff were advised of this and a more up to date form was in use on the following day but the minimum, and maximum temperature still had not been recorded. The Band 6 nurse in the ward who had responsibility for the staff in this clinical area was advised of the need for minimum and maximum recordings to ensure drugs were stored at the correct temperature to maintain safety and efficacy.
- Despite a key pad being on the door to the room where the drug fridge, clinical supplies and the trolleys for clinics were kept this was propped open during clinic hours. This was a risk to safe medication storage.

## Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images.
- Diagnostic images and reports were stored electronically and available to clinicians via PACS (Picture Archiving and Communications System).
- Staff reported that records were usually available in a timely manner for clinic appointments. Monthly figures showed that less than 0.1% of patients were seen without a full medical record being available between April 2015 and December 2015.

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- When records were not available, diagnostic reports and previous correspondence such as discharge letters and outpatient letters were available electronically.
  - Consultants dictated consultations into an IT system, which was immediately accessible to their secretaries. The secretaries generated discharge/ clinic letters on the system and sent them electronically to GPs.
  - Where a patient was seen without their medical record, a temporary record was created and merged with the main record as soon as possible following the appointment.
  - Records were transported securely, from the main hospital site to Ripon hospital and other outreach clinics either the day before, or the morning of the clinics. There was a system in place to ensure notes were logged when sent and received and this enabled staff to identify immediately if any were missing.
  - Records were stored securely away from waiting patients on the main hospital site and in the outreach clinics we visited.
  - We reviewed 10 samples of records across a number of outpatient areas and found that the notes were in good order and entries were legible.
  - At Ripon hospital, the door where the fax machine was kept was propped open during clinics, posing a risk to patient confidentiality.
  - In the corner of the staff kitchen, there were a number of old X-ray films containing patient details. Staff told us these had been kept for training purposes but were no longer used and needed to be returned to Harrogate for archiving or destruction.
- asked to be present. If out of hours, this tended to be the on call radiologist. If the patient was attending from A&E, a nurse would stay with the patient while in the radiology department.
- Staff understood there were potential safeguarding implications of children not attending for booked appointments and knew what to do should this happen. There was a policy for staff to follow for children missing appointments.
  - Staff told us they were up to date with safeguarding training for vulnerable adults and children's safeguarding. Clinical staff had received children's safeguarding training at level 2.
  - Overall compliance for outpatient and diagnostic areas with adult and children's safeguarding training was above the 95% trust target, with the exception of chronic pain and fatigue services who had achieved 93% compliance. This was still above the expected trajectory for the time of year (November 2015).
  - For children's safeguarding training there were some areas where compliance was below what was expected. For example, allied health professionals in the chronic pain and fatigue services had 66% compliance for face to face level 2 children's safeguarding training and out patients elective service did not have any staff trained to children's safeguarding to level 3.
  - A member of staff described how they had recently raised an adult safeguarding alert when a patient with a learning disability had disclosed that she suspected her carers at home were taking her money. The staff nurse involved had received feedback via the safeguarding team that a care plan had been put into place to protect the patient concerned.

## Safeguarding

- Staff we spoke with were aware of their responsibilities to safeguard vulnerable adults and children and knew whom to contact in the event of concern.
- Staff in radiology had easy access to protocols regarding children's safeguarding and they knew what to do if they suspected a non-accidental injury.
- Staff knew they needed to accurately document any safeguarding concerns or incidents and that they may need to make a formal statement.
- Radiographers were usually aware in advance if a child in need of safeguarding was going to attend the department and an extra member of staff would be

## Mandatory training

- Staff we spoke with told us they were up to date with mandatory training.
- We spoke to a member of staff who had been with the trust less than six months and who told us they had received a trust induction as well as being allowed time in the department to read and familiarise themselves with the policies and protocols.
- New staff were assigned a mentor, as part of their induction, who observed practice and signed off competencies before they were left to practice unsupervised.
- Mandatory training at trust level averaged 86% this was against an incremental target of 75-95% by the year-end.

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- Compliance with mandatory training for outpatient and diagnostic areas ranged from 91% to 98%. This performance at November 2015 was above the expectation for this time of year.
- Radiography staff told us that staffing pressures sometimes affected their ability to attend mandatory training.

## Assessing and responding to patient risk

- There were up to date policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- Registered nurses and health care assistants (HCAs) had training in basic life support and paediatric life support.
- Staff we spoke with knew what to do if a patient became unwell or collapsed in the department. They knew how to position patients, raise the alarm and when to transport patients to A&E if needed. Resuscitation equipment was available nearby.
- Staff were able to describe a situation that had happened the previous day and how that had been handled. The patient was treated appropriately and the crash team had arrived quickly. Reflection by the staff indicated that it had taken longer than expected to obtain a 12 lead electrocardiogram (ECG) machine for the patient. They had informed the matron of this and she was investigating why this had happened and if response time could be improved.
- Patient observations were monitored and recorded throughout the incident until the patient was recovered. We saw that the incident was fully documented and the GP was informed of the occurrence in the clinic letter. The patient was advised to see his GP for a follow up.
- As incidents of this nature were infrequent in outpatients, the manager had arranged a feedback / debriefing session for staff to learn from.
- The nursing staff in the Robert Ogden centre, the Elmwood centre and main outpatients held morning handover meetings to identify patients with additional needs that could range from care of external fixators and wires to highlighting patients with dementia or learning disability. Staff who came on duty after handover read this information in a communication book that was updated daily.
- The trust had an up to date policy for staff to follow on the use of ionising radiation including x-rays and radioactive substances. This had been endorsed by the health and safety committee and trust directors. This policy included the procedures for staff and patient safety. The trust also had in place written procedures required under the IR(ME)R.
- We saw local rules were produced and available for staff to follow in all of the imaging areas we visited. These were also available on the mobile imaging machines in accordance with IR(ME)R.
- There was a named certified radiation protection supervisors (RPS) to give advice to staff when needed. We were informed the radiation protection advisor (RPA) was based at Leeds Teaching Hospitals NHS Trust and they were available to provide regular advice and support to the local RPS by telephone or visit if needed.
- The radiologists working within nuclear medicine held an Administration of Radioactive Substances Advisory Committee (ARSAC) certificate.
- In accordance with radiation protection requirements and the identified risks to an unborn foetus, female patients were asked if they might be pregnant before exposing them to X-ray.
- The radiology information system (RIS) kept track of patients transferred in and out of the diagnostic imaging departments.
- The radiology staff used a red dot system to highlight potential problems on unreported films. This was also used for incidental findings that may not have been a focus for the original request.
- Referrals for CT scans were made via the IT system and any incomplete or incorrect requests were sent back to the referrer for checking and correction. Scans were not carried out with incorrect or missing information on the request form.
- A member of staff we spoke with was unaware of the lone worker policy for working weekends.
- Nurse escorts attended the imaging department with patients who were acutely unwell.
- Inpatients were rarely seen in the outpatient departments. When this did occur, a transfer information sheet was sent by the ward to the department.
- Patients' observations were recorded during interventional procedures in radiology and in the recovery bay. Early warning scores were used to monitor and manage patient risk when they were undergoing interventional procedures.
- There were processes in place for staff to raise an alarm if the patient's condition deteriorated.

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- Patients attending the phlebotomy service provided at Sainsbury's were risk assessed and if they were known to be needle phobic or were at high risk of fainting were asked to go to the hospital department. Staff told us if patients collapsed at this site then the emergency response was to call 999. The phlebotomist and shop first aider in line with Sainsbury's policy would provide basic life support.
- The emergency response for staff at other outreach centres was also to call 999. All staff were aware of the need to do this if working away from the main hospital site.
- Patients undergoing treatments for acne were assessed using a recognised mental health assessment tool. This was to establish a baseline pre-treatment and to determine whether the patient was suffering side effects from treatment, which were known to affect mood and cause depression.
- Dermatology patients undergoing phototherapy had numbers of exposures and cumulative dose of ultraviolet rays monitored and recorded. Patients showing no improvement 12 weeks (half way) into treatment were referred back to the consultant for a further assessment.
- We observed staff checking patients' identity before consultations and treatments.
- The WHO surgical safety checklist for Radiological Interventions had recently been implemented. An initial audit of completed checklists scanned onto the radiology information system showed compliance of 20%. The 10 random sets of paper records reviewed did not contain any WHO checklists. As staff training and rollout of the new documentation was still ongoing at the time of the audit, this was to be repeated in six months.
- A recent audit of compliance in completion of other safety documentation in November 2015 showed 100% compliance for nursing care records and radiology pre-procedure checklists.
- Ophthalmology patients had an open access card with a telephone number to call if they noticed a sudden deterioration of their eye condition. These patients received a call-back from a clinic nurse who completed an urgent referral form and undertook a clinical assessment over the telephone to determine the urgency of appointment needed.
- There was a registered nurse in charge of each clinic and a mix of registered nurses and healthcare assistants available to provide care to patients. Senior staff we spoke with were happy that they had appropriate levels of staff on duty in their areas.
- Staffing levels in the outpatient clinics were determined based on the number and type of clinics running each week and the number of patients attending. The band 7 sister and the matron reviewed skill mix periodically.
- Staff at Ripon told us that their biggest challenge was not having administration and clerical staff, which meant they needed to take all calls and enquiries during the clinics.
- Clinical nurse specialists (CNS) were available in many of the clinics we visited.
- There were few vacancies and there was very little bank staff use in any of the radiology or outpatient areas.
- Radiographers were concerned about the national shortage of trained staff and the length of time it took to recruit to posts.
- Assistant radiographers had been developed to support the radiographer workforce.
- There was a separate x-ray room within the A&E department, which was staffed on a rotational basis from the wider team.
- Radiography staff were available on call from home between 6.30pm to 7.45am to support CT scanning. There was a sleep-in room available if the staff member did not live near enough to the hospital to respond in less than 30 minutes. X-ray was staffed 8.30am – 5pm on Saturday and 9am – 6pm Sunday by two radiographers. There was an Assistant Practitioner in radiography on duty 9 – 3pm both days. An on-call radiographer covered emergency x-ray provision between 5pm on Saturday to 9am Sunday morning and Sunday overnight from 6pm until 8am on Monday.

## Medical staffing

- The individual clinical specialities were responsible for identifying and managing the medical staffing for the outpatients clinics. Medical staff were allocated to individual clinics.
- Outpatient clinics were consultant led with assistance from middle grade doctors. Training grade doctors worked in outpatients but were always supervised. Non-training middle grade doctors did hold some clinics if they had been assessed as competent to do so.

## Nursing, Laboratory & Radiology staffing

# Outpatients and diagnostic imaging

- Care was taken when allocating on-call rotas to ensure consultants were not away from the main hospital site at outreach clinics when they were on-call.
- There was senior medical cover in radiology, Monday to Friday between 8.30am and 6.30pm. The consultant radiologists worked a rota, which included a 'duty radiologist' who was available for discussion of urgent cases or queries regarding imaging, GP referral, CT, inpatient and A&E reporting. The rota included cover arrangements for ultrasound, MR reporting, one-stop breast clinics, interventional procedures and fluoroscopy.
- Radiologists were on call overnight for emergency ultrasound and CT scans. On-call radiologists had access to PACS from home so they could review and report on images if needed. The on-call consultants reported on CT images until 10pm. An external reporting service was contracted to provide the overnight cover for reporting.
- There was an advanced practice radiographer who performed joint injections in fluoroscopy.
- There was no locum use in any of the diagnostic services between April 2014 and February 2015.
- Where the trust was unable to fill middle grade positions in ophthalmology, funds were used to invest in the development of specialist nurses to help bridge the skills gap.
- There were ongoing worries for managers of this service regarding covering absence and ability to recruit to an expected future vacancy.

## Major incident awareness and training

- Staff in all areas were aware of the major incident and IT failure plans and where to access these.
- Staff were able to tell us how they had worked around a recent breakdown in the x-ray machine in the A&E area.
- Staff in radiology were aware of disaster recovery plans and had experience of implementing contingency plans to maintain business continuity.
- Comprehensive business continuity plans were in place to make sure that each department was able to continue to provide services in the case of a major incident. These also covered staffing shortages, electronic system failures and equipment breakdowns.

## Are outpatient and diagnostic imaging services effective?

Outpatients & diagnostic imaging services were inspected but not rated for effectiveness;

- Care and treatment in outpatients and diagnostic imaging was evidence-based.
- The staff working in outpatients and diagnostic imaging departments were competent, received an annual appraisal and there was evidence of multidisciplinary working across teams and local networks.
- Nursing, imaging, and medical staff understood their roles and responsibilities regarding consent and the application of the Mental Capacity Act.
- Staff undertook regular audits in imaging and pathology departments regarding quality assurance to check practice against national standards.
- Access to information, (electronic records, intranet and diagnostic reports) in the hospital, at outreach centres and on-call was good.
- Reporting times for imaging and other diagnostic tests were good.

However;

- There were a number of pieces of equipment, which were ageing, and in need of replacement, this was particularly in the imaging services.
- There were a small number of local policies past their review date.

## Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) and other guidance that affected their practice. For example, we saw nurses in the leg ulcer clinic using trust guidelines regarding wound dressings and the use of topical lotions and creams.
- There were six radiology pathways and five other department documents past their review date.
- New guidance was disseminated to staff via team meetings and briefings.
- The Pathology service was working towards United Kingdom Accreditation Service (UKAS) accreditation.

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The accreditation schemes provide assurance that the requirements for quality, competence and proficiency testing are met. The UKAS inspection was to take place during March 2016.

- The trust had a radiation safety policy in accordance with national guidance and legislation (Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000). There were nominated radiation protection supervisors (RPS) to lead on the development, implementation and monitoring of compliance.
- The October 2015 RPA audit showed that compliance with radiation regulations was good. This included compliance with local and national diagnostic reference levels. Diagnostic reference levels (DRLs) are used as an aid to optimisation in medical exposures.
- Staff were seen wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- The imaging department carried out quality control checks on images to ensure that the service met expected standards.
- We viewed readily accessible files containing information regarding clinical supervision for student radiographers, infection prevention and control and the local imaging protocols and procedures. All of these were up to date with a clear timescale for review.
- Physiotherapists had implemented outpatient group sessions for patients undergoing knee replacements with an aim to help patients achieve realistic expectations of pre-operative preparation, post-operative therapy and recovery. This approach had shown an improvement in patient compliance and outcomes of treatment.
- We saw there were a number of local audits regarding compliance with NICE guidance and others to determine the efficacy of certain diagnostic techniques. Details of audit meetings and presentations were available on the intranet.
- We saw out of date information in the staff areas at Ripon hospital including Essence of Care documents dated 2003 and NICE guidance relating to the prevention and treatment of pressure ulcers dated 2005.

## Nutrition and hydration

- Drinking water and cups were available for patients in the outpatient and imaging areas. Staff would offer tea and coffee to patients who had waited a long time.

- A trolley for hot drinks was prepared for clinics where patients were in the department for a long time such as in the one-stop clinics where patients would be undergoing multiple tests and consultations.
- Volunteers in the Elmwood centre and Robert Ogden centre provided patients with drinks.

## Pain relief

- Patients who attended the imaging department for interventional procedures such as uterine embolisation were seen by the pain nurse on the ward prior to this. The patients attended the department with patient controlled analgesia in situ.
- Other sedation and analgesia was available for patients undergoing interventional procedures and was administered in the department as needed. We saw that radiologists documented pain relief given during procedures in the patient's records and in the patient pathway document.
- A patient who had an accident told us she was not asked about pain relief at her first attendance to fracture clinic. However, this seemed to be an isolated incident.

## Patient outcomes

- Systems were in place to ensure that all requests for diagnostic investigations were registered, reviewed and prioritised on receipt. Reports were made back to the requesting practitioners when errors were detected or when requests were incomplete.
- Quality of referrals was audited periodically as were quality of surgical records.
- There were quality assurance systems and processes in place in the laboratories and in imaging services. This was to ensure local and national standards were met and results were as timely and accurate as possible.
- The radiology team leaders carried out bi-monthly audits of images from all imaging departments to ensure artefacts did not appear on images.
- The transfusion practitioner undertook ongoing monitoring of blood sampling errors. Work was ongoing to identify trends and errors were discussed with individuals if possible. If an individual made three or more errors they were referred for re-assessment. Serious errors were reported to Serious Hazards of Transfusion (SHOT) and the staff member was reassessed. The rate for sampling errors was around 2% and had been at this level since 2013.

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- The gastroenterology consultants and specialist nurse participated in the national irritable bowel syndrome audit.
- Radiation safety audits in November 2015 showed 100% compliance for the radiology department and 97% compliance for nuclear medicine. The items the nuclear medicine department failed on were; display of valid RPA certificate, classification status required for one member of staff and absence of a replacement programme for equipment.
- Staff doses of radiation or diagnostic reference levels (DRLs) were audited regularly and the most recent audit showed that all staff were within safe levels.
- Reporting times in radiology were continuously monitored against an internal seven-day target. Ninety nine percent of USS and mammography images were reported in less than seven days, 95% endoscopy, 93% fluoroscopy and 92% CT and plain film x-ray images were reported within this period. Of images from nuclear medicine and MRI 77% and 78% respectively, were reported within seven days. Sixty eight percent of dexta scans took more than seven days to report.
- Reports for A&E patients were available very quickly with 92% of reports being available same or next day and between May and October 2015 all images for patients who had attended A&E were available in four days or less.
- The extravasation review in radiology did not find any themes and observed staff followed procedure correctly.
- The average turnaround times for A&E full blood count tests were less than 15 minutes for all tests between June and December 2015. The average turnaround time for the same test for all other areas was less than one hour for tests between June and December 2015.
- The average turnaround times for Troponin T (which indicates damage to the heart) for the same period were between 29 and 46 minutes.
- The laboratories had a comprehensive rolling programme of quality assurance audits.
- Measure Yourself Concerns and Wellbeing (MYCAW), is an individualised questionnaire for evaluating complementary therapies used for patients suffering from cancer. The outcomes for these therapies were; patients reported concern 1 improved by 58.4%, patients reported concern 2 improved by 57.4% and patients reported their wellbeing was improved by 57.7% (2014-15).

- Patient Reported Outcome Measures (PROMS) were collected and reported nationally in line with Department of Health requirements.

## Competent staff

- Staff we spoke with in all imaging and outpatient areas told us they had an appraisal within the last 12 months. All nursing staff had a portfolio to facilitate collection of re-validation evidence and revalidation was incorporated into appraisal. Some staff we spoke with had a review meeting to discuss their portfolios partway through the year.
- The trust was supporting nursing staff with re-validation and staff could attend awareness sessions.
- The appraisal rate trust wide was 70% for April to November 2015. The cardiology and heart centre rate was 72%, the medical day unit was 80% and the Elmwood unit was 79% in January 2016.
- There were two trained assessors in the main outpatient department to support new healthcare assistants through their care certificate training and competency assessments.
- There was a mentorship process in place for newly qualified staff in the radiology department and staff were assigned to a senior radiographer for local induction and support.
- Staff within the radiology department were given opportunities for development in their role and other roles within the department. Training booklets and competency frameworks were in use in radiology and requests for training courses were usually granted. Training needs were met on an individual basis within the department and if staff needed more experience or supervision before undertaking roles alone this was accommodated.
- Radiographers received training regarding cannulation and were observed for minimum of 10 procedures before competency was signed off.
- Qualified nurses in outpatients had been able to develop as advanced nurse practitioners. For example, ophthalmic nurse practitioners had been given additional training so that they could undertake intra-vitreous injections for patients suffering with macular eye degeneration.
- There was an advanced nurse practitioner undertaking hysteroscopies and colposcopies. The nurse had undergone advanced clinical training and assessment of

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advanced clinical skills over an 18-month period. There was a support mechanism in place to support the nurse practitioner with re-accreditation, which was required every three years.

- A staff nurse in the Elmwood centre had completed an advanced leg-ulcer management course. Staff from the Elmwood centre supported ward staff with wound care management and shared learning from any training attended.
- Staff underwent a number of competency assessments such as compression bandaging, chaperoning, point of care testing and use of dynamap equipment for recording of patient observations.
- Some therapists had undergone additional training to enable them to remove and reapply wound dressings so patients could access all of their treatment in the physiotherapy department
- There were four HCAs in the fracture clinic being supported to work towards national vocational qualifications (NVQ) level three qualifications. One HCA told us how this was relevant to her role and was looking forward to the dementia module. She regularly cared for people living with dementia and felt the course would improve her knowledge and skill.
- HCAs in other areas had achieved a wide range of competencies and a new member of staff we spoke with had completed a 12-week care certificate.
- Most of the nursing staff rotated through the outreach clinics to ensure competence was maintained in all areas and staff were not isolated in terms of development or support. However, there were a small number of staff in Ripon hospital outpatients who did not rotate.
- Radiology staff rotated from the main department at Harrogate to cover the outreach centres including Ripon hospital.
- Nursing staff in outpatients were being trained to apply casts and fit orthotic appliances such as knee braces. Staff needed to be observed as being able to fulfil a number of competencies before being allowed to undertake these tasks unsupervised.
- The HCAs undertaking phlebotomy had received training and had been assessed as competent.
- Staff at Harrogate and Ripon had received extra training to enable them to undertake FIELD-testing in the eye clinics.

- Some band 2 and 3 staff felt that although they were trained and competent to do their jobs training opportunities for further development were limited.
- Volunteers we spoke with had received safeguarding training and heart start training.

## Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients and diagnostic imaging departments. Staff were observed working in partnership with people from other teams and disciplines, including A&E, ward nurses, administration staff and consultants.
- Staff reported good working relationships within MDTs and regular MDT meetings were held in the diagnostic imaging department.
- Radiologists routinely supported multidisciplinary team (MDT) meetings within the other clinical specialities.
- There was evidence of MDT working in the outpatients. For example, nurses and medical staff ran joint clinics, consultants from trauma and orthopaedics worked closely with therapists to make sure patients got the best outcome from their surgery. A consultant told us he met with the therapist weekly to discuss patients' progress and outcomes.
- MDT meetings were part of patient pathways such as those for suspected bowel cancer. These meetings may have included the gastroenterology consultant, the endoscopist and specialist nurse. These meetings were held when the patient had received all diagnostic tests and results were available.
- Staff communicated with other departments to improve the experience of patients attending their departments.
- Staff we spoke with were passionate about providing patients with a high quality radiology service and were working with other departments such as A&E to ensure improved patient flow and a better experience.
- We saw that the outpatient and diagnostic imaging staff had links with external professionals and organisations involved in patient journeys, such as GPs, community nurses and nursing homes.
- There were good working arrangements with Leeds Teaching Hospitals NHS Trust around cancer services.
- There was evidence of good relationships with visiting consultants and multidisciplinary work including dieticians, physiotherapy and occupational therapy.
- The Robert Ogden centre staff regularly had multi-disciplinary meetings, which included pharmacists, reception staff, benefits advisors and

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volunteers. Staff from the centre regularly worked with specialist nurses, the palliative care team and community nurses. Staff in the centre offered training sessions and updates that staff from other areas were invited to.

- There was ongoing work with GPs around the suspected bowel and breast cancer pathways regarding early initiation of diagnostic tests.

## Seven-day services

- Most outpatient services were provided during the day, Monday to Friday.
- The Elmwood department (medical outpatients) was open from 8.45 to 18.00 Monday to Friday
- Radiology was staffed from 7.45am until 6.30pm on weekdays and 8.30am until 4.30pm on Saturdays. There was 24 hour, seven day a week provision of x-ray services for emergencies.
- Saturday clinics were held on an ad hoc basis when there was increased demand. This was particularly in specialities such as ophthalmology to reduce the waiting list. Locums had also been used to provide extra weekday clinics to help manage the ophthalmic waiting lists.
- Radiology had also provided Sunday “waiting list initiative” clinics when needed to reduce the waiting time for CT investigations. Members of the radiology team staffed these on a voluntary basis.
- New consultant contracts included Saturday working.

## Access to information

- All staff had access to information relating to policies, procedures, NICE guidance and e learning via the trust intranet.
- Staff were able to access patient information, such as imaging records and reports, medical records and physiotherapy records through electronic records.
- Staff could view radiology images on wards and in departments via PACS. Images from other hospitals were available by using the ‘Image Exchange Portal’. Consultants, for reporting purposes, could review images remotely when on-call. Radiology images taken at outreach centres and at Ripon community hospital could be viewed by radiologists and reported from the main hospital via the PACs system.
- The trust was in the process of moving to a paper-light reporting process for both pathology and radiology

investigations. Almost all requests were received from and reported back to requesting practitioners using the electronic requesting and reporting system ‘ICE’. The ICE system also enabled staff to view the diagnostic status of each patient and the status of each diagnostic request.

- PACS, ICE and IT clinical records and administration systems were all available to consultants at the outreach centres.
- Critical pathology results were phoned through to the relevant clinician within a one-hour standard.
- Staff told us they would benefit from more computers within the departments to undertake work related activity including e-learning.
- Results of audits, risk assessments, infection control information, rotas and meeting minutes were all available to staff on the intranet and on information boards in staff rooms.
- GP’s could access reports from diagnostic imaging and other results directly through the ‘ICE’ system. Patients were given a pro-forma sheet with details of their consultation and this was used to book any follow up appointments at the main outpatient reception.
- The latest audit figures indicated that secretaries typed around 77% letters of consultations for GPs within two working days. Following typing it took on average another one-two days for letters to be authorised and issued.

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

- Registered nursing staff told us they had received training regarding mental capacity Act (MCA) and deprivation of liberty safeguards (DoLS). Compliance with training was 100% as of November 2015.
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients. We saw good examples of separate consent forms for adults, children, and adults who were unable to consent to treatment.
- Formal written consent was obtained for appropriate interventional and intrusive procedures in all outpatient and imaging areas as well as treatments with additional risk such as phototherapy and acne medications. We saw that verbal consent was obtained for other tests and procedures.
- Some nurses were trained to undertake written consent for procedures such as phototherapy.

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- Most staff we spoke with told us they were aware of mental capacity and deprivation of liberty safeguards and knew how to seek advice where they had concerns that a patient may not have capacity to give consent.
- Staff told us they would request support from the medical staff to assist in assessing a patient's mental capacity.
- Staff showed us a simple booklet they had been given to refer to when considering if a patient needed a mental capacity assessment.
- Nursing, Imaging, and Medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do this.
- Consent was obtained verbally in the majority of outpatient and imaging procedures. Staff in outpatients and diagnostic imaging departments understood the principles of informed consent, mental capacity and the right to refuse treatment or investigations.
- Staff told us they always assumed capacity unless they had documented information regarding a mental capacity assessment or best interest decision.
- If a patient refused an investigation, staff would go back to the referrer to discuss options for further care or treatment.
- We saw one patient, with dementia, attending the department for a procedure. Appropriate consent was recorded using the correct documentation and staff checked this prior to performing the procedure.
- We saw another patient who did not appear to understand what procedure he was having done or why. The radiographer felt he was unable to give a valid informed consent. This case was discussed with the patient's wife and radiologist and an alternative plan was made for this patient.
- Staff in the Robert Ogden centre had a good understanding of MCA and DoLS and explained how important informed consent was to cancer patients. They fully understood the right to refuse treatment and had examples of when patients had changed their minds about treatments. Staff felt it was important to ensure patients were given the opportunity to discuss any concerns, ask further questions and were able to change their decisions.
- An audit of recorded consent for patients undergoing interventional radiology between April and October 2015 found that evidence of consent was found in the

paper records of 70% patients reviewed. In patients, undergoing CT guided biopsy, 99% of consents were recorded on the radiology information system. The findings of the audit had led to a number of recommendations. There needed to be clarification of procedures where written consent was appropriate, the process for ensuring consent documents were scanned onto the information system needed to be improved and documentary evidence of information given to patients needed to be improved.

## Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because;

- We observed staff in all areas treating patients with kindness and respect.
- Privacy and dignity was maintained at all times and we saw staff answering patients' questions patiently and cheerfully with a caring manner.
- Patients were very happy with their care and information from all professional groups.
- Patients told us they understood the information that was given to them and what was happening to them.
- Patients were given plenty of time to make informed choices and consider the possible side-effects of certain treatments.
- There was good emotional support for patients within the departments and staff were able to signpost patients to support groups and counselling services when necessary.

### Compassionate care

- We observed staff in radiology interacting with patients in a pleasant manner and apologising to any patients who had been kept waiting.
- We observed many caring interactions between staff and patients. Patients were fully informed what was about to happen and assistance was given where needed. Staff checked patients' understanding.
- Interactions between staff and patients in all areas were professional and caring.

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- Care was provided in individual consulting rooms; we noted that doors were shut to ensure privacy. Consulting room doors had free and engaged signs in use to help maintain patients' privacy and dignity.
- Consultants introduced themselves to patients and spoke to them in a caring and understanding manner. We saw that examinations were fully explained and patients were requested to inform the consultant if any examination or procedure caused too much pain.
- Radios were playing in some areas to prevent patients in waiting rooms being able to overhear confidential conversations.
- Staff updated patients in outpatients regularly when clinics were running late.
- The most recent data for the national friends and family test (December 2015) shows that HDHFT outpatients had response rate of around 15% compared to the national rate of around 5%. The percentage of patients who would recommend the outpatients services at HDHFT was 84% in comparison to the national figure of 92%. Nationally 3% of patients who responded would not recommend outpatient services and 10% of patients at HDHFT who used outpatients would not recommend the service to friends or family.
- In the cancer, patient experience survey the trust scored in the top 20% of trusts for 21 out of 34 questions. No questions were rated in the bottom 20% of trusts.
- Between January 2015 and February 2016 patient feedback through NHS choices was largely very positive with regard to dermatology, Robert Ogden centre, cardiology, ophthalmology, orthopaedic and rheumatology outpatients. There was one negative comment in relation to not seeing the same doctor at the eye clinic leading to repetition and doctors giving differing clinical opinions. Positive feedback was in relation to staff attitude, staff introducing themselves, staff keeping patients informed and short waits.
- A patient satisfaction survey of people who had undergone an interventional procedure showed that patients felt staff communicated well, introduced themselves, were kind, professional and made patients feel at ease. Patients said their dignity was preserved, staff were reassuring and they were made to feel like they "mattered most".
- We observed a sister speaking to the estates department and asking if they could move a recently installed endoscopy storage cabinet as it was too noisy for patients using that area.
- Staff in outpatients told us how they had moved waiting patients from an area where a man had collapsed to protect his privacy and dignity as far as possible and to minimise the alarm for other patients.
- A member of staff had taken the patient's wife into a quiet room and stayed with her until her husband had been treated.
- Volunteers in the Robert Ogden centre provided a meet and greet service to put patients and relatives at ease.
- Chaperones were available and notices were in place advising patients to ask for a chaperone if they wanted one.
- Patients and relatives we spoke with in the Robert Ogden centre told us that staff were welcoming, the environment was comfortable and 'didn't feel like a hospital'. They said waiting times were good and they were always offered a tea or coffee when waiting. There was only one negative comment regarding information displayed on the TV screens, which one patient had found very frightening and distressing when he had attended the unit the first time.
- Patients also told us they had received support around benefits and entitlements and that staff never rushed them, always giving them the time they needed to ask questions and making them feel valued and cared for.
- We spoke to a small number of patients who had travelled to Harrogate as a matter of choice for treatment. They felt the hospital was clean and staff were friendly and waiting times were acceptable. They all told us that they would recommend the hospital to friends and family.
- In the urology treatment area, patients wearing open-back gowns were given dressing gowns to maintain their dignity. Carrier bags were given to carry clothes and nurses showed patients into an area where changing and washing facilities were available post procedure. We observed nurses explaining to patients how to dispose of used gowns and how to use disposable wipes for cleaning. Treatment rooms had an engaged sign when in use.
- Limited space in the urology area meant that notes were on a trolley where patients passed and we could easily view the contents and drawings in one set of notes open on a chair behind the reception desk.
- In the phlebotomy clinic we observed that the curtains between chairs were not routinely drawn, resulting in a

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lack of privacy for patients having blood taken. Patients in this area made comments regarding caring staff and good service. "Nursing care in Harrogate hospital is a very high standard".

- A patient told us she was very happy with the care from the cardiology out patients and was always treated with kindness and respect. "The service is punctual and there is good communication".

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

- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment to patients and we saw that carers were encouraged or enabled to support patients.
- Staff were good at explaining what was happening in a way the patients could understand and they were seen to check patients' understanding.
- We observed consultants giving very thorough and informative explanations to patients regarding their test results and condition. Discussions included treatment options and patients were given choices and were involved in decision-making.
- We saw that patients were encouraged to monitor their own health and well-being and to record any triggers that caused a flare up of their condition.
- Patients told us they were given all the information they needed and they were involved in their treatment and care. Those close to them said that they were kept informed and involved by nursing and medical staff.
- All those we spoke with told us they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- We saw staff inform patients if clinics were running late. Staff apologised and explained why appointments were delayed.
- A patient in radiology told us they had been given all of the information they needed if they had a concern following their investigation and knew whom to contact for advice.
- We observed that the mother of a teenage patient was allowed to accompany them into the examination room. The mother was able to wait until the patient was settled, before leaving the room for the scan to take place. We saw that this was reassuring for both the patient and the patient's mother.
- We observed a HCA in outpatients explaining an emergency care card to an elderly man in a way he could understand.

## **Emotional support**

- We saw evidence of changes being made to services to meet the emotional needs of patients. This included providing a second exit from the Robert Ogden centre for patients who were upset and would rather not walk out through the main waiting area.
- The specialist nurse in the dermatology service was available to be with patients when bad news was being delivered and to offer follow up support and advice.
- Cosmetic camouflage was also offered to acne patients and mental health assessments were undertaken regularly. Staff working in this area could signpost patients to support groups. They had written information to give to patients about counselling services that were available to them.
- As certain acne treatments could be a risk to pregnancy due to their toxicity, female patients, wanting these treatments, were counselled regarding contraception and risk to pregnancy. They were given a cooling off period to consider the information they had been given and to come to an informed decision.
- Patients told us that they felt supported by the staff in the departments. They reported if they had any concerns, they were given the time to ask questions.
- There was a patient information and wellbeing manager available to cancer patients for emotional and practical support.
- Cancer patients could access complementary therapies to help them cope with their illness and treatment.
- There was a volunteer who ran 'feel like you' skin, eyebrows, nails and makeup sessions for women suffering from cancer.
- Music was also played during diagnostic procedures to help patients stay relaxed.
- All of the patients we spoke with in outpatients and radiology, told us staff were very helpful, treated them with dignity and respect and had time for them even when the department was busy.
- One patient told us that the desk in radiology was not ideal as patients were easily overheard talking to the receptionist.

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## Are outpatient and diagnostic imaging services responsive?

Outstanding



We rated responsive as outstanding because:

- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. Initiatives including virtual clinics, and nurse led services meant patients could easily access specialist advice and support.
- The trust was consistently exceeding its performance targets and England averages for referral to treatment times (RTT) and for diagnostic waits.
- The trust consistently exceeded cancer waiting time targets.
- The Trust was actively managing its waiting lists for both new and follow-up patients and there was a clear plan to reduce the numbers of ophthalmology patients awaiting review appointments.
- The trust actively managed new to follow up ratios and investigated outliers from the expected range.
- Cancelled appointments were actively managed and were much better than the England average.
- The trust had developed a number of one-stop services for patients and had well-embedded outreach services.
- The clinical assessment team, fast track systems and the rapid access clinics meant patients could access specialist assessment and diagnostics very quickly.
- Staff worked hard to meet individual patient needs.
- Concerns and complaints were taken seriously, investigated and responded appropriately and staff and managers responded positively to patient feedback.

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

- Services were planned around the needs of patients and were delivered in a way that provided choice, flexibility and continuity of care.
- For example, a rapid improvement workshop had been undertaken to look for ways to reduce the ophthalmic waiting list and a new process had been trialled with 40 patients who had glaucoma. The process involved rating

patients as red, amber or green and streaming them to consultant led other medical grade or virtual clinics as appropriate. Following a successful trial, this process was to be rolled out in March 2016.

- The department had submitted a business case to recruit and train three advanced nurse practitioners for medical retina care. These nurses would support the consultant ophthalmologists with clinical assessment and follow up of these patients.
- The surgical outpatients' sister met with administration managers every two weeks to review waiting lists and to ensure patients were on the correct list. Regular review and planning meetings had contributed to the reduction of the ophthalmic waiting list from around 3,000 to 1,400 patients previous 12 month period.

### Access and flow

- Between July 2014 and June 2015, 269,918 outpatients attended HDHFT. Around 23,216 of these were in outreach centres, which included GP practices, health centres and Ripon and Wharfedale community hospitals.
- Thirty one percent of appointments were new patients and 62% were follow up appointments there were 7% unattended and cancelled appointments. The national averages were 25% new and 55% follow up appointments with 20% cancelled or unattended appointments. The trust's 'new to review' rate (the ratio of new appointments to follow-up) was consistently better than the England average between July 2014 and June 2015. The trust actively managed new to follow up ratios and outliers from the expected range were highlighted and investigated to ascertain the reasons for this and identify whether any improvements could be made.
- The trust had a 'did not attend' (DNA) rate of 5%, which was better than the national DNA rate of 7%.
- Patients who DNA for a diagnostic appointment were offered one further appointment and referred back to the GP if they failed to attend for a second time.
- Appointment letters contained information to patients about; not attending, how to cancel or rearrange and what to expect if an appointment was missed.
- There was a policy in place to ensure safeguarding checks were made when children did not attend appointments.
- The cancelled appointment rates were much better than the national averages during this time. At HDHFT

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1% of appointments were cancelled by the patient and less than 1% was cancelled by the trust. Nationally, hospitals cancelled around 7% of appointments while patients cancelled 6% of appointments. The hospital used a texting reminder service two weeks before the date of appointment.

- From July to October 2015 trust data indicated that 5.4% of clinics cancelled by the trust were cancelled within six weeks of the appointment date and 0.5% were cancelled over six weeks from date.
- Department of Health guidelines state that 95% patients should start consultant-led treatment within 18 weeks of referral. This rate applies to non-admitted patients and incomplete pathways. Both of these rates for this trust were consistently better than the standard and better than the England averages between September 2014 and August 2015.
- The trust actively monitored waiting lists and there was an escalation policy should waiting times increase to a level where patients may start to breach the standards. The trust investigated all breaches to understand why they had occurred and to help prevent future occurrences.
- The percentage of patients (with all cancers) waiting less than 31 days and 62 days from urgent GP referral to first definitive treatment was consistently better than both the standard and the England averages. Between Quarter (Q) 1 2013/2014 and Q 2 2014/2015, the percentage of people waiting less than 31 days ranged between 99% and 100%. The percentage of people waiting less than 62 days ranged between 90% and 91%, during the same time period.
- The percentage of people seen by a specialist within 2 weeks following an urgent GP referral was consistently better than both the standard and the England average. Between Q1 2013/2014 and Q2 2014/2015, the percentage ranged between 95% and 99%.
- Breaches of the national standards for; 13 weeks to first outpatient appointment, diagnostic tests within six weeks and rapid access chest pain service were very rare between May 2015 and October 2015.
- There were on average three breaches a month of the maximum 14 day wait for appointment for breast symptomatic patients.
- Breaches of the 14 day maximum wait from urgent GP referral for all urgent suspected cancers was around 30 a month during May 2015 to July 2015 but this had halved for the period August 2015 to October 2015.
- Patient initiated cancellations were also actively managed and admin staff would alert managers if there were no clinic capacity to re-book a patient within the required time. Cancelled appointments were utilised as far as possible by telephoning patients to offer short notice appointments.
- The diagnostic waiting times for this trust between October 2013 and October 2015 were consistently better than the England average. At times the trust reported no diagnostic waiting times of over 6 weeks, which is unusually low. There was a peak in waiting time during January 2015, which meant that around 0.7% patients waited more than six weeks for a diagnostic appointment.
- Outpatients' appointments usually originated from GP referrals through 'choose and book', an electronic web-based appointment system that offers patients a choice of where to receive health care.
- Patients at a focus group told us that the choose and book service was excellent and there was a short wait for outpatient appointments.
- Appointments for radiology and other diagnostic tests were arranged via GP referral or by referral from hospital doctors or other authorised healthcare professionals.
- The clinical assessment team (CAT) enabled access for GP's to refer patients for urgent diagnostics and same day appointments for procedures such as lumbar puncture, ECGs and assessment at the daily transient ischaemic attack (TIA) clinic.
- Rapid access clinics included; a twice-weekly chest pain clinic run by a consultant cardiologist with access to echo-cardiology and other diagnostics as required. This clinic enabled patients to move directly into the pathways for cardiac interventions if required.
- The pathway for rapid access for suspected bowel cancer was direct access to colonoscopy followed by an appointment with the consultant.
- Cancer services telephoned patients to agree a convenient first appointment, which helped patients make sure they could bring a family member or a friend with them. This also worked as a point of introduction. Further appointments were arranged before patients left the department.
- Imaging services had scheduled appointment slots for urgent patients each day.

# Outpatients and diagnostic imaging

- There were two week wait services available for dermatology and endoscopy. An atrial fibrillation clinic had recently been set up, for which patients could wait between two and four weeks for an appointment.
- Outpatients provided a number of one-stop services such as those for breast patients where consultation, biopsy and imaging were provided on the same day. There was also a one-stop haematuria clinic where patients could receive ultrasound scans and have blood taken.
- The women's unit offered a one-stop clinic for post-menopausal bleeding.
- Patients requiring urgent cystoscopy were seen within two weeks of GP referral. Following cystoscopy, patients were told the findings and what further appointments or treatment would be needed.
- Staff in the ophthalmology clinics were aware of the backlog of patients waiting for follow up appointments. To mitigate patient risk, they had introduced a card system and call back and assessment to ensure any patients with a sudden or concerning change in their condition were fast tracked into an urgent clinic. The ophthalmic administrator told us that sometimes patients were identified as needing an appointment in 1-2 days and they were always able to accommodate this. The service had been running Saturday clinics for around two years to help improve the follow up waiting list situation.
- The trust was in the process of implementing a red, amber, green rating system for patients requiring follow up ophthalmology appointments and was developing nurses as advanced practitioners to ensure waiting times for follow up appointments were kept within acceptable limits.
- A virtual clinic had been introduced for glaucoma screening which involved a consultant reviewing patient information such as pressure test results and photographic images and communicating with the patient's GP if there were no concerns. If concerns were identified the patient would be invited into a clinic at the hospital for further assessment. Patients had to attend the hospital for a first appointment and were assessed regarding their suitability for the virtual follow-up clinic.
- The dermatology service was the tertiary centre for acne offering specialist treatments and support services such as cosmetic camouflage. The dermatology service also offered one-stop clinics for patients needing minor procedures.
- Haematology services offered a virtual clinic where patients could receive and discuss their blood results with a specialist nurse over the telephone.
- Patients could access plain film and ultrasound scans (USS) at both Harrogate District Hospital (HDH) and Ripon hospitals. Plain x-ray at HDH was a walk in service and appointments for Ripon were available within 3-4 days. Maximum waits for USS between May and October 2015 at HDH and Ripon was 21 days.
- MRI, CT, nuclear medicine and dexamethasone scans were provided at HDH and longest waits, for these services, between May and October 2015 were 10, 11, 21 and 36 days respectively.
- The development of telemedicine at this trust had reduced the number of outpatient attendances for cardiology patients. For example patients with loop systems and pacemakers could remain at home for monitoring of heart rhythms as the information could be downloaded and reviewed by the consultant remotely.
- A one-stop new clinic for patients suffering from atrial fibrillation had been set up in August 2015 to enable patients to have all of their investigations, see the consultant or specialist nurse and start on appropriate medication all at one visit.
- The call-answering centre audited the number of calls received by the trust and the number of calls answered. The appointment centre staff answered 86% of calls.
- Clinic arrival, waiting and leaving times were audited every three months. An audit undertaken by the Elective Care Directorate found that 51% of patients waited over 30 minutes for their appointment once they had arrived at the department.
- During September 2015 to November 2015 data from two surgical outpatients clinics indicated that 48% of patients were seen within 30 minutes of appointment time, 12% between 31 and 40 minutes, 10% between 41 and 50 minutes, 6% between 51 and 60 minutes and 5% over 60 minutes. For 10% of patients the waiting time was not recorded and 9% of patients arrived late.
- The trust data indicated that 24% of clinics started late.

# Outpatients and diagnostic imaging

- Where it was noted that waiting times were increasing, outpatients sisters reviewed the information to identify reasons for wait and any bottlenecks. Where issues were identified, the sister could allocate catch up slots or amend patients' arrival times if needed.
- Most patients told us that their appointments were only a few minutes late starting and they had not experienced any problems.
- One patient told us he had three appointments within an hour and that everything was dealt with in that time.
- In the main outpatient department, there was a ticket machine for patients to take a number as they arrived to ensure they were seen in order; however, we noted that the machine was empty.
- Staff told us that they regularly updated patients, with reason for wait and expected waiting time, if waiting times were more than 20-30 minutes. Staff told us they spoke to patients individually if their waiting times were longer than expected and estimated waiting time if a patient needed to leave the department for any reason.
- Some services were providing outreach clinics and services based at health centres and GP practices to reduce the number of patients who may need to attend the hospital. We observed that patients in the outreach clinics were seen quickly and time waiting was rarely prolonged.
- The phlebotomy service also offered a clinic at a local supermarket five mornings a week which had proved very successful. Staff told us that this service was very popular and queues were increasing. Managers were reviewing this service to potentially offer additional times or perhaps offer the service from other locations.
- Nursing staff had improved patient flow and reduced the need for unnecessary waits in different departments, such as orthotics and the plaster room, by being trained to apply casts and fit orthotic appliances such as knee braces.
- An audit of waiting times in radiology, demonstrated an average 23 minutes wait for plain film imaging. Ultrasound waiting times showed most patients were early for appointments and were scanned early, and only 7 out of 50 were over 20 mins. In MRI, patients were mainly seen on or before their appointment time, the average wait was 8 minutes.
- The outpatient staff at Ripon had been trained to do phlebotomy to improve the patient pathway and prevent the need for further appointments.
- Staff in the Robert Ogden centre had looked at what equipment was needed along the patient journey and had taken care to ensure the right equipment was in the right place to avoid unnecessary delays and to improve the patient experience.
- Patients told us access to phlebotomy was good with short waiting times, patients took a ticket and waited for their number to come up on a display screen.
- One patient told us it was difficult to step off the pathway into the gastro-intestinal service if they wanted to see a consultant prior to undergoing diagnostic tests.
- To help meet demand for gastro-intestinal patients the trust had trained a clinical nurse specialist (CNS) who worked closely with the consultants and could provide follow up appointments for irritable bowel and colitis patients. Telephone reviews were also being undertaken in this service and there had been some work with GPs regarding initiation of diagnostic tests to improve patient flow.
- There was also ongoing work with GPs around early investigation of breast symptoms.

## Meeting people's individual needs

- We found that staff in outpatients and radiology were focussed on delivering a positive patient experience for all patients.
- The fracture clinic had a spacious waiting area with room to manoeuvre wheelchairs.
- We observed a nurse providing a patient with a leg support and asking if she was comfortable while she waited for her appointment.
- We observed a patient attending fracture clinic whose appointment had been cancelled as she needed to see a specialist about her knee. However, the clinic nurse was successful in getting an orthopaedic consultant who was on duty elsewhere in the hospital to review the patient.
- There was a welcome board at Harrogate main outpatients, which showed staff names, uniforms, and roles. There was also information regarding patient feedback, information about the patient voice group and website and contact details for patients with concerns.
- Information was available in the audiology department to advise patients regarding different conditions as well as the costs of lost or broken hearing aids.
- There were similar boards displayed in main x-ray and ultrasound waiting areas.

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- Patient feedback forms were available in braille, different formats and languages.
  - The patient information and well-being manager was available to offer additional support to cancer sufferers and their families and could liaise with carers and professionals on behalf of patients when needed.
  - Staff were able to describe how they cared for patients with memory impairments and learning disabilities. They gave practical examples of how these patients' needs could be accommodated in the departments and whom they could contact for further advice and support. Staff told us how they involved family and carers with the care of patients suffering from dementia and learning disabilities to alleviate as much anxiety and distress for the patient as possible.
  - We saw evidence of the 'butterfly' dementia scheme in use. Staff in fracture clinic told us they usually were aware when patients with dementia were attending and they gave priority to these patients when they arrived and supported them through the process of moving into the x-ray room and back to be seen by the doctor as soon as possible.
  - The environment at the Elmwood centre was 'dementia friendly'. There were pictures as well as words on the toilet doors and the doors had red frames. Other doors were also colour coded and doctors' names were displayed.
  - There was good wheelchair access around this department and in the toilets, which had low hand basins and call bells to use if help was needed.
  - Consulting rooms in the Robert Ogden centre were designed to be 'dementia friendly' with clear signage and toilet seats were coloured. However, staff told us the door frames needed to be colour coded.
  - Outpatient areas supported the use of loop system for people with hearing impairment.
  - The Robert Ogden centre was "step free" with gentle ramps for wheelchair users and for people with mobility difficulties, there were handrails along the corridors for patients who needed this support when walking from one area to another. There were also outside seating areas for patients waiting between treatments or appointments.
  - Bariatric equipment was available in the Robert Ogden centre.
  - Clinical records had a visible flag where people had additional needs such as a learning disability.
- Administrative staff would give these patients a double appointment slot and nursing staff would review any additional information on the record to enable the best management for these patients.
- There were quiet rooms available for patients who were upset or receiving bad news.
  - There was a patient information room set aside in this area where patients could access pre-treatment information.
  - Registered children's nurses were available for paediatric clinics at Harrogate and attended Ripon when necessary.
  - Children and young people were seen in some adult outpatient clinics such as ophthalmology and surgery. There was a small children's waiting area in the main department with books and toys available to distract children while waiting.
  - Doorways in the imaging departments were red to be easily identifiable to people living with dementia.
  - Staff in outpatients told us that they had received training regarding the needs of patients with dementia.
  - We saw a range of information leaflets were available across the departments.
  - We were told that outpatient staff at Ripon did not always know when a patient would require an interpreter when attending a clinic. They told us that they would use a family member if needed if they were present; however, this is outside of best practice guidance. Staff did know about the telephone service for interpreting.
  - Staff knew they could arrange for a face-to-face interpreter if they felt the telephone service was inappropriate for a particular patient's needs. They were also aware that if they needed information leaflets translating they could email the document to the interpreting service and they would usually be returned within 5 working days.
  - A patient in radiology told us they had been easily able to rearrange their appointment to a more convenient time.
  - Patients told us they felt comfortable in the departments.
  - There was a bariatric trolley available for outpatient use; however, there was no bariatric seating available in the main department. The department sister told us she had submitted a bid for funds to purchase bariatric chairs.

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- Hoists were available in imaging and outpatient areas for moving and handling of patients.
- Information for patients was on display in the radiology departments, which included information about how to raise a concern and information regarding chaperones. The TV displayed relevant messages for patients and included IPC information. There was a children's guide to radiology available and some toys for children to play with while waiting.
- Dermatology held a children's clinic every Monday.
- Staff at Ripon had acknowledged they needed to improve the patient information leaflets and had started to look at this.
- Appointments' staff told us that there was a flagging system for patients with visual impairment.
- Appointments' staff would note information from referrers about patients' additional needs and enter this onto an electronic system (SystemOne). The appropriate support service was arranged prior to the appointment. This information was printed on the clinic information sheets as a prompt to nursing staff that they may need to adjust their clinics to meet a patient's additional needs.
- The process for issuing letters to patients had been improved to offer options for flagged patients to receive communication to meet their needs.
- The public toilets in the out patients department at Ripon hospital were not easily accessible for wheelchair users as there was a very narrow corridor with a 90 degree turn. The toilet cubicles were also very narrow.
- There were information leaflets on display in the outpatient area at Ripon hospital and at Wetherby health centre.
- Staff names were not on display in the waiting room or at the x-ray reception at Ripon.
- Patients visiting the Robert Ogden centre for cancer treatments were able to access a pre-paid card for car parking.
- TVs were available in some waiting areas.

## Learning from complaints and concerns

- There were 66 formal complaints relating to outpatients and radiology in the 12 months October 2014 to September 2015. Themes from these included communication and staff attitude and ten were relating to potentially delayed diagnosis or treatment.
- We reviewed five complaint files relating to complaints in outpatient and diagnostic imaging areas and found

that these had been appropriately investigated. Responses were open and honest about mistakes made, an apology was given and there was evidence of learning and actions taken to improve patients' experience and prevent similar mistakes happening in the future.

- Staff in phlebotomy were able to tell us how a recent complaint had led to a review of glove use and the infection control policy for bloodletting in the department. Although the complaint did not lead to a change in practice, it reinforced the need for staff to follow policy and provided a clear rationale for current practice.
- Patients could feedback complaints and concerns in a number of ways; formally via PALS, and by completing patient feedback cards. Posters were displayed to explain how to raise concerns.
- All the staff we spoke with showed a willingness to pro-actively respond to patient feedback and try to resolve concerns as soon as they became aware of them. Staff were aware of PALS and the formal complaint process if they were unable to resolve a patient's concerns.
- Staff in outpatients and imaging told us that few formal complaints were received within the department and they told us the themes from informal concerns and PALS enquiries were; waiting times and car parking.
- There were suggestion boxes in the outpatient departments for patients to provide feedback.

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

Good



We rated well-led as good because;

- All services had clear vision and strategies, which were known to staff at all levels of the service.
- The services were visionary and innovative and there was a well-embedded culture of service improvement.
- Staff and members of the public were engaged in service improvements.
- There were clear governance structures and managers were clear about how they could escalate risks to senior managers and the executive team.

# Outpatients and diagnostic imaging

- Managers and staff had a good understanding of what risks their services faced and mitigated against these wherever possible.
- Risk registers were comprehensive and up to date.
- Staff recommended the trust as a good place to work and would be happy for relatives to receive care there.
- There was a strong culture of learning and improvement and numerous examples of innovation, improvement and sustainability.

## Vision and strategy for this service

- There were strategic business plans in place for all services within OPD and diagnostics. These were clear about areas for development, risks and included mitigations for risks wherever possible.
- There was a clear vision for the provision of outpatient services including the development of outreach and virtual services to meet the rising demand for outpatient services and to offer services closer to the patients' homes.
- Staff we spoke with were aware of the goals and aspirations of their own departments.
- Staff were proud to work for Harrogate and District NHS Foundation trust and were focussed on delivering the best patient experience they could.
- Leaders of speciality teams had clear ideas and rationale for future service developments e.g., ablation and services for abnormal uterine bleeding.
- Diagnostic imaging services were clear regarding the pressures on their services and had a clear vision of how to increase capacity to meet the rising demand, particularly for MRI, CT and Ultrasound. This included the increase in seven-day services.

## Governance, risk management and quality measurement

- All staff we spoke with were aware of the governance arrangements in place and who to report risks to. We saw from minutes of meetings that risks, complaints, incidents and litigations were discussed and actions shared through the monthly clinical business unit meetings.
- Governance arrangements, in outpatients and imaging services, facilitated the identification and management of issues, in multidisciplinary forums. Issues discussed included; quality of care, waiting lists, access, records, space/ rooms, finance and performance, breaches of standards and reasons why and incidents, complaints

and the learning from these. The meeting minutes also indicated that opportunities and ideas for improvement were also discussed. Topics included extending outreach and the possibility of virtual clinics and the results from audits and research that may lead to improvements in practice and pathways of care.

- Senior managers were clear about the risks their departments or services faced and minutes of governance meetings clearly demonstrated discussion, escalation and actions taken.
- Trust wide and service wide risk registers were in place and were regularly reviewed and updated. There were mitigations in place regarding all risks and there was evidence of these reducing the risk ratings.
- The main risks identified in outpatients were waiting times, environment and supporting patients with a learning disability. We saw evidence that these risks were being actively managed through weekly meetings with staff from medical records and the operations manager to look at and manage waiting lists, development of outreach and virtual clinics and staff training.
- The trust was concerned about waiting times for follow up of ophthalmology patients. There was an action plan in place to address this and the number of patients waiting follow-up had been halved over the previous 12 months.
- Department managers and matrons were aware of the risks in their areas and knew how to escalate risks through the organisation if needed.
- The key issue for radiology was the age of some of the equipment and the need for replacement. Managers had submitted business cases to replace equipment some of which had been successful and there was a capital replacement programme in place.
- There was a comprehensive quality assurance programme in place for all laboratory and imaging areas, which included bi-weekly and monthly audits.
- The blood sciences laboratory manager told us that point of care testing had been inspected by Clinical Pathology Accreditation (CPA) and had achieved full compliance. CPA assesses and declares the competence of medical laboratories. This provided independent assurance that the accredited laboratory services were meeting current standards for quality and risk management.

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- The colposcopy clinic received a three yearly quality assurance visit from the British Society for Colposcopy and Cervical Pathology, to ensure standards were maintained and up to date.

## Leadership of service

- Staff we spoke with were very positive about the management of outpatient and diagnostic imaging services. It was felt that the present management structure was clear and supportive at a local level.
- Nursing staff in outpatients told us their manager was visible and approachable.
- All the staff we spoke with reported that the senior executive team communicated well and that relevant information was disseminated to staff via email and bulletins.
- The manager and clinical leads worked well together and included operational staff regarding any service developments.
- We found that managers encouraged staff to participate in on-going learning and professional development and were open to ideas and suggestions for improvement. We spoke with staff that had benefitted from investment in their development and had recently successfully achieved promotion or been able to change role as a result.
- Managers felt empowered to act to improve services for patients. They felt supported in their career development and in supporting their staff.
- The manager of the fracture clinic had recently invited a tutor from the education department to speak to the HCAs regarding the role of a band 4 HCA and the training and qualifications that would be needed to fulfil the role.
- Staff told us there were good flexible working arrangements in place, teamwork was very good and they felt listened to.
- Staff told us they felt supported and knew who to escalate problems to if they could not solve something themselves.
- Staff and volunteers told us they enjoyed working for the trust and volunteers and support staff told us they felt part of the team.
- There was a senior sisters' development programme for ward managers and staff were supported to undertake other leadership programmes and courses.
- There were clear lines of accountability from the service leaders to the frontline staff.
- Staff spoke highly of clinical leadership and the clear direction they provided for service developments.
- Staff in diagnostic imaging had access to communication files containing minutes from the monthly MDT meeting, topic of the month information and other appropriate information and updates.
- Staff in radiology felt that the trust and the department were well run.
- The main outpatient department sister told us that she had regular one to one support and daily catch up meetings with her line manager.
- Staff in the Robert Ogden centre told us they had regular one to one support from their line manager in addition to appraisals and felt that they were involved in service developments. All staff had personal development folders.
- There was an ethos of caring for staff that care for patients in emotionally challenging areas.
- The new sister in the outpatients department at Ripon hospital had a clear action plan relating to areas for improvement and development, which included staff development, appraisal and supervision and the programme of audits to be undertaken.
- Band 7 sisters and matrons were encouraged to undertake a leadership programme, which included the requirement to undertake a service improvement project.
- Staff who had been through the programme felt it was very beneficial and the projects had led to real improvements in service delivery.
- We saw that service leaders were supported in developing business cases and moving service improvement forwards. For example, the manager in the outpatient department had been able to review the service following retirement of the plaster technician and invest the released monies in developing staff to deliver the service differently.
- There had been a recent change in leadership at Ripon outpatients, which meant that team meetings where information from the rest of the trust could be shared had only recently started. Staff felt this was a positive change as they had previously felt isolated. Staff told us that meetings included operational issues, safety issues and were an opportunity to raise concerns or voice ideas.

## Culture within the service

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- Staff gave positive feedback regarding the culture of the organisation and as a good place to work. They felt the culture was one of improvement and staff were encouraged to report incidents and learn from them. Staff felt the culture was open, with a learning not a blame culture when things went wrong.
- Staff felt confident to raise any concerns they had about patient safety and managers would listen and take appropriate action.
- Middle managers felt that the executive team had patient safety and experience at the forefront of their minds and told us that when issues had occurred the chief executive and finance team had supported necessary actions. Despite financial constraints managers told us that their experience was that the executive team did not allow this to risk patient safety.
- Sickness rates, for the last financial year, among nursing and allied health professionals were relatively low across outpatients and diagnostic services ranging from 0.5% to 5.6%.
- Staff told us the departments were a good place to work and that they felt well supported.
- Staff felt the culture within the department and organisation was open and honest.
- Staff told us that compliments and concerns were shared with staff within the imaging department.
- Staff told us they felt proud to work for the trust and they would be happy for their friends or family to receive care there.
- As a result of patient experience feedback, the hospital had made improvements to parking and patient transfer from the Robert Ogden centre to the main hospital site.
- Information regarding nephrostomy dressings had been amended following patient feedback. The new leaflet gives full product details including costs and staff reported that this had reduced the number of patients needing to contact the department for information, advice or to change their dressing.
- Staff in radiology had responded to feedback from breast patients by developing improved information for women, post breast biopsy, regarding post procedure care of biopsy site and contact details for advice and support.
- Radiology undertook a patient survey in December 2014 as part of the review of services. Results indicated that: staff were courteous and made every attempt to preserve dignity; 95.5% of patients were not kept waiting longer than they expected; 99.2% of patients were completely satisfied with the service and 84.8 % were very likely to recommend the service to family and friends.
- Outpatients' staff also worked with a number of local voluntary groups who supported the department to make improvements for service users. For example, the league of friends at Ripon hospital had raised money and purchased a FIELD testing machine for the eye clinic.
- Other community groups and charities such as; the Harrogate Lions, the Blind Society and other local services had helped with providing patient information. Local fundraising activity had successfully raised enough money to purchase a laser for the eye department.

## Public engagement

- It was clear that patient and public engagement was an integral part of outpatient and imaging's approach to service development.
- Business plans and the review of radiology referenced patient involvement and reported patient opinion regarding current services and proposed developments.
- There was an active patient voice group who had influenced the development of improved facilities for patients using the orthotics service and who had helped develop the outreach phlebotomy service at a local supermarket.
- Patient surveys were undertaken across the outpatient and diagnostic imaging departments and staff acted on feedback patients gave. Patient feedback was collected on an ongoing basis. Patients' comments were reviewed and 'you said we did' information was displayed.

## Staff engagement

- Most of the staff we spoke with felt engaged with the organisation and were able to share feedback and suggestions to improve services. We heard examples of where junior staff had made suggestions and these had been acted on.
- Staff told us of that their views were sought and taken into account when managers were considering changes to working patterns or work areas. Staff were able to express an interest in specialising in certain clinic areas.
- The organisation and services we inspected were very supportive of staff development.
- One HCA told us how the trust was supporting her undertaking nurse training through the Open University

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while continuing to work in her current role. Backfill was being provided for some of her working hours and the department sister was supporting her with the application.

- Nursing staff were aware of revalidation and had been able to attend road shows regarding meeting the requirements for the Nursing and Midwifery Council (NMC) revalidation.
- Staff were encouraged to engage in the Trust wellness programme and complimentary therapy was available to staff working in areas such as cancer services. The introduction of these services had shown a reduction in staff sickness levels.
- The executive team communicated with staff via newsletter 'Trust news', the trust intranet and by conducting walk arounds in clinical areas.
- Staff told us the senior management team and chief executive were approachable and they felt they were interested in their wellbeing.

## **Innovation, improvement and sustainability**

- We saw and heard of good examples of innovation from staff.
- The main outpatient department was an accredited centre for the treatment of faecal incontinence using percutaneous tibial nerve stimulation. Staff told us they were the first NHS centre to be awarded this accreditation.

- The laboratories had introduced a webcam that enabled staff to see when samples arrived in the department with the aim and result of improving sample to report time.
- The laboratories had introduced a paperless reporting system. Consultants received a weekly email regarding those results not recorded as reviewed to ensure diagnostic results were not missed.
- There was a nurse led oral health service which had improved patient compliance and reduced breakages. This led to fewer attendances and reduced pressures on appointments for patients waiting treatment.
- A review of the glaucoma pathway had led to; the redesign of the layout and content of the clinic rooms, the introduction of a virtual clinic for lower risk glaucoma patients and the ongoing development of nurse practitioners.
- The women's services had introduced a new Myosure procedure to remove endometrial polyps at hysteroscopy. Women, who could tolerate this procedure, did not need to return for a second appointment and a treatment under anaesthetic.
- There were ongoing plans to extend outreach provision of outpatients and diagnostics and virtual clinics.
- The department had invested in technology, which enabled; self-check in, clinical calling direct from consultation rooms and text reminders for appointments.

# Outstanding practice and areas for improvement

## Outstanding practice

- The supporting intensive therapy unit patients (situp) service.
- Clinical psychology service to inpatients and outpatients at the follow up clinic in critical care.
- The use of patient diaries on critical care by the multidisciplinary team.
- The critical care outreach team's leadership, advanced clinical skills and commitment to education
- The critical care online "virtual" journal club.
- We spoke with the diabetes specialist nurses who demonstrated how they used information from the Electronic Prescribing and Medicines Administration (EPMA) system to monitor patients' blood sugar readings and insulin doses. If a patient had a blood sugar reading of less than 4 or more than 15, a specialist nurse would proactively visit them. This enabled the team to target those patients early who required a review and allowed interventions to be made before referrals were received. This also helped to streamline the team's workflow. We thought this was innovative practice.
- The redesign of the acute admissions and assessment pathway, known as the 'FLIP' project was outstanding. The project was initiated and driven by staff. It involved the redesign and integration of the CATT Ward and the CAT team. Although the project started in October 2015, the benefits of the project were already being seen. Despite a 30% increase in non-elective in-patient activity within general medicine, the percentage bed occupancy had decreased from October 2015 to January 2016 compared to the previous year. Managers attributed the fact that the hospital had not needed to open up the 12 bedded winter pressures escalation ward to the success of the project.

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must take steps to ensure that the environment on the Woodlands ward is appropriate to allow the needs of children and young people with mental health needs to be fully taken into account. In addition, the trust must improve the facilities in and access to the mortuary.
- The trust must ensure that accurate nursing records are kept in line with professional standards particularly in urgent and emergency services and that medical records are stored securely in services for children and young people and within the mortuary area.
- The trust must ensure that good infection protection and control practices are adhered to particularly on all medical wards.
- The trust must ensure that all medicines are stored safely and are disposed of when out of date. This particularly applies to oxygen cylinders and drugs on the emergency trolleys in the hospital.
- 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 particularly in medicine, end of life care and children and young people's services.

- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal particularly: appraisal rates within maternity and gynaecology; mental health training for paediatric staff and; safeguarding training in both community and acute services for children and young people.
- The trust must ensure guidelines and protocols are up to date and there is an effective system in place to review these in a timely manner particularly in maternity and gynaecology and radiology.

### Action the hospital SHOULD take to improve

- The hospital should ensure compliance with the 'five steps to safer surgery' procedures and World Health Organisation audit.

# Outstanding practice and areas for improvement

- The trust should continue to address the areas where they do not meet the Guidelines for the Provision of Intensive Care Services (2015), for example, supernumerary nurse, medical staffing and post registration qualification in critical care.
- The trust should ensure that policies and guidelines are in date and contain a date of ratification and a date for review.
- The trust should consider access to toilet and washing facilities for patients on the critical care unit.
- The trust should collate the patient satisfaction survey results for wards/departments.
- The trust should take steps to ensure that the child's voice is reflected in the medical records.
- The trust should take steps to ensure that appropriate numbers of play specialists are available in accordance with the National Framework.
- The trust should take steps to ensure that an appropriate environment and staff are available to children and young people undergoing surgery in accordance with national guidance.
- The trust should take steps to ensure that appropriate transition pathways are in place for children and young people moving from paediatric to adult services.
- The trust should take steps to ensure that they increase the number of staff who have training in advanced paediatric life support.
- The trust should ensure the maternity delivery suite furniture is fit for purpose and effectively cleaned.
- The trust should ensure variable sizes of blood pressure cuffs are available within maternity services.
- The trust should consider providing a separate sitting room for patients visiting the early pregnancy assessment unit (EPAU), to ensure their privacy is protected.
- The trust should continue to address the backlog of outpatient follow-ups.
- The trust should ensure that imaging managers complete the review of all local policies and procedures so that staff have access to up to date information and guidance.
- Imaging managers should continue to replace ageing equipment based on prioritisation and risk.
- The trust should undertake a review of the outpatient and diagnostic areas at Ripon hospital in relation to IPC risks of issues such as a lack of no-touch taps at clinical hand wash basins and rusty handrails in the disabled toilet.
- The trust should review arrangements for anticipatory prescribing with the aim of reducing the number of occasions families needed to access medicines out of hours.
- The trust should consider whether their laryngoscope handle decontamination process addresses all the likely infection risks.
- The trust should ensure that staff have considered the requirement for a DNACPR review and ensure they are in place if needed.

## 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><b>How the regulation was not being met:</b> care was not always provided in a safe way as for some specific services there was limited evidence of: assessment that the that the environment on Woodlands ward was appropriate for children and young people with mental health needs; ensuring the facilities in the mortuary were fit for purpose; medical devices being serviced in line with recommended guidelines; ensuring that all medicines were stored safely and were disposed of when out of date; ensuring that good infection protection and control practices were adhered to on medical wards.</p> <p><b>The trust must:</b></p> <ul style="list-style-type: none"><li>• take steps to ensure that the environment on the Woodlands ward is appropriate to allow the needs of children and young people with mental health needs to be fully taken into account. In addition, the trust must improve the facilities in and access to the mortuary. Reg 12 (2)(d)</li><li>• ensure medical devices are subject to servicing in line with recommended guidelines. Reg 12(2)(e)</li><li>• ensure that all medicines are stored safely and are disposed of when out of date. This particularly applies to oxygen cylinders and drugs on the emergency trolleys in the hospital Reg 12(2)(g)</li><li>• ensure that good infection protection and control practices are adhered to particularly on all medical wards. Reg 12(2)(h)</li></ul>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p>

## Requirement notices

How the regulation was not being met: systems were not operated effectively in some services to ensure that guidelines and protocols were up to date and in some services not all records were kept in line with professional standards or stored securely.

The trust must:

- ensure guidelines and protocols are up to date and there is an effective system in place to review these in a timely manner particularly in maternity and gynaecology; radiology. Reg 17(2)(a)
- ensure that accurate nursing records are kept in line with professional standards particularly in urgent and emergency services and that medical records are stored securely in services for children and young people and within the mortuary area. Reg 17(2)(c)

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met: there were not always sufficient numbers of suitably qualified, competent and skilled staff particularly in medicine, end of life care and children and young people and not all staff had received the required mandatory training and appraisals.

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 particularly in medicine, end of life care and children and young people. Reg 18(1)
- ensure all staff have completed mandatory training, role specific training and had an annual appraisal particularly: appraisal rates within maternity and gynaecology; mental health training for paediatric staff and; safeguarding training in both community and acute services for children and young people. Reg 18(2)