Bradford Teaching Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Bradford Teaching Hospitals NHS Foundation Trust is an integrated trust, which provides acute and community health inpatient services. The trust serves a population of around 500,000 people from Bradford and surrounding area. The trust has around 900 beds and employs approximately 5,500 staff. The acute services are provided in two hospitals, Bradford Royal Infirmary and St Luke's Hospital. The trust provides urgent and emergency care, medical, surgical, maternity, critical care and children's and young people's services at the Bradford Royal Infirmary site. Outpatient services are provided across both acute sites.

The community health inpatient services in Bradford are provided in three community hospitals; these are Westwood Park, Eccleshill and Westbourne Green. The community hospitals form part of the elderly care directorate and provide a less acute environment. These services are aimed at avoiding the need for patients to be admitted to an acute hospital for rehabilitation and restoring functional abilities following an acute hospital stay.

At the time of this inspection Eccleshill was temporarily closed. At the previous inspection in October 2014, Westbourne Green had been closed; as this was now open we visited this hospital and Westwood Park Community Hospital as part of this follow up inspection.

We carried out a follow up inspection of the trust between 11 – 14 January 2016 in response to the previous inspection as part of our comprehensive inspection programme in October 2014. We also undertook an unannounced inspection on 26 January 2016 to follow up on concerns identified during the announced visit.

Focussed inspections do not look across a whole service; they focus on the areas defined by information that triggers the need for an inspection. We therefore, did not inspect all the five domains: safe, effective, caring, responsive and well led for each core service at each hospital site. We inspected core services where they were rated requires improvement or inadequate. We also checked progress against requirement notices set at the previous inspection due to identified breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the October 2014 inspection, we issued a number of notices, which required the trust to develop an action plan on how they would become compliant with regulations. We reviewed the trust's progress against the action plan as part of the inspection.

We inspected all eight core services at Bradford Royal Infirmary (BRI), although not all domains within each service. We also inspected medical services and outpatients at St Luke's Hospital. We inspected the community health inpatient services at Westbourne Green and Westwood Park Community Hospital.

Since the last inspection there had been change and development in mainly three areas-

- Leadership
- Internal and external relationships, including partnership development
- Governance arrangements

Changes had taken place in leadership across all levels, including the executive team and throughout various management posts. An improvement plan had been introduced by the leadership team designed to address the challenges faced by the trust, some of which were historical, some driven by increasing demand on services and some externally generated through review and regulatory requirements. In parallel with the improvement programme was recognition that the trust was facing financial challenges and forecasting a deficit of around £7 million. This was in the main as a result of agency costs and underperforming against quality improvement targets. Therefore, working more efficiently and effectively was also seen as a key challenge.

The trust had committed to improving engagement both internally with staff but also externally with other stakeholders, patient groups and the general public. The trust had increased engagement with staff groups. More communication was taking place, from weekly Chief Executive bulletins to consultation with staff groups on shaping the future of the trust. There had been a strategy review, which had commenced with increased local and regional engagement. Greater collaborative working had taken place, particularly around integrated ways of working. The trust was exploring new models of care and

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better integration opportunities through the West Yorkshire Association of Acute Trusts. The trust was leading the 'Well North' initiative aimed at improving health across some of the most deprived areas in the north of England.

We saw an improving picture across the trust regarding leadership development and arrangements. There had been a revision of the governance systems across the trust from changes to the board assurance framework to arrangements on wards and in departments. There remained some fundamental issues such as the idenfitication of inconsistent practice at ward level that led us to believe that the assurance processes still need time to embed and become fully effective. It was too early to assess whether they would deliver the intended improvements in Trust Board assurance.

We had serious concerns about the reconciliation of medication, the monitoring of refrigerators used to store medications; the monitoring of resuscitation equipment and record keeping within the urgent and emergency care service. We wrote to the trust with our concerns and were given assurance that improvements were made immediately and that systems had been changed so that there were mechanisms in place to ensure effective monitoring took place.

Our key findings were as follows:

- The trust was in the process of constructing a new hospital wing, which would enable the critical care unit to re-locate to a new 16 bed unit, accommodate a 56 bed paediatric unit, including high dependency and stabilisation suites." In addition a 31 bedded dementia friendly elderly care ward will also be provided. This will link across on the same level to an existing dementia friendly elderly care ward which has 28 beds. The wing was due to be open in November 2016.
- The new wing would address many of the issues with the hospital environment identified in the previous inspection and the trust had commenced a full condition survey of the remaining estate. The trust was also in the process of redeveloping the urgent and emergency care department and gastroenterology service.
- The new hospital wing represented £28 million of a £75 million investment in improving the hospital estate over the next five years. In the interim, the trust had taken action to address some of the issues with the environment, particularly critical care. However, wards 7, 9 and 15 remained very cramped with limited space around beds. We were concerned that in an emergency situation this would present a challenge.
- The facilities and layout within the urgent and emergency care services (ED) was no longer sufficient or appropriate for the increasing demand on the service. Concerns continued over the lack of side rooms, which limited access to isolation facilities and the layout of reception did not protect patients' privacy and dignity. The lack of side rooms also impacted on patient flow from ambulance arrivals. There was a cubicle for patients with a mental illness, but this was not a dedicated facility and was not suitable for its purpose.
- We found that there had been improvements in some of the core services and this had resulted in a positive change in the overall ratings from the previous CQC inspection, notably incritical care services and outpatients and diagnostic and imaging.
- However, the ratings remained the same in urgent and emergency services, medicine and surgery. This was because we either did not see significant improvement since our previous inspection or because we identified new areas of concern.
- In relation to outpatient services, the trust had taken the necessary steps to ensure that the backlog of over 250,000 patient pathways on the non-referral to treatment pathway had been clinically reviewed and actions taken to reduce risks to patients, including prioritising appointments and the assessment of potential harm. An improvement plan had been developed and systems and processes had been changed. The trust had revised executive, clinical and managerial leadership arrangements for outpatients and invested in additional administrative staff and a rolling programme of staff training.
- However, the new systems and processes had not yet been embedded within the outpatient service and further work was required to establish the new

Summary of findings

centralised patient booking system. Staff did not feel engaged with the changes and expressed frustration at the new systems. There were still a large number of patients waiting for outpatient appointments and there was a downward trend in referral to treatment times, which could delay access to treatment.

- The trust had taken action to address some of the staffing concerns identified in our previous inspection. An integrated patient acuity monitoring system had been introduced to assess patient acuity and staffing levels on a daily basis. Nurse staffing levels had been reviewed across the trust and in December 2015 the Board of Directors approved a £2.5 million investment in staffing.
- Staffing levels and skill mix had improved since our previous inspection. However, nursestaffing levels did not always meet best practice guidance across the ED, medical services, surgical services, theatres (including the obstetric theatres), maternity services and children's and young people's services.
- Governance and assurance arrangements had been reviewed since the last inspection. However, we found that these were not robust enough to identify issues relating to issues such as medicines storage, medicine reconciliation and gaps in records in the ED. There was inconsistent daily checking of equipment such as resuscitation equipment in the ED and maternity services, which was not in line with the Resuscitation Council (2005) guidance.We wrote to the trust to ask for information about how they would address our concerns. The trust provided us with assurance that they were addressed promptly and we have seen evidence to support this, for example medicines reconciliation rates are now above the trust's target. The trust has developed a robust plan to improve the quality of records in ED.
- Our previous concerns about the safety of children who were cared for in the stabilisation room pending transfer out had largely been addressed. There were suitably qualified and trained staff to support critically ill children until the paediatric transfer team arrived. The service had been reviewed by the Royal College of Paediatricians and Child Health in August 2015 and an action plan had been developed to address the recommendations made in this report.
- Our previous concerns about the care of patients requiring non-invasive ventilation (NIV) had been addressed. Patients requiring NIV were now grouped together in the respiratory unit on ward 23 and the service was compliant with British Thoracic Society Standards.
- There was a dedicated infection prevention and control team with arrangements in place to prevent the spread of infection. However, we observed staff not following infection prevention and control practices on a number of occasions. The Methicillin-resistant Staphylococcus Aureus and Clostridium difficile rates for the trust were above the England average for the period August 2014 to August 2015.
- Policies and procedures were not always up-to-date. We saw policies and procedures that were past their review date and in critical care some of the policies did not refer to current guidance and standards.
- The trust used the five steps to safer surgery process in the operating theatres to improve patient safety and reduce the risk of clinical incidents. The five steps included the use of the World Health Organisation surgical safety check list. However, we observed patients receiving surgery when the surgical safety checklist process had not been followed. This meant there was a risk that safety issues might not be identified before a procedure took place.
- There had been changes in the leadership and the management structure in children's services, which had established a children's board. There were clear governance structures to report to the Trust Board.
- There was an improved culture in relation to incident reporting and feedback with learning from incidents across most services in the trust. However, there were inconsistencies within the operating theatre department.
- Figures from May 2015 indicated no evidence of risk for the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI). There was one open mortality outlier for peripheral visceral atherosclerosis.

Summary of findings

- Improvements had been made within the urgent and emergency care services (ED) in a number of areas such as the initial streaming of patients, access for children's emergency services and effective learning from incidents.
- Generally documentation was found to be of a good standard across core services with risk assessments completed. However, within the ED, we found inconsistent recording in patient records; some were incomplete, lacking key safety and essential information such as completed pain scores and national early warning scores. This exposed patient to the risk of avoidable harm as clinicians may not have the necessary information to ensure appropriate care and treatment could be given in a timely manner.
- The nutrition and hydration needs of patients were attended to and generally well documented.
- There were systems in place for the safeguarding of adults and children. Training in safeguarding adults and children was part of the mandatory training programme. Not all staff had completed the appropriate levels of training appropriate to their roles.
- Staff demonstrated a good knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and decisions were generally appropriately documented in patients' records, although needed further embedding in practice.
- Overall figures for the completion of mandatory training had improved, for some courses such as basic life support and adults and children's safeguarding Level 2 and Level 3 were below the trust target of 95% in medicine. Appraisal rates for staff were low in some areas.
- Paediatricians ran a rapid access clinic from the child development centre, which provided clinical assessment to prevent admission where possible and to support early discharge home.
- End of life services were effectively planned, designed and delivered, including spiritual and the diverse needs of patients. There was timely access to assessment, diagnosis, treatment and care.
- Community health inpatient services were provided across three community hospitals. The services had made improvements since the last inspection in 2014. Nursing staffing levels had increased based on patient acuity and medical staff arrangements had been reviewed and formalised.

We saw several areas of outstanding practice including:

- The trust was collaborating with another local trust to work towards recruiting and retaining a workforce that reflected the 35% black, Asian and minority ethnic (BAME) population in the Bradford area. Between June 2014 and September 2015, the trust had improved the BAME representation on the Trust Board of Directors from 0% to 29%.
- The trust was leading the 'Well North' programme, which was a collaborative programme aimed at improving the health of some of the poorest communities in the most deprived areas in the North of England.
- The Bradford, Airedale, Wharfedale and Craven Managed Clinical Network of Specialist Palliative Care had won the British Medical Journal, 'Palliative Care Team of the Year' award in 2015.
- The trust had performed better than the England average for all indicators in the 2015 Hip Fracture Audit.
- The trust had engaged with staff and the public to contribute to the design of the new building to create an environment which was reflective of the needs of local children's and families.
- The Bradford Learning Disability Eye Service had brought together community health, hospital eye services, education teams, patients and carers to improve access to ophthalmic services for people with a learning disability. The trust won VISION 2020 UK's Astbury Award for excellence in collaboration in eye care.

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

Importantly, the trust must:

Summary of findings

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

Information on what the trust should do in addition to the above can be found in the individual location reports.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Bradford Teaching Hospitals NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust is an integrated trust, which provides acute, community in-patient and children's health services. The trust serves a population of around 500,000 people from Bradford and surrounding area. The trust has approximately 900 acute beds and employs around 5,500 members of staff. The acute services are provided in two hospitals, Bradford Royal Infirmary (BRI) and St Luke's Hospital. The main acute services, including the urgent and emergency care services are concentrated within the BRI site, whereas St Luke's Hospital generally specialises in rehabilitation and step down services. The trust has three community hospitals: Westwood Park, Westbourne Green and Eccleshilll

The urgent and emergency care services based at BRI received 131,243 attendances in 2015, on average 360 patients were treated each day with around a quarter leading to an admission to the hospital. Almost a quarter of patients seen in the department were children. The nearest major trauma centre was in Leeds.

The BRI had 12 medical wards including an elderly acute assessment unit, an acute medical unit and a discharge lounge. The medical division included a number of specialties including general and acute medicine, care of the elderly, cardiology, respiratory medicine, renal medicine, diabetes and endocrinology medicine, oncology, haematology, neurology, stroke care, emergency medicine, infectious diseases/HIV, rheumatology, dermatology and palliative care. The were 13 wards providing a range of surgical services. There were twenty operating theatres. The critical care services comprised of a 12 bedded ICU/HDU unit.

The trust offered a full range of maternity services for women and families from BRI and within the community. The maternity service delivered approximately 5,700 babies each year. Services included specialist care for women who needed closer monitoring and a home birth service. There were six teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics and General Practitioner locations across the city. There was also an integrated women's health unit, which provided a range of treatments for gynaecological problems.

The children's and young people's service included three in-patient children's wards based at BRI. Ward 16 was a 10 bedded medical ward, which included a two bedded stabilisation room and a children's assessment unit with four observation beds. The assessment unit accepted medical referrals from the children's emergency department, direct GP referrals and children with direct access. In addition there was a 25 bed medical ward and a 27 bed surgical ward. At night, the number of beds on this ward was reduced to 16 beds.

End of life care (EOL) services were provided across BRI. The hospital specialist palliative care team (HSPCT) had a clinical and educational role within the trust. The service offered was an advisory one, with the care of the patient remaining with the referring medical team. The HSPCT worked closely with a community palliative care team (from another NHS trust) and local hospices.

The trust provided a wide range of outpatient clinics, predominantly based at BRI and at St Luke's Hospital. Between January 2014 and June 2015, 709,602 patients attended outpatient clinics. Outpatients were managed within the diagnostic and therapeutic division, which included a central patient booking service.

St Luke's Hospital had two medical wards: Ward F6 stroke rehabilitation and Ward F5 care of the elderly rehabilitation. There was also one ward run as a community hospital ward. There was a virtual ward, which had a team that delivered care in the community and aimed to keep patients at home, where possible. The team consisted of nurses, therapists, rehabilitation support workers, an advanced nurse practitioner and medical consultants. The virtual ward had around 55 patients referred to them each month. There was also a community children's service located at this hospital.

Community health in-patient services were provided across three community hospitals: Eccleshill, Westwood park and Westwood Green.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Christopher Tibbs, Medical Director Royal Surrey County Hospital NHS Foundation Trust

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical, surgical and obstetric consultants, a junior doctor, senior managers, nurses, a midwife, a palliative care specialist, children's nurses and an expert by experience, who had experience of using services.

How we carried out this inspection

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

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

As this was a focused inspection we did not look across the whole service provision; we focussed on the areas defined by the information that triggered the need for the focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning

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

We carried out the announced inspection visit between 11 – 14 January 2016 with an unannounced inspection on 26 January 2016. During the inspection we held focus groups with a range of staff including nurses, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also held focus groups with community groups who had experience of the trust services.

What people who use the trust's services say

The NHS Friends and Family Test (FFT) results between August 2014 and July 2015 indicated the percentage of patients who would recommend the trust's services was consistently better than the England average each month in this period.

The Care Quality Commission In-Patient Survey (2014) asks questions such as ; 'Did a member of staff answer your questions about the operation or procedure?'; 'Did you feel you got enough emotional support from hospital staff during your stay?' and; 'Did doctors talk in front of you as if you weren't there?' The results showed this trust scored about the same as other trusts for all questions.

The Patient Led Assessments of the Care Environment (PLACE) showed the trust scored better than the England average from 2013-2015 in each of the four areas rated; cleanliness, food, facilities, privacy and dignity and well-being.

Summary of findings

The Cancer Patient Survey (2013/14) results showed the trust scored in the middle 60% for 29 out of the 34 questions (similar to other trusts). Five questions scored in the bottom 20% of trusts. These were: 'Patient given the name of the CNS in charge of their care', 'Patient had confidence and trust in all doctors treating them'; 'Nurses did not talk in front of patients as if they were not there'; 'Hospital staff did everything to help control pain all of the time'.

The number of written complaints received by the trust in 2013-14 was 553 with 550 received in 2014-15. Data received from the trust for the period between August 2014 and July 2015 showed the most common complaint subjects included: aspects of clinical treatment (53%); appointments, delay/cancellation - out-patients (17%) and attitude of staff (12%).

Healthwatch – information was received from the local Healthwatch organisation following a survey of public views and experiences. Of 374 response 192 were classed as concerns/complaints – general themes were around waiting times in outpatient clinics, communication, aspects of clinical treatment and car parking. 143 were compliments with general themes of good outreach services, cancer services and individual care experiences. 39 comments were classed as points of view with similar themes as above.

External Focus Groups – we held four focus groups to capture the views of the local community groups. We spoke with 21 women and 16 men.

Positive themes - notes were available in out-patients at appointments and outpatient information on letters in other languages; notes and interpreters available at out-patient appointments; hospital and clinics cleanliness; good service in the prayer room; care on ward 12, on paediatrics and the stroke unit; excellent care and treatment from cancer team, good care and treatment from diabetic team and eye clinic.

Negative themes – waiting in emergency care and outpatients, delays in outpatients and not informed of clinics running late; long time to wait for an outpatient appointment; delays with appointment letters; difficulties in cancelling or rearranging appointments; appointments made not always on the system when attend clinic; car parking, people not aware of how to make a complaint, staff busy, some staff attitudes; delays in answering call bells, delays in accessing pain relief and no information in other languages.

Facts and data about this trust

Bradford Teaching Hospitals NHS Foundation Trust is responsible for providing hospital services to a population of around 500,000 in Bradford and in a growing number of specialities, for communities across Yorkshire. There were approximately 5,500 staff.

The health of people in Bradford is generally worse than the England average. Deprivation is higher than average and around 23.9% (29,225) of children live in poverty. Life expectancy for both women and men is lower than the England average. The Bradford area has a higher than average proportion of the population who are under 16 years old. The black, Asian and minority ethic (BAME) population is higher than the England average, with 32.7% BAME residents compared to an England average of 14.6%.

The trust became a foundation trust on 1 April 2004.

The trust has around 900 beds and operates over the following sites:

- Bradford Royal Infirmary
- St Luke's Hospital
- Westbourne Green
- Westwood Park Community Hospital
- Eccleshill Community Hospital

Finances (December 2015)

Revenue £369 million

Full Cost £376 million

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? There had been improvement in the trust since the last inspection. Staff were aware of incident reporting and the Duty of Candour. Staff were aware of the Mental Capacity Act 2005 and the deprivation of liberty safeguards. There had been some improvement in staffing levels but there remained some areas where staffing levels did not meet national guidance. There were systems in place to prevent and control infection, but in some areas practices were not always consistent with policy. We had concerns over the how medications were arranged including their reconsilation and also check systems for resuscitation equipment. We drew some of our concerns to the attention of the trust, who took immediate steps to address the issues.	Requires improvement 

Duty of Candour

- The duty of candour regulation ensures that providers are open and transparent with people who use services in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, truthful information and an apology when things go wrong.
- The trust had a Duty of Candour policy in line with the requirements of the Health and Social Care Act 2014 and staff were aware of this and the trust's approach of being honest and open.
- The trust had a monitoring process in place to identify when breaches of the regulation had taken place and take appropriate action. Four breaches were reported to the performance committee in September 2015, which had been escalated to the corporate risk register.
- The trust used its electronic reporting system to report and record incidents, including where the Duty of Candour applied. Each incident was investigated using Root Cause Analysis (RCA) to establish the factors leading up to the incident and what learning would result from this. The process involved the patient concerned and the giving of an apology.
- Within each directorate, the matron was responsible for ensuring staff were aware of their duty of candour. Staff were able to give examples of were the duty of candour had been applied, including the giving of an apology to patients following an incident.

- We reviewed a number of incidents, root cause analysis investigations and complaints and found examples of the duty of candour in operation.

Safeguarding

- The trust had a safeguarding strategy in place, with appropriate policies and procedures for safeguarding adults and children. The chief nurse was the executive lead for safeguarding. Annual reports were presented to the Trust Board giving an overview of adults and children's safeguarding activities. The annual safeguarding children report (2014-15) highlighted that there had been a significant increase in the work and activity relating to safeguarding children during the financial year.
- There was a safeguarding team whose role it was to ensure the trust's safeguarding practices met current regulations and to provide support and training to staff. These included a head of safeguarding, a named nurse, doctor and midwife for safeguarding. The team oversaw safeguarding issues such as child protection assessments, training and working with other agencies.
- The trust had reviewed its safeguarding arrangements and identified it had a shortfall of two band 7 training and liaison posts, a named midwife post and a shortfall of 0.8 hours for paediatric liaison in the ED. As a result of the review, there had been an investment in the safeguarding team and recruitment was underway.
- The trust had developed an action plan in response to the recommendations following the Jimmy Savile Inquiry (2014-2015), which related to the arrangements in place for managing visits by celebrities, VIPs and other official visitors. A draft policy had been prepared; all wards and clinical areas maintained a sign in book to record visits by company representatives and external official visitors. The policy was due for approval and sign off by the clinical executive group in January 2016.
- As part of the response to the Savile Inquiry, the trust had reviewed its voluntary services arrangements. There was a policy in place and all volunteers recruited underwent a Disclosure and Barring Service (DBS) check (formally known as Criminal Records Bureau check) and a trust induction. There were employment checking processes in place for the recruitment of permanent staff and locum staff. Work was in progress through the workforce improvement programme to centralise all agency bookings overseen by the human resources department; a business case was progressing with a target date of April 2016.

- There was a mandatory training framework in place, which included safeguarding training for staff and volunteers. A policy was out for consultation regarding the induction and training for agency staff. The outcome to this was expected by 1 February 2016.
- At the October 2014 inspection, there had been concerns over the numbers of staff completing the mandatory safeguarding training, particularly those required to undertake Level 2 and Level 3. At this inspection we found that there continued to be staff across some core services who had not completed the appropriate safeguarding training relevant to their role. It was reported that the impact of staff shortages and access difficulties for some staff meant that although there was training available, not all staff could attend.
- The trust target for safeguarding training was 95%, however, for Levels 2 and 3 in adults and children's safeguarding there remained shortfalls. For example, at the BRI in medicine, for Level 2 adult and children's training there was 56% completion, for Level 3 in children's training there was 52% completion. The completion rate in surgical services for adult and children's safeguarding was 68% for Levels 2 and 48% for Level 3. The trust was aware of shortfalls, for instance concerns had been identified at the previous CQC inspection in October 2014 for Level 3 training in children and young people's services; the children's safeguarding annual report (2014- 2015) identified a completion rate of 63% by May 2015. The trust developed a strategy to improve the situation, this was progressing. In addition to training actions had been put in place to improve other aspects of safeguarding activity, for instance, access to safeguarding supervision for staff had increased by 50%; 360 staff had received supervision in 2014/15, against 170 staff the previous year.

Incidents

- Between November 2014 and December 2015 the trust reported two never events: one wrong site surgery and one where a throat pack was not removed following oral surgery. There were 52 serious incidents, 24 of which were Grade 3 pressure ulcers. There were no discernible trends for pressure ulcers, falls with harm or catheter acquired urinary tract infections.
- There were 9,450 incidents reported to NRLS between November 2014 and December 2015, 73% resulted in no harm. The trust had 7.2 incidents per 100 admissions; this was below the England average at 8.4. The NRLS reports showed the Trust to be within the top 25% of reporters within its peer group

Summary of findings

- The trust had a serious incident and never event policy, which outlined the responsibilities of the trust in managing incidents and to support staff in learning from incidents. This included recognising mistakes made and making changes to practice and policy to ensure that there was no repeat of the events leading up to the incident.
- The trust held weekly quality of care panels so that executive directors could review all incidents that met the reporting threshold for serious incidents.
- Since the last inspection, the trust had introduced safety huddles to ensure that feedback on incidents was captured daily and discussed by senior nursing staff.
- Most staff understood their responsibilities to raise concerns and report incidents or near misses. Incidents were reported on the trust electronic system. Where incidents occurred, staff were involved in the investigation and findings were shared.
- The NHS Staff Survey (2015) rated the trust at 33% for staff witnessing potential harmful errors and near miss incidents; this was worse than the England average of 31%.
- Staff reporting potential harmful errors and near miss incidents in the same survey showed a rate of 90%, this was the same as the national average and had improved on the trust's performance in 2014 survey, which was 88%.
- Staff reported that lessons from incident reports were shared with them, although there was inconsistency with individual feedback on reporting. However, we found that learning from incidents was not fully embedded in the operating theatres. There had been a never event in surgery, which had identified that improvements were required with applying the World Health Organisations Five Steps to Safer Surgery Safety Checklist. We found that there continued to be inconsistent implementation of the safety check list and not all staff were aware of the changes to practice following the never event investigation.
- There was a single centralised service for all staff training, including mandatory and specialised simulation. Real incidents were used for scenario training to promote shared learning. Training included Human Factors with DVDs of actual incidents. Examples of lessons learnt and actions taken included checking pressure areas around the nose when nasal oxygen was administered and working with the improvement academy on ward 29, where there had been a high incidence of falls. In maternity services, guidelines had been updated for when women should have foetal monitoring following induction.
- Serious incidents were investigated using a root cause analysis and included incidents for pressure ulcers that met the incident

criteria. Since March 2015 there had been a change in the reporting of pressure ulcers to include grade 3 as well as grade 4. This created an increase of reporting by 50 cases up until November 2015, although the overall trend was reducing. For example in medicine from December 2014 to November 2015, 12 grade 3 pressure ulcers had been reported, but none from April 2015.

- With pressure ulcers, the ward sister would lead the investigation and the outcome would be presented to the pressure ulcer panel each month, including a review by the tissue viability nursing team. Training was provided to staff on the prevention and care of pressure ulcers and the trust followed the "think skin – react to red" campaign. There were pressure ulcer champions across ward areas and monthly meetings took place to update and report on practice issues.

Staffing

- The trust had taken action to address some of the staffing concerns identified in our previous inspection. However, the trust continued to experience staff shortages, particularly in ED, medicine and children's services. Staffing levels regularly did not meet best practice and national guidance. We were not assured that the trust was providing sufficient trained staff to meet the British Association Stroke Services Standards (2014) on the hyper acute stroke unit. There should be a ratio of 1 qualified nurse for every 2 patients in the first 72 hours of an acute patient admission. This had been escalated as a risk on the corporate risk register. We raised this with the trust and were assured that staffing levels were safe at the time of the inspection.
- The trust had introduced a workforce report, which was presented to the quality and safety committee. The report addressed workforce issues in one meeting. The report dated 15 October 2015, showed that there were a total of 5563 staff in post with a 13.03% staff turnover. Bank staff usage had been 259.58 full time equivalents (FTE) and agency usage had been 285.85 FTE.
- By August 2015, the year to date sickness percentage was 5.31%.
- As of 21 September 2015, the nurse vacancy rate in surgery and anaesthesia was a total of 12.07%, with 14.21% unregistered (bands 2/3/4), 12.62% band 5, 12.35% band 6. In medicine the nurse vacancy rate was 15.53% with 12.70% unregistered, 21.74% band 5 and 6.88% band 6. For children's services the vacancy rate was 4.79%, with 1.45% unregistered, 13.83% band 5 and 0.62% band 6.

Summary of findings

- An integrated patient acuity monitoring system had been introduced to assess patient acuity and staffing levels on a daily basis. In maternity services the trust had adopted the Birth-rate Plus tool, which calculates the number of clinically active midwives required to deliver a safe, high quality service. Nurse staffing levels had been reviewed across the trust and in December 2015 the Board of Directors approved a £2.5 million investment in staffing. This included funding for 11 whole time equivalent (WTE) nurses in ED.
- Reports were presented to the board on safe nurse and midwifery staffing levels based on the Safer Nursing Care Tool, in line with NICE guidance the report detailed a retrospective analysis of staffing levels day by day and for each ward at each site. Planned and actual staffing levels were displayed in ward and department areas across the trust.
- The chief nurse had weekly confirm and challenge meetings with senior nurses as part of the planning process. Staffing levels were risk rated - red, amber or green (RAG rated), these showed the planned numbers of staff and the actual numbers. To cover shortages staff were moved from other areas in the hospital; bank and agency staff were used.
- Nursing vacancies, recruitment and retention plans had been drawn up following discussions with the chief nurse office, heads of nursing and education. Initiatives included targeting overseas nurses already working in unqualified roles and the development a band 4 healthcare support worker role.
- The trust had recruited 45 overseas nurses; the first group were due to start in January 2016.
- The board of directors meeting on 12 November 2015 reported that for staff in post overall numbers had increased by 43 full time equivalents (FTE) with the largest increase in the administrative and clerical staff group (19 FTE) in the central patient booking service.
- At the previous inspection in October 2014, concerns were raised about the out of hours medical cover at St Luke's Hospital and the management of the deteriorating patient. At this inspection we found that all staff had a good understanding of the arrangements for medical cover out of hours. The trust had also commissioned an external review of medical staffing at St Luke's and had concluded the medical cover was adequate for the service.
- From November 2014 to November 2015, the medical skill mix was better than the England average with 43% consultants in

post compared to the England average of 38%. There was 33% registrars in post, which was slightly lower than the England average of 39%. The use of medical locums had increased from December 2014 to December 2015.

There were a number of consultant vacancies within the trust. There were two oral and maxillofacial consultants' vacancies. Due to the difficulty recruiting to these posts and the impact on the delivery of service, this was escalated as a risk on the corporate risk register. The service did not have a full middle grade tier in maxillo-facial surgery. However, the trust implemented a middle grade tier in September 2015.

Infection Prevention and Control

- The Methicillin-resistant Staphylococcus Aureus and Clostridium difficile rates for the trust were above the England average for the period August 2014 to August 2015.
- The trust had three MRSA cases attributed to it for the 2015/16 year until January 2016 and 13 cases of Clostridium difficile – the national 2015/16 threshold was 51.
- There was an infection prevention and control (IPC) programme in place, with a dedicated team to support staff with practice, surveillance and training. The IPC team comprised of a director of infection prevention and control (DIPC), three microbiologists, a lead infection control nurse, four nurses. There was an IPC committee, which met every 2 weeks and a Clostridium difficile scrutiny panel. The IPC staff reported that there was generally good engagement with staff.
- There was an audit programme with monthly/ two monthly audits and spot checks. The trust had an MRSA screening programme,
- Infection prevention and control training was part of the mandatory training programme. There were challenges with attending training. There was mixed completion rates with some nursing and medical groups achieving only 75%, whilst others were above the trust target, for example the nursing and medical staff in ED.
- In the October 2014 inspection, it was highlighted that one of the major challenges facing the trust was the lack of isolation facilities; this was particularly noted in critical care and ED. There was also a lack of access to handwashing facilities. Improvements had been made to critical care with regard to access to washing facilities but this remained a challenge in some areas such as the infectious diseases ward. The trust was

in the process of constructing a new wing due to be open in November 2016. It was envisaged that this would alleviate many of the issues over isolation facilities and hand washing facilities in the BRI.
- In the meantime, it was particularly important to ensure that infection prevention and control practices amongst staff mitigated any risk due to facility constraints. We found that not all staff were complying with IPC practices, including handwashing and PPE putting patients at risk from infection.
- There had been antibiotic audits of documentation, stop dates, appropriate use and induction. The trust had found a 50 – 75% improvement in prescribing practices.

Records

- The trust was in the process of moving to an electronic patient record system, which was expected to transform the way the trust managed health information.
- Generally records across most areas were appropriately completed, including national early warning scores and risk assessments.
- However, this was not the case in the ED where we found that for 30 sets of patient notes, including 10 paediatric patients, there were omissions from notes in four cases where the name and grade of staff member assessing patient was not recorded. Pain scores were not documented in 15 sets of notes, where the presenting complaint would make pain recording appropriate. National early warning score or clinical observations were not complete in ten sets of notes. There was no record of consent requested or gained in any of the notes reviewed. Of the 30 sets of notes reviewed, 16 did not have key times recorded such as assessment time, time seen by doctor and time discharged.
- Notes were not always legible and there was a high use of acronyms and abbreviations. This could make it hard for other clinicians to review notes, and understand what had been recorded.
- Allergies were not recorded in six of the 30 patient notes reviewed. This put patients at risk because they may be administered medicines which may cause harm or not receive appropriate treatment.
- Risk assessments were not routinely recorded for falls, pressure ulcers or nutrition and hydration. Only two of the 30 records made reference to risk assessment of these areas.
- In the Ed, we also found that patient confidential information regarding victims of domestic violence were not securely stored.

Medicines

Summary of findings

- The pharmacy team had the responsibility of achieving the trust target of 75% of patient medicines being reconciled. The average figure for April 2015 to September 2015 was 30.7%. Medicine reconciliation is the process of creating the most accurate list of a patient's medication to ensure what should be prescribed is prescribed. We wrote to the trust who took immediate action to address this and strengthened the assurance processes. The latest results (March 2016) were shared with us and show significant improvement with 85% of medicines reconciled.
- Medicines were not always stored safely and securely, particularly in the ED. Controlled drugs were appropriately stored with access restricted to authorised staff. However, there were omissions in controlled drug books in several instances for dosage administered. Daily balance checks were performed in line with the trust policy.
- The temperature of refrigerators used for storage of temperature dependent medicines and in maternity the milk fridge were not consistently monitored. There were gaps in checking and we found where there were issues of temperatures being outside of the required ranges that escalation had not taken place nor had pharmacy advice been sought to ensure medicines within the refrigerators were still fit for use. We escalated concerns to the trust who took immediate action and put in arrangements to ensure that this issue was addressed and improvements sustained
- In ED, we were told that Patient Group Directions (PGDs) were in use by some nurses, but no signed copies were available in the department. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We spoke with a senior staff member who was unsure what medicines were currently covered by a PGD and could not provide us with a list of staff who were authorised to administer them by PGD. This did not meet the trust policy for PGD management.
- Within the major incident cupboard in ED, we observed a large quantity of out of date drugs in a controlled drugs cupboard, including some that had expired in January 2013. The alarm in this controlled drugs cupboard had been disabled. We found a drugs trolley which contained a variety of drugs, some of which were out of date. We found fluids that were out of date in backpacks that would be taken to the scene of major incidents. We raised these issues at the time of the inspection and the

trust acted immediately and we were informed that these drugs were not used and the cupboards and drugs contained in them were condemned and were disposed of as a result of our inspection.

Are services at this trust effective?

Good

We found that the trust was following national and best practice guidance for the care and treatment of patients. Generally care and treatment was audited with action plans put in place where improvements were required. Pain relief was administered effectively and patient's nutrition and hydration needs were being met. There was good multidisciplinary team working. However, not all policies and procedures had been reviewed and the latest national guidelines were not always referenced within documents.

Evidence based care and treatment

- We found that care was given in accordance with national and evidence based guidelines such as the National Institute of Clinical Excellence (NICE). For example, the medical service used sepsis and acute kidney injury bundles; these were often commenced when the patient first arrived in the ED.
- Medical services had recently implemented patient group directives for MRSA suppressive treatment and adrenalin to be used in an emergency.
- However, we found that there were examples of poor policy and document control, including a lack of version control or review dates. We found four policies in medical care and 11 policies in critical care services out of date. We did not see any evidence to suggest that the care and treatment was not in line with current guidelines, but not all the policies and procedures, particularly in critical care had the latest guidance referred in the documentation.
- Monthly audits were completed in medical services by the ward sisters as part of ward assurance documents, these included areas such as dementia and infection prevention. This information was not reported to the Board. However we were told it was discussed at team meetings. If there were particular concerns or trends this would be reported to the chief nurse through the matrons.
- Pain relief was available and on the whole patient pain scores were recorded and monitored on the patient record as part of daily routine monitoring. We looked at five patient records in the critical care unit and pain levels were recorded and assessed appropriately.

- Staff were able to access the pain assessment team if they required advice to manage a patient's pain levels. Staff told us the pain team would visit the ward if required.
- Nutrition and hydration assessments were undertaken using the Malnutrition Universal Screening Tool (MUST) score and risk assessment. The MUST record is a means of preventing malnutrition by, for example, recording changes in weight and body mass index. Where appropriate patients were referred to the dietician service.
- The trust was using national early warning scores (NEWS) to assess the deteriorating patient in adults and the paediatric advanced warning score (PAWS) for children. Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary.

Patient outcomes

- The trust had taken part in all mandatory national audits and 94% of clinical audits.
- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. Figures from May 2015 indicated no evidence of risk.
- The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level throughout NHS hospitals in England. The SHMI is represented as a ratio and indicates the number of patients who died following being in hospital, compared to the England average of the number who would be expected to die looking at the characteristics. The figures are represented at trust level and data from May 2015 indicated no evidence of risk.
- The trust was notified in July 2015 that it was a statistical outlier for patients who died with a primary diagnosis of peripheral or visceral vascular atherosclerosis. The trust developed an action plan, which in the main related to coding issues and improvements in primary diagnosis. None of the deaths were deemed avoidable.
- Over the course of the current financial year the trust had redeveloped the governance and assurance structure. Part of this had been the development of a mortality sub-committee which reports to the Quality & Safety Committee, a committee of the Board via the patient safety committee.

Summary of findings

- Mortality and morbidity was now being reviewed across the trust at clinical governance meetings at divisional level. This had been an improvement since the last inspection, although further work was needed to ensure consistency of minute recording.
- The national diabetes audit provides a comprehensive view of diabetes care, measuring it against NICE guidelines and standards. Published data from January 2016 indicated the trust performed better than the England and Wales average for 15 of the 22 indicators. This was an improvement from the 2013 audit. Other areas which were still below the England and Wales average still showed some improvement from the previous audit, for examples staff knowledge.
- In the Sentinel Stroke National Audit Programme (SSNAP) audit, the trust had previously scored at a level 'D', on a scale of A to E, with E being the worst. Data from July 2015 to September 2015 showed this had improved to a 'C'. The rating is based on ten domains relating to different aspects of care delivery for patients experiencing a stroke. The trust had improved in three of these domains. The trust was aware of the areas where further improvements were needed for example; not achieving screening swallows in four hours, and staff sickness impacting stroke responders. We were told by medical staff further funding was being sought to provide additional posts to address some of these issues.
- The Myocardial Ischemia (heart attack) National Audit Project (MINAP) for 2013/2014 showed that the trust scored worse than the England average on three of the measures. The trust had also deteriorated on two of the measures from their previous year's performance.
- The trust's performance in relation to the heart failure audit 2015 showed a significant improvement from their previous year's performance. They achieved the same or better than the England average in eight of the 11 measures.
- The National Hip Fracture Database is a clinically led audit system of care and secondary prevention for patients following a hip fracture. The annual report for 2015 showed this trust had met all the criteria for best practice tariff and this was significantly higher (better) than the average for the Yorkshire and Humber region and the overall average. (Trust score 80.5%, region average 61.5%, and overall average 63.3%).
- The average length of stay for elective patients in the medical division from September 2014 to September 2015 was 2.4 to 5.0 days. For the same time period for emergency admissions it was between 3.8 and 5.1 days. The trust had not identified a threshold for this.

- The standardised relative risk of readmission for elective and non-elective medical patients was slightly higher than the England average. However, for non-elective cardiology 33% more patients were likely to be admitted than the England average.
- Concerns were raised at the comprehensive inspection in 2014 in relation to the management of patients requiring non-invasive ventilation (NIV). Significant improvements had been made in this area.A dedicated unit had been established in February 2015 ensuring all patients were cared for in a designated area. The unit had been subject to an external review looking at the service provision for patients requiring NIV, with recognition and positive comments on the changes in provision and environment. This was supported by a quality assurance audit and a nomination for team of the year within the trust.

Multidisciplinary working

- We observed multidisciplinary working in all areas we visited. Staff reported good working relationships between disciplines.
- We observed a safety huddle on ward 29 with the multi-disciplinary team (MDT) including the ward doctor. Risks on the ward such as staffing, pressure sores and patients who were at high risk of falls were discussed. The discharge coordinator and community staff were also in attendance to discuss patients' discharge plans.
- Staff handovers were MDT focused with reference to the involvement of speech and language therapy and physiotherapy.
- Staff had access to specialist nurses and teams had formed good working relations with departments such as dietetics.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There had been improvements in the assessment of mental capacity in line with the Mental Capacity Act 2005. However, we found that this was not yet fully embedded within the trust as there were still some inconsistencies in the application of the Deprivation of Liberty Safeguards (DoLS). For example we looked at three DoLS applications and found that the documentation had been appropriately completed but the expiry dates had passed on two without a visit from the safeguarding team to decide next steps and one was reported as no longer needed, but this was not stated within the documentation.

Summary of findings

- The Deprivations of Liberties Safeguards (DoLS) formed part of the dementia awareness training.

Are services at this trust caring?
This domain was not reviewed during this inspection.

Good

Are services at this trust responsive?
The trust consulted a wide range of staff and external stakeholders, including patient groups in the development of service plans. A new hospital wing was being built to improve the facilities within critical care, children's and young people's services and medical wards. There were strategies in place to meet individual needs and improvements in progress to respond to people living with dementia or a learning disability.

However, there was further work required on access targets for outpatients, delayed transfers out of the critical care unit and response times for complaints.

Requires improvement

Service planning and delivery to meet the needs of local people

- A new ED unit was planned as the emergency facilities no longer were suitable for the increasing demand and the layout did not comply with today's best practice and national guidance. The trust had consulted with the community, other stakeholders including the ambulance service and the mental health provider as part of the planning process.
- ED provided an afternoon and evening services for conditions that would usually be provided in primary care. GPs were working in the department and the trust was planning to recruit additional GPs to increase capacity of provision.
- The ED operated a virtual ward for patients ready for discharge but waiting for test results or follow up to ease pressure on the emergency department services and be more responsive to patient needs. The department had worked with the local social services, substance misuse and homeless services to develop plans for patients with known risks.
- At the previous inspection, the trust was using the framework, "The route to success in end of life care – achieving quality in acute hospitals" (2010) to develop and pilot a Last Year of Life Project. The project had now been rolled out across the medical division and included a comprehensive education programme aimed at ward staff, senior nurses and clinicians. The programme included training for staff on the use of the

amber care bundle, which provides a systematic approach to manage the care of patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.
- The End of Life Operational Group with clinical and non-clinical representation had developed a policy for Caring for Patients in their Last Days of Life. The purpose of the policy was to support staff in delivering care to adult patients in the last hours and days of life. There was a separate policy for children under the age of 16.
- The chaplaincy team had developed an education and training programme for the trust staff for 2016. The programme included, culture, last days of life, bereavement care and support, diversity awareness, stereotyping, discrimination and the Equality Act. The training of staff meant they would be more aware and responsive to people's cultural and diverse needs when caring for people in the last days of life.

Meeting people's individual needs

- In children's and young people's services, we observed that staff involved patients and relatives when delivering care and worked in a way which was family centred. The unit allowed 24 hour visiting to meet the needs of parents, and there were facilities on all the wards for parents to stay overnight with their child.
- The service had a number of specialist nurses to support patients with long-term or complex conditions, on the wards and in the community. For example, epilepsy, cystic fibrosis and diabetes.
- There was a transition service to support patients aged 15 to 21 years old with complex and continuing physical care needs.
- Staff told us that they had rapid access to child and adolescent mental health services (CAMHS) if there was a patient with mental health needs. We were told that those patients would be seen within 24-hours from the time they were medically fit.
- There had been concerns about the layout of ward 2 and the ability to provide patients and their families with privacy. We saw the layout of the ward had not changed. There was still limited space between beds for patients and their families and this meant there was little privacy and respect for dignity. This would be addressed by a decrease in beds when the new build was completed.
- Surgical lists specifically for children had been established to reduce excessive waiting and fasting times. The length of stay for patients was similar to the national average.

- Weekly ward rounds were held with children's community nurses to support discharge plans for children with complex needs.
- Staff had access to a 24-hour translation service to support patients and families whose first language was not English. However, information was generally in English only.
- Information relating to end of life care and support was available in easy read formats, through use of British Sign Language interpreters and interpreters for people who were not able to communicate in English.
- The trust was planning a new department for multi-faith, chaplaincy services. These included toilet/ ablution facilities to address the environmental issues which had been identified at the previous inspection. As an interim measure, temporary accommodation had been identified to help address the shortfalls and these were to be available for use, by the beginning of June 2016.
- End of life services were effectively planned, designed and delivered to meet the needs, including spiritual and diverse needs of patients who used the service. There were processes in place to ensure patients had timely access to assessments, diagnosis, treatment and care.
- There was a critical care outreach team who would come and support ward staff if a patient was deteriorating.
- In end of life care, patients on the Gold Standards Framework continued to have access to 'The Gold Line.' This was a dedicated service using tele health for patients and carers, which could be accessed as an alternative to phoning 111, when the GP surgery was closed, or if patients were finding it difficult to get help during the day and required advice. A senior nurse staffed the Gold Line service, which was available 24 hours a day, seven days a week.
- The hospital specialist palliative care team aimed to respond to urgent referrals on the same day, or within one working day and saw routine referrals within two working days. Figures for the last 12 months showed on average patients who received an urgent referral were seen on the same day. Data for July to December 2015 showed that 9% of patients died in hospital, and 91% of patients were discharged and achieved their preferred place of death.
- The trust had a strategy in place for supporting people with a learning disability, which included liaison with a local learning disability support team. The chief nurse was the lead for learning disabilities at board level.
- The trust had systems in place to alert staff to when a person with a learning disability was to arrive at the hospital. Staff

reported that they would prioritise people with learning disabilities and ensure that decisions would be made involving the person and their carer if appropriate. Staff used a document called 'closing the gap hospital assessment' when admitting patients.

- There was a learning disabilities forum on a quarterly basis. However, it was acknowledged that the trust was unable to track activity around care for patients with a learning disability unless there were safeguarding issues. This meant that the trust was not able to audit the quality of care being given and identify if improvements were needed or where services were meeting the needs of people with a learning disability.

Dementia

- The trust had a dementia strategy in place, with a lead and 70 dementia champions working on ward and in department areas. There was a dementia steering group to oversee progress with developments in the trust and future planning. Refurbishment of some ward areas and corridors had taken place to make them more dementia friendly. Elderly care wards in the new hospital wing were to be designed to be dementia friendly.
- A three day training course was offered to staff covering dementia care, cognitive impairment, and delirium and communications skills. A one day course was also available.
- The trust operated the 'forget me not symbol', which was used to identify patients living with dementia and these were recorded on the ward boards. In addition, the trust's electronic recording system had a field to identify when a patient had a cognitive impairment and/or dementia.
- The trust had introduced delirium monitoring as part of the intentional rounding but it was recognised that there was a need to develop preventative measures and that this required real timeassessment of whether the care they were providing was meeting patients' needs.
- The trust used the 'My life' interactive TV software, consisting of videos, music, games, and quizzes as part of the care provided. This had been rolled out to 20 units across the medicine division. It was reported that this had reduced the need for staff to undertake one to one care of patients and over six months had saved the trust £89,000.
- In ED there was a dementia pathway, with dementia boxes available. The aim was for the patient to see as few staff as possible and to not be moved around the department unnecessarily. Patients were seen as soon as possible to reduce waiting times.

Summary of findings

Access and flow

- Bed occupancy rates had been lower than the England average from quarter 2 2013/14 to quarter 2 2015/16.
- The ED used electronic recording systems to monitor the flow of patients through the department.
- The Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival was consistently met from November 2014 to November 2015. The weekly average was 90.9% and the department fell below this on three occasions during this period and failed to meet the 95% target on 27 occasions.
- The total time spent in the department was consistently higher than the England average. From July 2013 to September 2015 the median waiting time had risen from 150 minutes to 165 minutes (national average peaked at 145 minutes over the same time period). In the last 12 months (September 2014 to September 2015) the total minutes in ED per patient ranged between 150 minutes and 176 minutes. At this time the England average ranged between 135-145 minutes.
- The department had done a lot of work to reduce ambulance handover times since the previous inspection. From the period of December 2014 to July 2015 there had been 6 black breaches (where the time from arrival by ambulance to hand over completion exceeds 1 hour) in the department. The average handover time was 92.54% completed in fewer than 15 minutes between April 2014 and March 2015. The national target is 85%.
- In critical care the capacity of the service to meet demand remained an issue. The bed occupancy for the unit was about 92% and patients were sometimes being cared for in the recovery area in the nucleus theatre because there was not a bed available on critical care. It was unclear if the new unit would be sufficient to reduce the occupancy rates because the number of beds was not being increased.
- There had been no review of unmet demand for beds, which was identified as an action from the previous inspection and quality key indicators reports.
- The service was still not seeing all patients within 12 hours of admission although improvements had been made and processes put in place to mitigate the risk.
- The Intensive Care National Audit and Research Centre (ICNARC) data for April 2015 to June 2015 showed the critical care unit was performing as expected to other similar units for 37 of the reported outcomes including length of stay in all hospital admissions, transfers out and non-clinical transfers out. The service was performing better than similar units for eight of the reported outcomes including discharges out of

hours, early discharges and unit acquired infections in blood (ICNARC). The medical staff now worked one week in seven on critical care and therefore met the Core Standards for Intensive Care Units.

- Delayed discharges of over four hours still occurred in critical care. However, the number of delayed discharges of over four hours had reduced since the last inspection and delayed discharges were better than similar units. Quicker discharges were facilitated by staff attending bed meetings to discuss discharges.
- During this inspection we found there had been a reduction in the number of operations cancelled.For the month prior to this inspection there had been five cancelled operations due to a lack of critical care beds. We looked at the board performance report and found between April and October 2015 that 101 operations had been cancelled due to a critical care or high dependency bed not being available. There had been a reduction in the number of operations cancelled from 24 in June 2015 to 8 cancelled in August and September 2015. However in October 2015, 28 operations had been cancelled due to a bed not being available.
- In children and young people's services, all medical patients were admitted to the children's wards through the children's assessment unit. To facilitate access the surgical ward would admit any overflow medical patients. We were told that the surgical ward was well supported by the paediatricians, for the outlying medical patients (children receiving medical care on the surgical ward) and also for those children receiving surgical care.
- Since the identification of the backlog in April 2015 of around 47,000 non-RTT patient pathways, there had been a steady decrease to around 11,790 patients by December 2015. The trust was working to a base level of around 6,000, which they were aiming to reach by February 2016.
- In November 2015, there were 1,654 patients within the non-RTT process failure position for which an RTT or non-RTT pathway had been completed but the referral remained open with no clinically defined see by date.
- Planned patients waiting more than six weeks past their see by date had reduced from 263 in August 2015 to 66 in December 2015.
- The trust had not achieved the 90% target for admitted RTT performance from April to October 2015. The performance had been trending down and in October 2015 it stood at 76.86%.
- Referral to treatment within 18 weeks for non-admitted patients had been trending downwards since May 2015. The

Summary of findings

performance committee report dated 25 November 2015 stated that between April to October the trust had only achieved the 95% target in May. The performance in October 2015 was reported to be 90.67%.
- The target of 92% for the 18 week incomplete pathway had been achieved and stood at 92.02% for October 2015.
- The number of patients on the RTT total waiting list as of October 2015 stood at 22,087 patients.
- The number of patients waiting less than 18 weeks on the RTT total waiting list as of October 2015 stood at 1762 patients.

Learning from complaints and concerns

- The number of written complaints received by the trust in 2013-14 was 553 with 550 received in 2014-15. Data received from the trust for the period between August 2014 and July 2015 showed the most common complaint subjects included: aspects of clinical treatment (53%); appointments, delay/ cancellation - out-patients (17%) and attitude of staff (12%).
- There had been 544 complaints, 53 had been referred to Health Service Ombudsman Service (13 accepted for investigation) and 3 upheld.
- There were concerns over the delay in the percentage of complaints which were outstanding after 25 days. The chief nurse was working with divisions and engagement with patients to keep them informed of progress was taking place.
- The executive team received weekly reports on numbers of complaints and progress on responses, including information over themes and complexity. The trust was not meeting its target of acknowledging complaints received within three days.

Are services at this trust well-led?

Requires improvement

We saw an improving picture across the trust regarding leadership development and arrangements. There had been a revision of the governance systems across the trust from changes to the board assurance framework to arrangements on wards and in departments. There remained some fundamental issues such as the idenfitication of inconsistent practice at ward level that led us to believe that the assurance processes still need time to embed and become fully effective.

It was too early to assess whether they would deliver the intended improvements in Trust Board assurance.

Changes had taken place in leadership across all levels, including the executive team and throughout various management posts. An improvement plan had been introduced designed to address the challenges faced by the trust.

Summary of findings

The trust had committed to improving engagement both internally with staff but also externally with other stakeholders, patient groups and the general public. The trust had increased engagement with staff groups. Greater collaborative working had taken place, particularly around integrated ways of working.

Vision and strategy

- The leadership team planned for the future taking into consideration previous challenges, which included engagement with staff, patients and the public; issues over an estate no longer suited for the increasing needs of the population; historically being seen as an organisation that was inward looking; issues over information quality and the challenge of developing an integrated governance and risk system.
- The trust had revised its quality improvement programme and planned to implement this from April 2016 onwards. The programme intended to link reporting from ward to Board, spread the implementation trust-wide, particularly with the review of avoidable deaths, sepsis, safety huddles and attention to acute kidney injury.
- The trust had launched the improvement programme entitled, 'Future', with three key words to inspire staff – imagine, innovate and improve. Not all staff were aware of the trust's vision, but had heard about the future programme.
- In parallel with the improvement programme was recognition that the trust was facing financial challenges and forcasting a deficit of around £7 million. The financial position as of 30 September 2015 was an increased deficit to £4.1million, £2.4 million behind plan. The Financial Sustainability risk rating was amended to 2. This represented a 'material risk on a range where 4 means no evident concerns to 1, which is significant risk. The main reason for the additional expenditure was agency staff and the under delivery of the Quality, Innovation, Productivity and Prevention (QIPP) targets. QIPP is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS. The forecast year to end deficit remained £7.0million against a planned £3.5 million deficit for the year.
- There had been a strategy review, which had commenced with increased local and regional engagement. Greater collaborative

working had taken place, particularly around integrated ways of working. The trust was exploring new models of care and better integration opportunities through the West Yorkshire Association of Acute Trusts.
- The trust was the lead on the 'Well North' initiative, aimed at improving health across some of the most deprived areas in the north of England.
- To underpin planned improvements the trust had developed a vision at each divisional level.
- We were told of the aim to change the culture within the trust, to set objectives that developed strategy through internal and external engagement, prioritised governance, recognised and rewarded quality improvement (trust presentation January 2016).
- The trust strategy, 'Together, putting patients first' was seen in various documents and displayed in some areas around the trust. Some staff were aware of the trust vision from bulletins. Some had seen the logo but were not clear as to its meaning.
- The leadership team recognised that progress was still to be made on embedding the trust vision and values throughout the organisation, but that improvement had been made since the last inspection in this respect.
- The trust had five core values – we care, we value people, we strive for excellence and we make every penny count.
- The trust was working with another trust on the Workforce Race Equality Standards and had set an aspirational target of a 35% black, minority and ethnic (BME) staff workforce. The ten year target would involve a 1% increase each year in staff employed from BME backgrounds. There was no BME representation on the board of directors in June 2014; this had risen to 29% by September 2015.

Governance, risk management and quality measurement

- There had been a revision of the governance arrangements, including the board assurance framework; corporate risk register and the integrated governance and risk committee had been redeveloped.
- Many of the new arrangements had only been introduced over recent months or were progressing through board sign off processes and had yet to embed. It was too early to assess whether they would deliver the intended improvements in Trust Board assurance.
- We found the trust assurance arrangements were not yet providing detailed feedback on what was happening at the ward and department level. We had serious concerns about the reconciliation of medication and monitoring of refrigerators

used to store medications, we raised this with the trust at the time of the inspection. We also drew to the attention of the trust issues over monitoring of resuscitation equipment and record keeping within the urgent and emergency care service. We wrote to the trust with our concerns and were given assurance that improvements were made immediately and that systems had been changed so that there were mechanisms to ensure effective monitoring took place.

- There were a number of policies and procedures in need of review, particularly on the critical care unit. Despite there being an infection prevention and control audit programme in place, staff in some areas were still not adhering to infection prevention policies and practices. In the operating theatres there was inconsistent implementation of the World Health Organisation's Five Steps to Safer Surgery safety checklist, despite there having been a never event that had identified that part of the cause had been non-compliance with the WHO safety checklist.
- The trust had taken action to address the staffing concerns identified in our previous inspection. The trust had introduced integrated patient acuity monitoring systems to assess patient acuity and staffing levels on a daily basis. Staffing levels were assessed in daily matron huddles that were led by the head of nursing and staffing levels were risk rated and monitored by the chief nurse.
- However, we found that there continued to be significant staff shortages, particularly across the ED, medical wards, maternity and children's and young people's services and outpatients. Nurse staffing levels had been reviewed across the trust and in December 2015 the Board of Directors had approved a £2.5millon spend on staffing. Recruitment was actively taking place, including internationally.
- In the NHS staff survey (2015) the percentage of staff working extra hours was 68% this was better than the England average of 72%. The percentage of staff feeling pressure in the three months before the staff survey to attend work when feeling unwell was 65%, this was worse than the England average of 59%.
- There was a risk management policy. The trust was in the process of introducing a new risk escalation framework.
- The quality and safety's subcommittees had been reviewed and had revised terms of reference and work plans. The trust had undertaken a review of clinical governance system for each division.

Summary of findings

- The trust was structured with four clinical divisions, each led by a divisional clinical director, supported by a head of nursing and a divisional general manager. Clinical leads and specialty leads were supported by a directorate manager and matrons.
- At the previous inspection we had serious concerns about the large backlog of patient pathways on the non-refer to treatment pathway, which was around 250,000 by April 2015, without a follow-up appointment date, or had been clinically validated to ensure that they were protected from harm due to potential delays to treatment. The trust commissioned external reviews of the outpatients' service, in particular the recently configured centralised patient booking service and developed an action plan to address concerns.
- The trust reviewed the management and assurance processes in the central patient booking service and strengthened systems, recruited additional staff and introduced a training and development programme. However, we found that changes had not yet been fully established and there was still some confusion around booking appointments, access to patient notes, delays in booking appointments and staff lacked confidence in the new systems.
- Since the identification of the backlog and action taken to address this, there had been a steady reduction in the size of the backlog, which stood at 11,790 cases by December 2015.
- The trust had not achieved the 90% admitted refer to treatment target from April to October 2015. The performance was trending down, for October 2015 it stood at 76.86%.
- Our previous concerns about the care of patients requiring non-invasive ventilation (NIV) had been addressed. Patients requiring NIV were now grouped together in the respiratory unit on ward 23 and the service was compliant with British Thoracic Society Standards.
- Our previous concerns about the safety of children who were cared for in the stabilisation room pending transfer out of the hospital had largely been addressed. There were suitably qualified and trained staff to support critically ill children until the paediatric transfer team arrived. The service had been reviewed by the Royal College of Paediatrics and Child Health in August 2015 and an action plan had been developed to address the recommendations made in this report.
- In critical care service, the capacity of the service to meet demand remained an issue. The bed occupancy for the unit was about 92% and patients were sometimes being cared for in recovery in the nucleus theatre because there was not a bed available on ICU. It was unclear if the new unit would be sufficient to reduce the occupancy rates because the number of

ICU beds was not being increased. There had been no review of unmet demand for beds, which was identified as an action from the previous inspection and quality key indicators reports. The service was still not seeing all patients within 12 hours of admission although improvements had been made and processes put in place to mitigate the risk.

- Overall figures for the completion of mandatory training had improved. However, some courses such as basic life support and adults and children's safeguarding Level 2 and Level 3 were below the trust target of 95% in medicine. Basic life support training was 31% completion for doctors and 65% completion for nurses in ED. Appraisal rates for staff were low in some areas.

Leadership of the trust

- Changes had taken place in leadership across all levels, including the executive team and throughout various management posts. The leadership team comprised of seven executive posts. A new post had been appointed to since the last inspection, the director of governance and corporate affairs. There was a new medical director and interim chief nurse and director of operational management and turnaround. The Chief Executive was now substantive in post.
- There had been a number of changes within the trust's governance membership with new appointments to governor roles, particularly increasing representation from the black, Asian and minority members of the local population.
- The trust was in the process of appointing a head of organisational development and a practitioner.
- To drive improvements in leadership and engage staff in this process monthly senior leadership forums were held, with masterclasses. In addition, work was progressing with leadership programmes with the leadership academy.
- Staff reported that the Chief Executive and executive team were visible but that they did not see members of the non-executive team or the governors at the trust.
- In the NHS staff survey 2015, the trust scored 3.57 for support from immediate managers, this was worse than the England average of 3.69. staff

Culture within the trust

- The trust had increased its engagement with the staff within the trust and improved communication generally. There was a drive to include and involve staff with the developments of the trust including future strategies.
- Staff were generally more positive about the culture and reported that they were proud to work at the trust.

- Staff reported that when things go wrong they heard about it but they would like to also hear more about what went well so they could celebrate it and get recognition.
- Staff across most areas reported that they worked well as a team.
- In the NHS staff survey (2015) 46% of staff reported most recent experience of harassment, bullying or abuse. This was better than the England average of 37%.
- The percentage of staff experiencing physical violence in the last 12 months was 1%, this was better than the England average of 2%.
- The percentage of staff who agreed that that their role made a difference to patients/service users was 92%. This was better than the England average of 90%

Fit and Proper Persons

- The trust had arrangements in place to meet the Fit and Proper Person Requirement (FPPR), Regulation five of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors for NHS providers were fit and proper to carry out their role.
- The trust had a policy in place regarding compliance with the Fit and Proper Person Regulation. This included what the trust needed to do to ensure compliance with Regulation five and the assurance process in place to ensure that these were implemented.
- There was a regular review as part of the appraisal process, including the person's self-declaration of fitness.
- We reviewed 7 of the executive and non-executive files and found all the requirements were met. All existing directors had to sign a board level declaration and there was evidence of this in all files. All new directors as part of the recruitment process had to sign a board level declaration as above which was available to the interview panel and in all files.
- However for one director, some of their references were addressed "to whom it may concern", not the trust and they were not signed. We asked the trust about this but there was no explanation as to how they were assured that these references were legitimate or provided by an appropriate person.

Public engagement

- The trust had introduced the, 'Hello my name is' campaign.
- Patient stories were heard at Board meetings and action taken to address areas requiring improvement.

Summary of findings

- The trust leadership including the Chair were engaging with public representative groups and promoting the services at the trust externally.
- The trust took part in a range of patient experience surveys including the NHS Family and Friends Test and the National Care of the Dying Audit.
- The NHS Friends and Family Test (FFT) results between August 2014 and July 2015 indicated the percentage of patients who would recommend the trust's services was consistently better than the England average each month in this period.
- The Care Quality Commission In-Patient Survey (2014) asks questions such as ; 'Did a member of staff answer your questions about the operation or procedure?'; 'Did you feel you got enough emotional support from hospital staff during your stay?' and; 'Did doctors talk in front of you as if you weren't there?' The results showed this trust scored about the same as other trusts for all questions.

Staff engagement

- The trust had committed to improving engagement. The trust had developed further its communication mechanisms with staff. Weekly news letters had been introduced from the Chief Executive called, 'Let's Talk'.
- The trust had improved its corporate induction and introduced communication through social media. There was a drive to increase engagement with staff and empower staff to become more involved in trust development. For example, eight members of staff had attended a shared leadership day with another trust.
- Generally, staff were positive about the improved communication and engagement, although some groups felt more could be done to progress and recognise their contribution such as healthcare support workers with enhanced roles.
- 54% of staff in the NHS staff survey (2015) would recommend the organisation as a place to work. The England average for acute trusts was 70%.
- 26% of staff reported good communication between senior management and staff, this was worse than the England average of 32%.
-

Innovation, improvement and sustainability

Summary of findings

- The development of the frail older people pathway using multidisciplinary team working and focussing on skills and training had enabled the elderly care directorate to be one of the highest performing in the county. It is in the top 10% for length of stay.
- The trust provided a home NIV service and had 100 patients receiving complex ventilation.
- The children's and young peoples' service was developing care pathways in partnership with GPs and emergency departments. The aim of the pathways was to promote consistency in the management of illness and to ensure children had care at the right time and place. Bradford had volunteered to be a pilot site for the neurosciences electronic referral system and was working with the regional neurosciences unit at Leeds Teaching Hospitals NHS Trust.
- The ICU service was moving into a new unit at the end of 2016. The new unit would improve patient experience and care. The new ICU would comply with the NHS England D16 NHS Standard for Adult Critical Care.
- The service was moving HDU beds from ward 20 to the former discharge lounge to allow patients to be cared for in two 2 bedded bays instead of a single four bedded bay.
- There were two nurse led clinics in the orthopaedic area and a nationally recognised course in plaster casting being held regularly to 'grow' in house expertise in this field.
- A young people's event at Bradford City Football Ground – your Future, your health. An event where young people have been invited to engage in discussion directly with senior leaders about health and wellbeing priorities.
- The Bradford Learning Disability Eye Service had brought together community health, hospital eye services, education teams, patients and carers to improve access to ophthalmic services for people with a learning disability.

Overview of ratings

Our ratings for Bradford Royal Infirmary

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

Our ratings for St Luke's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	N/A	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	Good	Not rated	N/A	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Bradford Teaching Hospitals NHS Foundation Trust

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

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good	Good	N/A	N/A	Good	Good
Overall Community	Good	Good	Good	Good	Good	Good

Notes

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

2. Follow up inspections focus on the areas identified as requiring improvement in the previous inspection and any areas of concern identified in the time since the last inspection. Therefore, at this inspection, not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

Outstanding practice and areas for improvement

Outstanding practice

- The trust was collaborating with another local trust to work towards recruiting and retaining a workforce that reflected the 35% black, Asian and minority ethnic (BAME) population in the Bradford area. Between June 2014 and September 2015, the trust had improved the BAME representation on the Trust Board of Directors from 0% to 29%.
- The trust was leading the 'Well North' programme, which was a collaborative programme aimed at improving the health of some of the poorest communities in the most deprived areas in the North of England.
- The Bradford, Airedale, Wharfedale and Craven Managed Clinical Network of Specialist Palliative Care had won the British Medical Journal, 'Palliative Care Team of the Year' award in 2015.
- The trust had performed better than the England average for all indicators in the 2015 Hip Fracture Audit.
- The trust had engaged with staff and the public to contribute to the design of the new building to create an environment which was reflective of the needs of local children's and families.
- The trust operated the Bradford Project Search, a 9 month internship to develop skills and widen the social circle to support people with a learning disability find work opportunities. This was the third year, 60% of the year's internship had found permanent work, three with the trust.

Areas for improvement

Action the trust MUST take to improve

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

Outstanding practice and areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust must ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that risks can be identified assessed and managed. The trust must ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed.

This section is primarily information for the provider

Requirement notices

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels. The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.