Harrogate and District Foundation Trust

Evidence appendix

Harrogate and District NHSFT
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Date of inspection visit:
6 to 8 November 2018
4to 6 December 2018

Date of publication:
14 March 2019

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

A list of the acute hospitals at the trust is below.

Name of acute hospital site	Address	Details of any specialist services provided at the site	Geographical area served
Harrogate District Hospital	Harrogate District Hospital, Lancaster Park Road, Harrogate, North Yorkshire, HG2 7SX	Acute and community services, general medicine/surgical services, Urgent and emergency care, critical care, maternity, outpatients and diagnostics, services for children and young people	Harrogate and rural district
Lascelles Rehabilitation Unit	Lascelles Rehabilitation Unit, Highgate Park, Harrogate, HG1 4PA	Neurological services, rehabilitation.	Harrogate and rural district

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

Community sites at the trust

Name of community hospital site	Address	Details of any specialist services provided at the site	Geographical area served
Ripon Community Hospital	Harrogate District Hospital, Lancaster Park Road, Harrogate, North Yorkshire, HG2 7SX	Minor injuries unit, intermediate care.	Harrogate and rural district

(Source: Routine Provider Information Request (RPIR) P2 – Sites)

Facts and data about the trust

Harrogate District Hospital has 346 inpatient beds, 18 day-case beds and 16 children's beds across 20 inpatient wards. There are 698 outpatient clinics per week and 74 community clinics per week.

(Source: *Routine Provider Information Request (RPIR) P2 – Beds)*

Patient numbers

From June 2017 to May 2018 there were:

- 311,382 outpatient attendances
- 52,390 inpatient admissions
- 2,569 planned elective surgical cases
- 51,796 attendances at the accident and emergency department
- 1,726 deliveries

(Source: Hospital Episodes Statistics June 2017 to May 2018)

Is this organisation well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high quality sustainable care.

The leadership team were experienced and stable. Other than the Chair and Director of Workforce and Organisational Development the executive team had remained the same since the last inspection. The Director of Finance had been in post since 2006, and he also held the role of Deputy Chief Executive. The non - executive directors had had some changes, however there was still a wide range of appropriate experience, skills and knowledge. The Trust had used natural turnover within the NED group to recruit new NEDs with specific skills and experience relevant to the changing needs of the Trust. Since the last inspection the trust had expanded its children and young people community services, and as a result they had strengthened and increased the leadership capacity within children's and countywide community care directorate.

The chair and chief executive both understood the key challenges and strategic direction of the trust. In interview the executive team could identify the challenges the trust faced across all sectors, the plans in place to meet those challenges and the current strategic direction for the trust within the wider healthcare system. Board members had a range of skills, knowledge, and experience to perform its role.

Leaders were very visible and approachable. There was a strong sense that they worked collectively and collaboratively, whilst still being able to challenge. Non-executive directors and governors felt well informed and trusted. Governors were engaged, enthusiastic, and proud of the hospital, the staff and their relationship with executives. The executive team had been particularly effective with their visibility within community services. Focus groups completed prior to this inspection confirmed this.

Following a governance review, board meetings structure and format had recently changed. Board meetings were now completed on alternative months with the remaining meetings being dedicated to strategic development, formal and informal visits by the executive and non-executive team to services within the trust including community. The trust had patient stories being presented to the board. This could be a story regarding a patient's own experience of the care and treatment provided by the trust or a story from a member of staff regarding the care they provided to patients.

Providers were required to ensure that directors were fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. The trust's guidance for the requirement of the Fit and Proper Persons Test (FPPT) for Directors set out the expectations with executive directors. This was an ongoing process to continuously monitor fitness at senior level. Both executive and non-executive directors were subject to checks including Disclosure and Barring Service checks, references and checks that candidates are not barred from being a director. Fit and proper person checks were in place. Employment records of the appointed directors or non-executive directors provided evidence of meeting this requirement. Discussions with the Chair and other executive directors confirmed that they understood this requirement and were aware of guidelines to support best practice.

The trust had a leadership development strategy (Leadership Development Strategy 2016 - 2019). This three year strategy set out the aims and objectives, and development pathways for leaders at different levels within Trust to enable succession planning. It was an inclusive strategy aiming to reach leaders from Executive Board members through to frontline managers across the trust. The strategy also acknowledged the challenges the trust had in terms of national workforce shortages, new business development and collaborative working.

Over the past twelve months a number of leadership development initiatives had been completed by the trust. These included:

- Leadership Development Programme for Matrons and Senior Clinical Staff
- HELM Consultants Leadership Programme
- Participation in the NHS Leadership Academy Programmes
- Leadership Group and Leadership Forum
- Establishment of mentor scheme for newly recruited/qualified consultants
- Development and launch of Pathway to Management – Induction Programme
- One new cohort of Platinum level Quality of Care Champions recruited to be trained in Virginia Mason Service Improvement model.
- Seven silver Quality of Care Champion cohorts trained in-house in abbreviated service improvement methodology during Dec 2017 to Dec 2018.
- Clinical Leads Development Programme
- Shadow Board Programme.
- 2 qualified coaches were enrolled to undertake the NHS Leadership Academy Coaching for Inclusion Programme in February 2019 to enable specialised coaching support for BAME colleagues to further enable progression.
- The trust had identified and explored a leadership development programme "Moving Forward" targeted at Band 5/6 BAME employees, run by a Bradford Community Trust, which 2or3 staff are attending in June 2019.

Board Members

Of the executive board members at the trust, 0% were Black Minority Ethnic (BME) and 33% were female.

Of the non-executive board members 0% were BME and 57% were female.

Staff group	BME %	Female %
Executive directors	0.0%	33.0%
Non-executive directors	0.0%	57.0%
All board members	0.0%	46.0%

(Source: Routine Provider Information Request (RPIR) – P64 Board Members - Diversity and list)

Both the executive and non-executive board members acknowledged the lack of diversity at senior level, specifically BME, and had strategies in place to help address this. The Chief Executive and Chair were actively exploring organisations who adopted governance and board best practice in relation to this and were considering options such as use of associate non-executive roles.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a clear statement of vision and values, driven by quality and sustainability. The vision and values were fully embedded, understood by most staff, and were underpinned by strategic

objectives, operational plans and key performance indicators. The vision and strategy had been developed in collaboration with staff, people who use the services and external stakeholders. The trust's strategy was aligned with the plans in the wider health economy, both locally and within the integrated care system.

The overall vision of the trust was "Excellence every time". This was underpinned by 3 strategic objectives:

- To deliver high quality healthcare.
- To work with partners to deliver integrated care.
- To ensure clinical and financial sustainability.

Underpinning the corporate strategy, the trust had various other strategies including a clinical workforce strategy, information management and technology strategy, business development strategy, innovation and improvement strategy and as an estates strategy. The trust also had a strategy for dementia. The trust was working with a medicines optimisation strategy 2016-2018 which was reviewed in July 2018. The relevant executive team member reviewed the strategies and progress was monitored through the appropriate committees up to the trust board.

Non-executive directors were clear about their involvement in the development of the strategy and were fully committed to it. They talked about the benefits to patients and the overall health economy.

The trust was actively involved in the West Yorkshire and Harrogate Integrated Care System and Committee in Common between the acute trusts in West Yorkshire and Harrogate.

The trust's values, respectful, passionate and responsible, were clearly articulated and embedded throughout the organisation. Staff interviewed within the core services we inspected, the leadership team and staff we spoke to in focus groups talked about the values of the organisation and how they linked to their employment and the service provided. The values were visible on the trust website, on posters and in documentation.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The overall culture of the trust was very positive and patient focused. At ward and community level, staff were motivated by wanting to provide the best care for patients and they spoke positively about the care they delivered. They told us compassionate quality care was a priority. Most staff we spoke with during the unannounced core service inspection and focus groups we completed said they were proud to work at the trust. We found there was respect between specialities and we saw examples of team working between staff of different disciplines and grades. Front-line staff told us they felt valued by their peers and leaders, both locally and at senior level. We found staff were supported in their roles. This was reflected in the NHS Staff Survey 2017.

NHS Staff Survey 2017

Questions better than average and/or scores that have improved since the 2016 survey;

Key Finding	Trust Score	National Average
KF11: percentage of staff appraised in the last 12 months	90%	86%
KF12: quality of appraisals	3.15	3.23
KF20: percentage of staff experiencing discrimination at work in the last 12 months	7%	10%
KF21: staff believing the organisation provides equal opportunities for career progression or promotion	90%	85%
KF28: percentage of staff witnessing potentially harmful errors, near misses or incidents in the last 12 months	25%	29%
KF18: percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from manager, colleagues or themselves	50%	53%
KF15: Percentage of staff satisfied with the opportunities for flexible working patterns	61%	51%
KF4: staff motivation at work	3.95	3.91
KF9: effective team working	3.82	3.74
KF5: recognition and value of staff by managers and the organisation	3.53	3.44
KF6: percentage of staff reporting good communication between staff and senior management	35%	33%
KF10: support from immediate managers	3.83	3.76
KF3: staff agreeing their role makes a difference to patients/ service users	91%	90%
KF22: percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	11%	14%
KF23: percentage of staff experiencing violence from staff in the last 12 months	1%	2%
KF25: percentage of staff experiencing bullying, harassment from patients, relatives or the public in the last 12 months	20%	27%
KF26: percentage of staff experiencing bullying, harassment from staff in the last 12 months	21%	24%
KF27: percentage of staff reporting most recent experience of bullying, harassment or abuse	49%	47%

Questions worse than the average and/or scores that have worsened since the 2016 survey:

Key Finding	Trust Score	National Average
KF13: quality of non-mandatory training, learning or development	4.04	4.15
KF29: percentage of staff reporting errors, near misses or incidents in the last 12 months	90%	91%
KF31: staff confidence and security in reporting unsafe clinical practice	3.74	3.67
KF1: staff recommendation of the organisation as a place to work or receive treatment	3.79	3.75

KF7: percentage of staff able to contribute to towards improvements at work	70%	70%
KF2: staff satisfaction with the quality of work and care they deliver	3.84	3.90
KF24: percentage of staff/ colleagues reporting most recent experience of violence	62%	67%

(Source: NHS Staff Survey 2017)

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	22%	26%	24%
		BME	28%	27%	22%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	19%	23%	21%
		BME	34%	29%	15%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	91%	88%	93%
		BME	96%	73%	94%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	4%	6%	3%
		BME	0%	15%	4%

Statistical analysis of results was not undertaken due to the low number of BME respondents (under 50).

(Source: NHS Staff Survey 2017)

The 2017 staff survey identified that the percentage of staff experiencing harassment and bullying or abuse from staff in the last 12 months was found to be 34% for BME staff compared to 19% of white staff. This had increased since the previous staff survey in 2016.

The trust was aware of this deterioration and other key metrics in their Workforce Race Equality Standard (WRES) and had produced an action plan which was presented to the board in September 2018. The WRES was also discussed and reviewed at the Workforce Equality Group and Workforce and Organisational Development Steering Group.

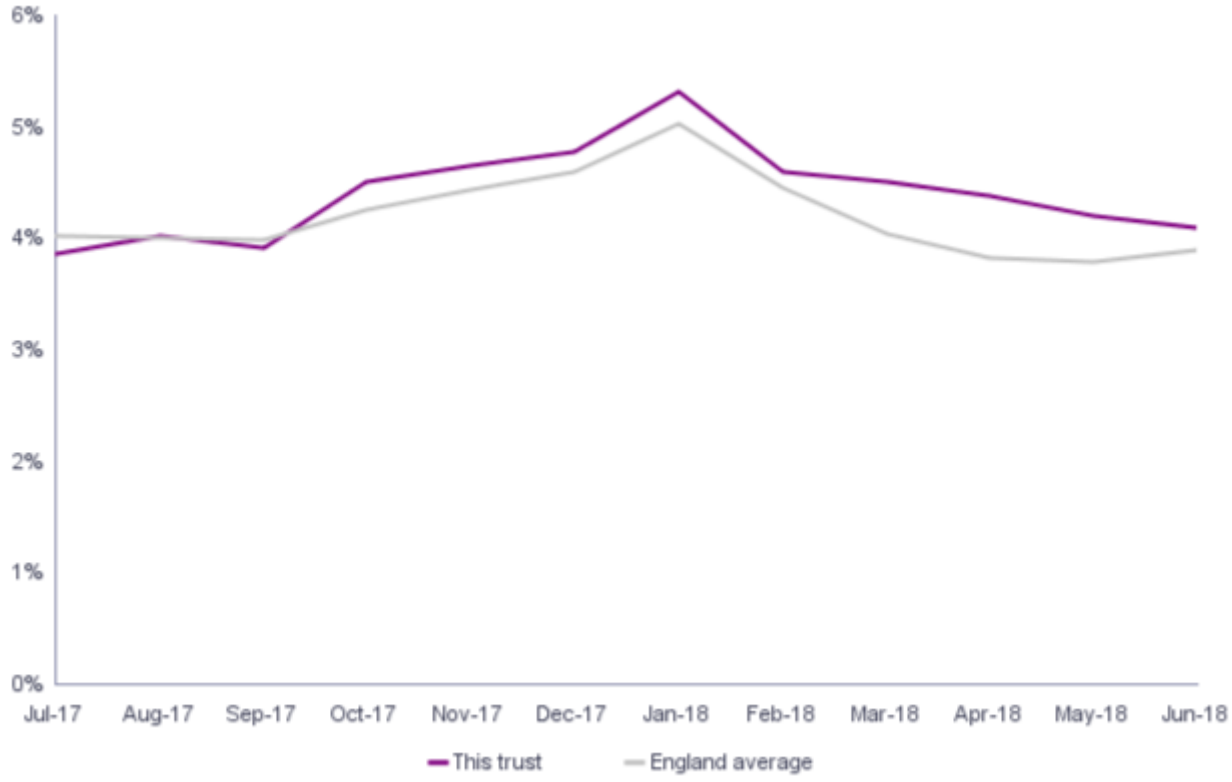
The Workforce Equality Group had also focussed on engagement with underrepresented groups to help to understand what were the key concerns from BME staff. A series of interviews were undertaken with individuals from departments across the Trust.

Following this and to further explore culture within the trust, a series of listening events open to all staff to discuss a fair and just culture had been completed. These were led by the Chief Executive. BME staff were encouraged to attend the events to discuss their experiences.

In addition, the trust had added questions relating to a fair and just culture in the Staff Friends and Family Test. The trust received 231 comments which related to the additional questions which demonstrated that there were differing views as to whether staff felt able to raise concerns and their perception as to whether HDFT's culture is fair and just. The trust were currently developing strategies to help address this.

Sickness absence rates

The trust's sickness absence levels from May 2017 to March 2018 were generally higher than the England average.



(Source: NHS Digital)

We spoke with the Freedom to Speak up Guardian at the trust. This person had been in post since October 2016 and had received training to undertake the role and was active within the regional network of guardians. The guardian also used the national guardian office for advice and support if required. The role had been well publicised in both community and in the acute trust. We heard examples where concerns raised by staff had been appropriately escalated and dealt with. The guardian produced quarterly reports for the board which highlighted any themes or trends. We discussed the role of freedom to speak up guardian and potential for conflicts of interest. They were aware of potential conflicts and how this might impact on staff confidence to share their concerns. To help address this the trust highlighted alternative points of contact for speaking up, had appointed fairness champions and was also going to appoint an additional independent Freedom to Speak up Guardian. The fairness champions were also to help drive cultural change

towards an expectation of fairness, listening to colleagues who have concerns and signposting them to those who can help them to speak up. These fairness champions were from all levels of staff, including consultants.

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Training Scheme Survey the trust performed the same as expected for all indicators.

Survey area	RAG
Overall satisfaction	
Clinical Supervision	
Clinical Supervision out of hours	
Handover	
Induction	
Adequate Experience	
Supportive environment	
Work Load	
Educational Supervision	
Feedback	
Local Teaching	
Regional Teaching	
Study Leave	

(Source: General Medical Council National Training Scheme Survey)

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical areas would flourish.

The trust's services were structured under three clinical directorates: long term and unscheduled care, planned and surgical care and children's and countywide community care. The board of directors and the council of governors provided oversight of the strategic and governance functions of the trust. Corporate assurance was provided through four committees each chaired by a non-executive director: quality, resources, audit and remuneration.

Governance processes were straightforward and easily understood at both the strategic and operational levels. The senior management team was attended by each executive board member and oversaw delivery and performance. There were directorate boards for the operational delivery of long term and unscheduled care, planned and surgical care and children's and countywide community care. Clinical directors representing the three clinical directorates attended the senior management team and also the trust board meetings and contributed particularly to clinical discussions and decisions involving their directorate.

Governance processes and practices were regularly reviewed. The arrangements for meetings of the executive and senior management teams were changed during 2018 following an invited external review by NHS Improvement. An executive task and finish group reviewed the recommendations presented by NHS Improvement and changes were implemented which increased the robustness of scrutiny within governance processes and rebalanced the focus of the board on both strategic and operational matters. For example, the remit of the resources committee (previously finance) was extended to include workforce matters and to meet monthly

rather than quarterly. At our inspection we found that changes to the scrutiny function of the committees, particularly the resources committee, were still to become fully embedded.

Meetings of the Board were changed to bimonthly from September 2018 with a workshop format being introduced for the intervening month. The change in format provided for executive and non-executive directors to visit dispersed locality services and to contribute to operational workshops in community settings which provide for clinical matters to be considered in a less formal setting. These changes to the board arrangements enabled the main bimonthly board meeting to refocus on strategic governance whilst still providing a focus on the integrated board report. Governance processes provided for extraordinary meetings of the board to be held if these were required.

We found governance structures operated effectively with clear connection from ward to board. Management arrangements supported the delivery of the trust's strategy and the delivery of high quality services. Governance and management arrangements at all levels interacted with each other appropriately in providing oversight of the trust's performance.

Staff at each level in the trust we found were very clear about their roles. Staff we spoke with understood what they were accountable for delivering and to whom they reported. Staff accountability was effective at all levels in the trust. Members of staff we spoke with were clear about who did what. Staff worked closely together as part of a group. This was demonstrated particularly in the recently acquired community services.

Arrangements the trust had in place with its partners and third party providers we found were governed and managed effectively. The trust's interactions with other organisations supported the coordination of services and promoted patient-centred care.

The trust's partnership arrangements were well illustrated through the role it took within the West Yorkshire Association of Acute Trusts (WYAAT). The trust was one of six acute trusts in the West Yorkshire and Harrogate integrated care system. A formal committee in common consisted of six chairs and chief executives which supported collective decision making. The trust participated in a number of collaborative work streams within WYAAT and collaborated effectively in delivering hospital services within West Yorkshire and including the Harrogate area. A memorandum of understanding was used to support collective decision making and a new partnership board was planned for implementation from April 2019. The trust's CEO and a number of executive directors were leading priority work streams on behalf of WYAAT.

The trust had implemented a wholly owned subsidiary to provide facilities management services in the previous 12 months. The subsidiary was being operated successfully and had generated significant cost improvement. Since its inception, staff morale had improved, vacancies had reduced significantly and levels of satisfaction with services had improved although workforce issues required some ongoing engagement. An IT business partnership with another NHS trust outside the WYAAT area was being used to support the implementation of a web based virtual ward system which included mobile communications.

The aligned incentive contract arrangements with commissioners had exposed the trust to some risks which it was taking steps to manage in cooperation with regulators.

Arrangements for hospital managers to discharge their specific powers and duties according to the provisions of the Mental Health Act 1983 were embedded. The trust's arrangements took account of patients with dementia and patients with a learning disability. The trust had obtained additional specialist nursing resource. The trust worked with other trusts within the north east and Yorkshire and Humber regions in meeting the requirements of the Mental Health Act 1983.

Management of risk, issues and performance

Finances Overview

Financial metrics	Historical data		Projections	
	Previous financial year (2 years ago)	Last financial year	This financial year	Next financial year
Income	217.4m	216.5m	232.4m	235.0m
Surplus (deficit)	3.7m	1.1m	4.0m	4.0m
Full costs	213.7m	215.4m	228.4m	231.0m
Budget			228.4m	231.0m

(Source: Routine Provider Information Request (RPIR) – P69 Finances)

Trust corporate risk register

The trust provided the corporate risk register in July 2018 which lists the highest operational risks across the organisation. There were a total of 11 risks, all of which had a risk score of 12 at that time.

Harrogate District Hospital

Risk ID	Description	Risk score (current)	Target review date
CR 2	**Rota gaps in Medical Staffing** Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process, and medium- term sickness. NB specific risk to provision of gastroenterology service and increased waiting times for outpatient appointment due to inability to recruit to gastro consultant post noted November 2017 (PSCD49)	12	March 2019
CR 5	**Nursing shortage** Risk to service delivery due gaps in registered nurse's establishmentNB. Risk to patient safety, experience and staff welfare due to staffing establishment Granby Ward noted October 2017 (LTUC 45)	12	March 2019
CR13	**Capacity to support timely discharge for community ready patients** Risk to patient care, experience and quality due to a lack of capacity to support patients following discharge	12	March 2019
CR14	**Delivery of annual plan** Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income.	12	March 2019

CR17a	**Risk of patient harm as a result of being lost to follow up as a result of current processes** Risk to patient care due to Cash Up Sheets not being completed correctly by clinic teams, medical records staff not updating correct actions and medical secretaries not communicating outcome after tests/further actions.	12	September 2018
CR17b	**Risk of patient harm as a result of being lost to follow up as a result of historic processes - Outpatient appointments without outcomes prior to 1 Jan 2017** Risk to patient care due to Cash Up Sheets not having been completed correctly by clinic teams, medical records staff not updating correct actions and medical secretaries not communicating outcome after tests/further actions.	12	December 2018
CR18	**Risk to provision of service and not achieving national standards in cardiology** Risk to quality of service and risk of patient safety. Potential to breach national waiting times due to cancellations arising from not being able to provide a cardiology testing service due to potential for lab equipment breaking down.	12	March 2019
CR 24	**Community capacity** Risk to patient safety, quality, experience, reputation, staff wellbeing due to reduced capacity in the Community Care teams (CCTs). Additional financial risk as services do not fit within the financial envelope, therefore technically overstaffed.	12	March 2019
CR26	**Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community** Risk of; • Missing a safeguarding concern • Missing a maternal medical problem - such as pre-eclampsia • Missing a small gestational growth	12	November 2018
CR27	**Capital programme** Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan	12	April 2019
CR29	**CATT Environment** Risk to patient safety, quality of care, patient experience and privacy and dignity due to environmental factors on CATT Ward and Clinic. Environment also impacting on recruitment and retention	12	September 2018

(Source: Trust Corporate Risk Register / Board assurance framework)

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust used its board assurance framework and corporate risk register effectively. Strategic risks were recorded in the board assurance framework, which was arranged to align with the trust's strategic objectives and linked with the trust's strategic key performance indicators. Operational risks which scored 12 or more were included in the corporate risk register and were reviewed monthly. The board assurance framework was reviewed monthly by the executive team. Newly identified risks were included in the chief executive's board report. Risk scores were updated for consistency and progress was tracked against key performance indicators. The board assurance framework informed the board agenda and was reported monthly to the board through the chief executive's report, as well as through quarterly reports.

The board assurance framework provided evidence of ward to board assurance at a strategic level for the trust. We found systems to manage risk and performance were effective. The risks recorded in the board assurance framework (BAF) included all areas of the trust's work as well as regulatory compliance. The BAF was regularly reviewed to ensure that risks related to each area of the trust's business were reflected, including community services.

Following the recently revised format for meetings of the board, a board workshop was arranged to review the board's approach to risk appetite and risk tolerance. Periodically the board conducted a 'deep-dive' to explore an identified area of strategic risk linked to the review of the board assurance framework, for example linked to the cost improvement programme. Any gaps in assurance were identified and mitigating actions were agreed by the executive team. The trust through its internal auditors had recently undertaken a comparison with nearby NHS trusts of its board assurance framework and related risk processes. The piece had provided a comparative basis for further development of the board assurance framework.

Operational risks impacting patients, services and staff were recorded in the trust's departmental, directorate and corporate risk registers. Directorate risk registers were linked to services within each directorate and a framework was in place for escalation between departmental, directorate and corporate risk registers to support consistent risk scoring and progress tracking. Risks were reported monthly to the senior management team and cross referenced to the board assurance framework where relevant, again highlighted to the board through the chief executive's report, and through quarterly reports.

The trust's escalation processes worked effectively. Escalation was used if a member of the executive team felt the trust was in danger of falling behind in its approach to an identified issue. Escalation was also used by the senior management team in responding to the chief executive's report. An example was the trust's approach to the management of outpatients. The trust reviewed an incident involving a patient lost to follow up and implemented a comprehensive action plan. Effective lines of communication made it straightforward to escalate concerns and ensure action was taken promptly.

The trust had well developed assurance systems particularly for performance. Both current and future potential performance issues were identified quickly and escalated appropriately using defined structures and well-developed processes. The trust understood the causes of a potential issue and how to address this. The forecasting of demand for services and of challenges to the workforce were examples where important levels of assurance were in place.

The committee structure provided assurance through cross-representation and the chair of each committee presented a summary at the board meeting, which meant that board time was being used effectively. The functioning of the recently reconfigured resources committee was due to be reviewed within the financial year to ensure an executive focus was maintained on finance issues

and more specific information on staff vacancies and recruitment initiatives was under development.

The trust had in place processes to manage both current and future performance. Processes to review the trust's strategic key performance indicators were evidenced which included observation of executive meetings and review of minutes of recent meetings. Board and committee meeting papers included a monthly integrated board report and quality dashboard with key performance indicators. Quality metrics within the dashboard included information at ward level where this was appropriate. The quality dashboard included, for example, mandatory training and appraisal rates, and safety thermometer data.

At our inspection, work was in progress to develop a small number (five initially) of additional key performance indicators for community based services within the integrated board report. An extended set of key performance indicators had recently been agreed by the quality committee, which was due to recommend these to the board.
The trust had also identified a group of similar NHS organisations to provide a benchmarking group for performance metrics.

A full programme of national and local clinical audit and internal audit was in place. The trust's system of internal audit provided significant assurance. Audit reports were reviewed by the audit committee in conjunction with the audit manager and head of internal audit. Clinical audit was under the oversight of the quality committee. The trust regularly reviewed its processes in response to audit and action was taken to implement areas identified for improvement.

The programme of clinical and internal audit enabled the trust to monitor quality, operational and financial processes. The audit committee met formally six times a year and external auditors attended and actively participated in audit committee meetings. The audit committee reviewed the minutes of both the quality committee and the corporate risk review group. A formal audit report was prepared by the internal audit team for each meeting. Meetings were held to review audit findings and action plans and recommendations were developed. Areas identified from audit as requiring action were followed up in a subsequent audit.

Potential risks were reflected in the planning of services. Areas of risk identified in service planning included seasonal variations and both expected and unexpected fluctuations in demand where potential disruption to staffing arrangements, facilities or infrastructure were identified.

The trust's planning cycle was undertaken from September through to March each year and included a planning workshop in December which was informed by detailed planning guidance developed within the service. Planning outcomes were reported to the resources committee. Detailed service planning to develop priorities was undertaken through weekly strategy meetings and summarised in monthly meetings. Due diligence which reflected identified risks was completed prior to bidding for acquired services. Business cases were prepared where new services were planned.

The board had appropriate oversight of quality and performance, with the focus retained on maintaining quality. Quality and sustainability were considered when developments to services, including efficiency changes were being considered. The impact of proposed service developments on quality and sustainability was assessed by the trust executive in considering any proposed changes. Quality impact assessments were completed as part of proposed service changes. A quality improvement team supported this approach. A quarterly quality improvement report was prepared for the board.

In 2018/19 the trust is on plan at month 6 and is forecasting delivery of its financial plan and control total. In 2017/18 the trust delivered a surplus position, including STF/PSF, of £655k. Excluding STF/PSF, the trust delivered a £2.9m deficit versus a control total of £2.1m surplus. The trust demonstrated an awareness of situations where financial pressures may compromise care.

The annual cost improvement programme was subject to quality assessment. The quality committee met monthly and the agenda included the quality dashboard and a “hotspot” section in which any immediate quality concerns could be scrutinised including any quality impact of the cost improvement programme. We did not identify any examples where care had been compromised for financial reasons. The committee also agreed and monitored progress with priority quality work streams with the quality account taken to the board for final approval.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
The trust had an information management and technology policy which had been revised and updated in March 2018. There was also a strategy in place which reflected the current priorities and challenges in terms of information management and technology, and data security within the trust. The trust was improving technology within children and young people community services in terms of agile working and introducing standardised system across the different localities. It was also working in collaboration with the acute trusts in West Yorkshire as part of the West Yorks Association of Acute Trusts (WYAAT) to deliver information management improvements. This included using a single system to transfer radiology images between the relevant trusts and having a single scanning system known as Scan4 safety.

The trust had clear service performance measures in place which were effectively monitored and reported. There was evidence of integrated reporting which was used to support decision-making at board level and performance information was used to hold senior leaders and staff to account. We saw that information used in reporting, performance management and delivering quality care was usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses. The trust acknowledged there was more work to do in terms of improving information in the integrated performance report regarding children and young people community services.

The trust board received information on finance, performance and quality from a range of sources that were both internal and external to the trust.

A financial governance diagnostic review undertaken during 2018 included review of board papers and observation of board and board committees. Some improvements were suggested, but no fundamental issues with the financial information being provided and utilised by the trust were identified.

The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system (NRLS) or the NHS strategic executive information system.

Electronic prescribing had been rolled out across the trust. This was used to manage medicine reconciliation performance and to highlight priority patients, missed doses and antibiotic prescribing information and well as other medicine searches and audit. A joint CCG/ Trust business case had been submitted to link the trust IT system with Pharma outcomes system so that discharge information can be accessed by community pharmacies.

Caldicott guardian

The medical director had taken on the role of Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Senior Information Risk Owner (SIRO) for the organisation was the Chief Operating Officer. There were good working relationships with the SIRO who was accountable for managing information risks and incidents.

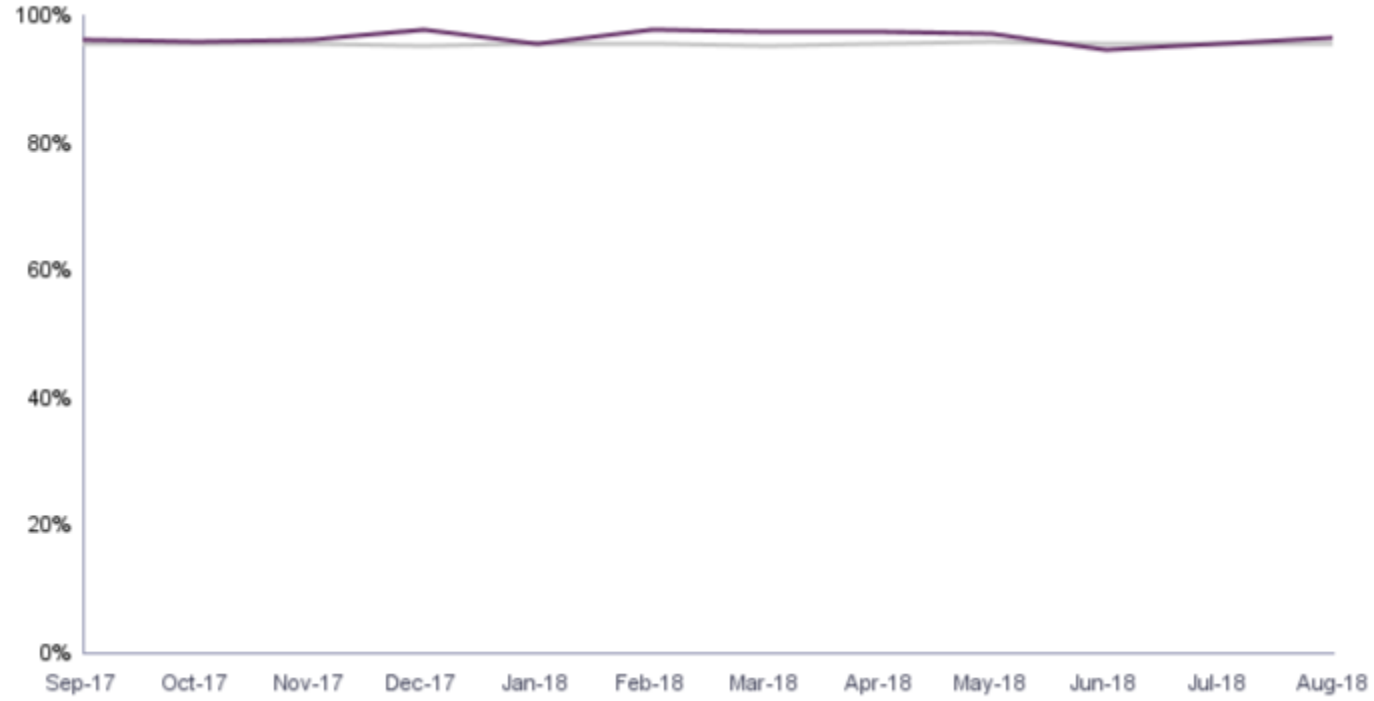
Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

From September 2017 to August 2018 the trust's performance was similar or higher than the England average



(Source: NHS England)

The trust did engage well with patients and the public to shape services.
There were a range of methods in place to engage with patients and the public to shape services. Patients and carers were invited to take part in surveys, both locally and nationally. The Friends and Family Test (FFT) was available to all patients to complete with good participation and performance in most areas. The trust also involved patients and the public in planning, delivery and improving services through the development of a youth forum, patient voice group, patient experience group, stakeholder equality group and the use of patient stories at board meetings. Patients and the public had also been integrated into the drug and therapeutics committee.

The trust had a plan and framework for a patient and public participation strategy 2018-2021. This had been presented to the board in September 2018. The framework articulated how the trust will proactively work with people to improve and sustain services. It had been developed following consultation with multiple stakeholders.

Staff are actively engaged so that their views are taken into account when planning and delivering services, and in promoting a positive culture. The trust engaged with staff using a range of mechanisms. It proactively engaged, promoted and celebrated the achievements of staff through team brief, a weekly bulletin, and use of social media. As part of the trust's quality charter, it had well embedded and effective making a difference and team of the month awards. These initiatives were open to individuals and teams who work or act in a way that goes above and beyond; show

how they were living the Trust values; and made a difference. Anyone (including the public) could nominate and any colleague could be nominated. More than 400 nominations had been received across both categories since the Charter was launched, with the majority of these being successful and going on to receive an award. Awards were given personally by an executive or non – executive member of the board.

The trust also held an annual Quality Conference to engage staff. This conference provided opportunities to share, learn and celebrate success relating to quality improvement, clinical audit, service evaluation and research initiatives across the Trust.

Within community services, the trust operated a locality management structure which supported staff engagement and feedback across its numerous sites and wide geography, and the board held public meetings in different venues during the year to be accessible to staff and public across its geography. Focus groups held with staff from community children and young people services provided positive feedback about this approach.

The trust had a positive and collaborative relationship with external partners. It had a significant role in the wider local health system, actively contributing to workstreams within the West Yorkshire Association of acute trusts (WYAAT), the West Yorkshire and Harrogate Integrated Care System and Committee in Common between the acute trusts in West Yorkshire and Harrogate.

Accessible Information Standard

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly funded adult social care have been legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, carers and parents with a disability, impairment or sensory loss. It covered the needs of people who are blind, deaf, deafblind and/ or who have a learning disability. It also included people who have aphasia, autism or a mental health condition, which affected their ability to communicate.

The trust had a draft accessible information standard policy. There were some processes in place to enable staff to ask, record, flag, share and act on the information and communication needs of some of the patients. For example, for people with a learning disability, the trust had an LD flag which supported the provision of accessible information by identifying that the patient had specific needs. An Enhanced Admission Proforma which prompted the admitting nurse to consider communication and information needs was also in place. The trust also had an identification and flagging process for people with a certificate of visual impairment (CVI) that enabled staff to recognise and meet their needs. It had recently implemented an automated notification of the admission of a patient with a CVI flag to Advanced Nurse Practitioners in Ophthalmology in order for them to support the needs of these patients whilst they were in an unfamiliar environment. The records of patients who require a British Sign Language (BSL) interpreter were also flagged, in order that this information was readily available and could be used to anticipate the need for an interpreter for these patients. HDFT were also part of a tendering process across WYAAT for BSL interpretation services, which would provide an improved BSL service for patients, carers and visitors. The plan was that the services would be in place by the end of March 2019.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a strong focus on quality improvement throughout the trust which was well embedded. The trust had an innovation and improvement strategy and quality charter which was effective in enabling it to grow skills and capacity in quality improvement, value and reward staff and teams;

and celebrate innovation and quality improvement. As a result, the trust had established quality of care champions who supported staff to deliver improvement projects within their area of practice, a quality improvement team accreditation scheme which recognised and rewarded teams who identified and achieved high quality services in their area; and quality improvement campaigns which focussed on specific areas to enhance best practice.

Alongside the quality charter, the trust had an improvement schedule. These were a series of improvement events planned up to twelve months in advance and shaped through consultation with staff across the trust. Rapid process improvement methodology was embedded throughout the trust to support this.

Complaints process overview

There was a comprehensive policy to guide staff on responding to concerns and complaints, Making Experiences Count policy. We reviewed seven complaints as part of our well led review and found concerns were investigated sensitively and confidentially, and lessons were shared and acted on. When something went wrong, people received a sincere and timely apology and were told about any actions being taken to prevent the same thing happening again. In each case, complainants were kept informed and communication with them was personalised and appropriate. The CEO was actively engaged with the complaints process and signed off each complaint response.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Target performance
What is your internal target for responding to complaints?	Three working days	100%
What is your target for completing a complaint	25 working days	95%

(Source: Routine Provider Information Request (RPIR) – P61 Complaints)

Number of complaints made to the trust

The trust received 209 complaints from July 2017 to June 2018. The average time taken to close complaints was 68 days, this was not in line with the trusts policy which states complaints should be closed within 25 working days or within 60 days for more complex cases. A breakdown of complaints is shown below:

Core service breakdown

Core Service	Total complaints
AC - Medical care (including older people's care)	46
AC - Outpatients	42
AC - Surgery	42
AC - Urgent and emergency services	25
AC - Maternity	13
CHS - Children, Young People and Families	13
CHS - Adults Community	10
Other - PMS service	6
AC - Services for children and young people	4
CHS - Community Inpatients	3

AC - Diagnostics	2
Other	2
CHS - Urgent Care	1
Grand Total	**209**

The top three service areas were:

- Inpatient services – 87 (41.6%)
- Outpatients – 59 (28.2%)
- Emergency services – 25 (12%)

The top three subjects were:

- Other – 84 (40.2%)
- Communications 30 (14.4%)
- Values and behaviours – staff – 26 (12.4%)

(Source: Routine Provider Information Request (RPIR) – P61 Complaints)

Number of compliments made to the trust

The trust received 36 compliments from July 2017 to June 2018. A core service breakdown is shown below

Core service	**Total**
AC - Medical care (including older people's care)	9
AC - Surgery	7
AC - Maternity	3
AC - Outpatients	3
Provider wide	2
CHS - Adults Community	2
AC - Gynaecology	2
AC - Diagnostics	2
CHS - Children, Young People and Families	1
(blank)	1
AC - Services for Children and Young People	1
AC - Urgent and emergency services	1
AC - Medical Care	1
AC - Critical care	1
Grand Total	**36**

(Source: Routine Provider Information Request (RPIR) – P62 Compliments)

A learning from deaths process was in place and complied with the Learning from Deaths' national guidance in 2017. Any unexpected death would often be alerted directly to the Medical Director, and always to the Risk Management team. Certain categories of death are reviewed using the structured judgement review method. We reviewed six death reviews during our well led inspection and found most were comprehensive and action plans developed when appropriate.

We reviewed eight serious incidents investigations as part of our well led review. We reviewed five serious incident investigations and found evidence that families were informed and involved in each of them. Incidents were thoroughly investigated, and learning used to help prevent reoccurrence. Duty of Candour was applied appropriately.

The trust participated and had gained successful accreditations in numerous schemes. These included Joint Advisory Group on Endoscopy (JAG), Gold Standards Framework Accreditation Gold Standard Framework Hallmark Award in End of Life Care, Anaesthesia Clinical Services Accreditation (ACSA), Imaging Services Accreditation Scheme (ISAS), Clinical Pathology Accreditation and Medical Laboratories ISO 15189; and UKAS accreditation to standard ISO22870:2006 - Point of Care testing requirements for Quality & Competence. This accreditation for Point of Care Testing service is the only NHS accredited POCT service to international standard ISO 22870.

The Trust had effective systems for receiving and acting upon internal and external reviews. Examples of initiatives either introduced, or enhanced following review of external reports and recommendations included:

- Freedom to Speak Up Guardian
- WHO checklist and more latterly LOCSIPPs
- Structured Judgement Reviews as part of mortality governance
- Electronic flagging of LD patients which enabled early involvement of specialist LD Nurse in patient care
- Policy changes made following receipt of safety alerts.
- Implementation of Health Education England guidance on cross cover arrangements

There were systems to support innovation and the trust had been recognised for this. In 2018 the trust received a Top 40 Hospitals award from CHKS. This award is based on an analysis of over 20 indicators of performance considered critical to patient care from all hospital trusts in England, Wales and Northern Ireland. It had been awarded the Silver Employer Recognition Scheme (ERS) as one of the country's leading employers for support of the Armed Forces. The trust had also embedded the use of Schwartz rounds to support staff emotional health and wellbeing. This was a multidisciplinary forum designed for staff to come together to discuss and reflect on the emotional and social challenges associated with working in healthcare. Rounds provided a confidential space to reflect on and share experiences.

Acute services

Surgery

Facts and data about this service

The Trust is the principal provider of hospital services to the population of Harrogate and Rural District and also provides hospital services to people in North East and West Leeds. . This represents a catchment population in excess of 250,000 which is still increasing in relation to North and West Leeds. In addition, the organisation now also serves a wider population, including Harrogate and Rural District, of approximately 600,000 across North Yorkshire as it provides a range of specialist Community Services including a wide range of community-based services for both adults and children.

The trust provides both emergency and elective surgical intervention at Harrogate District Hospital. Planned and Surgical Care directorate is split into a number of specialities as listed below:

- General surgery (lower GI, upper GI, breast)
- Critical care
- Acute pain
- Obstetrics and Gynaecology
- Urology
- Theatres & anaesthetics
- Critical care
- Trauma & orthopaedics
- Rheumatology
- Head & neck (ENT, oral surgery, orthodontics)
- Ophthalmology
- Vascular
- Bowel screening
- Endoscopy
- All outpatients departments
- Dermatology
- Gastroenterology

The trust has eight surgical wards. The trust has 18-day case and 346 inpatient beds.

(Source: Routine Provider Information Request (Acute RPIR) – Info about service)
The trust had 22,988 surgical admissions from May 2017 to April 2018. Emergency admissions accounted for 4,253 (19%), 16,157 (70%) were day case, and the remaining 2,578 (11%) were elective.

(Source: Hospital Episode Statistics)

Following a comprehensive inspection in 2016, the trust was told to complete the following actions:

- The trust must ensure at all times there are suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients dependency levels.
- The hospital should ensure compliance with the ‘five steps to safer surgery’ procedures and World Health Organisation audit.
- The trust should consider whether their laryngoscope handle decontamination process addresses all the likely infection risks.

During this inspection we visited all surgical wards, the surgical assessment unit, and the day surgery unit. We observed care being given and surgical procedures being undertaken in theatres and recovery areas. We spoke with 24 patients and 61 members of staff. We observed care and treatment and looked at 11 care records.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trusts training compliance was RAG rated: Red was 0-49%, Amber was 50% - 74%, Green was 75% - 94% and Blue was 95% - 100%.

Trust level

Training is reported on a monthly rolling basis; a breakdown of compliance for mandatory training courses as of July 2018 at trust level for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Health & Safety	144	150	96%	Blue
Basic Life Support	17	18	94%	Green
Data Security Awareness (previously Information Governance)	139	150	93%	Green
Infection prevention & Control (no renewal and Level 2)	133	154	86%	Green
Manual Handling Face to face & eLearning	239	291	82%	Green
Medicine management training	210	275	76%	Green
Resuscitation	124	172	72%	Amber
Fire Safety - Level 1 (annual)	106	150	71%	Amber
Mental Capacity Act Level 1	62	140	44%	Red

In surgery, nursing and midwifery staff achieved a blue rating for one module and a green rating for five out of nine modules.

A breakdown of compliance for mandatory training courses as of July 2018 at trust level for medical staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Resuscitation	1	1	100%	Blue
Health & Safety	114	130	88%	Green
Data Security Awareness (previously Information Governance)	105	130	81%	Green
Fire Safety - Level 1 (annual)	82	130	63%	Amber
Infection prevention & Control (no renewal and Level 2)	96	152	63%	Amber

Medical and dental staff achieved blue rating for one module where one member of staff for eligible

and a green rating for two out of five modules.

A breakdown of compliance for mandatory training courses as of November 2018 at trust level for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Health & Safety	13	13	97%	Blue
Infection prevention & Control (no renewal and Level 2)	13	13	94%	Green
Basic Life Support	4	4	89%	Green
Data Security Awareness (previously Information Governance)	13	13	87%	Green
Manual Handling Face to face & eLearning	13	13	87%	Green
Fire Safety - Level 1 (annual)	13	13	79%	Green
Medicine management training	23	23	76%	Green
Resuscitation	18	18	67%	Amber

Nursing and midwifery staff achieved one blue rating for health and safety and six green ratings for mandatory training. Resuscitation received an amber rating with 67% completion.

(Source: Routine Provider Information Request (RPIR) – Training tab)

A breakdown of compliance for mandatory training courses as of November 2018 at trust level for medical and dental staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Resuscitation	3	3	100%	Blue
Health & Safety	16	16	82%	Green
Infection prevention & Control (no renewal and Level 2)	16	16	78%	Green
Data Security Awareness (previously Information Governance)	16	16	76%	Green
Manual Handling Face to face & eLearning	16	16	71%	Amber
Medicine management training	26	26	71%	Amber
Fire Safety - Level 1 (annual)	16	16	68%	Amber
Basic Life Support	12	12	63%	Amber

Medical and dental staff achieved one blue rating for resuscitation and three green ratings for mandatory training.

However, we saw overall improved training compliance scores and the trust had plans in place to

drive further improvement.
(Source: Routine Provider Information Request (RPIR) – Training tab)

All staff we spoke with told us that time was provided by managers to complete mandatory training. One ward told us it was difficult due to staff shortages; however, staff were given details of the e learning courses, so that training could be completed from home. All staff told us they were reimbursed if training was completed in their own time.

Ward staff told us that they were sent an email to remind them when training was due and we saw incremental pay rises were reviewed in line with mandatory training completion.

We saw mandatory training compliance rates were recorded within the ward quality dashboard data. Training reports were provided to managers to support staff with completion.
Staff we spoke with told us they were given sepsis screening training and we saw screening documentation within patient's records.

Safeguarding

The trusts training compliance was RAG rated: Red was 0-49%, Amber was 50% - 74%, Green was 75% - 94% and Blue was 95% - 100%.

Trust level

Training is reported on a monthly rolling basis; a breakdown of compliance for safeguarding training courses as of July 2018 at trust level for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Safeguarding Children (Level 1)	133	145	92%	Green
Safeguarding Children (Level 2)	106	121	88%	Green
Safeguarding Children (Level 3)	7	19	37%	Red

In surgery nursing staff achieved two green ratings for safeguarding training, safeguarding children level 3 received a red rating with a completion rate of 37%.

A breakdown of compliance for safeguarding training courses as of July 2018 at trust level for medical staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Safeguarding Children (Level 1)	29	31	94%	Green
Safeguarding Children (Level 3)	14	38	37%	Red

In surgery medical and dental staff achieved a green rating for safeguarding children level one and a red rating for safeguarding children level 3.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

In relation to Safeguarding adults training the provider told us in January 2018 the staff groups requiring this training as mandatory, was expanded to include appropriate band 6, 7 and 8

clinicians in each department/area. This increased the staff numbers requiring the training by 230 people. This increase in staff numbers is reflected in the overall training compliance figure of 36% for substantive staff and 33% for bank staff. However, training is being implemented over 3 years. Compliance for the total staff groups requiring this training is 128% for substantive staff and 120% for bank or locum staff.

The service had systems and processes in place to protect patients from abuse and staff were aware of safeguarding and how to get help so that safeguarding was everyone's responsibility. We saw that the trust had an up to date safeguarding policy that staff accessed on the trust's intranet. Staff told us they had completed safeguard training.

The trust had lead nurses for both adult and children safeguarding. These were available for advice and support if required. The Safeguarding Children Governance Group and Adult Safeguarding team reported to the Supporting Vulnerable People Steering Group which provided assurance to the Senior Management Team which reports to the Board of Directors

Staff could describe circumstances when they would make a safeguarding referral with the help of the central team. Staff at ward level described good support from the psychiatric team for patients with mental health needs.

Staff on one surgical ward gave an example of a recent safeguard that they made in relation to a possible homeless patient. Staff told us they received support from social care colleagues and ongoing feedback from the safeguarding team.

Cleanliness, infection control and hygiene

All areas we visited were found to be visibly clean and tidy and the service had systems and processes in place to monitor and eliminate the risk of infection. Clinical equipment was visibly clean and labelled providing assurance of cleanliness.

We saw there were alcohol hand gels available on entry into the ward and posters on hand washing and sinks were available with adequate supplies of soap and paper towels. We saw sluice and linen rooms on each ward were visibly clean and tidy and all commodes seen were clean.

Infection prevention and control and hand hygiene audits were completed on a monthly basis. Results were collated through the quality dashboard. We reviewed the latest results which showed Littondale achieved 97% compliance in the most recent hand hygiene audits and 92% on Wesleydale ward.

Environmental cleaning audit results were clearly visible in public areas, for example the ward entrance and we saw high compliance rates across the wards we visited. We saw staff washing their hands, using hand gel between patients and staff and complying with 'bare below the elbows' policies. Isolation rooms were available on all wards for the isolation of patients; signage was in place to advise anyone prior to entering an isolation room. We reviewed the latest hand hygiene audit results in the discharge lounge and saw they scored 100% compliance.

One patient told us 'the cleaning staff have been around four times already this morning on this ward'.

The trust had a policy for Methicillin resistant staphylococcus aureus (MRSA) screening and all emergency and elective patients undergoing surgery and procedures fitting the national criteria were tested for MRSA.

The trust had reported zero cases of hospital acquired Methicillin resistant staphylococcus aureus (MRSA) and 10 reported cases of hospital acquired clostridium difficile between July 2017 and June 2018.

Personal protective equipment (PPE) and hand sanitising gel was available throughout wards and departments. We saw that infection prevention and control information was visible on all wards and that staff wore PPE and complied appropriately with the principles of infection control.

All patients were screened for healthcare acquired infections and the assessment of patients who were at risk of developing a healthcare infection were incorporated into nursing assessment documentation as part of the electronic patient record. All wards visited had isolation for the treatment of patients identified as at risk of infection.

We reviewed patient led assessment of the care environment (PLACE) results specific to environmental cleanliness and noted 99.9% vs. a national average of 98.4%.

Following our last inspection Wensleydale ward (elective orthopaedic ward) had taken steps to ring-fence elective only patients as per best practice recommendations. We saw all patients requiring elective admission were clearly identified and isolated from people requiring emergency surgery.

We saw that since the last inspection the provider had taken steps to ensure all theatre instruments including laryngoscopes were decontaminated in accordance with The Association of Anaesthetists of Great Britain and Ireland 2008. We saw during inspection; all equipment was cleaned appropriately.

Environment and equipment

Some areas we visited were cluttered due to the small working spaces and large pieces of equipment, specifically theatre 3 in day surgery. We saw the preparation room was full of large items of machinery such as scanning devices. These items were needed by staff to perform their roles but due to a lack of overall storage in day surgery, the working space available to staff was compromised. However, the environment was visibly clean.

We inspected ten pieces of small portable electrical equipment. All equipment appeared to be in visible working order.

We saw that resuscitation trolleys were checked daily and accessibly located in ward areas. We inspected resuscitation equipment in wards and surgical areas and confirmed daily checks had been undertaken. All sharps bins seen were properly assembled, stored off the floor, not over full and signed and dated.

Within theatres we saw pre-use checks of anaesthetic machines were in place in accordance with The Association of Anaesthetics. These checks were added to current theatre protocols following our last inspection.

We saw within theatre 3 in day surgery that a portable screen was the only barrier between the reception area and the preparation and theatre rooms. This presented a security risk to the area as unauthorised personnel were potentially able to enter these rooms freely. The preparation room contained potentially dangerous items such as loose needles and IV fluids. We saw this area had been risk assessed in 2016, but the risk was in regard to the prevention of privacy and dignity of patients being potentially viewed by visiting patients passing through. There was no risk assessment regarding the security of this area.

Staff we spoke with reported that they had enough equipment to provide safe treatment to patients. Specialist equipment was also available such as bariatric equipment.

There were adequate stocks of equipment and we saw evidence of stock rotation.

Two patients we spoke with told us that televisions in day rooms did not work, which they said was very frustrating.

Assessing and responding to patient risk

The surgical directorate had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. We reviewed the adult escalation policy which required all ill or deteriorating patients to be screened for sepsis, using bedside observations, clinical skills, blood tests (including lactate) and imaging where appropriate.

We saw patient observations were recorded electronically and the trust used the National Early Warning Score (NEWS) tool; which was also recorded electronically. This allowed the staff on the ward to electronically record patient observations, with trigger levels to generate automatic alerts to the medical staff of acutely ill patients. This scoring system supported the process for early recognition of patients who were becoming unwell.

In addition, we saw the provider followed the septic six pathways for patients identified with severe sepsis. This included timely bloods, and antibiotic therapy.

All staff we spoke with told us the system worked well and provided a clear indication of patient deterioration. Following our last inspection, the service had taken steps to review the parameters in which medical staff received alerts of the deteriorating patient. The scores were amended to alert medical staff when patient had a first NEWS score of 5 or 6 (or a score of 3 or 4 where an individual parameter score 3). The electronic patient alert system would automatically send a bleep to and require a response from the holder of the junior doctor bleep for the team currently caring for the patient.

We saw that each ward displayed posters about the risk of sepsis and used red sticker sepsis alerts when identifying high risk patients. All staff we spoke with could describe what they would do to treat and escalate sepsis. Staff also had access to the critical care team if NEWS scores were abnormal and staff required additional help.

The trust had a sepsis policy in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis.

We reviewed sepsis screening results for July 2018 and saw Farndale scored 89% and 75% in Wensleydale wards. Littondale scored 75% and Nidderdale 73%. We reviewed updated data for October 2018 and saw Wensleydale scored 100% compliance, however compliance rates had dropped to 78% in Farndale, and 74% in Littondale. Nidderdale ward had increased slightly to 79%. We saw information within the ward newsletters to support improvement to low scoring wards.

Risks associated with falls, pressure ulcers, VTE, catheter and urinary infections were audited and reviewed each month.

In theatres staff used the World Health Organisation' (WHO) surgical safety checklist. The national safety standards for invasive procedures (NatSSIPs) incorporated the contents of the WHO surgical safety checklist. These required the checklist to be completed for every patient undergoing a surgical procedure (including local anaesthesia).

Theatre staff told us that improvements had been made regarding compliance with WHO checklists. In addition, the hospital undertook the five steps to safer surgery procedures and audit including the World Health Organisation (WHO) safety checklist. The hospital demonstrated

compliance with the safety checklist via an audit of surgical patients' medical notes. We reviewed audits undertaken in September, October and November 2018. All of which achieved 100% compliance.

Theatre on-call was provided by a team of eighteen anaesthetists, each of whom has a specific interest in surgery or specific skill.

Nurse staffing

The trust reported the following nurse staffing numbers for surgery in from April 2017 to June 2018. The trust's fill rate was below 90% for both reporting periods.

April 17 - March 18			**April 18 - June 18**		
Planned staff – WTE	Actual staff – WTE in month	Fill rate %	Planned staff – WTE	Actual staff – WTE in month	Fill rate
149.8	130.3	87.0%	155.9	136.8	87.7 %

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

This represented the second highest fill rate across the directorates. In addition, we reviewed nursing staff fill rates within the directorate and saw fill rates scored between 90% to 100% across all of the surgical wards.

Vacancy rates

From June 2017 to June 2018, Harrogate and District NHS Foundation Trust reported a vacancy rate of 13.4% for nursing and midwifery staff in surgery; this was higher than the trust target of 7.6%

Ward staff told us that nursing staff recruitment had been successful and the number of current nursing vacancies had reduced. We requested updated date which showed nursing vacancies had reduced to 8.87% in October 2018.

Turnover rates

From April 2017 to March 2018, Harrogate and District NHS Foundation Trust, reported a turnover rate of 15% for nursing and midwifery staff in surgery. This was the same as the trusts turnover target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, Harrogate and District NHS Foundation Trust reported a sickness rate of 5.0% for nursing and midwifery staff in surgery; this was higher than the trust target of 3.9%.

The total sick days taken, in comparison to other departments, was relatively low at 7,030 sick days out of 149,434 days.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From July 2017 to June 2018 the trust reported bank and agency usage for qualified nurses in surgery as below:

Type	Total number of hours	Total %
Hours available	24,090	7.7%
Filled by bank	3,736	1.2%
Filled by agency	20,354	6.5%
Hours not filled	10,489	3.3%

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

From July 2017 to June 2018 the trust reported bank and agency usage for non-qualified nurses in surgery as below:

Type	Total number of hours	Total %
Hours available	19,585	10.9%
Filled by bank	7,942	4.4%
Filled by agency	11,643	6.5%
Hours not filled	7,194	4%

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

The trust used the safer nursing care tool to assess nursing staff required per shift. We saw nurse staffing figures were displayed in each ward and planned staffing numbers matched actual numbers in each ward we visited on this inspection. When the actual staffing levels dropped below the planned level, ward sisters utilised the escalation/flow process for staffing shortages which required approval by senior nursing staff.

Two ward sisters we spoke with told us they used a closed social media site to contact bank staff when shortages were identified.

Out of usual Monday to Friday working hours, site co-ordinators would ring the hospital manager to seek approval to book agency staff.

Matrons assigned to surgical areas completed ward assurance visits each morning. Patient acuity was reviewed alongside the numbers of both qualified and unqualified staff. Assurance visit findings were then discussed at twice weekly bed management meetings, which were attended by the Head of Nursing, Planned and Surgical care and staffing manager. We attended the morning bed management meeting and saw that access and flow was considered which included patient activity in the emergency department and elective planned theatre lists for the day. Staff skill mix was also reviewed in each of the surgical wards. Staff were then asked to move to wards rated highest risk where necessary, to mitigate safe care staffing numbers.

During particular periods of staff pressures matrons worked operationally on wards. All of the ward staff we spoke with told us it was not uncommon to see matrons providing ‘hands on’ support on the wards when required.

We saw on Farndale that seven patient beds were closed at the time of inspection. Matrons told us that this was due to staffing shortages but the beds could be reopened at any time as staffing numbers were assessed daily.

Theatre staffing levels were planned according to the lists on a daily basis. Staff told us that no theatre lists had been cancelled due to a lack of staff.

Staffing was on the directorates risk register because the senior management team recognised that, while it achieved safe staffing levels, the position was only maintained with daily close monitoring.

A number of actions had been identified to address staffing vacancies, e.g. recruitment plans for current vacancies, robust sickness monitoring, the use of bank nurses, overtime, daily board rounds prioritising care, monitoring of staff rotas. Longer term plans had also been developed, such as vacancies advertised and international recruitment, implementation of the e-roster, escalation processes in place through the matron, business manager and chief matron, daily matron's assurance reports.

We spoke with four student nurses who all told us they felt extremely supported even during particularly busy periods on the ward.

Medical staffing

The trust reported the following medical staffing numbers for surgery from April 2017 to June 2018.

April 17 - March 18			**April 18 - June 18**		
Planned staff – WTE	Actual staff – WTE in month	Fill rate %	Planned staff – WTE	Actual staff – WTE in month	Fill rate
111.7	111.1	99.4%	112.6	105.4	93.6 %

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

From June 2017 to June 2018, Harrogate and District NHS Foundation Trust reported a vacancy rate -0.1% for medical and dental staff in surgery, this indicated a surplus of staff. The trusts vacancy target was 7.6%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, Harrogate and District NHS Foundation Trust, reported a turnover rate of 11% for medical and dental staff in surgery. This was lower than the trusts target of 15%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, Harrogate and District NHS Foundation Trust reported a sickness rate of 1% for medical and dental staff in surgery; this was lower than the trust target of 3.9%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From July 2017 to June 2018 the trust reported bank and locum usage for medical staff in surgery as below:

Type	**Total number of** Hours	**Total %**
Hours available	12,1108	2%
Filled by bank	1,386	1.1%
Filled by agency	1,081	0.9%
Hours not filled	8	0%

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical agency locum tab)

Bank and locum staff usage - Middle grade/ trainee doctors

From July 2017 to June 2018 the trust reported bank and agency usage for non-qualified medical staff in surgery as below:

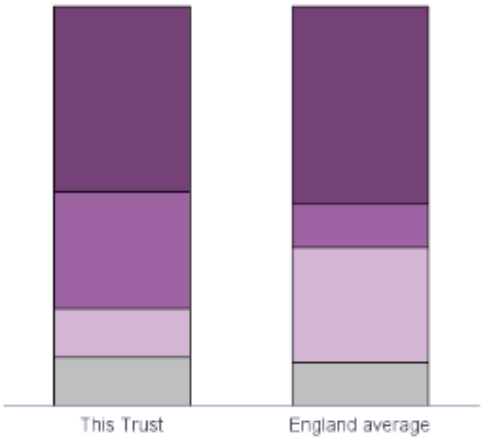
Type	**Total number of Hours**	**Total %**
Hours available	15,9978	8.8%
Filled by bank	11,984	7.5%
Filled by agency	2,101	1.3%
Hours not filled	2,337	1.5%

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical agency locum tab)

Staffing skill mix

From May 2018 to May 2018, the proportion of consultant staff reported to be working at the trust was lower than as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the whole time equivalent staff working at Harrogate and District NHS Foundation Trust



	This Trust	England average
Consultant	47%	49%
Middle career^	29%	11%
Registrar Group~	12%	29%
Junior*	12%	11%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medical cover was available on-site 24 hours a day and the directorates of surgery made use of a number of on call rotas. Consultants were supported at ward level by foundation year one doctors assigned to each ward. Consultants were available 24hrs, with on-call cover provided evenings and at weekends.

We spoke with one of the consultants who told us they would review patients who required it at weekends on the surgical ward, even if they were not under their direct care.

Prior to inspection we reviewed skill mix data and saw that the proportion of registrars working within surgery was significantly lower than the England average at 12%. England average is 29%. Middle grade medical working within surgery was significantly higher at 29% compared with the England average of 11%. All junior doctors we spoke with told us that they felt fully supported by senior members of the medical team and felt that the training and leadership within the organisation was strong.

Out of hours, there was a three-tier surgical cover available. Junior doctors were available on site on a 24-hour basis. Middle grade doctor cover was available on site until 8.00pm and on-call access available over night. Consultants were available on a 24-hour basis.

We saw ward rounds were conducted daily and the ‘consultant of the day’ was clearly identified. Ward staff described ‘doctors jobs lists’ and we saw clear written patient lists outlining tests and reviews that were required each day. For example, blood tests and discharge reviews.

We witnessed a surgical handover and noted effective discussion about the clinical care of surgical patients and agreement for patient management plans. Surgical outliers were identified and were included within the planned daily reviews.

Post-operative ward rounds were completed daily. We were told medical outliers on a surgery ward awaiting a bed on a medicine ward were seen by consultants from medicine usually before midday each day.

Records

The trust had introduced an electronic patient record supported by paper records for each patient. Electronic records held basic observation information such as blood pressure monitoring and temperature checks. Paper nursing and medical notes were comprehensively maintained.

We reviewed 11 sets of nursing and medical records, across wards and checked care plans and risk assessments in detail. These were completed accurately and updated regularly and included nutrition, fluid balance, pressure area care, rounding checks and hydration charts. We saw do not attempt cardiopulmonary resuscitation (DNACPR) forms, situated at the front of the patient records.

In addition, we saw the completion of venous thromboembolism (VTE) assessments which were displayed on the wards within the reception areas. We saw high compliance rates of over 90% on all of the wards we visited.

Electronic discharge letters were sent to G.P's. Staff told us the system worked well and had not encountered any issues.

Medicines

We saw the trust had an up to date medicine policy that detailed the safe storage and management of medicines, including controlled drugs. Access to medicines was restricted to authorised staff.

We saw TTO medicines (medication that the patient takes home) was planned at the point of admission for elective patients.

On Farndale ward we reviewed six patient clinical records, and spoke with one member of staff and one patient and reviewed medicines storage. On Nidderdale we reviewed four patient clinical records, spoke with three members of staff and three patients and reviewed medicines storage. On day surgery we reviewed fridge temperature medicines storage.

We found inconsistent practice across wards regarding the management of medicines. Although trust policy identified arrangements for monitoring medicines which required refrigeration, maximum and minimum temperatures were not recorded on wards. On some wards the same temperature had been recorded for each day without the thermometer being reset and recalibrated giving a potentially wrong reading.

Emergency medicines and equipment trolleys were stored and a visual check was completed in line with trust policy.

Controlled Drugs were stored and administered appropriately with staff completing checks in line with trust policy. Pharmacy completed three monthly audit checks and we saw evidence that this had occurred.

Staff recorded administration of medicines using the Electronic Prescribing and Medicines Administration (EPMA) system. The nursing and pharmacy staff used EPMA to complete medicines rounds and medicines reconciliation effectively.

The pharmacy provided a medicines reconciliation service across the surgery wards. Pharmacists worked within the pre-assessment service for elective surgical patients. We saw that this service meant that patients were prescribed their medicines in a timely manner and the information was accurately documented at the point of admission.

Records reviewed on Farndale showed medicine reconciliation had been completed in four of the six records we looked at. Allergies were recorded in line with trust policy. We found oral antibiotics were prescribed with a stop date and indication. Intravenous antibiotics were not prescribed with a stop date but were reviewed on a regular basis and the trust could access a live database using their electronic prescribing system which showed any patient prescribed intravenous antibiotics throughout the entire hospital to ensure regular reviews were completed.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in surgery which met the reporting criteria set by NHS England from July 2017 to June 2018. This was slips/trips/falls meeting SI criteria.

(Source: Strategic Executive Information System (STEIS)

Surgery reported only one serious incident which related to a patient fall. Staff told us a root cause analysis was carried out which identified concern relating to the initial assessment of this patient. Staff spoke of the importance of completion documentation thoroughly to avoid any future missed opportunities.

Staff we spoke with knew how to report incidents and could describe lessons that had been learnt. For instance, following several incidents relating to falls we saw on Wensleydale ward that a falls huddle was carried out as part of handovers, to identify patients at high risk of falls. As a result of these huddles the numbers of falls had reduced, which was evident within the safety thermometer data.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Staff described various ways in which learning was shared about incidents such as handovers, ward meetings and newsletters. In addition, on the wards there were communication folders or monthly bulletins displayed, for staff to see and read.

We reviewed ward newsletters on surgical inpatient wards and saw actions taken as a result of recent incidents.

Matrons shared lessons learnt at ward level with the ward manager and sister within each ward. Matrons also met regularly with the ward leaders and the head of nursing for the surgery directorate to discuss learning from incidents. Mortality and morbidity was discussed at regular mortality sub-committee meetings.

Safety thermometer

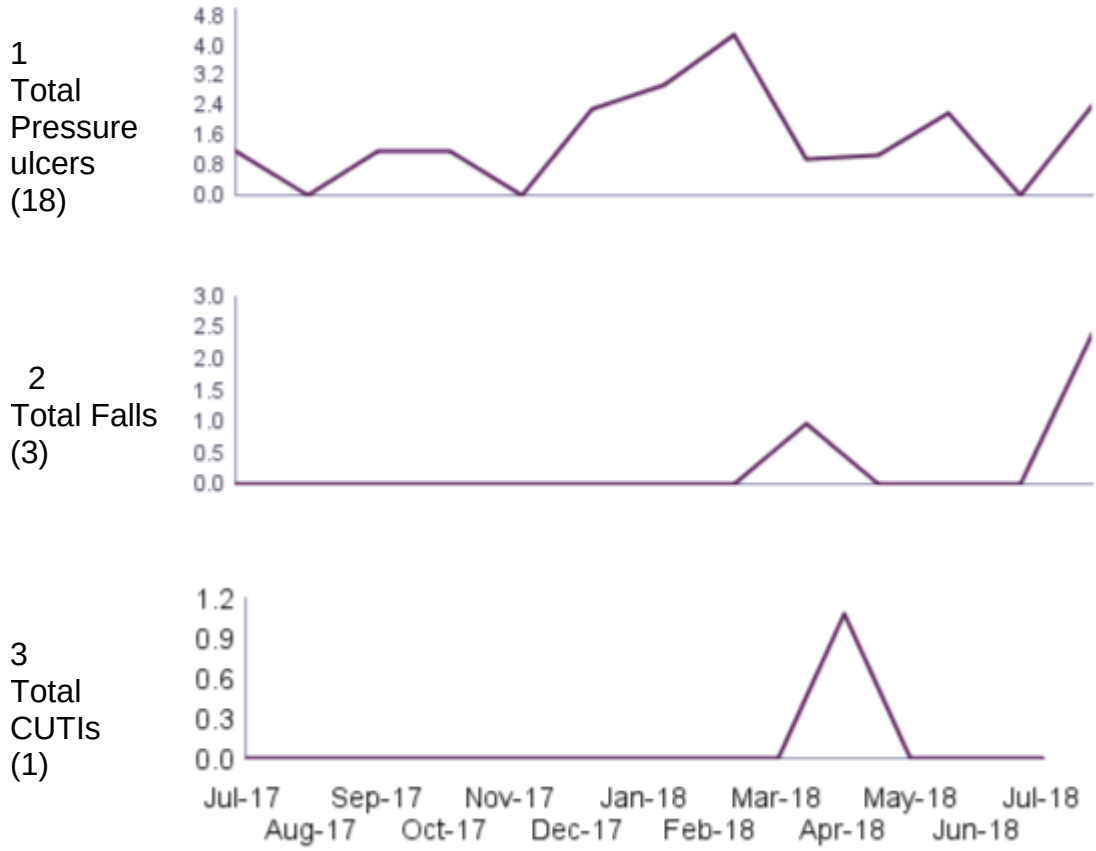
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Ward managers told us that safety thermometer data completion was a priority each month and time was provided by senior managers in order to complete this.

Data from the patient safety thermometer showed that the trust reported 18 new pressure ulcers, three falls with harm and one new catheter urinary tract infection from July 2017 to July 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulc and catheter urinary tract infections at Harrogate and District NHS Fou Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

We requested safety thermometer data following inspection and saw patient harm free days on all surgical wards increased from 89% harm free, recorded in January 2018 to 98% in October 2018.

Safety results were on display to the public on each ward. These included staffing levels, days since the occurrence of pressure ulcers, falls and CUTIs as well as medication errors, hand hygiene and cleaning audits. Compliance rates for the assessment of venous thromboembolism and the provision of patient information and the completion rates for mandatory training and appraisals were also displayed.

Is the service effective?

Evidence-based care and treatment

Trust policies and clinical pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). All ward staff referred to national guidance during clinical discussions with inspectors and demonstrated a robust understanding of best practice within the directorate of surgery.

Clinical practice was monitored through clinical governance meetings and we saw evidence of this through a review of clinical governance reports.

In addition to existing care pathways such as stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis, we saw a number of new pathways that had recently been developed and introduced such as a surgical pathway from A & E and enhanced recovery pathways for caesarean sections and colorectal surgery.

In addition, SSKIN bundles were evident for those patients deemed to be at risk.

Staff accessed policies, procedures and other guidance through the trust intranet. We reviewed policies and found them to be in date with version control and a named author. Integrated pathways were in use for patients undergoing day surgery procedures including documentation to assess risk such as venous thromboembolism (VTE).

Audits were undertaken for the completion and accuracy of care bundles, the use of NEWS, medication and documentation such as those which related to infection prevention and control. Results showed good levels of compliance. Ward sisters completed trust-wide nursing audit programmes and we saw results and action plans in ward files.

The directorate participated in a number of national audits including the national hip fracture database and the national bowel cancer audit programme. Staff records reflected training initiated and completed. Medical staff undertook clinical audits and these were discussed at clinical governance meetings.

Nursing staff completed a number of audits on patient experience and outcomes, these audits were completed internally and were completed by observation or review of documents. These audits included medicines administration, environment and hand hygiene.

Nutrition and hydration

The nutritional needs of patients were assessed as part of the generic nursing assessment booklet and the MUST nutritional scoring tool was incorporated within the documentation. Risk

assessments for those patients requiring additional support were clearly documented such as those patients at risk of malnutrition.

Patients receiving intravenous fluids had fluid balance charts in place and we saw these were fully completed, although target fluid balance intake at the end of the day was not shown. Staff told us that fluid balance was recorded electronically several months ago, but following feedback from staff that there were difficulties with the electronic recording, staff were advised to revert back to paper records.

Protected meal times were in operation and we saw patients being supported to eat and drink. We saw the trust enabled carers and family members to support patients with nutritional and hydration needs.

In additional we saw band two nutritional assistants were in place on all of the wards we visited. These staff provided specific nutritional support to patients. We spoke with two assistants who spoke passionately about their role and were knowledgeable about the effects of poor diet, such as slow recovery and poor wound healing.

Patients whom were fasting or had a specific nutritional need identified were shown on the ward white board which acted as a clear visual tool to all professional staff visiting the wards as to the needs of the patients.

Policies were in place regarding fasting times and intravenous fluids in line with best practice and we saw patients were fasted for the least amount of time possible.
Most patients said food was good, menus were varied. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which showed an overall satisfaction of 89% following the 2018 survey. The England average scored 90%.

One patient on Farndale told us the food was “perfectly serviceable”

Another patient told us they were dehydrated when they came in. Staff went ‘over and above to remind me how important it is to keep drinking’.

Seven other patients told us how staff encouraged fluids at every opportunity and fresh water was said to be replaced frequently.

Pain relief

The majority of patients we spoke with told us that their pain levels were managed effectively. Only one patient told us that they were required to wait for analgesic but this was due to the wrong medication being sent to the ward, which caused a delay. This patient told us however that staff were extremely apologetic and attended to the problem quickly and professionally.

Staff used a pain score tool to assess patient’s pain levels; staff recorded the assessment on the patient records computer system. We saw nursing staff discuss pain levels with patients in a timely and professional manner. In addition to the generic pain assessment tool we saw a specific pain assessment tool which was developed to support patients with dementia ‘PAINAD’.
We spoke with a pain nurse who told us that following recent attendance at a national pain conference, this tool was now recognised as best practice. We saw that the tool was in use at the time of inspection.

We reviewed care plans related to pain management and pain relief was provided as prescribed and was regularly reviewed by medical staff.

Post operatively the department used local infiltration and spinal anaesthetics for major surgery to assist with pain relief post-operatively, which improved patient comfort.

All patients we spoke with informed us they were very happy with their care and had received pain relief in a timely manner on all occasions they had requested it.

Patient outcomes

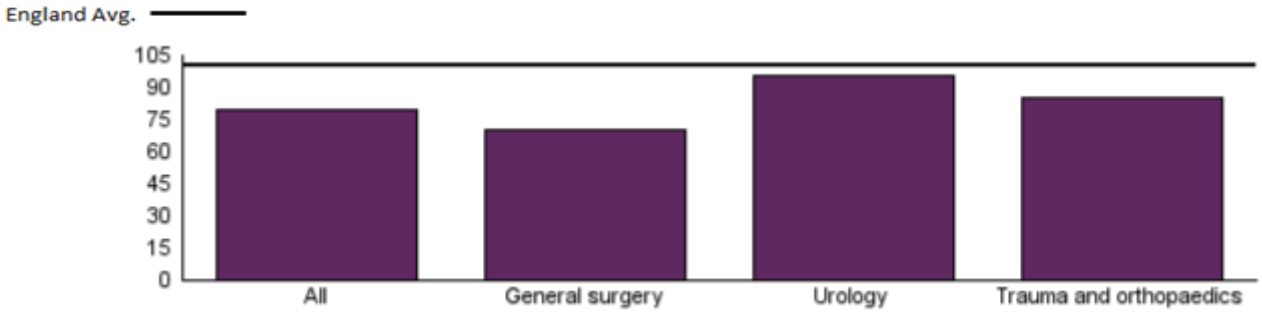
Relative risk of readmission

Harrogate District Hospital

From May 2017 to April 2018, all patients at Harrogate District Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at Harrogate District Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Harrogate District Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Harrogate District Hospital had a lower risk of readmission for elective admissions when compared to the England average.

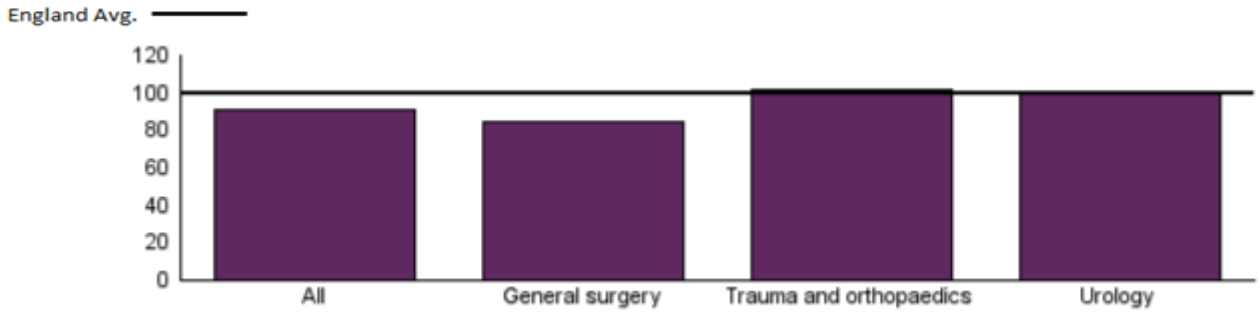
Elective Admissions - *Harrogate District Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

- All patients at Harrogate District Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at Harrogate District Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Harrogate District Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Harrogate District Hospital had as expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *Harrogate District Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 – 30/4//2018))

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 7.8% which was within the expected range. The 2016 figure was 6.7%.

The proportion of patients having surgery on the day of or day after admission was 84%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 82%.

The perioperative medical assessment rate was 98%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 78%.

The proportion of patients not developing pressure ulcers was 98%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 95%.

The length of stay was 23.2 days, which falls within the middle 50% of trusts. The 2016 figure was 20.7 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 67% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than expected. The 2016 figure was 60%.

The risk-adjusted 90-day post-operative mortality rate was 2.0% which was within the expected. The 2016 figure was 3.3%.

The risk-adjusted 2-year post-operative mortality rate was 14% which was within the expected range. The 2016 figure was 24%

The risk-adjusted 30-day unplanned readmission rate was 11% which within the expected range. The 2016 figure was 10%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 40% which was within the expected. The 2016 figure was 46%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not participate in the National Vascular Registry (NVR) audit. The Trust had a vascular outpatient service through an alliance with York Teaching Hospital and therefore it was not appropriate for HDFT to participate in this audit.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 17%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 14%.

The 90-day post-operative mortality rate data was not eligible.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 39%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the Harrogate and District NHS foundation trust achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 70 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 68 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 36 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 26 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 70 cases.

(Source: National Emergency Laparotomy Audit 2016)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 the proportion of patients reporting an improvement following groin hernia surgery for the Harrogate District Trust was lower than the England average, however the proportion of patients reporting worsening of symptoms was at the England average.

For varicose veins, the performance data was not eligible

For hip replacements, performance was about the same as the England average.

For knee replacements was about the same as the England average.

(Source: NHS Digital)

Competent staff

Appraisal rates - trust level

From April 2018 to June 2018, 51% of staff within surgical care at the trust received an appraisal compared to a trust target of 90%. A breakdown by staff group is shown below:

Staff Group	Individuals required (YTD)	Staff who have received an appraisal (YTD)	Appraisal rate %	Trust Target	Met (Yes/ No)
Other Qualified Scientific, Therapeutic & Technical staff (other qualified ST&T)	6	5	83%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	34	17	50%	90%	No
Medical & Dental staff - Hospital	20	10	50%	90%	No
Support to doctors and nursing staff	35	17	49%	90%	No
Qualified Allied Health Professionals (Qualified AHPs)	2	0	0%	90%	No

All five staffing groups failed to meet the trusts 90% appraisal completion target they also failed to meet the target in the last financial year (April 2017 to March 2018) were they achieved 77%. However, all staff we spoke with told us that appraisals had been a recent priority and most of the staff had undergone a recent appraisal.

We requested updated appraisal completion data following inspection and saw that qualified and nursing staff appraisal completion had increased to 88% in October 2018.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

All staff we spoke with told us that the service had made significant progress in regard to appraisal compliance rates. We saw ward compliance ranged from 72% to 93%.

All newly qualified staff employed by the trust were subject to a period of preceptorship and supervision, which varied according to the area worked in and was subject to competency sign-off. Staff received formal engagement sessions with their ward supervisor or academic lead. These took the format of one to one meetings, clinical supervision sessions, attachment to specialist practitioners, mentoring and observation, reflective practice, and revalidation.

Multidisciplinary working

We observed multidisciplinary team meetings held each week in which different specialities attended, for example radiologists, speech and language therapy and consultants. We saw during three meetings that therapy colleagues commenced discharge planning at the point of admission to ensure effective and timely discharge processes.

Specialist nurses were available to review patients in specialties, such as respiratory and diabetes, physiotherapy, speech and language, pharmacy, child and adolescent and adult mental health liaison. Link nurses were trained on each ward to support staff with dementia and learning disability patients.

Specialists were also available to support staff groups with training and we saw educational sessions to supplement staff clinical knowledge.

The discharge co-ordinator actively worked alongside ward staff to proactively plan for discharge from point of admission.

Allied Health Professionals we spoke with confirmed there was good multidisciplinary working and offered training to nursing staff where appropriate. Dieticians completed daily reviews of those patients referred for their input.

The trauma orthopaedic department worked collaboratively with a range of disciplines to maximise patient outcomes.

Seven-day services

On-site medical cover was available 24hours a day; junior doctors provided this. Senior medical cover from middle grade doctors and Consultant cover was available on-site for approximately 12 hours a day and on-call cover was available on a weekend and evening, in line with professional standards.

Daily ward rounds with medical staff took place for all patients.

Physiotherapy and occupational therapy were available 7 days a week on the orthopaedic wards. On the general surgical wards there was a 7-day physiotherapy service for respiratory conditions, and a Monday to Friday general physiotherapy and occupational therapy service with on call arrangements out of hours. In addition, the Supportive Discharge Service included physiotherapists, occupational therapists and registered nurses and provided a seven-day service to all wards within the hospital.

The department had access to, diagnostics and radiology services 24 hours, seven days a week, to support clinical decision-making.

Pharmacy staff were available on site between the hours of 8.30am to 5.30pm, Monday to Friday. There was a limited ward-based clinical pharmacy service at weekends between the hours of 9.00am and 2.00pm. Outside of these hours, an on-call service was provided.

Orthopaedic consultants had access to dedicated trauma lists five days a week and then shared the emergency list with other surgical specialities on a weekend.

Ward and theatre staff told us that Saturdays were usually busy days due to theatre list scheduling and as all department staff were not available on weekends this could at times create additional pressures.

Health promotion

Patients said staff gave them advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention on all wards.

Patient leaflets were available throughout the hospital, prominently displayed on communication boards within wards and corridors and available for patients to take with them.

We did not see patient information leaflets in other languages than English but were assured they were available on request.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Training is reported on a monthly rolling basis; the trust reported that as of July 2018 Mental Capacity Act (MCA) training was completed by 40% of all staff within surgery.

A staff group breakdown is shown below;

Staff group	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	RAG Rating
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	8	8	84%	Green
Support to doctors and nursing staff	20	20	60%	Amber
Qualified nursing & health visiting staff (Qualified nurses)	25	25	59%	Amber
Other Qualified Scientific, Therapeutic & Technical staff	3	3	50%	Amber
Medical & Dental Staff - Hospital	25	25	45%	Red
Qualified Allied Health Professionals	4	4	36%	Red
NHS Infrastructure Support Staff	1	1	0%	Red
Support to Scientific, Therapeutic and Technical Staff	2	2	0%	Red

One staff group achieved a green rating for MCA level 1 training, nursing and health visiting staff achieved an amber rating whereas medical and dental staff achieved a red rating.
The trust told us that plans were in place to improve the training levels for staff. MCA Level 2 training was also due to be rolled out to selected staff groups and we saw planned training dates to deliver this.
(Source: Routine Provider Information Request (RPIR) – Training tab)

There was mandatory training on recognising and managing patients with dementia. Staff were aware of online learning that was available through the hospital intranet. Staff were also aware of short training sessions offered by the mental health liaison team focused on depression, dementia and delirium. Staff who had attended spoke highly of these sessions and were knowledgeable about the application to the patients they cared for. More recently (November 2018) the learning disability liaison nurse had introduced learning disabilities training that also included basic awareness of autism and would ensure staff achieve the competencies set out by HEE in the Learning Disabilities Core Skills Education and Training Framework.

Staff had limited understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff reported that Mental Capacity Act eLearning was available and that capacity assessments were completed for surgery and discharge. However, staff were not able to identify any other situations when capacity assessments would be necessary, for example for the use of bedrails or for other non-surgical treatments.

Ward staff reported that doctors completed capacity assessments for surgery. When a patient lacked capacity, doctors completed a form which included both a capacity assessment and documented the best interest decision making process. The form was comprehensive and the first part of the form recorded the assessment of mental capacity assessment. This section included tick boxes to identify why a person did not have capacity. There was also a box to explain how the decision regarding capacity was made for example what efforts to support the capacity of the person had been made. This box was usually either blank or had a repeat of the impairment, rather than an explanation of how the decision was made. There was also space to detail the involvement of relatives or an independent mental health advocate. Although several of the

capacity assessments stated the involvement of relatives, there was no detail about when this had been discussed with them and only one form included the signature of the relatives.

We reviewed nine patient capacity assessments and saw in all nine, documentation was not clearly completed, missing signatures to confirm consent or did not clearly identify the reason for undertaking a capacity assessment in the first instance.

Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test response rate for surgery at Harrogate and District NHS Foundation Trust was 39% which was better than the England average of 26% from July 2017 to June 2018.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Harrogate and District NHS Foundation Trust, by site.

Ward name	Total response	Response rate %	Annual Perf.
Day case	2838	43%	97%
Farndale	290	41%	97%
Littondale	322	16%	96%
Nidderdale	577	37%	95%
Wensleydale	935	61%	97%

	Percentage recommended											
Ward name	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Day surgery					97%	97%	96%	98%	98%	98%	97%	95%
Farndale	100%	97%	94%	100%	90%	100%	95%	95%	100%	93%	97%	96%
Littondale	94%	91%	98%	100%	97%	94%		100%	100%	100%	97%	93%
Nidderdale	97%	98%	96%	91%	93%	100%	94%	96%	100%	87%	97%	98%
Wensleydale		97%	96%	97%	96%	100%	97%	99%	98%	100%	100%	93%

Day surgery, Farndale and Wensleydale wards had the highest percentage recommended rate all with 97%.

(Source: Friends and Family Test)

The NHS Friends and Family test (FFT) is a satisfaction survey that measures' satisfaction with the healthcare the patient has received. There was also a better than England average response rate in day surgery (43%), Farndale (41%), Nidderdale (37%) and Wensleydale (61%) wards. It is

We spoke with 24 patients during our inspection. All feedback we received regarding the caring nature of staff was extremely positive. Many of the patients told us that Harrogate had 'high expectations' and staff 'did not disappoint'.

Another patient on Farndale ward told us 'the service has been great here, I can't fault them'.

During the inspection, we observed genuine positive interactions between patients and all levels of staff, from consultants to domestic, and volunteer which corroborated the praise we were provided.

One member of staff told us they used to teach individuals to climb before they came into health. This member of staff had cared for a pupil he used to teach to climb but was no longer able due to knee problems. The member of staff was supporting this patient to climb again post operatively when fully recovered.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Staff were enthusiastic to ensure that patients with additional needs were supported, and staff at all levels spoke about how they could enhance the patient journey. For example, patients bringing in comfort objects from home, using 'about me forms' and health passports, and considering the timing of meals for patients with dementia.

A patient on Nidderdale ward told us 'the staff are always being polite and kind and in fact couldn't have been kinder'. One patient told us 'they accommodate all of my needs, which makes all the difference'. Other patients described how 'quick' staff were and 'incredible'.

We reviewed comments cards that had been left from patients on Littondale ward. All five cards we reviewed during inspection were extremely positive. Comments included 'Thank you to staff for their professionalism and vigilance during my stay' and 'I have stayed here many times and have always been treat with the best of care'.

One patient on Wensleydale ward told us they had been invited for Christmas Lunch by ward staff following discharge, as the patient mentioned they would be alone at Christmas.

Within day surgery theatre we spoke with two patients who told us 'The whole journey today has been impeccable from start to finish' and told us 'As soon as I walk through the door I felt welcome. The same nurse looked after me all day. It's like a spa but with anaesthetic'.

We saw following the 2018 Patient- led assessments of the care environment (PLACE), the trust scored lower than the England average of 84% with 75% overall satisfaction for privacy dignity and well-being.

We saw family test results as well as 'two minutes of your time' feedback. Comments on display on wards showed a variety of responses from patients, most of which were positive. Patients we spoke with told us that staff were friendly, supportive, compassionate and caring. They said their privacy and dignity was respected and maintained.

We saw the wards were busy but saw staff responded promptly to call bells or requests for assistance as quickly as they could.

With day surgery we saw large numbers of thankyou cards displayed around the entrance of the unit.

Emotional support

Staff we spoke with told us they had mandatory training on dementia. The wards provided a care bundle for people living with dementia and there was a carer's pass for families visiting wards for people living with dementia.

Staff reported they routinely discussed the psychological and emotional needs of patients, their relatives and carers within handover meetings.
Staff used health passports and 'all about me' forms with patients which captured their care preferences, anxieties and things that comfort them. These enabled all staff to quickly understand what support individuals needed.

Staff within day surgery described assistance and support they provided to patients with learning disabilities. A recent example involved a patient requiring dental surgery whom experienced heightened anxiety. Staff explained the additional time made available to the patient to 'play' and familiarise themselves with equipment such as the oxygen mask and side room surroundings before undertaking procedures later that day.

In another example, staff told us additional support was provided to a patient with learning disabilities whom presented with challenging behaviour due to anxieties. Staff told us provision was made for the patient to have his favourite music played into the treatment room, and was met personally by staff upon arrival with his carer from home. This patient's personal belongings were brought in to support his mood and was placed first of the list to avoid any waiting time, leading to increased anxiety.

Ward staff told us they could refer patients for counselling services following diagnosis of potentially life limiting conditions such as cancer and palliative care pathways.

Clinical nurse specialists could refer to an oncology Psychologist.

One patient on Farndale told us 'nurses regularly check in on me'.

All patients seen looked well cared for and were supported to move around, with staff assistance where necessary.
One HCA told us they made time to curl a patient's hair each day as this made a difference to the lady's self-confidence.
Another patient on a separate ward told us 'the girls do my hair for me every day. They make me feel normal again'.

Understanding and involvement of patients and those close to them

The wards worked with different services and staff to organise and manage discharges. There was a discharge liaison team available to assist in discharge from wards.

From reviewing patient notes and observation of interactions staff had with patients we were assured staff had tried to understand patient needs or those close to them. We saw how staff attended to a patient who was shouting out, gave reassurance and spent time with the patient to calm them down.

The wards and departments used a bespoke Harrogate friends and family feedback questionnaire, questions included questions about pain control, pain relief offered, timescale for administration and overall effectiveness.

Carers and families of vulnerable patients were issued with a carer passport which provided them with free car parking and free meals.
In addition to providing ongoing nutritional daily support, one of the nutritional assistants told us they visited patients identified as struggling to reach their recommended daily calorific intake. Staff told us they offered additional food items to tempt their appetite such as small cakes. Staff described the popularity of these visits and displayed a genuine caring attitude.

Patients told us that they knew what was happening with their care and what their treatment plans were. Almost all patients said they had been kept informed about what was being done in a way they could understand so that they felt involved in their care.

One patient on Nidderdale ward told us 'I am in total awe of the system here in surgery'. Another patient told us that they often forget information and staff were 'only too happy to repeat information when needed'.

Another patient on Farndale told us ‘staff go above and beyond in terms of politeness and attending to my needs’.

All wards involved relatives in the care of patients where possible and with the permission of the patient. Although there were set visiting times, all wards were flexible and provided information regarding current care and treatment. Wards told us they were planning to pilot ‘open visiting’ times.

We saw on all wards we visited active fund raising in place. Staff told us they were involved in several areas of charitable events for the ward and described it with enthusiasm and passion. We saw donation points provided by the trust on several of the wards we visited and staff provided examples of items of equipment that had been bought as a result of funds raised. For example, on one ward we saw a portable interactive electronic device for patients diagnosed with dementia. On another ward staff knit twiddle muffs again for dementia patients.

We saw separate male and female waiting areas within the pre-admission / discharge lounge.

How well the needs of patients with a disability were monitored through patient led assessments of the care environment (PLACE). We saw the trust scored 87% which was higher than the England average of 84%.

Is the service responsive?

Service delivery to meet the needs of local people

Senior managers planned services in line with the annual trust business plan which included surgery. Managers described working with business managers, the clinical director and matrons to plan services.

There were systems in place to assist in the delivery of care to patients. For example, people living with dementia and children receiving surgery in theatre.

Meeting people's individual needs

All ward staff told us they had access to translation services and all staff told us the service provision was effective. One ward manager explained that while the ward had access to interpreters, they had used a nurse from another ward who spoke fluent Spanish to support the discharge of a patient who did not speak much English.

There was a variety of patient information leaflets available in wards; however, there were no leaflets available in different languages. Ward staff told us they would be made available upon request.

All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward, and general useful signposting on where to get further information such as Patient Advice and Liaison Services (PALS), and complaints.

The department used the butterfly scheme to support people living with dementia or who presented with confusion or delirium. A blue butterfly was available on patient boards and some handover information to indicate the patient had a dementia diagnosis. A white butterfly was available to identify patients who did not have a diagnosis of dementia, but who were confused or showing delirium and who staff were concerned about.

We saw a specific room made available to patients diagnosed with dementia within the discharge unit, which provided a quiet relaxing environment.

Staff used a similar system to identify vulnerable inpatients such as people with learning disabilities. Staff reported good working relationships with the learning disabilities liaison nurse who supported any adults with learning disabilities within the hospital. Their details were publicised within ward areas.

Each ward had link nurses focusing on the needs of vulnerable inpatients. These link nurses attended regular meetings to develop their knowledge and skills.

Health passports and nursing passports were used with patients with learning disabilities to identify their additional needs and any behaviours and anxieties they may have. Day surgery spoke passionately about the learning disability liaison service and the staff who visit and support the patients in the unit. Staff gave us several examples to demonstrate how service provision was tailored to meet individual's needs.

Staff have access to communication aids to help patients become partners in their care and treatment. Staff had easy access on the wards to a range of communication aids. These were both locally developed books of pictures related to basic needs and a nationally developed Hospital Communication resource. This resource included advice for staff on a range of communication issues and included Makaton signs, basic sign language and symbols.

Mental health support was available through the adult psychiatry team if required and there was a service level agreement with a mental health trust for mental health liaison and Mental Health Act management.

The service had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. The mental health liaison team and the adult crisis team provided cover across 24 hours a day. All staff we spoke to were aware of how to contact the mental health teams in an emergency. The team manager for mental health liaison explained the team had a 1-hour response time for accident and emergency and 24 hours for other wards. However, staff on the surgery wards reported a much faster response time when they contacted the team with concerns.

The trust wide delirium team also attended wards to provide support to patients with delirium.

Patients' religious needs, dietary requirements, and hearing, sight or language difficulties were identified through structured assessments. Patients were provided with information leaflets on their surgical procedures.

Staff identified patients who had additional care needs at handovers and safety huddles, for example falls huddles on Littondale ward.

Wards and departments were accessible for patients with limited mobility and people who use a wheelchair.

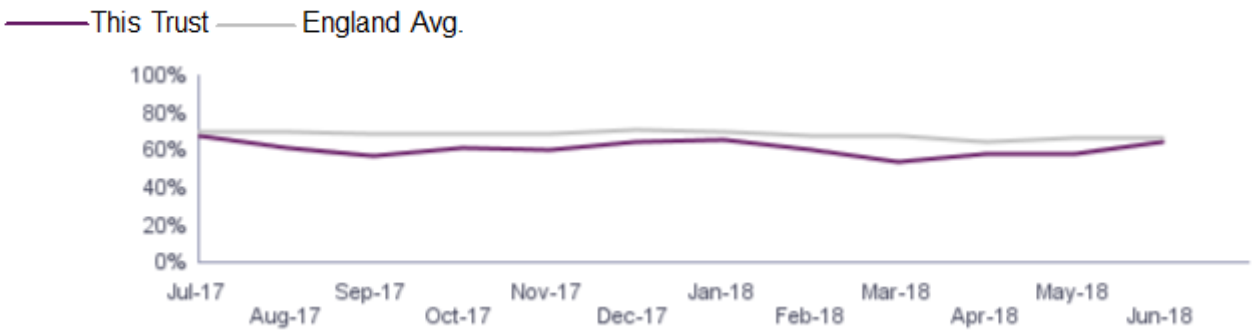
The generic nursing assessment documentation was comprehensive and enabled individualised assessments to be completed. For example, religious needs and dietary requirements.

A multi-faith chaplaincy service was available within the trust and during the inspection, we saw three different chaplains visiting surgical ward areas. A bereavement service was also available that staff were able to access to support patients or carers who needed.

Access and flow Referral to treatment (percentage within 18 weeks) - admitted performance

From July 2017 to June 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. This trust's score was consistently lower than the England average, with March 2018 having the biggest difference, where England's average was 8.9% higher.

However, we saw the scores began to improve overall from March 2018.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	90.6%	76.8%
Plastic surgery	85.0%	81.4%
General surgery	84.7%	72.7%

Six specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
ENT	56.3%	63.2%
Trauma & Orthopaedics	46.2%	60.4%
Ophthalmology	41.7%	69.0%
Cardiothoracic surgery	0.0%	79.8%
Neurosurgery	0.0%	70.3%
Oral surgery	0.0%	60.5%

(Source: NHS England)

Cardiac surgery and neurosurgery are not undertaken at Harrogate and District Hospital.

The current RTT for ENT is 95.53%.

Elective Average Length of Stay - Harrogate District Hospital

Harrogate District Hospital - elective patients

From June 2017 to May 2018

- The average length of stay for all elective patients at Harrogate District Hospital was 2.9 days, which is lower compared to the England average of 3.9 days.
- The average length of stay for trauma and orthopaedics elective patients at Harrogate District Hospital was 3.3 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for general surgery elective patients at Harrogate District Hospital was 3.5 days, which is lower compared to the England average of 3.9 days.
- The average length of stay for urology elective patients at Harrogate District Hospital was 1.7 days, which is lower compared to the England average of 2.5 days.

Harrogate District Hospital - non-elective patients

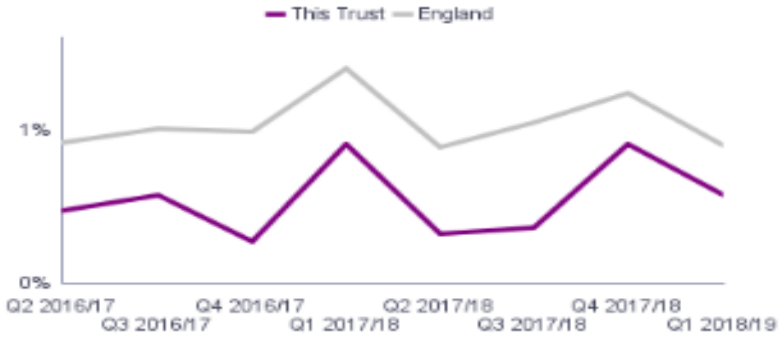
- The average length of stay for all non-elective patients at Harrogate District Hospital was 4.9 days, which is as expected compared to the England average of 4.9 days.
- The average length of stay for general surgery non-elective patients at Harrogate District Hospital was 3.7 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at Harrogate District Hospital was 8.8 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at Harrogate District Hospital was 2.1 days, which is lower compared to the England average of 2.9 days.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Harrogate and District NHS Foundation Trust

Cancelled Operations as a percentage of elective admissions - Harrogate and District NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust was lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.
(Source: NHS England)

Theatre usage had remained consistently above 79% for day surgery and above 90% for main theatres August to October 2015. Elective theatre lists were available Monday to Saturday and emergency theatre lists were available seven days a week. Access to emergency theatres was available 24 hours a day; however, orthopaedic trauma and general surgery shared the theatre access overnight and at weekends.

A theatre dashboard had been in place for approximately nine months and was devised by HDFT information services staff with clinical input. This provided a range of information in relation to theatre utilisation, including start times, turnaround times, early/late finishes. Screen shots of this along with further information had been provided in a previous information submission.

The service had established robust processes to maintain effective flow within surgical services. We saw most patients would be assessed through the surgical pre-assessment clinic for elective procedures.

The trust told us that a new surgical assessment area was due to open in 2019 and we saw a designated area currently being developed on the ground floor of the hospital. All staff we spoke

with were excited with these developments and told us that having a designated purpose-built assessment facility would improve patient experience.

A temporary surgical assessment unit was created on Littondale ward so that it was integral to the surgical ward.

Trauma patients were ring-fenced on elective surgical wards and we saw processes were in place to admit patients into overflow wards which were identified for possible admissions. We saw a separate trauma theatre to ensure effective day to day running of theatre lists.

In addition, we saw discharge planning commenced at the point of admission and we observed multi-disciplinary meetings to ensure the patient's home environment was supportive of discharge. We saw therapy ward staff liaising with social services colleagues to arrange deep cleaning in a patient's home before discharge.

A designated discharge lounge enabled patients to move from the surgical wards whilst they awaited medication, to enable effective patient flow.

The service had appropriate discharge arrangements for people with complex health and social care needs. During the inspection, staff from a residential home visited the ward to assess the ongoing suitability of the accommodation for the person. Ward staff worked actively with other agencies if accommodation became unsuitable during the patient's stay in hospital to ensure a timely discharge. When necessary, staff held a discharge meeting and completed capacity assessments and best interest decisions regarding discharge.

We observed a beds management meeting and saw surgical 'boarders' were clearly identified when patients were on other wards. Staff told us that medical patient reviews took place each day, regardless of the host ward speciality. We spoke with three doctors who told us they would assess patients daily and strict criteria was in place for boarding patients which was: no confusion, no palliative care patients, near discharge and no infections present.

Learning from complaints and concerns

From July 2017 to June 2018 there were 42 complaints about surgical care. The trust took an average of 74 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be that all complaints are responded to within 60 days they do not have a target for non-complex cases.

Complaint	Number of Complaints
Admissions and discharges (excl delayed discharge due to absence of care package)	11
Other (specify in comments)	11
Patient Care	10
Communications	3
Values & behaviours (staff)	3
Access to treatment or drugs	1
Admin/policies/procedures (inc patient record)	1
Consent	1
Facilities	1
Grand total	42

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From July 2017 to June 2018 there were 21 compliments within surgery.

We asked staff and managers on wards about complaints and were told that formal complaints were investigated by ward managers and feedback was provided to staff through team meetings or displayed as information on staff boards. We reviewed staff newsletters on Farndale and main theatres and saw information regarding the promotion of the discharge lounge, the last RCA undertaken following a serious incident and positive feedback regarding the last skin inspection audit. Staff on all wards were aware of their most recent complaints and provided assurance regarding action taken to try to reduce further occurrence. For example, improving communication exchange between medical staff and patients awaiting diagnosis.

Wards had patient information leaflets available for the patient advice and liaison service and all patients we spoke with told us they knew how to make a complaint.

Is the service well-led?

Leadership

The Planned and Surgical care directorate had a 'triumvirate' management structure in place with clear lines of responsibility and accountability. The directorate was led by a senior management team that included the clinical director, operational director and head of nursing.

These were further supported by respective heads of service, service managers and matrons.

Ward managers and sisters said they had constructive and positive relationships with directorate matrons and told us that they visited wards and offered support daily. Most staff felt that managers communicated well with them and kept them informed about the management of the wards and service changes.

Staffing levels were planned so that ward managers were given management time to complete audits and performance data collection. All ward managers said they were supported well by the senior management team and that members of the board were visible and matrons regularly visited the wards. During this inspection we saw matrons visiting the wards frequently to provide support and collate assurance information.

The nurse in charge on the ward was clearly identifiable by a red badge on their uniform.

Junior doctors were well supported by senior colleagues and supervision from a mentor for each activity as well as an education supervisor.

Vision and strategy

Senior managers of the service recognised the key challenges for the next 12 months and beyond but balanced future difficulties with current success.

Several key pressures were outlined by the service, which included meeting national expectations and guidelines, cost improvement programme (CIP), staffing including junior doctors' gaps and consultant cover, costs incurred by the service, capacity within theatres and clinics, maintaining staff morale and maintaining overall performance.

Managers celebrated the success of the delivery of cancer targets and improving RTT rates and recognised the work that had been undertaken in relation to the strengthening of governance processes including risk register compliance, complaints response, quality of care meetings and serious incident action plan management.

Planned and Surgical care business planning included key points to ensure future challenges would be met. These included robust day to day management practices, clear workforce plans; focus on productivity, active forward planning in line with the direction of the trust and the wider health system and a continued and consistent approach. Specific arrangements were in place to support the overall financial management of the service.

The trust was a member of the West Yorkshire Association of Acute trusts and had a number of work streams as part of this collaboration which were relevant to surgical services.

The Planned and Surgical Care directorate held a number of clinical alliances with local healthcare providers. For examples, the alliance with Leeds Children's Hospital (LCH) and York Teaching Hospital, regarding plastic surgery service for children and adults.

There has been joint working with the Harrogate and Rural District (HaRD) CCG to:

- Reduce repetition of appointments/ changing clinical pathways so that the number of face to face appointments are reduced;

- Ensure effective management of demand in to secondary care.

Staff were not able to define the strategy but clearly understood the vision, challenges and the capabilities of the service. We saw there were displays of the trust vision across many of the public areas.

The service had a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually.

Culture

Staff at all levels spoke passionately about their work, and about the quality of care delivered. Staff spoke openly about some of the staffing difficulties faced on the wards but described their commitment to deliver the best possible care at all times.

We observed staff working together on the wards and a sense of 'pulling together' to get the job done. We saw staff from a variety of specialisms and grades of staff working together to proactively plan treatment and care.

Staff morale was extremely positive and all staff we spoke with told us that they felt staff morale had improved in recent months.

All staff acknowledged the efforts of managers to recruit more staff and fill vacancies and the recent introduction of new staff was well received.

Staff considered staffing issues as 'national problems' and generally described their managers as supportive and hard working.

Staff spoke positively about the service they provided for patients and high quality care was a priority. All staff were clear about their roles and responsibilities, patient-focused, and worked well together.

All staff felt they received appropriate support from management to allow them to perform their roles effectively.

Governance

We asked senior managers about governance arrangements and were told there was a weekly governance meeting for the Planned Surgical Care Directorate.

Alongside these meetings there was a quality and safety meetings and a weekly referral to treatment performance meeting.

We reviewed planned and surgical care quarter 2 review report which showed overall operational data and the current position for the directorate. The report covered quality, human resource, theatre stand down time, staff engagement and elective, outpatient and day case activity. In addition, directorate monthly team meetings covered strategic, operational, divisional and business unit items.

We saw review reports were shared with senior managers within the directorate to enable clear identification of risk and challenge but equally to highlight progression such as the improving appraisal completion rates.

Directorate Matrons reviewed wards each day and completed assurance review assessments to determine those wards deemed to be a greater risk. All assurance information including patients' dependencies were fed into the beds management meetings which were held at least twice daily.

Wards held a daily huddle and staff we spoke with told us they would discuss discharge, safety, staffing and complaints.

Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care. Ward managers, senior managers and clinical leads showed knowledge, skills, and experience. A clear responsibility and accountability framework had been established. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.

Ward managers described audits and safety checklists which they completed and explained how the data linked into dashboards and safety thermometer reports.

Management of risk, issues and performance

We asked senior management about managing risks and were told that risks were identified through the electronic incident reporting system and risks were discussed at the weekly governance meeting, then to the quality and safety meeting. In addition to these discussions senior managers within the surgical directorate also addressed specific concerns relating to medicines risk at medicines safety review meetings. We reviewed minutes from May 2018 meeting and proactive safety measures were discussed to improve current practice and recent medication incidents and future prevention measures.

The senior management team could describe the risks to the services, for example staffing vacancies and referral to treatment performance. There was a quarterly performance meeting for the surgical directorate.

The directorate had a risk register which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions. Governance meeting minutes showed risk registers were reviewed regularly.

The risks and issues contained within the registers reflected current risks relevant to the operational effectiveness of the service.

We discussed these with the senior management team who were well informed about the difficulties and had action plans in place to address the risks.

In response to mixed sepsis compliance audit results we saw the provider submitted a sepsis report to Improving Patient Safety Steering Group in November 2018 with results of screening and timely IV antibiotic administration audits. The report outlined early detection alerts and treatment pathways and the on-going audit work on the surgical wards.

As a further prompt to consider sepsis and to focus on all aspects of its immediate management, the trust recently ordered new packs for taking blood cultures. This provided a clear, visual reminder of red flag sepsis, together with stickers for the medical notes to ensure adequate documentation of blood culture collection and also a treatment pathway if red flag sepsis is identified.

Information management

The accessible information standard (AIS) was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.
We saw that all patient observations were recorded on the electronic patient record system accessible to staff through the input of a password.

The majority of patient information was paper based with separate nursing and medical files. This included risk assessments, test results, and ongoing treatment and care plans.

Ward staff told us that additional electronic software was to be introduced in 2019.

The electronic patient record enabled staff to ask people if they had any information or communication needs. These were clearly recorded and highlighted in the record and covered disabilities, impairment or sensory loss. We saw contact methods, formats (audio, braille, easy read or large print) and support needed (e.g. interpreter, lip-read, hearing aid) were detailed timescales per speciality.

We saw manager's utilised data using dynamic dashboards which provided current activity information such as theatre usage, non-elective waiting times, cancer waiting times and RTT figures.

Engagement

Public engagement

People using the service were encouraged to give their opinion on the quality of service they received. And the surgery directorate carried out 'two minutes of your time' surveys to gather feedback on the services from patients. The teams had a weekly team meeting where positive and negative feedback was discussed. The senior management team told us there had been a surgical away day with staff where improvement work was discussed.

Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.

Leaflets about the friends and family test, and the Patient Advice and Liaison Service were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.

Ward sisters were visible on the ward, which provided patients opportunity to express their views and opinions.

Discussions with patients and families regarding decision making was recorded in patient notes. We saw thank you cards and letters and "You said we did" boards, displayed at the entrances to wards.

The trust had developed a bespoke Harrogate friends and family feedback questionnaire, questions included questions about pain control, pain relief offered, timescale for administration and overall effectiveness.

Staff engagement

The service participated in the 'Quality of Care Champions' launched in October 2016, which was a scheme open to all staff in every job role. The aim of the schemes was to help improve quality of care for patients who use the service. The training for Bronze, Silver and Gold level champions is accredited by the Yorkshire and Humber Improvement Academy and recognised by most Trusts in the region. Examples of some of the champion projects include:

- Reducing follow up appointment waiting lists for glaucoma patients in Ophthalmology
- Introducing acupuncture as an alternative therapy in pregnancy
- Bring forward and stagger annual induction of FY1 and FY2 junior doctors, to ensure adequate staffing provision for patient care within the Planned and Surgical Care directorate.
- Implementation of productive outpatients

- Producing a photo album and survey to support patients through facial reconstructive surgery

Department managers spoke with us about an “open door policy” for staff to discuss issues with them.

The service used newsletters to help engage staff. We saw within ward newsletters on Farndale that staff were praised by senior managers, for the recent skin audit findings. Staff were thanked for their continued hard work on the ward. We also saw patient quotes were included within the newsletters, which included complimentary comments and positive feedback from relatives. For example, ’We admire and appreciate the wonderful work you do’.

In addition, Wensleydale had developed an employee of the month scheme, which recognised the efforts of staff specific to that ward.

Staff in theatre told us a local Harrogate anaesthetic social media group had been set up to share educational opportunities within the area. In addition, case meetings are held once a month to discuss challenging cases and aid shared learning.

Learning, continuous improvement and innovation

Senior managers of the services recognised and celebrated key achievements over the last 12 months and were proud to showcase the many improvements that had been made. Managers also ensured that staff who were involved in these projects were recognised and thanked for their innovation and dedication. Service managers provided an extensive number of achievements. These included:

- Theatre dashboard development
- Cultural change in theatres through closer working relationships and the subsequent implementation of new roles
- Improved relations between management and clinical team during a very challenging time for the trust
- Introduced improved Gastro rota with better compliance and therefore better capacity
- New ENT Consultant
- 11th Orthopaedic Consultant locum and resultant activity
- Effective management of risk whilst CSSD of site
- Management of the transition of a long-standing GS Consultant leaving and ensuring arrangements in place for the transition period
- Working with CCG on reducing microscution patients
- Day cases in oral surgery
- Increased nurse led surgical sessions for Dermatology
- SAU introduced on Littondale (reduced admissions)
- EADU opened 87% to 97% admissions on day of surgery
- Pre-assessment screening with 40% not returning to full pre-assessment.

In addition, the directorate had developed a number of initiatives to improve and enhance care and treatment:

- A number of initiatives to reduce 90-day mortality within surgery such as;
  - Introduction of CPET testing
  - Introduction of a pre-op IV iron pathway to better optimise patients' pre-op
  - Improved risk assessment and advice
  - Improved Shared Decision Making in relation to consent for theatre
  - Standardised anaesthetic peri-op care with pathways
  - Standardised post-op risk assessment for HDU/ward
  - Use of troponins to post-op risk stratify HDU patient - pathways
  - Perioperative medicine fellows x4 within anaesthetics giving much improved continuity of care and a lower reliance on locums
  - Running national trials e.g. PREPARE ABC
  - Multiple audits of the above to understand outcomes and to further alter pathways for the benefits of patients
  - Presentations and posters at national meetings to promote good practice and to ensure good practice is recognised by staff

The trust appointed a consultant in 2013 who has been leading nerve blocks for the anaesthetic department, resulting in positive use of nerve block outcome data, presented in New York at the America Society of Regional Anaesthesiologists conference this year.

A new lead consultant is working on a research project with research and development and general medicine to evaluate a new medical device to help reduce pain on injection of local anaesthetic for carpal tunnel surgery.

The trust supported staff creativity to overcome operational issues. The trust submitted an example of you said by demonstration a staff suggestion of ensuring wheelchairs were available at all times outside the day rooms on the in-patient surgical wards.

We saw proposals were in place at the time of inspection, to introduce surgical care practitioners into trauma and orthopaedic theatre areas. The provider told us discussions with the Clinical Lead in Trauma and Orthopaedics were underway which would further progression of roles to ensure clinical consistency for patients whilst also offering progression opportunities for staff.

The provider had recently undergone a theatre staffing review in April 2017. We saw staff engagement events were held to discuss drivers for change and the potential for improvements to staff sickness and vacancies. A new theatre structure January 2017 had also been developed and shared with staff and we saw 'time out' sessions were held t best understand the staff perspectives.

We saw a new elective admissions unit opened in March 2017 with the discharge lounge transferring up onto the unit in June 2017. This was initially a 6-month project as part of the Planned Care Transformation programme. The pilot impact in the first 6 months was significant with a month to month improvement in 2017 (92% to 96%). From September to January the average same day admission sustained at 97%. Over the same period year on year this is the equivalent to a reduction of 378 patients not being admitted before the day of surgery. The trust told us savings for the directorate for 2017/18 were £177k and the same day admission rates on EADU contributed significantly to sustaining bed closures to achieve this saving.

The role of Stores Assistant commenced in July 2016 following a request from all the Ward Managers regarding the amount of nursing time spent managing stores. With wards under increasing pressure from staff shortages and an increase in patient acuity/activity the post was

agreed for an initial 12 months. Benefits demonstrated following this post introduction include Increased patient safety by having the right product at the right time, increased patient safety as products subject to recall can be easily identified and Significant reduction in the incidence of expired stock.

In June 2018 a joint programme of work was initiated between HDFT and HaRD CCG The 'Aligned Incentive Planned Care Steering Group' chaired by PSC Operational Director Jonny Hammond with a deputy chair from the CCG is focused on schemes of work to manage demand in to secondary care and schemes of work that can reduce the cost of the provision of secondary care. Schemes of work are clinically led and examples of which are uploaded.

In the context of RTT, reduction of appointments in to secondary care would allow clinician's job plans to be altered to focus time on those patients that most require intervention, potentially giving a higher proportion of time to operating so improving waiting times. This same principle applies to schemes that reduce the need for face to face appointments.

Services for children and young people

Facts and data about this service

Children and young people's services were located at Harrogate District Hospital. The children's service was previously inspected in 2016 where an overall service rating as required improvement was given. Areas to improve were identified following this inspection.

During our inspection we visited Woodlands ward, the special care baby unit, children's outpatients, the emergency department, day surgery and theatres. We spoke to 40 staff members, 15 parents, one grandparent and seven young people. We reviewed 10 children's medical and nursing records.

Woodlands ward was a 16-bedded ward which included a designated bay where the clinical assessment unit (CAU) was based. Included within the 16-bed complement was one high dependency bed and one cubicle designed for children admitted with mental health issues. Woodlands ward accepted patients for elective surgery, alongside emergency admissions via the emergency department. GP services also saw patients. Woodlands ward provided beds for elective surgery in orthopaedics, general surgery, ophthalmology, ENT and occasionally gynaecology. Surgery was provided by both local and visiting consultant surgeons on children aged over two years and over 15kg.

The trust provided a consultant of the week model to give consultant delivered care and improve continuity for patients.

The children's outpatient department had been refurbished and was located off the main outpatient department. General paediatric outpatient clinics are provided in Ripon, Wetherby and Yeadon. The trust provided clinics from visiting tertiary specialists in paediatric urology, surgery, neurology, rheumatology, orthopaedics and genetics as well as numerous nurse led clinics within the outpatient department. *(Source: 20180517 RPIR Acute – HDFT Master – Context tab)*

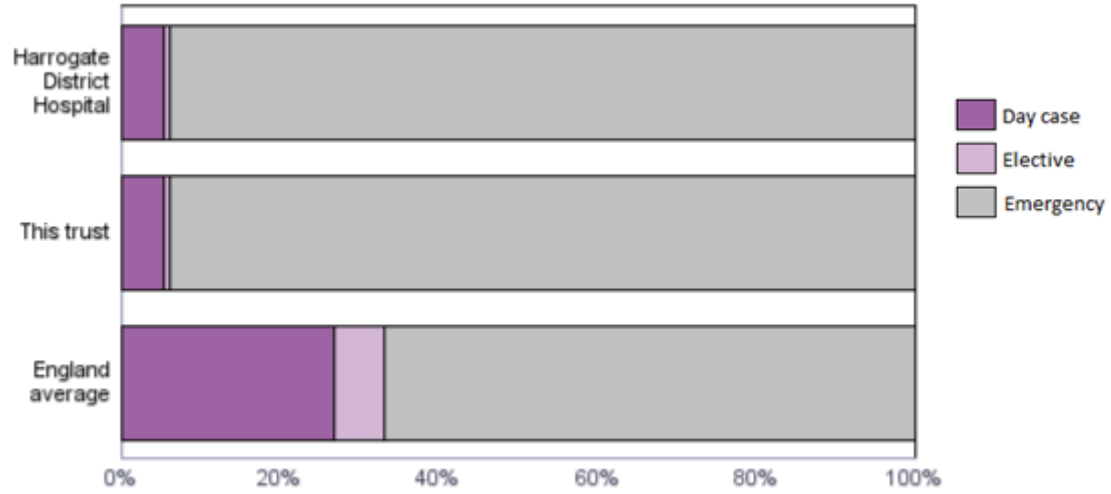
The trust had consultants and specialist nurses with interests in paediatric epilepsy, allergy, diabetes, endocrinology and respiratory medicine. *(Source: 20180517 RPIR Acute – HDFT Master – Context tab)*

The Special Care Baby Unit (SCBU) cared for babies with a range of conditions who required special care. Infants born before 32 weeks gestation and / or less than 1500g were resuscitated and stabilised prior to transfer to tertiary centres. The SCBU was part of the Yorkshire and Humber Neonatal Operational Delivery Network. Babies who required high dependency care were transferred to tertiary centres. The SCBU had seven funded cots.

Areas outside of children's services where children and young people were seen included the emergency department, day surgery, and theatres.

The trust had 3,377 admissions otherwise known as spells from June 2017 to May 2018. Emergency spells accounted for 94% (3172 spells), 5% (177 spells) were day case spells, and the remaining 1% (28 spells) were elective.

Percentage of spells in children's services by type of appointment and site, from June 2017 to May 2018, Harrogate and District NHS Foundation Trust.



Total number of children's spells by Site, Harrogate and District NHS Foundation Trust.

Site name	Total spells
Harrogate District Hospital	3,377
This trust	3,377
England average	1,122,195

(Source: Hospital Episode statistics)

Is the service safe?

Mandatory training

Mandatory training completion rates

The trusts training compliance was RAG rated: Red was 0-49%, Amber was 50% - 74%, Green was 75% - 94% and Blue was 95% - 100%.

Training was reported on a monthly rolling basis; a breakdown of compliance for mandatory courses as of July 2018 for nursing staff/ medical and dental staff in children and young people's services is shown below:

Nursing and midwifery staff

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Data Security Awareness (previously Information Governance)	29	31	94%	Green
Health & Safety	29	31	94%	Green
Infection prevention & Control (no renewal and Level 2)	30	32	94%	Green
Fire Safety - Level 1 (annual)	26	31	84%	Green
Manual Handling Face to face & eLearning	51	62	82%	Green
Basic Life Support	33	44	75%	Green

Nursing and midwifery staff achieved a green rating for all six mandatory training modules.

Mandatory training statistics were provided by the trust in the 'Department Percentage Report' dated 1 November 2018. The report identified individual staff group attendance at mandatory training sessions for individual clinical areas in children's services. Mandatory training statistics provided for Paediatric Outpatients was 86%, Special Care Baby Unit (SCBU) 91% and Woodlands ward 88%. Medical Staffing attendance was identified as 81%. We noted a decline in mandatory training attendance since the last Care Quality Commission (CQC) inspection where mandatory training targets were met.

Medical and dental staff

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Health & Safety	27	29	93%	Green
Data Security Awareness (previously Information Governance)	26	29	90%	Green
Manual Handling Face to face & eLearning	43	50	86%	Green
Fire Safety - Level 1 (annual)	23	29	79%	Green
Medicine management training	19	24	79%	Green
Infection prevention & Control (no renewal and Level 2)	27	35	77%	Green
Resuscitation	17	23	74%	Green
Basic Life Support	31	48	65%	Red

Medical and dental staff achieved a green rating for seven out of eight mandatory training modules; Basic Life Support received a red rating with a completion of 65%

We requested the latest mandatory training attendance statistics for medical staff in the children's service to ascertain whether all medical staff had completed mandatory training sessions. Mandatory training attendance for medical staff was identified in the 'Department Percentage Report' dated 1 November 2018 as 81%. This showed an 8% increase in mandatory training completion since July 2018. We noted a decline in mandatory training attendance since the last Care Quality Commission (CQC) inspection where mandatory training targets were met.

Senior medical staff identified difficulties in achieving the mandatory training target due to the regular movement of junior medical staff. Senior staff said they monitored training attendance via the Learning & Development team and by receipt of monthly mandatory training updates.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff confirmed the online mandatory training programme was a rolling programme. On SCBU, staff told us that individual staff completion dates were dependent on their original start dates.

Clinical staff did not receive mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, or autism. Staff undertook de-escalation training and some staff were aware of online learning related to mental health conditions available through the hospital intranet. The manager of the child and adolescent mental health crisis team reported the team provided 'hot topics' training for Woodlands staff and shadowing opportunities within the crisis team. Staff on Woodlands ward had all started since March 2018 and were unaware of these opportunities.

The trust policy for the 'Management of Corporate, Clinical & Local Induction' (September 2016) supported new staff induction to the trust. Corporate inductions were identified for clinical and non-clinical staff groups. Staff confirmed that new staff attended a two-day corporate induction followed by local inductions. The type of local induction was dependant on whether the nurse was newly qualified or an experienced nurse who had moved into a new role.

Staff were not aware that formal trust-based sepsis six training was available. Woodlands ward staff received teaching sessions to support introduction of the new admission documentation. The teaching sessions took the form of a power point presentation which identified what to look for if a child was showing signs of sepsis and the actions to take. Since September 2018 sepsis learning had been undertaken with staff to ensure they understood sepsis management. Training data dated 8 November 2018 confirmed that 16/19 (84%) of relevant substantive staff and 5/6 (83%) of relevant bank/locum staff were up to date with intravenous fluid training which included sepsis training. During the specified period 1 April 2017 to 5 November 2018, nine staff received training. The required service sepsis training frequency was three yearly. Doctors received sepsis training at induction.

Staff told us that all staff had completed the paediatric critical care passport competencies spread over a two-year period. The competencies included the recognition of essential patient care, for example, familiarity with the paediatric advanced warning system tool (PAWS), assessment and recognition of changes in a child's condition and clinical observations. Resuscitation training and the assessment and management of the child's airway and breathing were also included in the passport.

Safeguarding

The trusts training compliance was RAG rated: Red was 0-49%, Amber was 50% - 74%, Green was 75% - 94% and Blue was 95% - 100%.

Training was reported on a monthly rolling basis; a breakdown of compliance for safeguarding courses as of July 2018 for nursing staff/ medical and dental staff in children and young people's services is shown below:

Nursing and midwifery staff

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Safeguarding Children (Level 1)	26	30	87%	Green

Nursing and midwifery staff achieved a green rating for safeguarding children level one.

Level one and level two training was delivered through an established e-learning programme. The data supplied by the trust showed some departments had not completed the required hours of training for this year to date. The trust safeguarding team reported safeguarding attendance at entry level (level one) as 96% of staff in Woodlands ward, 93% of staff in the SCBU and all (100%) staff in the children's outpatients' department. (September 2018).

Nursing staff in main theatres, day surgery and outpatients completed safeguarding children mandatory training at level one and level two. We were not given safeguarding training attendance figures to confirm whether all staff in these clinical areas had completed these training sessions.

Medical and dental staff

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Safeguarding Children (Level 1)	23	23	100%	Blue
Safeguarding Children (Level 2)	1	2	50%	Amber
Safeguarding Children (Level 3)	13	28	46%	Red

Medical and dental staff achieved a blue rating for safeguarding children level one, safeguarding children level three received a red rating with 46% completion.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

At the time of inspection, one consultant had completed safeguarding children level three training, 93% of radiographers completed safeguarding children training at level two and 85% of all staff had safeguarding children level one training.

The trusts training target was 75-94%. Training statistics provided for level three safeguarding training by the trust as on the 1st November 2018 showed 74% compliance for Woodlands ward, 92% for SCBU and 78% for paediatric outpatients.

We requested the latest safeguarding training rates for neonates split into nursing and medical staff. The data provided (15 November 2018) by Learning & Development showed an overall percentage compliance for registered and unregistered nursing for safeguarding children level 1 as 93% and level 3 as 93%.

Level three training provided by the trust safeguarding team was a rolling programme. Scenario based level three training included the identification and responding to concerns using the local framework. Training had recently included child sexual exploitation, female genital mutilation (FGM), neglect, mental ill-health and domestic abuse. Other training topics included refresher training on fabricated or induced illness (FII) and the trust's 'was not brought' procedures.

Level four safeguarding children's face to face training attendance for 2017/18 was 97% for senior staff groups allocated to attend this training.

Nursing staff completed their personal 'safeguarding passport' which enabled them to log all training events, topics covered, the number of hours taken and their reflections of the training. The passport enabled staff to record formal and informal safeguarding supervision sessions and their reflections of discussions during those sessions. We saw two completed examples of this passport and saw they were used well as a reflective tool. The passport was a new initiative which all staff were to take up.

Formal safeguarding supervision was in place for nursing and medical staff. Staff were obliged to attend two of the monthly sessions annually. The designated doctor held quarterly safeguarding peer review meetings for paediatricians and junior doctors.

The chief nurse was the executive lead for safeguarding children and adults whose responsibilities included the safeguarding children team; the named nurses for looked after children; child protection and midwifery; safeguarding champions; and the safeguarding children governance group (SCGG). A named doctor and a paediatric consultant were available 24 hours to carry out child protection medicals. At ward level, four safeguarding champions and the daily presence of a member of the trust safeguarding team on Woodlands ward had raised the profile of safeguarding children.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so**.** Following review of the safeguarding liaison role in the emergency department

(ED) two weekly regular attenders' meetings were introduced for safeguarding. The paediatric matron met with the ED monthly; the safeguarding named nurse attended alternate months.

The trust's policy on children not brought to appointments described the recall process and enabled staff to consider the risks present when children were not brought to two or more appointments. Staff we spoke with were familiar with this procedure and described past incidents and how they were managed.

Should safeguarding concerns or families with complex needs be identified by maternity staff a full briefing was prepared to share information with health professionals who provided post-natal care to mother and baby. If women accessed the service who were subject to FGM and had children, police and a children's safeguarding referral was made as per national policy.

We joined a doctor's ward round on Woodlands ward and observed the doctors had made assumptions about the adults present with one child and they did not check the adults' relationship to the child. The doctors thought the adults were Mum and Dad. However, the woman present was Dad's partner, not mum.

Cleanliness, infection control and hygiene

CQC Children and Young People's Survey 2016 - In the CQC Children and Young People's Survey 2016 the trust scored 9.15 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.
(Source: CQC Children and Young People's Survey 2016, RCPCH)

The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. Control measures to prevent the spread of infection were in place, with high compliance in infection control audits, but we observed that these control measures were not always applied.

During the inspection observed a situation where a child was in isolation to minimise the risk of infection and saw the cubicle door left open at times. When asked, the father confirmed they were not given any information on infection control or handwashing and we found nothing documented in notes. We observed nursing staff enter the cubicle to remove the child's cannula without wearing an apron or gloves, which were outside of the cubicle and easily accessible.
In the children's outpatient department in 'Badger' consultation room we observed that the examination trolley cover was torn. The nurse said that a new examination trolley had been ordered as a replacement.

Clinical areas were visibly clean. Hand gel pumps, gloves, aprons and washbasins were located throughout the clinical environment including entry and exit points to clinical areas. Staff performed hand hygiene at the point of care. Notices placed throughout the environment advised staff, parents and visitors about controlling infection and of the use of the antiseptic dispensers.

Cleaning schedules identified the tasks and frequency of cleaning in each area. Discussions with staff confirmed that nursing and ward assistants had specific roles in relation to cleaning duties. Bagged waste guidance was displayed in clinical areas. Children's toys were cleaned by the play specialist or nursing staff.

The September Infection Prevention Quality Assurance Tool (IPC QAT) 2018/2019 confirmed compliance levels achieved on several named infection control audits across the service. An overall compliance total and risk rating were awarded to these audits monthly. Compliance across these audits was between 95 to 100% and the risk rating awarded was a green rating.

Staff we spoke with told us they were up to date with training in infection control. Staff received infection prevention and control training as part of their induction and at mandatory training.

Environment and equipment

A designated contractor was onsite. A defined schedule for equipment management, maintenance and repair both on the main hospital site and within the community was in place. Performance maintenance targets showed that 96% of equipment had had safety checks done as of June 2018. On this inspection we looked at 21 items of electrical equipment all had a safety check sticker. We found four out of testing date. We escalated our concerns with staff at the time of the inspection who contacted the engineers.

Areas visited were safe and secure with staff swipe access, intercom access and CCTV. All exits were securely locked to prevent children from leaving without staff being aware. Visitors pressed the buzzer twice for entry through to a reception area and again for entrance to the ward. We noted that visitors often buzzed the wrong department and staff had to ascertain which ward they needed. On Woodlands ward a poster reminded everyone not to allow visitors or staff through the door and instructed them to use the intercom system.

A panic alarm was available at the nurses' station which alerted staff on Woodlands ward and Maternity. Staff could also call access immediate support via the switchboard if needed.

Paediatric resuscitation equipment was available. Resuscitation trolleys had laminated UK resuscitation council algorithm procedures attached and visible. We checked the resuscitation equipment and found appropriate drugs and equipment present which was checked in line with trust policies.

The children's outpatient department (COPD) shared a resuscitation trolley with the emergency department which was a short distance from the COPD. At the time of the inspection no formal risk assessment had been undertaken regarding the placement of the equipment, however medications including anaphylaxis treatment were readily available and following the inspection a risk assessment was completed.

In 2016, we asked the trust to ensure that the environment on the Woodlands ward was appropriate for children and young people with mental health needs. This was partially addressed. The designated room was close to the nurse's station and had reduced ligature points. However, some ligature points remained which included the sink and taps. Staff we asked were not aware of a formal ligature risk assessment for the ward. No environmental risk assessment existed for the dedicated patient room for children admitted with mental-ill health or who had self-harmed. However, there was a ligature risk assessment that covered the whole of Woodlands ward.

A comprehensive behavioural assessment was commenced when the child was in the emergency department and followed the child to the ward. This assessment informed staff if a child or young person was not sufficiently well enough to be left in the room unsupervised or required specialist emotional one-to-one support. In which case the risk presented by the environment was mitigated by the behavioural risk assessment.

Assessing and responding to patient risk

In the CQC Children and Young People's Survey 2016 the trust scored 7.22 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

In the CQC Children and Young People's Survey 2016 the trust scored 9.05 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?' This was about the same as other trusts.

CQC Children and Young People's Survey 2016 questions, safe domain, Harrogate and District NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG	KLOE
6	How clean do you think the hospital room or ward was that your child was in?	0-15 adults	9.15	About the same as other trusts	S1
20	Were the different members of staff caring for and treating your child aware of their medical history?	0-15 adults	7.22	About the same as other trusts	S3
36	Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?	0-15 adults	9.05	About the same as other trusts	S4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Staff completed risk assessments for each patient. We reviewed two babies' records on the SCBU and found gaps in the completion of the neonatal early warning score assessments.
We reviewed an additional six children's records on Woodlands ward for completion of septic screening assessments and noted that four children's septic screening assessments were not completed as part of the admission process. Service guidelines and protocols assessed and assisted monitoring of patient risks. One example, were twice daily safety huddles which informed staff of current or emerging risks.

The special care baby unit had two neonatal intensive care cots for babies who required stabilization and transfer to tertiary centres. Occasionally babies who required high flow oxygen were cared for in the SCBU, supported by the tertiary centre. Staff had completed level three competencies to enable them to care for these babies. Staff told us that one nurse was booked onto the advanced neonatal life support course and basic life support was completed by staff on induction to the SCBU.

Risks to babies on the neonatal unit were identified during initial assessment and documented within care plans. Ongoing reviews of babies' risks took place and were discussed at shift handovers where discussions included safeguarding issues and specific risks.

The paediatric early warning score (PEWS) is used to monitor children at risk of deterioration by grading the severity of their condition. Patientrack, the electronic observation and escalation tool used notifies medical staff automatically at specific trigger points. All staff we spoke with knew how to raise an alarm for a deteriorating child and had completed or were in the process of completion of paediatric critical care passport competencies if new to the service. Deteriorating children were stabilized and either moved to the high dependency bed or to theatres where they would remain until the retrieval team arrived to take them to a tertiary centre. Transfer of intubated or unstable neonates and children was undertaken by the regional paediatric and neonatal transport service (EMBRACE).

Sepsis screening of children took place. Prior to the implementation of the new sepsis screening tool into the MDT children's admission document sepsis screening for 2018 was low. Please see the table below:

Month	**Total patients with documented screening – Woodlands Ward**
January-March	56% (85/152)
April	50% (5/10)
May	33% (2/6)

June	6% (1/17)
July	15% (2/13)
August	19% (3/16)
September	73% (11/15)

To monitor the progress of sepsis screening monthly audits were implemented. On Woodlands ward the sepsis six screening tool was incorporated into the new multi-disciplinary team children's and young people admission document. This assessment tool had been in use for two months and statistics for sepsis screening had increased. In October 2018 sepsis screening was 84%.

Nurse staffing

The service had not fully met the Royal College of Nursing (RCN) 'Defining staffing levels for children's and young people's services (2013) clinical standards'.

The service did not have sufficient senior nurse cover at band six and above 24/7. Where there was no band 6 on duty between Woodlands ward and SCBU there was a nurse in charge who had completed the "Nurse in charge" competency. Only 62% of shifts were covered by a nurse with the enhanced paediatric life support qualification, however all paediatric doctors had an enhanced paediatric life support qualification which helped mitigate this risk.

The children's service confirmed that all registered nurses within the children's unit were trained in accordance with The Nursing and Midwifery Council (NMC) requirements to care for sick children and Royal College of Nursing (2013).

An Escalation Policy for Acute Paediatrics' (March 2017) advised staff of the measures to take to enable efficient management of a workforce and bed / cot capacity within paediatrics. When necessary the staffing shortages checklist was completed by the nurse in charge as part of their assessment into staffing levels and patient dependency.

Sickness rates
From April 2017 to March 2018 the trust reported a sickness rate of 7% for nursing and midwifery staff in children and young people's services, this was higher than the trust's target of 3.9%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
From July 2017 to June 2018 children and young people's services had a total of 3,581 hours covered by qualified nursing bank and agency staff. 2,465 hours were left unfilled however the trust has not provided us with the total number of hours required therefore we cannot complete the analysis required.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The senior nurse confirmed a lot of agency staff had been used. We saw the use of agency staff confirmed on two duty rotas which showed high levels of long term sickness, staff left for other jobs and were on maternity leave. Some staff had returned to work which had improved staffing numbers. Staff told us that staff had left due to personal reasons, nurse training and career progression. To mitigate any risks and maintain safety staff used the paediatric escalation framework to determine staffing needs.

The trust reported the following nurse staffing numbers for children and young people's services from April 2017 to July 2018. The trust's fill rate remained below 90% in both reporting periods.

April 17 - March 18			April 18 - June 18		
Planned staff – WTE	**Actual staff – WTE in month**	**Fill rate %**	**Planned staff – WTE**	**Actual staff – WTE in month**	**Fill rate**
31.7	25.9	81.6%	31.7	27.8	87.7 %

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Staff described the funded and actual staffing establishment for Woodlands ward. The band seven nurse spent 50% of their time on Woodlands ward and the remaining 50% on the special care baby unit. The band six planned establishment was 2.41 whole time equivalent (wte); actual band six establishment was 2.54 wte. ,. The Royal College of Nursing (RCN) 'Defining staffing levels for children's and young people's services' (2013) clinical standards document identified a standard which related to a competent, experienced band six staff required throughout the 24-hour period. We reviewed rotas dated 8 July to 4 August 2018 and 5 August to 11 August 2018 with staff and found band six cover limited. Day duty band six cover was 53.5% to 57.1%. Night duty band six cover was 3.5% to 10.7%.

Vacancy rates
From June 2017 to June 2018 the trust reported a vacancy rate of 9.2% for nursing staff in children and young people's services, this was higher than the trust target of 7%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
From April 2017 to March 2018, the trust reported a turnover rate of 16% for nursing staff in children and young people's services, this was similar to the trust's target of 15%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

A shortfall of 4.14 wte band five nurses was identified against the planned establishment of 15.98 wte. Nursing staff were also supported by staff at band two and band four levels. A shortfall of 1.81 wte band four staff was identified against the planned establishment of 6.64wte. Staff told us the registered nurse vacancies were recruited into and these nurses were due to start at the trust from September 2018 to January 2019. One band six advert was in place.

Two advanced nurse practitioners and three nurse specialists worked within the service. The nurse specialists included diabetes, asthma and allergy and epilepsy specialists. The epilepsy specialist commenced on a permanent basis in September 2018 and was part funded by an external organisation.
On Woodlands ward trained staff ratios per shift were: Day duty: three trained nurses worked 11.5-hour shifts on Woodlands ward; one trained nurse worked from 1030am to 11pm on the assessment unit; plus, one care support worker worked on the ward. Night duty – Three trained nurses and one care support worker worked on Woodlands ward. The trust identified on a paediatric day surgery unit (DSU) day additional staff were rostered to ensure Woodlands ward and the DSU, had adequate cover. There were four paediatric registered nurses (P-RN) on Woodlands ward and two P-RN on the DSU. One care support worker was rostered to provide extra support in DSU if required. Staff we spoke with told us that there were often occasions when the Woodlands ward was understaffed owing to the need to provide coverage for the child assessment unit between the hours of 10:30am and 10pm. On the second day of our visit three nurses and one care support worker (CSW) were on duty. On the third day of our visit there were three nurses, one CSW and one further agency nurse who worked on the child assessment unit.

Staff identified concerns which related to redeployment on occasion within the hospital. We spoke with senior staff about these concerns and they confirmed that there had been occasions where staff had been moved to work on adult wards. The last time staff were redeployed to work on an adult ward was late summer. The trust confirmed from 1 October 2017 to 31 October 2018 staff redeployed from Woodlands to other areas, were:

- One registered nurse was redeployed in the last 12 months to an adult ward.
- 5 care support workers shifts were redeployed to adult wards.
- All other redeployments were to paediatric areas.

Staff told us that staffing had been challenging in the paediatric outpatients' department over the last 12 months. Whilst the unit was without a manager the ward manager from Woodlands ward supported the staff in the children's outpatient department. The ward manager was given additional responsibilities and pay commensurate with that to undertake the Outpatient manager role during this period. This was supported by the sisters on Woodlands and SCBU being given more management time to further release her time to undertake this duty.

Children's services said staffing levels were audited against the RCN 'Defining Staffing Levels for Children's and Young People's Services'. Senior staff used the 'Safer Staffing Tool' to determine the staffing and skill mix levels required on Woodlands ward. A two-week audit of staffing levels against Royal College of Nursing staffing guidance had taken place. One outcome was the introduction of a new shift from 1030am to 11pm. Senior staff told us this nurse was allocated to work in the clinical assessment unit. Safety huddles were introduced on the special care baby unit (SCBU) and Woodlands ward and staffing rotas were checked daily. We saw evidence of discussion of staffing needs at a multi-disciplinary safety huddle we attended.

During the last 12 months 76 children required high dependency care (HDU) on Woodlands ward. The trust identified funding which ensured these children were cared for by staff competent in caring for children with HDU requirements. Senior staff said 62% of shifts were covered by a nurse who held the enhanced paediatric life support (EPLS) qualification. However, staff recognised that not all trained nurses who took charge of a shift had obtained the EPLS qualification; so, the risk was mitigated by the presence of a paediatric doctor who was EPLS trained. Three dates for EPLS training were identified for 2019.

Neonatal Staffing
The neonatal service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The special care baby unit (SCBU) staffing funded establishment met the British association of Perinatal Medicine (BAPM) Guidelines (2011). Staffing levels in the SCBU were funded for BAPM compliance, the funded establishment for SCBU was 13.86 whole time equivalent nurses. 'Qualified in Speciality' (QiS) funded staff was 80.13%. The current QiS nurse ratio was 79.91% with a unit occupancy level between 60 to 80%.

Planned staffing for day shifts was two trained nurses, at least one was QiS and one nursery nurse. Night duty shifts were supported by two trained nurses.

Each shift was 12.5 hours and staff rotated between days and nights. Nursing staff rosters were monitored through an electronic roster and at monthly workforce review meetings. There was an escalation policy for staff shortages. Staff in the special care baby unit (SCBU) reported that they were fully staffed and there were no shortages.

Staff to patient ratios on the SCBU were one nurse to four babies. When required this staffing would flex if a baby with higher dependency needs required it. For example, if a neonate required high dependency care the staffing ratio for this area would revert to one nurse to two babies. On the day of our visit there were four neonatal patients and two nursing staff on duty.

We spoke with one staff member who said on occasion there had been one qualified nurse and a nursery nurse on SCBU. They said this was because one qualified nurse had been transferred to Woodlands or because a qualified nurse had reported in sick and had not been replaced. We asked the trust for further information. The trust identified that from 1 November 2017 to 31 October 2018 there were three separate occasions when registered nurses were left on their own

on SCBU. The trust provided further information and had risk assessed and mitigated on each occasion.

Medical staffing

The trust reported medical and dental staffing numbers for children and young people's services from April 2017 to Jun 2018. The fill rate declined to below 80% for the period April to June 2018.

April 17 - March 18			April 18 - June 18		
Planned staff – WTE	Actual staff – WTE in month	Fill rate %	Planned staff – WTE	Actual staff – WTE in month	Fill rate
18.3	18.1	98.6%	23.9	18.13	76.0 %

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

The trust partially met Standard Eight of the Facing the Future Standards which identified that 'All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive'.

At the time of the inspection the trust had nine Consultants on the Consultant rota. Although not all full-time, all Consultants had a full on-call commitment, this included a full consultant of the week and full on call cover, as per the rota, so that there were nine WTE on the Paediatric on-call rota. This was increased to nine in March 2018 with the successful recruitment of a second diabetes Consultant to the department. A tenth Consultant had been appointed on a locum contract with an agreement that they would also carry out full on-call resulting in ten WTE members on the Paediatric on-call rota from April 2019. The trust confirmed both tier one and tier two training rotas were compliant with UK Working Time Regulations and European Working Time Directive.

Staff confirmed nine consultant staff worked in the paediatric and special care services, with a designated lead consultant for the special care baby unit. The foundation year one doctor was supernumerary, practised under supervision and did not take the SCBU bleep.

Vacancy rates

From June 2017 to June 2018 the trust reported a vacancy rate of 0% for medical and dental staff in children and young people's services compared to a trust target of 7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Medical agency and locum staff usage – Trainee doctor/ middle grade

From July 2017 to June 2018 the trust reported bank and locum usage for trainee doctors/middle grade staff in children and young people's services as below;

Type	**Total number of hours**	**Total %**
Hours available	3,024	9.3%
Filled by bank	2,642	8.1%
Filled by agency	382	1.2%
Hours not filled	29,632	90.7%

(Source: Routine Provider Information Request (RPIR) P21 Medical Locum)

Medical agency and locum staff usage - Consultants

From July 2017 to June 2018 the trust had a total of 176 medical staff hours; all of which were covered by bank staff.

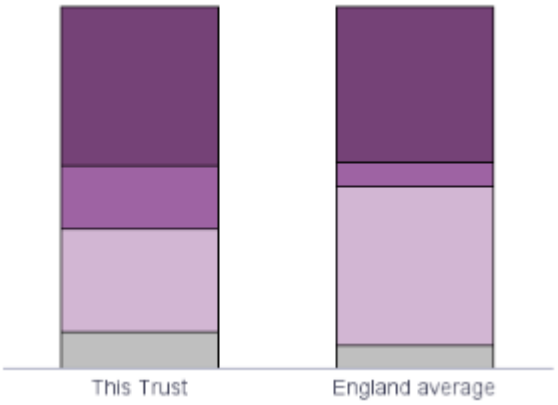
(Source: Routine Provider Information Request (RPIR) P21 Medical Locum)

We were told that locum doctor use would be reduced to zero by January 2019 as by this time they hoped to have nine middle grade doctors in post. The service planned for Certificate of Eligibility for Specialist Registration (CESR) doctors to be in post which replicated the current system used in the emergency department. An advert was to be placed in January 2019 for a further CESR post.

Staffing skill mix

In March 2018, the proportion of consultant staff and proportion of junior (foundation year 1-2) staff reported to be working at the trust in the children and young people's core service were both higher than the England average.

Staffing skill mix for the 20-whole time equivalent staff working in children's services at Harrogate and District NHS Foundation Trust



	This Trust	England average
Consultant	44%	43%
Middle career^	18%	7%
Registrar Group~	28%	44%
Junior*	10%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The children's service confirmed they were not fully compliant against the 'Facing the Future' standards one, three and eight.

Standard one – 'A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week. (*or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota)'. There was a practice agreement within the Paediatric department that the on-call Paediatric Consultant would return to the department if there were concerns about any child or young person from any member of staff, whether this be medical or nursing. This was evidenced by an audit of the work of eight of the Consultant Paediatricians over a one month period. During this time Consultants stayed late working on the wards on six occasions and returned to the hospital on eight occasions staying for between one and nine hours.

Standard 3: ‘Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned’. A Trust audit completed in April 2018 stated that there was overall compliance score of 89% against the 14-hour review by a consultant paediatrician.

A Consultant was available from 0830 to 1730 weekdays and from 0830 to 1130 on Saturday and Sunday. Patient ward rounds were carried out daily and new patients seen. The Consultant of the week also saw new patients admitted during the day. The April 2018 audit confirmed not all patients admitted to the ward were reviewed within the 14-hour time frame. Compliance against the 14-hour review was 75% of patients admitted during weekdays and 100% of patients admitted at the weekend. This gave an overall compliance score of 89% against the 14-hour review by a consultant paediatrician. A business case to increase the level of on-site presence was within the Trust business case process as part of the seven-day standards and would be risk assessed alongside other priorities in the Trust business planning process.

Weekend consultant cover commenced at Friday lunch time until Monday 5pm. All patients regardless of whether in hours or out of hours requiring specialist paediatric input were referred following assessment in the emergency department or by the GP out of hours service. The paediatric middle grade and junior doctors resident in the hospital would see any referred patient on the ward, in ED or in the GP out of hours area if required. The consultant-on-call was available out of hours to support the middle grade doctors. Staff told us that doctors also rung the on call paediatric consultant for advice.

The trust confirmed the neonatal service was mostly compliant against the latest BAPM medical staffing guidelines issued in November 2018. The standard ‘In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology). A lead consultant was identified for the special care baby unit. The CPD requirement for all Consultants to undertake a minimum of eight hours CPD in neonatology had just been put in place when the BAPM standards were agreed. This would be added to all Consultant job plans going forward so that this standard was met.

An adult general surgeon with paediatric experience saw children. However, the level of paediatric experience was dependent on which surgeon was on call and / or available.

The clinical lead for anaesthetics normally saw children and young people prior to surgery. Children and young people who experienced a mental health crisis were managed by the children’s and adolescent mental health service (CAMHS) crisis team. A CAMHS Consultant was available 24 / 7.

Sickness rates

From April 2017 to March 2018 the trust reported a sickness rate of 1% for medical and dental staff in children and young people’s services, this was lower than the trust’s target of 3.9%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Discussions with medical staff about sickness management identified short term sickness was covered internally. Longer term sickness of two weeks or more lead to merged clinics or reduced numbers of new patients were seen. Currently, there was no set plan for covering long term consultant sickness.

Turnover rates

From April 2017 to March 2018 the trust reported a turnover rate of 23% for medical and dental

staff in children and young people's services. This was higher than the trust target of 15%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Records

Staff had not kept detailed records of patients' care and treatment. We reviewed ten patients records overall and in the first three records we found some gaps in the completion of documentation and some doctors writing was illegible**.** Two patient records were from the SCBU; the other Woodlands ward. The Woodland ward patient notes showed some of the theatre model was completed; the recovery post-op information or handover was not documented. The child was on a planned surgery pathway and we saw good identification of patient concerns. We reviewed the discharge checklist and found it incomplete.

In the SCBU records some doctors writing was illegible, but, there was good use of the name stamp. Sign, print, date column was not used by doctors, but was used by nurses correctly. There was no signature/date/time when information was crossed out. The nursing notes were complete.

We reviewed an additional six patient records which included completion of the sepsis tool on Woodlands ward. Four records did not have a sepsis tool completed as part of the child's admission process. It was evident from two of these records that sepsis was identified for these children. We also noted other gaps in documentation such as non or partial completion of admission plans. The theatre model was incomplete in one child's records. We also found an incomplete intravenous fluids chart and within the emergency department assessment the paediatric pain score chart was not completed.

In the special care baby unit (SCBU), medical records were stored in a locked trolley and nursing charts kept at each bedside. Other patient data was stored on 'Badgernet' which is a secure nationally recognised and endorsed database.

Medicines

The service followed best practice when prescribing, giving and recording medicines. Patients received the right medication at the right dose at the right time. We reviewed five patient clinical records and spoke with five members of staff. Of the five records we looked at one did not have a weight recorded.

We observed staff had not completed daily checks on fridges and freezers; we found 18 checks were missed over a 68-day period from September to 7 November 2018 on SCBU and Woodlands ward. Readings higher than the eight degrees maximum fridge temperatures were missed on eight occasions. We reviewed the trust medicines policy (2018), section 3.6.6 (page 47) which identified daily checks of refrigerators and freezers should take place and 'The temperature of the refrigerator is kept between 2 and 8°C and the freezer kept between -25 and -15°C'. There were no explanations regarding the missing entries. Staff said recordings outside of range were reported and written on the staff handover sheet with action taken. A new procedure had commenced in September 2018, because of missing temperature readings, where fridge checks formed part of the CD check.

Observations of staff administration of medicines showed processes were safe and robust. Nursing staff double checked medicines before handing these to parents. A full explanation of the use of the medicine, including frequency of dose was provided to each parent.

Daily, pharmacists checked newly admitted children's medicines. Pharmacists also provided a clinical check of newly prescribed medicines through the trust electronic prescribing system and electronically sent orders to pharmacy once clinically verified which reduced waiting times for newly prescribed items.

We observed the use of e prescriptions; outpatient prescriptions were used for discharge purposes. As discharge planning was not started on admission, children were often left waiting for medicines to take home, despite the use of outpatient prescriptions. We discussed these delayed discharges with senior managers. To speed up children's discharges parents collected their child's medicines from the hospital pharmacy on discharge.

The medicines governance team provided a range of functions to support the safe and secure use of medicines across the trust. This included error reporting, monitoring, investigations and learning from events. Children's medication issues were discussed at the 'Medication Safety Review Group' in April, and June 2018. Governance pharmacist reports identified no medicines incidents in the last 12 months.

All medicines we looked at were all in their original labelled packaging and within the expiry date. Medicines, including intravenous fluids, were stored securely and access restricted to authorised staff. Medicines which required refrigeration were stored appropriately.

Controlled Drugs (CD) were stored and administered and staff completed checks in line with trust policy. The CDs were checked daily at 8am and signed for by two staff members. Keys were kept with the nurse in charge. Random sampling of CDs confirmed they were all accurately recorded and within expiry dates. Pharmacy completed three monthly audit checks and we saw evidence that this had occurred.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. In accordance with the Serious Incident Framework 2015, the trust did not report any incidents (SIs) in children and young people's services which met the reporting criteria set by NHS England from August 2017 to July 2018. (Source: NHS Improvement – STEIS)

Incidents and significant events were discussed at ward meetings, governance and paediatric meetings in association with the risk register. Incidents were overseen by the Quality of Care (QoC) meetings and staff who reported incidents were often invited to participate and contribute to the discussion. Learning from incidents was communicated to staff through email using the SBAR technique so that staff were clear about the incident and the factors that contributed to it before the incident was marked as 'resolved' by the QoC meeting. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Medical and nursing staff confirmed they knew how to report incidents through the incident reporting system and had received feedback from the incidents they reported. Incidents reported were also notified to the ward manager who allocated further actions dependant on the nature of the incident. We reviewed three incidents with the ward manager which demonstrated this process and the resulting outcomes to ensure the incident was not repeated. Incidents were discussed at morning safety briefings, so staff were aware of procedural changes or learning from them.

Mortality reviews which led to service improvement took place through the neonatal operational delivery network (NODN). One example identified learning and change in practice related to the type of monitoring Downs syndrome babies with heart problems received. The change in clinical practice was to monitor the baby's oxygen saturation levels four hourly for 24 hours following birth.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers followed national guidance on how to prevent them. Each never event type had the potential to cause serious patient harm or death but neither need have happened for an incident to be a

never event. From July 2017 to June 2018, the trust reported no incidents classified as never events for children and young people's services at Harrogate and District NHS Foundation Trust. *(Source: NHS Improvement - OBIEE NRLS STEIS)*

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection took place one day each month and data must be submitted within 10 days of suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcer, no falls with harm and no new urinary tract infections in patients with a catheter from July 2017 to July 2018 for children's services. *(Source: NHS Digital)*

The paediatric safety thermometer had not yet been fully established following its introduction in November 2018. Prior to this the service completed the adult safety thermometer. Data collection for the children's safety thermometer will include; pressure ulcers, pain, moisture lesion, extravasation, early warning score and harm free care statistics.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance; monitoring and review of clinical guidelines had taken place.

Guidance from the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed 12 evidenced based guidelines which included one network guideline. All guidelines were in date and demonstrated an ongoing review process had taken place. Monitoring and discussion of clinical guidelines and policy reviews were also documented in minutes of clinical audit and governance meetings.

Following a review of the National Institute of Clinical Excellence (NICE) guidelines, the trust identified they were not meeting the target of one week to review children with constipation. The paediatric outpatient business case enabled the establishment of this clinic and ensured the NICE Guidelines were met. In addition, patient information leaflets were developed.

Some staff were not aware of the existing fasting guidelines that were in place for children and young people. The paediatric team confirmed that they were in the process of reviewing the existing guidelines to ensure they met best practice and as part of this where raising awareness amongst staff.

Staff said the special care baby unit had implemented the Bliss Baby Charter'; a practical framework neonatal unit used to self-assess the quality of family-centred care delivered against seven core principles.

The national neonatal critical care network had peer reviewed the SCBU on the 19 October 2017. The action plan identified 16 areas of concern; evidence provided confirmed all but two concerns were actioned. The outstanding concerns were the unit did not have a transitional care facility for babies and to audit against NICE – 'Early onset neonatal sepsis'. Actions were identified against both areas with completion dates attached. For transitional care areas to develop included staff training and to formalise the current transitional care process with maternity teams. By February 2019, plans were identified to upload the latest early onset neonatal sepsis guidelines and to complete the first audit three months after guidance implementation.

The trust completed a gap analysis against the Royal College of Surgeons (2013) Standards in 2017 which confirmed compliance with all standards except two. One gap identified related to the competency of theatre and recovery staff in the management of paediatric patients. This was to be addressed through appraisal and training. The second gap related to recovery and the physical separation between children and adult patients. From October 2017, two children's surgical days were introduced in the Day Surgery Unit to improve patient experience and meet the required standards for children's surgery for a greater proportion of patients. Outside of these paediatric days every effort was made to ensure children were first on an operating list. Where this was not the case there should be specific reasoning.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Food choices were available which included special diets, for example diabetic, gluten free, renal, and textured and allergy diets. Specialised milk formulae were provided through pharmacy.

Basic foods were kept on the wards, which could be provided outside of the main meal times. We observed one child who had returned to Woodlands ward after surgery was offered something to eat and drink. This was declined but shortly before midday the child's parent asked if she could be provided with some toast at her bedside and this was provided immediately.

The infant feeding co-ordinator liaised with the special care baby unit daily Monday – Friday and provided support and training to staff and parents as required.

A parent from the special care baby unit (SCBU) told us breast feeding was promoted. There was no specific breastfeeding room on Woodlands ward. On SCBU women who breastfed were encouraged to stay next to their baby's cot with screens available for privacy and dignity. On Woodlands ward women who breastfed were encouraged to use the side rooms or the parents room.

On SCBU and Woodlands ward a kitchen area was accessed by parents to make their own drinks and snacks. Staff told us that families who attended the food allergy challenge were not told about these facilities. Woodlands ward had a drinks trolley outside the kitchen so that older children and parents could help themselves to juice and water.

Pain relief

Pain assessment tools were in place but we observed an inconsistent approach to management of pain and use of pain tools.

The trust paediatric pain policy (September 2018) identified the pain tools available to assist identification of pain and comfort levels. For example, the bears chart was used with children less than five years of age and the pain ruler and verbal tools were identified for use with older children. A separate pain chart assisted children less than five years of age with learning difficulties to identify their pain levels. Although guidance and tools were available to staff, we saw limited use of these pain charts on Woodlands ward despite children being present who would have benefited from them.

We found one set of pain assessment charts on Woodlands ward. The set was incomplete and included the 'poorly bear faces' and 'pain ruler', therefore, it was not clear what staff were using to assess pain. When we visited the adult day surgery unit to track a child from admission to discharge, we observed the 'faces' pain tool was in use on the ward.

The trust employed one band six adult nurse to provide pain management support and advise trust wide. Staff told us they were not aware of who the pain nurse specialist was or how to contact them. Nurse cover for the pain service was not provided at weekends, sickness/holidays/study leave. We were told this was recorded on the risk register but no action was taken. We reviewed the trust risk registers, the anaesthetic risk register confirmed reference to nurse pain management support shortfalls.

We spoke with three parents on Woodlands ward and asked them their experiences of how their child's pain had been controlled whilst on the ward. Two of the parents identified concerns about how their child's pain had been managed. On Woodlands ward we reviewed one child's notes with staff to see whether the child's post-operative pain management was effective. The mother had expressed concerns and the doctors had been bleeped on four occasions. Review of the child's notes found none of the mother's concerns or the escalation which took place was documented. The child went to theatre and returned to the ward at approximately 11.45am. The child was distressed; despite this observation three nurses said the child could not have any pain relief as none was prescribed electronically. We checked the child's e-prescription with the pain specialist nurse, analgesia was not administered until 3pm and no pain assessment documented in their care plan. The child's paediatric early warning score (PEWS) was checked with a staff member and we noted incorrect completion of the pain score and a two-hour documentation gap.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

Paediatric diabetes audit 2015/16

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The proportion of patients receiving all key care processes annually was 23.3%, the previous year's score was 0%. The average HbA1c value (adjusted by case-mix) at the trust was 72.7% which was worse than expected compared to a national aggregate of 68.3%. The previous year's score was a negative outlier. The median HbA1c value recorded amongst the 2015/16 sample was 66.5, compared to the previous year's median which was 70.5. This indicated a clinically significant improvement.

(Source: National Paediatric Diabetes Audit 2015/16)

Senior staff identified the measures to improve diabetic children's outcomes which included an overhaul of the diabetic service, recruitment of an additional consultant and nurse specialist and doubling of psychology input. Clinic systems were reviewed which ensured everything was recorded. The trust identified positive outcomes since the introduction of these measures as children's HbA1c levels had decreased.

Emergency readmission rates within two days of discharge

From March 2017 to February 2018 there were no patients aged under one and aged 1-17 years old readmitted following an elective admission. From March 2017 to February 2018 for the under one-year age group there were 39 readmissions within two days of discharge following emergency admission. The one to 17 years age group had 79 readmissions. The readmission rates were both 3.7% which was higher than the England average at 3.3%.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (March 2017 to February 2018)				
Specialty	**Harrogate and District NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	3.7%	1,049	39	3.3%
There were no emergency admissions to any other specialty among patients in the under 1 age group at this trust over this period				

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (March 2017 to February 2018)				
Specialty	**Harrogate and District NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	3.7%	2,115	79	2.8%

(Source: CQC analysis of Hospital Episode Statistics February 2017 to January 2018)

Staff said they had audited this area extensively and looked at groups which had been readmitted. Readmissions were mainly within the respiratory infection and tonsillitis category and part of the reason for returners was that patients were not given sufficient information at discharge. This resulted in the creation of discharge leaflets and patients were also given verbal advice.

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From April 2017 to March 2018 the trust performed worse than the England average for the percentage of patients 1-17 who had multiple readmissions for asthma.

The trust had looked at management and process to reduce asthma readmissions. This included educational events for staff, plus, a separate educational event in September 2018 for local GPs and practice nurses on the management of paediatric asthma. We saw a comprehensive asthma referral pathway in place which guided staff as to which route the child and / or young person should follow in relation to their treatment.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years). (April 2017 to March 2018)				
	Harrogate and District NHS Foundation Trust			**England**
Long term condition	**Multiple admission rate**	**At least one admission (n)**	**Two or more admissions (n)**	**Multiple admission rate**
Asthma				
Under 1	-	-	-	12.1%
1 to 17	18.2%	33	6	16.3%
Diabetes				
Under 1	-	-	-	23.1%
1 to 17	*	23	*	13.4%
Epilepsy				
Under 1	-	-	-	35.7%
1 to 17	*	14	*	26.8%

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'.

(Source analysis of Hospital Episode Statistics February 2017 to January 2018)

National Neonatal Audit Programme

In the 2017 National Neonatal Audit Harrogate and District NHS Foundation Trust performance in the four measures relevant to children and young people's services was as follows:

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc?**

There were eight eligible cases identified for inclusion, 67.4% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C. This was within expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C. The hospital did not meet the audit's recommended standard of 90% for this measure. Staff told that they had now achieved a standard of 100% for this standard.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 93 eligible cases identified for inclusion, 99.4% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission. This was better than expected when compared to the national aggregate where 90.5% of cases had the first

consultation within 24 hours of admission. The hospital met the audit's recommended standard of 100% for this measure.

- **Do all babies < 1501g or gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)**

There were 15 eligible cases identified for inclusion, 95.8% of babies with a weight of < 1501g or gestational age of < 32 weeks at birth received the appropriate ROP screening. This was within expected range when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening. The hospital did not meet the audit's recommended standard of 100% for this measure. Staff told that they had now achieved a standard of 100% for this standard. They had introduced tailored weekly documentation for the consultant of the week ward round. This was changed to include a section looking at eligibility for ROP screening. A "reminder diary" was implemented to ensure that screening took place.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

There were seven eligible cases identified for inclusion, 57.1% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age. This was within expected range when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age. The hospital did not meet the audit's recommended standard of 100% for this measure.

Staff told us follow ups had not happened because follow up was not documented on the Badger Net system. The measures the service put in place to improve children's follow up at two years included:

- Six monthly reports were run on BadgerNet to ensure a list of babies due a two year follow in the next six months was available.
- The named consultant for these babies received an alert email two weeks prior to date of review.
- A double appointment was booked to ensure clinicians had time to record the review on BadgerNet.
- Reception staff in outpatients now print the BadgerNet form and put it on the front of medical notes as a second reminder for the consultants on the day of review appointment.

Performance data 2017/18 was tracked and showed 50% of eligible babies had a two year follow up. This compared to a national average of 48.3% in 2015/16.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service**.**

Appraisal rates

From April 2018 to June 2018, 67% of staff within services for children and young people received an appraisal. A staff group breakdown is shown below;

Staff group	Individuals required (YTD)	Staff who have received an appraisal (YTD)	Appraisal rate %
Qualified Allied Health Professionals (Qualified AHPs)	1	1	100%
Medical & Dental staff - Hospital	2	1	50%
Grand Total	3	2	67%

Medical and dental staff achieved an appraisal rate of 50% (two members of staff were eligible for an appraisal). There was no data provided for nursing and midwifery staff. They also failed to meet the target in the last financial year (April 2017 to March 2018) were they achieved 76%.
(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

All staff we spoke with told us they had received an appraisal in the last year. Appraisal statistics provided by the children's service confirmed to-date that 100% of nursing staff on Woodlands ward and the children's outpatients' department (COPD) had received an appraisal. On the special care baby unit 95% of staff had received their appraisal, one staff member was due their appraisal. Nursing appraisal data provided by the trust confirmed that appraisal rates had improved from 80% in 2017/2018 to 94% completion in 2018/19.

Medical staff confirmed daily supervision was provided by the consultant of the week. All foundation year doctors had a named educational and clinical supervisor. Speciality and associate specialist (SAS) doctors and Certificate of Eligibility for Specialist Registration (CESR) doctors had a named clinical supervisor. GP trainees had a Community GP supervisor. Medical staff teaching sessions took place on Wednesday's and on the Thursday grand round. Medical staff also told us that reflective learning and discussion of learning had taken place at handover sessions.

We asked what children's competencies recovery staff in theatres, radiology and adult outpatients staff had where children were seen. The trust said all staff were expected to work within their professional training and competency and mandatory safeguarding children training. Two radiographers and one radiologist took a lead in paediatrics, provided advice and updated other staff in techniques and practical imaging skills.

Woodlands ward staff had received training in supporting the de-escalation of a child or young person who was anxious or emotionally unwell. However, this training was part of the induction training and was not refreshed.

Staff completed a preceptorship style document that charted their competence in skills related to an activity. For example, venepuncture, preparing the child, consent, assessing the puncture site to find a vein and needle insertion. We reviewed two staff preceptorship documents and saw they had completed a staged route to achieving competence, through; a teaching session, a practical session, observed practice and final sign off when the competence was achieved. The COPD band three care support worker was trained and carried out tasks such as taking bloods, skin prick testing and sweat testing.

Staff told us they each completed a critical care passport as part of a two-year programme so that they developed the skills required to provide high dependency care. One band five and band six nurse had completed the paediatric intensive care course. The band five nurse worked part time

and was 0.77 whole time equivalent in post. The band six was the recognised lead in this area, held a clinical educator remit one day a week (7.5 hours) and was also a clinical supervisor.

Yearly multi-disciplinary simulation training took place, the last training was the 26 October 2018. The day consisted of real time scenarios. Three qualified nurses' and one care support worker had attended from Woodlands ward.

Paediatric life support training figures identified shortfalls in nursing staff attendance. On Woodlands ward 50% or three of six nursing staff had completed this training. In paediatric outpatients 62% or five of eight staff had completed paediatric basic life support training. On neonates 69% or nine of 13 staff had updated their new-born basic / intermediate life support training. These figures did not identify whether all relevant staff in the service had completed or refreshed paediatric life support training. In day surgery, care support workers had completed basic paediatric life support training with registered members of the team who had undertaken intermediate paediatric life support.

Clinical supervision for nursing staff was to be implemented across the service. The senior nurse we spoke with did not identify a start date for implementation.

Multidisciplinary working

In the CQC Children and Young People's Survey 2016 the trust scored 8.36 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

Question Number	Question	Age group	Trust score	RAG	KLOE
23	Did the members of staff caring for your child work well together?	0-15 adults	8.28	About the same as other trusts	E4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Discussions with staff throughout the service confirmed effective working between the multi-disciplinary teams. This was confirmed further by our observations of multi-disciplinary team interactions during ward rounds.

We saw discharge planning for babies, children or the young person involved members of the multidisciplinary team involved in their care, for example, health visitors, nurses, community teams, continuing care team, GP, social care professionals and therapists.

Whilst on the SCBU we observed a comprehensive discharge planning discussion between the consultant, nurse in charge and the parents of a baby during the morning ward round. The discussion included whether the parents had received CPR training and an explanation from the doctor about how their baby should progress in the days to come. In addition, discussions included the environment the baby would be returning to and sleeping arrangements. The nurse in charge discussed with parents the arrangements for follow-up at home. These arrangements involved the community midwife follow-up, health visitor involvement and how communication would be shared with the family GP.

On Woodlands ward we observed a discharge meeting between two of the nurses and the parents of a child that was receiving take home medicines for pain relief. The nurse provided a full explanation of the medicines and when they could be taken and responded to mother's questions about this. Staff told us that all children and young people were seen by a middle grade doctor before discharge.

To ensure access to specialist consultant staff the children's service worked with other children's services within the region. An example of this was a paediatric surgeon from a neighbouring trust held outpatient clinic consultations at Harrogate. This consultation included decisions based on identified criteria as to whether children were to be seen at Harrogate or Leeds NHS Trust. The allocation criteria used during this process by the paediatric surgeon were: Children less than 2yrs, less than 15kg and with complicated issues were seen at Leeds.

The multi-disciplinary team provided clinical assessment and treatments using a child friendly approach, which utilised play and distraction therapies. The play specialist and magnetic resonance imaging (MRI) teams worked together to prepare children for MRI scans and had scanned a lot of children without the need for sedation. Play specialist staff told us they worked alongside the learning disabilities liaison specialist which worked well with de sensitisation work pre- appointment.

A dedicated transitions health professional for young people was not identified within the service. Each healthcare professional was responsible for the transitional arrangements for children on their caseload. Senior staff said that transition from paediatric to adult services for young people with asthma and diabetes usually began at age 15 years. Young people with greater self-management skills and understanding of their condition started sooner whereas those who were not yet ready would start later. Transition involved joint clinic sessions with the young people's practitioner and the adult practitioner. The clinic sessions included a phased handover of care with an objective that the young person was discharged before their 18th birthday.

A transition pathway for young people with a diagnosis of a learning disability (LD) was accessed by referral to the Community Learning Disability Team in Hambleton and Richmondshire.

In Harrogate & Rural District (HaRD) transfer to the adult health LD team occurred if the young person met specific criteria.

Young people with 'Educational Health Care Plans', annual reviews included discussions of their ongoing health needs which included transition. Onward referrals to adult therapy services (e.g. for young person with an ongoing health need in mainstream education) often led to a GP referral who decided if an onward referral could be made.

The Yorkshire and Humber Critical Care Operational Delivery Network met with the children's service bimonthly.

Seven-day services

Pharmacy support and pharmacy access were available.

Staff told us that children's and adolescent mental health service support was available throughout the week and after 5pm.

Radiology services were provided.

The children's community team supported children who were discharged to their care in the community.

Paediatrician support at consultant level was available. Out of Hours this was through the on-call service.

Physiotherapy provision with on-call provision was available.

Staff told us they could access anaesthetic support.

Access to information

Staff in the special care baby unit (SCBU) worked closely with maternity services, health visitors and GPs. We were told that all information about a mother and baby's episode of care was shared with the GP and health visitor on discharge. We did not see examples of this information on inspection, however, we observed some parents were told their information would be passed to their GP and the health visitor would be in touch. Hospital electronic patient records systems were not compatible with the primary care systems and so information was shared by letter.

Staff said they routinely discussed the psychological and emotional needs of patients, their relatives and carers at handover meetings. Staff on SCBU explained that a two-part handover process involved speaking with parents when they were handing over and how the parents were feeling. On Woodlands ward the handover structure did not prompt discussion of mental health needs, however it was evident staff had considered mental health needs for patients and there was occasional reference in medical notes to young people's emotions.

Staff referred patients they suspected to be experiencing depression for a mental health assessment. Staff explained that in addition to the daily telephone call with the CAMHS crisis team, they also contacted the team when needed. On SCBU, staff had begun to refer parents who would benefit to the 'Increasing Access to Psychological Therapies (IAPT)' team.

Safeguarding information was shared electronically as the trust safeguarding team had access to the electronic patient records system in use in most GPs in Harrogate [System One] and so safeguarding information was shared through that system.

If a child moved out of area trust reports were provided and colleagues contacted by telephone to ensure smooth transition to the next service.

Health promotion

Primary health leaflets were displayed throughout the children's service. These leaflets included advise in areas such as safeguarding, grooming and drug crime – signs to spot were identified.

Information for parents was displayed on a 'Parents Information Board' in Woodlands ward. Information related to hearing impairment support and how to request hearing loops, pocket talkers and access 'British Sign Language' support. In addition, Physiotherapy drop in sessions at local children's centres were displayed with contact details.

The 'In a Crisis' board on Woodlands ward gave parents and young people information in areas such as Child Line, Young Minds and bereavement support.

Specialist dental programmes were in place to promote and support oral health in children.

Healthy eating and weight management was encouraged.

Children with asthma may have to use spacer devices to assist them when taking their inhaler. We were told that compliance with the use of spacer devices was poor. To improve compliance a training programme was developed and taken into schools and the community. Stickers were developed to put around the spacer device to make them child friendly and fun.

A home assessment tool was in use which identified neglect and looked at home safety for the children up to age five years. This assessment tool was the result of work which related to the reduction of accidents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed the trust policy and procedures when a patient could not give consent, but the principals of Gillick competence were not well understood by staff. Three staff members were not able to explain accurately who the assessment for Gillick competence was for or how it would be assessed when we tested this out with a range of scenarios.

The trust identified that paediatric nursing staff had completed level three face-to-face training which did not include specific training on Gillick competence. Going forward the safeguarding team would include training on Gillick competence and associated safeguarding issues.

The level three e-learning package provided to paediatricians included consent and refusal of medical treatment. It looked at scenarios of adolescents presenting for treatment and explored consent within in a clinical setting. The training provided a link to for the doctors to access General Medical Council (GMC) publications. Eighteen paediatricians had completed this e-learning package training from 19/11/17 to 19/11/18.

We reviewed children's and babies notes for evidence of consent processes and saw completed consent forms for specific investigations, for example, prior to surgery. We followed a child through from admission to discharge on the day surgical unit and observed consent was obtained. The consent and surgical site were checked again prior to anaesthetic induction. One parent in Woodlands ward explained, "we knew last night what was going to happen, they outlined the risks and asked us to sign to say we understood and that we consented".

We saw staff asked for and documented verbal consent. One example of verbal consent obtained related to the use of a baby dummy. Confirmation of the parent's verbal consent was seen in the baby's nursing notes.

Other CQC Survey Data

CQC Children and Young People's Survey 2016 Data

The trust performed about the same as other trusts for four questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

Q54: Did hospital staff play with you or do any activities while you were in the hospital: 6.11 – No score

Question Number	Question	Age group	Trust score	RAG	KLOE
21	Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.08	About the same as other trusts	E3
9	Did staff play with your child at all while they were in hospital?	0-7 adults	6.84	About the same as other trusts	E4
19	Did different staff give you conflicting information?	0-7 adults	8.04	About the same as other trusts	E4
33	During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	7.48	About the same as other trusts	E4

54	Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	No Score	No Score	E4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service caring?

Compassionate care

CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

Question Number	Question	Age group	Trust score	RAG	KLOE
10	Did new members of staff treating your child introduce themselves?	0-7 adults	8.82	About the same as other trusts	C1
14	Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.78	About the same as other trusts	C1
22	Were members of staff available when your child needed attention?	0-15 adults	7.77	About the same as other trusts	C1
42	Do you feel that the people looking after your child were friendly?	0-7 adults	9.05	About the same as other trusts	C1
43	Do you feel that your child was well looked after by the hospital staff?	0-7 adults	8.69	About the same as other trusts	C1
44	Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	7.93	About the same as other trusts	C1
58	Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	6.23	About the same as other trusts	C1
64	If you had any worries, did a member of staff talk with you about them?	8-15 CYP	8.79	About the same as other trusts	C1
74	Do you feel that the people looking after you were friendly?	8-15 CYP	9.37	About the same as other trusts	C1
75	Overall, how well do you think you were looked after in hospital?	8-15 CYP	8.28	About the same as other trusts	C1

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We spoke with 15 parents, one grandparent and seven young people.

Most parents were happy with the care and support received. We saw several examples of where children and their parents were spoken to compassionately and courteously. Children were involved in discussions and were spoken ‘to’ as opposed to spoken ‘about’.

We observed members of medical and nursing staff provided compassionate and sensitive care. The parents on Woodlands ward described their child’s care. “The care has been brilliant, from the moment we walked into A&E and were seen within five minutes”.

Staff had a positive and friendly approach, demonstrated active listening and gave caring responses. Caring interactions were observed from non-clinical staff such as domestics, ward clerks and porters. One child told us that a member of the domestic staff had given them an activity book and a parent said that staff always checked on their wellbeing and comfort.

We observed all staff engaged with children's care and one patient said they were made to 'feel at ease'. A parent on the special care baby unit (SCBU) told us that staff 'were good at getting you involved' with baby care. They described how they had been encouraged to have skin to skin contact inside the incubator and helped them to bathe, dress, tube and then breastfeed their baby.

We observed parents in the special care baby unit (SCBU) were supported with their emotions in a manner that maintained their dignity. Staff on SCBU expressed frustration about other staff walking through the unit to access Woodlands ward due to the potential impact this would have on parents.

Children and their families who attended Woodlands ward for food allergy testing were treated in the clinical assessment unit (CAU). This was an open environment which meant conversations, including personal details, were overheard. We spoke with nursing staff about the open environment on the CAU. They were aware of the need to maintain confidentiality. Staff explained this area was chosen as the safest place as it meant staff could see patients and recognise any allergy response in a timely manner. The allergy clinic nurse explained the communal treatment area was used at the child's initial clinical appointment, but a side room was also offered. During the inspection we observed outpatient staff checking on children in the communal area. Feedback cards and comment boxes were available for parents to use throughout the service. We saw positive feedback given by parents on cards displayed throughout the service.

Emotional support

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for the five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

Question Number	Question	Age group	Trust score	RAG	KLOE
7	Was your child given enough privacy when receiving care and treatment?	0-7 adults	9.00	About the same as other trusts	C3
29	If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	8.41	About the same as other trusts	C3
45	Were you treated with dignity and respect by the people looking after your child?	0-7 adults	9.15	About the same as other trusts	C3
65	Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	9.00	About the same as other trusts	C3

67	If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	9.15	About the same as other trusts	C3

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Staff provided emotional support to patients to minimise their distress. Two parents described how nursing staff had comforted them when they were upset. One parent commented 'staff are always on hand to have a chat even though they are busy' and they 'completely understand how we feel as we go through many emotions'. On the special care baby unit (SCBU) posters were displayed about baby massage and comfort holding, to promote emotional bonds with their baby.

Parents said nursing staff always introduced themselves at the start of shifts, were helpful and medical staff had spoken with them and reviewed their baby's care needs daily.

The needs of new mothers were re-evaluated regularly, demonstrating that appropriate emotional support was available for both mother and baby. For mothers who experienced mental health problems or learning disabilities additional emotional support was provided through the multi-disciplinary team which included health visitors and social workers.

A 24-hour chaplaincy service was provided. A chapel was available for worship and quiet reflection and could be used for multi-faith worship and spiritual support. Staff told us that the trust chaplain regularly visited the special care baby unit.

Staff told us bereaved parents were supported by the bereavement link nurse, chaplaincy service and BLISS. BLISS is the leading UK charity for babies born premature or sick. It supports families with a baby in neonatal care, works with health professionals to provide training and improve care for babies, campaigns for improved hospital resources across England, Scotland, Wales and Northern Ireland, and is actively involved in pioneering neonatal research. Bereaved parents were routinely given keep sake boxes which included the hands and footprints of their babies.

Links with local support network groups, such as speech and language therapies provided parents, children and young people assistance with individual needs on discharge from hospital.

Understanding and involvement of patients and those close to them

CQC Children and Young People's Survey 2016

The trust performed better than other trusts for three questions, worse than other trusts for three questions and about the same as other trusts for 14 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016.

Question Number	Question	Age group	Trust score	RAG	KLOE
11	Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	8.61	About the same as other trusts	C2
12	Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	7.10	Worse than other trusts	C2

13	Did a member of staff agree a plan for your child's care with you?	0-15 adults	9.21	About the same as other trusts	C2
15	Did staff involve you in decisions about your child's care and treatment?	0-15 adults	7.96	About the same as other trusts	C2
16	Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.26	About the same as other trusts	C2
17	Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	7.73	About the same as other trusts	C2
18	Were you able to ask staff any questions you had about your child's care?	0-15 adults	9.00	About the same as other trusts	C2
31	Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.82	Better than other trusts	C2
32	Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.52	About the same as other trusts	C2
34	Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.57	About the same as other trusts	C2
39	When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	7.14	Worse than other trusts	C2
41	Do you feel that the people looking after your child listened to you?	0-7 adults	8.16	About the same as other trusts	C2
59	Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	8.84	About the same as other trusts	C2
60	When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.49	About the same as other trusts	C2
61	Did you feel able to ask staff questions?	8-15 CYP	9.22	About the same as other trusts	C2
62	Did the hospital staff answer your questions?	8-15 CYP	9.94	Better than other trusts	C2
63	Were you involved in decisions about your care and treatment?	8-15 CYP	6.16	About the same as other trusts	C2
66	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	No Score	No Score	C2
69	Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	10.00	Better than other trusts	C2

70	Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	8.70	About the same as other trusts	C2
72	When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	6.81	Worse than other trusts	C2

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Staff involved patients and those close to them in decisions about their care and treatment. Staff used appropriate language to interact and engage with children, young people and their families. Access to interpreters ensured parents, carers and young people were kept informed and able to ask questions. Parents and several young people said they were involved in their care and decision-making and were happy with the care and treatment received. One child was not sure what pre-tests were performed during their allergy testing and two parents told us they had not been kept up to date with information about treatment plans after admission.

We observed a ward round on the SCBU and staff involved the parents in discussions about care and treatment and all records were made in the presence of the parents. The paediatric consultant asked parents questions about their child and the way that they responded to their care. We saw that parents asked questions which received explanations understood by parents.

We observed that all doctors engaged with the children but spoke predominantly with the parents. All doctors introduced themselves and gave a good explanation of all procedures. The patient satisfaction survey (August 2018) showed that 15 of 22 of parents said they felt they were given adequate opportunity to discuss their baby's condition with a doctor at a time convenient to them, 20 of 22 of parents said they felt fully informed about their baby's care and progress, 21 of 22 parents felt, where appropriate, they were adequately involved in the decisions made, and involved in the day to day care of their baby.

Discharge procedures and documentations had been improved so parents received the information they required, both verbal and written, prior to discharge home. The leaflets advised parents when to bring their child back into hospital and who to contact for advice. The parent survey showed that 21 of 22 parents were very satisfied with the clear, understandable, written and verbal information they received. Information leaflets were available for parents and carers which could be accessed in other languages and formats.

Is the service responsive?

Service delivery to meet the needs of local people

CQC Children and Young People's Survey 2016

The trust performed better than other trusts for one question and about the same as other trusts for 14 questions relating to responsiveness in the CQC Children and Young People's Survey 2016. Questions two and three had no score.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Question Number	Question	Age group	Trust score	RAG	KLOE
4	For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.81	About the same as other trusts	R1

5	Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	8.77	About the same as other trusts	R1
25	Did you have access to hot drinks facilities in the hospital?	0-15 adults	8.75	About the same as other trusts	R1
26	Were you able to prepare food in the hospital if you wanted to?	0-15 adults	2.88	About the same as other trusts	R1
28	How would you rate the facilities for parents or carers staying overnight?	0-15 adults	6.77	About the same as other trusts	R1
55	Was the ward suitable for someone of your age?	12-15 CYP	8.04	About the same as other trusts	R1
8	Were there enough things for your child to do in the hospital?	0-7 adults	6.90	About the same as other trusts	R2
24	Did your child like the hospital food provided?	0-7 adults	6.12	About the same as other trusts	R2
37	Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.14	About the same as other trusts	R2
38	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.27	About the same as other trusts	R2
40	Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	7.35	About the same as other trusts	R2
56	Were there enough things for you to do in the hospital?	8-15 CYP	5.66	About the same as other trusts	R2
57	Did you like the hospital food?	8-15 CYP	8.27	Better than other trusts	R2
71	Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	6.77	About the same as other trusts	R2
73	Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	8.10	About the same as other trusts	R2
2	Did the hospital give you a choice of admission dates?	0-7 adults	No Score	No Score	R3
3	Did the hospital change your child's admission date at all?	0-7 adults	No Score	No Score	R3

The trust planned and provided services in a way that met the needs of local people. We saw that service delivery had improved and the needs of the local population considered.

Bi-monthly paediatric day surgery lists were undertaken on the adult day surgery unit (DSU). The whole area was assigned to paediatrics and included waiting areas, operating theatres and two recovery rooms. At the last inspection there was only a segregated area.

When children attended the DSU on non-paediatric days they were listed first, and staff used their discretion to draw curtains around the child to maintain dignity and reduce anxiety. Theatre lists were audited to ensure children were first on the list in line with national guidance.

Families were involved in the redesign and refurbishment of the children's outpatient department (COPD). The parent of one child was so pleased with the quality of care their child received within the COPD and Woodlands ward they established the 'Rainbow Fund' which raised the money required to redesign the COPD in conjunction with other charities. The redesign of the COPD included an additional two rooms, increased clinic capacity and the introduction of additional nurse-lead clinics in paediatric phlebotomy and skin-prick testing. Another parent donated her company's time and talent and designed the artwork used throughout the department. We noted the COPD's environment had been upgraded and had child friendly decoration and equipment.

Staff told us that parents and children had been consulted on and involved in the redesign of the activity room on Woodlands ward.

Stakeholder involvement in service development outcome had resulted in the recruitment of an epilepsy nurse who was part funded by this stakeholder for three years. This nurse started in post in September 2018.

Parent accommodation included access to shower and toilet facilities and a parent lounge. A recent survey completed by the ward showed that 59% of parents stayed in the parents' room overnight stay room. Stays were rated as excellent (61%) and good (38%).

The SCBU had a child friendly multi-purpose family room and relaxation room for parents, a play room for visiting siblings, a breastfeeding room and a room for confidential conversations. A room was available for parents to sleep with babies 48 hours prior to discharge to prepare them for child going home. One mum confirmed that this family room was a good environment to cater for her and family needs. Parents could access personal lockers and there were laminated posters above each cot 'hello my name is… and my mummy and daddy are called…' and a wardrobe next to each cot for parents to keep clothes and baby things.

Parents were offered a 50% car parking discount for the first two weeks and 100% discount thereafter.

Age appropriate toys and games were available in all areas except the child assessment unit and the waiting area in paediatric theatres where the toys were for younger children. Woodlands ward had a designated indoor and outdoor play area. One six-year-old patient reported that they 'liked the playroom' and said it was 'great.' They described that the playroom has 'got everything in here, plays with all the toys'.

Meeting people's individual needs

The service took account of patients' individual needs.

Staff told us that the community play specialist prepared children and young people who had disabilities, so they knew what to expect at hospital. We saw how a child with Downs syndrome was prepared for dental surgery. The dental, anaesthetic, paediatric and theatre nursing staff with the learning disabilities team worked together to ensure surgery went well. The narrative provided identified effective multi-disciplinary team working, involvement of the child and family in decision making and how the child was familiarised with equipment which was part of the process.

The dental list dated 14 November 2018 showed children's and young people's needs were considered. For example, two patients required side rooms due to specific needs.

The staff we spoke to were unaware of the flagging system in use to identify parents or young people with additional needs. Link nurses were in place on both Woodlands ward and SCBU..

Staff identified effective working relationships between the children and adolescent mental health service (CAMHS) professionals and paediatricians. The crisis team were based in the Briary Unit within Harrogate District Hospital and provided cover between 10am and 10pm. Outside of this time, the adult mental health crisis team saw young people aged between 16 and 18 years. A clear escalation process was in place. The CAMHS Crisis team was nominated for a 'living the values' award by the Harrogate children's service as young people now spent less time on the wards unnecessarily.

Behavioural risk assessments were commenced on children and young people who attended the emergency department (ED) having self-harmed, in mental health crisis or had anxieties. This assessment determined if they required one-to-one care by mental health trained agency nurses.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The CAMHS crisis team contacted the wards daily to identify children who required assessment or support. They provided an appointment time when they visited the ward and saw the child or young person the same day. We saw evidence that young people could speak to staff without their parents when requested so they could provide a fuller history of their mental health and any associated risks.

The hearing screening service visited the special care baby unit (SCBU) daily to ensure all neonates were screened prior to discharge home.

Ophthalmologists attended the SCBU to ensure screening for retinopathy of prematurity in the at risk neonatal population was undertaken.

The ward had created an information booklet which was finalised in summer 2018 following a period of design and involvement with nursing, medical, patients and parents.

Neonatal babies with an identified physical or learning disability were referred by the paediatric consultant to the trust's community nursing team for follow-up. Babies with a learning disability were referred by the consultant to the care of a community paediatrician child development centre (CDC) for follow-up, usually within six to eight weeks of discharge. Staff advised that this has happened three times in the last months in relation to babies born with Downs Syndrome. Transitional care arrangements for babies took place on the postnatal ward by a named midwife with paediatrician support. The neonatal early warning track and trigger system via Patientrack alerted paediatricians if the baby's physiological parameters fell outside of expected range.

Access and flow

Activity	Previous	Latest	Change	National comparison
Admissions (total)	4,553	4,637	(+2%)	
Under 1	1,018	1,048	(+3%)	
1 to 3	1,070	1,154	(+8%)	
4 to 15	2,093	2,100	(0%)	
16 to 17	372	335	(-10%)	
	Apr 16 - Mar 17	Apr 17 - Mar 18		

ource(s): Hospital Episode Statistics

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The service confirmed their 18-week referral to treatment (RTT) performance for children was above the required 92% standard.

Escalation processes ensured management of beds and capacity within the service. Guidance was provided on bed management and capacity, what to do in peak hours and out of hours.

Within the paediatrics specialty, a total of 599 patients were waiting, of which 10 waited over 18 weeks. This equated to 98.3% performance. In addition, 970 patients aged 0-17 waited in other specialities (predominantly orthopaedics, ear, nose and throat speciality and dermatology). Of these, 61 waited over 18 weeks. This equated to a performance of 93.7%.

Staff said the paediatric matron met regularly with adult nurse managers to ensure outpatient services were child friendly and a safe environment provided. When children attended clinics in the main outpatient's department staff encouraged the use of the paediatric waiting area. We were told that the first three appointments in the morning and afternoon were reserved for children who attended the adult outpatient clinic.

The number of outpatient clinics by specialities, orthopaedics and ophthalmology, other than paediatrics had increased and were now located in the children's outpatient department (COPD). Staff told us that twice weekly pre assessment clinics led by the paediatric nurse practitioner also took place.

Phlebotomy and skin prick clinics moved ward attenders from the ward to COPD where a dedicated service with play therapist support was provided. Patient and family experiences had improved and waiting times reduced from approximately eight to 12 weeks to four to six weeks.

Staff in the day surgery ward said they thought that children who missed appointments were not effectively followed up through the safeguarding route. The staff we spoke with were not aware of the 'Did not attend' policy and procedure, however they said they would approach the safeguarding lead for advice.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The ward manager described the complaints and concerns process.

Verbal and written complaints were directed to ward staff or the patient experience team. Verbal complaints directed to staff were attempted to be resolved informally and the outcome documented in the patient notes. We did not see documentation to confirm the records of complaints resolved informally.

If complaints were not resolved, the issue was more serious or required further investigation the complaint was logged with the patient experience team as a formal complaint and the trust's complaints process applied. We saw and tracked a complaint which confirmed that the complaint had followed the stages of the complaints process within identified timescales. Not all complaints resulted in the completion of an incident form. However, all complaints were discussed at the monthly Quality of Care meeting.

Details of how to access the patient experience team for complaints was displayed.

Summary of complaints

From July 2017 to June 2018 there were four complaints about children's services at the trust. The hospital took an average of 84 days to investigate and close complaints. This was not in line with the trust's complaints policy, which stated complaints should be completed within 25 days. Two complaints were from Woodlands ward and two from paediatric outpatients. Complaints generally related to the overall care of patients.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From July 2017 to June 2018 one compliment was given to Woodlands ward in May 2018.
(Source: Routine Provider Information Request (RPIR) – Compliments tab).

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Staff spoke positively about the children and young people's service management team (matron, ward manager and outpatients' manager). They said an open, honest culture was promoted and concerns could be discussed freely. Staff confirmed that the paediatric matron and ward manager held a visible presence throughout the service.

Monthly senior nurse and departmental meetings had taken place which allowed exchange of information and discussions about the service, needs, developments and progress.

The children's day case service was managed by a band seven adult nurse for the last six months. One senior children's nurse said they worked on the day surgery unit when children's lists took place.

Staff told us the chief nurse had visited the service recently and were described by staff as visible and approachable. The deputy chief executive officer visited Woodlands ward in October 2018. We were told that all paediatric consultants had job plans which had been reviewed yearly.

Staff all knew who the consultant of the week was and how to contact them. Everyone said they would have no problems approaching them if required.

Vision and strategy

Hopes for Healthcare and standards which detailed the service strategy had been established and was to be presented to the board in January 2019. Discussions with senior staff identified that they wanted to ensure that the trust vision and values were fully embedded within children's services before developing a service specific vision and values. We saw the trust vision and values displayed on Woodlands ward. The trust identified the organisational strategy set out how they implemented their vision in a changing operating context. Their "This is Us" graphic captured their vision and values and was refreshed by the Board in July 2018.

Senior staff confirmed that they had developed yearly work plans specific to both the neonatal and children's services. We saw a copy of the work plans for 2016 – 17 and 2018. We were told that

staff were encouraged to contribute to these work plans and that they were discussed and agreed at monthly board and governance meetings.

A paediatric outpatient business case to improve patient services was agreed and implemented to develop and increase nurse led clinics in children's outpatients which included the implementation of the epilepsy nurse specialist service, to establish formal constipation clinics, increased phlebotomy clinics and an increased skin prick service. All of these were implemented and had improved the patient experience.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We spoke with staff in the special care baby unit (SCBU), Woodlands ward and COPD who all said they felt very well supported by their peers, supervisors and managers. Staff recognised that the culture had improved throughout the service.

Three nurses we spoke with spoke positively about the levels of support and the learning culture at Harrogate. One nurse told us "The focus here is very much on learning – it's a learning culture. Managers were described as very supportive and focused on helping staff to achieve their full potential". Another nurse said, "There is always a manager around, they come to the ward to offer support".

A 'Freedom to speak up safely poster' was displayed in COPD. The staff we spoke with said they felt confident to raise concerns with their immediate manager.

Following every child bereavement staff were supported emotionally by their managers. This support included a debriefing session and access to occupational health support.

Governance

The service had improved the quality of its services.

Senior staff described a clearly defined governance structure led by the clinical director, operational director and governance lead. Other key people involved in governance were the paediatric clinical lead, paediatric matron, service manager and ward manager.

The Trust board had a designated executive and non-executive lead for children and young people. Children's services were also represented at the board by the clinical director for CCCC who is a consultant community paediatrician.

A named paediatric consultant oversaw audit within the service.

An anaesthetist consultant had identified responsibilities for coordinating and overseeing anaesthesia services for children.

A designated surgeon oversaw children's surgical services.

The paediatric matron worked closely with clinicians and managers to develop children's services.

Monthly paediatric quality of care meetings, directorate board, audit and governance and performance meetings took place. Our review of three children's and county wide community care governance meeting minutes and two paediatric governance and audit meeting minutes showed multi-disciplinary team involvement, service monitoring and ongoing clinical reviews had taken place. Discussions included audit, clinical guidelines, patient feedback, NICE guidance reviews,

transition planning, incidents and complaints. It was evident from the discussions held and work which had been progressed that embedded governance processes were central to the service.

The quality of care meeting agenda included incidents, family and friends test and complaints. It was at this forum incidents were approved, and incident themes identified. We were told that this meeting was open to all staff to attend.

Safeguarding reporting arrangements ensured safeguarding processes were monitored trust wide. The 'Safeguarding Children Governance Group' (SCGG) met bi-monthly, reported to the trust 'Supporting Vulnerable People Steering Group' (SVPSG), and was accountable to the chief nurse. The SCGG oversaw the development, review and implementation of safeguarding children policies. It was responsible for the scrutiny of supervision and training compliance, with actions developed to support departments where compliance fell below the expected level. The trust identified that the SCGG monitored all action plans from inspections, serious case reviews, learning lessons and root cause analysis.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The 'Improving Patient Safety Steering Group', chaired by the Medical Director was the trust level group which led the work to improve patient safety.

The service risk register identified service specific risks, where current risk level was identified. Mitigating actions and the latest update were identified against each risk. Senior staff we spoke with were sighted on risks to the service and could confirm what actions had been or were being taken to mitigate against the risks.

The trust had developed a local safety standard for invasive procedures, based on the framework document "National Safety Standards for Invasive Procedures (NatSSIPs)" published by NHS England in September 2015. Theatre managers were responsible with input from a named consultant anaesthetist and deputy chair of the Trust's 'Improving Patient Safety Steering Group'.

The Chief Nurse was the executive lead for safeguarding children and adults with overall responsibility for safeguarding children. The trust had a strong multi-agency focus and had collaborated with partner agencies. The last safeguarding children's report (2017/18) was presented at the quality committee on the 2 May 2018.

Joint working and meetings took place with the Yorkshire and Humber Operational Delivery Network (ODN) took place. Minutes of the meeting dated 7 November 2018 confirmed discussions, for example, perinatal key performance indicators, in utero transfers, the Yorkshire and Humber ODN quality standards.

The service participated in the national clinical audits and had completed identified audits internally. Internal audits included sepsis assessment, patient assessment warning score (PAWS) and infection control. A comparison of the annual PAWS audits undertaken in 2016 and 2017 confirmed a significant improvement in 2017 there was a significant improvement in documentation which followed implementation of Patientrack. The trust confirmed that all actions were completed.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust is part of the Child Protection Information System (CP-IS) project, an NHS England sponsored information sharing solution which delivered a higher level of protection to children and unborn babies at NHS unscheduled care settings. CP-IS connects local authorities' child social care information technology systems with those used by NHS unscheduled care settings in England. This ensured better care and earlier intervention for children/unborn babies who were considered 'vulnerable and at risk. The CP-IS alert system was used in the emergency department (ED) to identify children subject to a child protection plan and this information was shared with relevant staff on the child's admission to hospital.

Numerous patient safety benefits were delivered due to the use of nurse-led technology-enabled care using Patientrack. Patientrack flagged patients at risk of deteriorating, and automatically alerted medical staff. Patients benefited from improved observations accuracy, pediatric early warning scores' response rates and faster clinical attendance.

Woodlands ward used an interactive whiteboard to track patients which identified patients in each area of the ward and their status. However, staff reported this board sometimes did not work.

Staff told us that an electronic staff handover sheet was used at each shift handover. We observed the use of this handover sheet when we attended the units' morning safety briefing.

The trust had implemented an electronic prescribing system (ePMA Medchart), a chemotherapy electronic prescribing system (Chemocare), dispensing automation, Omnicell in the emergency department and had access to reporting systems such as Define.

Engagement

The trust engaged well with patients, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The 2016 CQC report identified a need to re-establish staff engagement. Previous meeting minutes for Woodlands ward confirmed that one staff meeting had taken place in July 2017 and three staff meetings were held in 2018. Staff said all staff were encouraged to attend staff meetings, but there was limited or occasionally no uptake in attendance, despite staff being given the time back. An agreement was recently made was to hold quarterly staff meetings. Bi-monthly staff unit meetings took place in the special care baby unit (SCBU).

We saw that outcomes of parent surveys had been actioned. For example, the August 2018 SCBU satisfaction survey identified some areas for development. Sixteen or 73% of parents confirmed they had received sufficient verbal and written information about breast feeding.

The Trust had developed a tool for collecting feedback from children and young people and used the information to improve services.

We saw how Woodlands ward had responded to parents under the 'you said, we did' approach. All parent feedback displayed was very positive and actions were taken following feedback. For example, 'Upgrade parents' rooms', the service had redecorated the rooms, bought new beds and bed linen. These actions have shown the service had listened to parents and where feasible actioned requests.

A service evaluation to assess the parental satisfaction of their child's dental general anaesthetic service provided at Harrogate District Hospital was completed. The review ran from 1 October 2017 and 1 April 2018. In total, 49 parents and /or guardians consented to taking part in the service evaluation. A 56% response rate was obtained from the survey. Twenty-five full responses were received over six months. The outcome was positive, and four recommendations resulted, one of which was to continue the online survey.

The Acute Paediatrics team had been nominated for Team of the month on two occasions in the last twelve months; Woodlands nominated Sept 2018 and November 2018 by parents.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Staff said a ‘Children’s Directorate’ had been established since the last inspection to ensure a stronger focus on children and young people’s needs trust wide.

The Paediatric Asthma Nurse Specialist had received a "Making a Difference" award in recognition of the work undertaken to educate staff and improve the care of children with asthma.

Weekend theatre lists reduced the paediatric dental list and approximately 120 children had their operations over a three-month period. Without this project children would have had to wait potentially six to 12 months for a general anaesthetic. This project resulted in the team winning a ‘Making a Difference Team Award’. The team continued to work together to improve the care of patients with complex needs who were easily distressed outside of their usual environments. The learning disabilities nurse had established links with community learning disabilities nurses, who visited children at home and prepared them for hospital.

A ‘Youth Forum’ established 18 months ago was actively involved in the development of the children’s service. Their involvement had contributed to the development of standards trust wide which were due to be finalised and implementation was set for March 2019. Representatives from the youth forum were involved in the redesign of Woodlands ward and sat on recruitment panels, for example, the recent appointment of the epilepsy in action funded nurse specialist.

A local primary school had raised money to refurbish the playroom. The school visited the ward with some children to discuss ideas on how they would like to spend the money. The youth forum also presented their views and ideas. The room has been renamed an activity room with zones for different aged children. At a ‘Paediatric Quality Forum’ meeting two parents contributed their ideas after viewing the present facilities. The work is at now at planning stage awaiting quotes.

In August 2017 the Special Care Baby Unit (SCBU) was awarded full accreditation under the ‘Baby Friendly Initiative’ award. The unit was reviewed against a series of international standards of care (World Health Organisation and UNICEF) to achieve this and at the time was only the second service within the UK to receive this.

Community health services

Community health inpatient services

Facts and data about this service

Harrogate and District NHS Foundation Trust provides community services in the Harrogate locality, a specific range of community services across North Yorkshire (with a population of 400,000) and provides Children's Services to North Yorkshire, County Durham, Darlington, Stockton-On-Tees, Middlesbrough, Gateshead and Sunderland.

HDFT runs a 16 - bed in-patient ward on Trinity Ward at Ripon Community Hospital, Firby Lane, Ripon. Trinity ward includes two beds dedicated to the provision of palliative care. They have clear criteria for admission which includes - intensive rehabilitation, Step Up from the Community, palliative Care.

Trinity ward has strong input from the physiotherapy and OT Teams based at Ripon Community Hospital. Local GPs are contracted to provide medical management of inpatients on the ward with additional oversight of care from a Care of the Elderly Consultant.

(Source: Routine Provider Information Request (RPIR) CHS Context)

Patients were admitted to Trinity ward at Ripon Community Hospital from acute hospital wards at Harrogate District General Hospital and occasionally from other hospitals such as York District General Hospital, The James Cook University Hospital in Middlesbrough and the Friarage Hospital at Northallerton. Patients could also be admitted from the community as a step-up facility, avoiding acute hospital admission or for end of life care. The ward is a mixed sex rehabilitation ward with 16 beds. There is appropriate segregation with the physical capacity to increase to 20 beds. This included two dedicated palliative care beds in a separate part of the ward specifically for end of life care.

Most patients were elderly and the ward occasionally cared for younger adult patients over the age of 18. The average length of stay in the 5 months prior to December 2017 was 27 days as stated in the RPIR. However, the average length of stay in the service between December 2017 and June 2018 was 20 days. At the time of our inspection there were 14 beds occupied with no patients waiting for transfer to the ward. Actual nurse staffing levels met the planned number for both day and night shifts

Percentage of patients that were children

The ward provided rehabilitation for adults over the age of 18, following falls, infection, fractures, amputation or neurological conditions. No children were treated on the ward.

Is the service safe?

Mandatory training

Mandatory Training completion

The trusts training compliance was RAG rated: Red was 0-49%, Amber was 50% - 74%, Green was 75% - 94% and Blue was 95% - 100%.

Trust wide

Training is reported on a monthly rolling basis; a breakdown of compliance for mandatory courses for nursing and midwifery staff in community health inpatient services as of July 2018 is shown below.

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Manual Handling Face to face & eLearning	27	30	90%	Green
Data Security Awareness (previously Information Governance)	13	15	87%	Green
Health & Safety	13	15	87%	Green
Infection prevention & Control (no renewal and Level 2)	12	15	80%	Green
Basic Life Support	8	10	80%	Green
Medicine management training	21	30	70%	Amber
Fire Safety - Level 1 (annual)	10	15	67%	Amber

In community health inpatient services, nursing and midwifery staff achieved five green ratings out of seven mandatory training modules. However, there were low numbers of staff eligible for each module and managers were confident all targets would be met by the end of the year. We saw staff training information held by the ward manager covered any gaps to ensure all staff completed training and were given sufficient time to do so. However, some dates for additional training courses were awaited. Staff told us they supported colleagues who lacked IT confidence to complete e-learning modules.

Compliance with training was managed through a RAG (red, amber, green) rated system for the individual through to directorate and trust level. The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the Trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.

All staff, including bank staff, received all mandatory training as part of their induction and did not start work in the clinical area until they had completed the corporate induction.

Some staff told us they did not like the amount of e-learning they were required to undertake for mandatory training. They also did not like having to travel to Harrogate District General Hospital for training due to the time it took and the difficulties with car parking.

Medical staff told us they completed mandatory training within their own directorate or GP practice and this information was held by the senior management team.

Safeguarding

Safeguarding Training completion

The trusts training compliance was RAG rated: Red was 0-49%, Amber was 50% - 74%, Green was 75% - 94% and Blue was 95% - 100%.

Trust wide

Training is reported on a monthly rolling basis; a breakdown of compliance for safeguarding training courses as of July 2018 for nursing and midwifery staff in community health inpatient services is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Safeguarding Children (Level 1)	15	15	100%	Blue
Safeguarding Children (Level 2)	14	15	93%	Green

In community health inpatient services, nursing and midwifery staff achieved a blue rating for safeguarding children level 1 and a green rating for safeguarding children level 2 with 93%.

Trust records for Safeguarding adults training showed the same data as for safeguarding children level 1; 100% compliance. However, safeguarding adult's responder training compliance was 36% trust-wide. Following our inspection, we requested data for Trinity ward and trust information showed 20% of those eligible for this training had completed it.

Trinity ward staff told us they completed safeguarding training as part of statutory mandatory training.

Medical staff told us they completed mandatory training within their own directorate or GP practice and this information was held by the senior management team.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Between July 2017 and June 2018 three safeguarding referrals were made from community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Staff could identify the circumstances when an alert to the safeguarding team would be required. All staff we spoke with were aware of the safeguarding process and could give examples of this through experiences. Staff had made two referrals in the last 12 months to the trust safeguarding team regarding concerns about patients' home lives and living conditions. Staff gave examples of learning opportunities regarding safeguarding cases from other departments at Ripon Community Hospital, and from the trust safeguarding team.

Cleanliness, infection control and hygiene

Staff completed Infection Prevention and Control (IPC) training as part of their statutory mandatory training. Twelve out of 15 eligible staff had completed level two IPC training and the remainder were booked to complete it before the year end.

There had been no Clostridium difficile episodes or Methicillin-resistant Staphylococcus Aureus (MRSA) infections on the ward for over six months.

All staff followed infection control principles and were seen to wash their hands and use hand gel appropriately. All ward staff were bare below the elbow.

Personal proactive equipment (PPE) was available for staff to use and we observed this being used appropriately during our inspection.

Hand hygiene audits for both staff and patients were completed monthly and results were 100% for the six months before our inspection. This information was on display for patients and visitors to see.

At our previous inspection we found staff had not documented or acted on infection control incidents. However, at this inspection we saw good documentation of infection control processes and staff followed correct procedures.

We observed patients being offered hand wipes prior to lunch being served.

At our last inspection there had been some discrepancy relating to cleanliness of commodes. However, at this inspection we saw all commodes were clean. There were posters showing staff the correct cleaning process. Staff used labels to show commodes were clean and the ward manager carried out regular audits as well as spot checks. All checks had shown commodes had been cleaned correctly.

Cleanliness and equipment decontamination checklists were completed which included Legionella flushing. We saw that this documentation was kept up to date and was sent to the supervisor for checking and entering onto a database. We did not see any cleaning products being stored inappropriately.

Environment and equipment

The ward was situated in an old building with a very challenging layout. The fabric of the hospital building was a concern to the trust due to its age and condition and was on the risk register. The building was owned by NHS Property Services Ltd. Staff told us the whole ward was due for a major refurbishment in 2019. The building had been inspected and the presence of asbestos was identified. However, staff told us the properties company ensured all works carried out and refurbishment plans took account of asbestos safety. The trust provided evidence to show there had been some improvements made to lighting and flooring and some decorative works completed.

The layout of the ward meant there were corridors and bays situated away from the nurses' station. However, patients who required more regular observations were placed in bays easily seen and accessed by staff.

The ward environment was visibly clean and tidy. However, in some areas there was a lack of space. There was no clutter and trolleys were stored in corridors and non-clinical areas. The area at the entrance to the ward regularly became a bottle neck. We observed trolleys were quickly moved to allow wider access for example when staff took a patient on a trolley for an x-ray.

Patient led assessment of the care environment (PLACE) carried out in 2015 gave cleanliness the rating of 99.7% which is above the national average of 97.6%. Patients and visitors, we spoke to on our inspection were very satisfied with the ward environment and stated that is was very clean. The PLACE review in 2015 gave the facilities at Ripon Community Hospital a score of 85.8% which was lower than the England average at 90.1%.

Two showers on the ward had been decommissioned and were no longer in use. Staff told us these were listed for replacement during the ward refurbishment. In the meantime, there were sufficient showers and bathrooms for patient use.

There was an area near the rehabilitation room where unwanted equipment had been stored while staff waited for it to be removed. Staff recognised this could affect the emergency evacuation route for patients in beds and requested its removal. The area was cleared before the end of our inspection.

At our last inspection we were told the matron was planning to undertake a security review as a digital locking system was to be fixed to the ward door in the near future. This would improve the safety of patients who may attempt to exit the ward and to prevent members of the public entering without staff's knowledge. However, at this inspection there was no lock or swipe access system to enter the ward. Staff told us a further incident had occurred when a member of the public had recently gained access to the ward when they tried to access the minor injuries unit after hours. The person had been frustrated and angry the unit was closed and ward staff had felt vulnerable. Following the incident, a swipe access system had been requested again but staff told us installation had been arranged to take place during the planned ward refurbishment due to take place in April 2019. In the meantime, the main front door was now always locked after the minor injury unit closed in the evenings.

Resuscitation trolleys and equipment were regularly checked, fully stocked and records were complete and up to date.

Equipment stores were well organised, well-stocked and clean and dirty equipment was segregated appropriately. No supplies were found to be out of date.

Staff told us storage space was very short and one store room was accessed via the bay set aside for palliative care patients. Staff told us when this bay was in use they took great care to collect everything they needed for the shift on one journey to avoid unnecessarily disturbing patients and visitors.

A wide range of appropriate therapy and mobility equipment was in use and was found to be clean and in good condition.

At our last inspection we found a number of items of equipment without labelling or with out of date labelling and staff could not be assured that the equipment they were using was safe to use. However, at this inspection we found all equipment was checked, calibrated and labelled appropriately.

Fire doors were free from obstacles.

At our last inspection we reported there was a lack of therapy space and there was no occupational therapy kitchen or bedroom for patients to practice independent living skills. At this inspection staff showed us a large room with rehabilitation equipment. There was a kitchen area where staff carried out patient assessments. Staff told us and patients confirmed they set out patient bed areas to copy their home environment as closely as possible. For example, staff positioned the bed and chair so the patient could practice their usual routine before returning home.

Assessing and responding to patient risk

Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. At our last inspection we reported we did not see any evidence of safety alerts being displayed. At this inspection we saw safety information including alerts and notices were displayed in the medicines room. Staff told us these were also communicated trust-wide via e-mail.

Nursing staff worked a three shift pattern rota with early and late shifts as well as a night shift. There was a handover of patients at the beginning of each shift and a daily rehabilitation huddle. This included patient safety and concentrated on holistic rehabilitation including mental and physical needs as well as mobility and progression. This ensured that any changes in the patient's care or condition were relayed to new staff members. We saw documentation throughout patient records showing patient allergies, resuscitation status, moving and handling requirements, diet and fluids, nursing needs and the multi-disciplinary plan including outstanding actions.

A wide range of patient risk assessment, screening tools and record charts were used. Staff had implemented the use of a new joint risk assessment form which collated several areas together although not all risks were covered. Staff continued to complete separate assessments for areas such as nutrition. We saw that observations were carried out every 12 hours for most patients and more frequently if required.

Care plans included prevention and early identification of pressure ulcers and staff told us they had regular support from the Tissue Viability Service. We found good documentation of risks identified and actions taken.

The ward used a national early warning score tool (NEWS) for all patients to enable staff to recognise and respond to a deteriorating patient. These were completed on at least a daily basis Staff were aware of what to do if a patient's score had increased. There was a clear escalation policy to transfer patients directly to Harrogate District General Hospital. Urgent medical needs were accessed via the 999 service. Staff told us they could contact the trust consultant or the patient's GP for advice or to request they attend the ward outside of regular attendances.

Staff were using appropriate tools to assess risk including falls risk assessments, skin risk assessment and nutritional risk assessments. These were regularly updated in patient records.

Patients transfer and mobility status, level of assistance required for washing and dressing, diet and fluid requirements and unique needs (e.g. dementia/falls risk) was displayed on the board above their bed.

Staffing

Safer staffing levels

Trust information stated "Staff fill rates compare the proportion of **planned** hours worked by staff (nursing, midwifery and care staff) to **actual** hours worked by staff (day and night). Community health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; In January 2016, 70% of the planned working hours for daytime nursing staff were actually 'filled'."

Details of staff fill rates within community inpatient services for registered nurses and care staff in July 2018 for each site published on their website by the trust are below:

Some of the wards shown below are for acute services as this is from the trust website;

	Jul-2018						
	Day		Night		Care hours per patient day (CHPPD)		
Ward name	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Registered nurses/ midwives	Care Support Workers	Overall
AMU	97.4%	98.6%	98.8%	108.6%	4.58	2.90	7.48
Byland	103.5%	119.8%	107.3%	110.8%	3.12	4.35	7.46
CATT	92.9%	102.7%	93.1%	103.2%	5.34	3.30	8.64
Farndale	92.6%	103.2%	101.6%	100.0%	3.64	3.63	7.27
Granby	97.2%	125.8%	100.0%	116.1%	3.93	4.18	8.12
Harlow	102.4%	90.3%	100.0%	-	7.46	1.92	9.38
ITU/HDU	97.2%	-	94.2%	-	27.32	1.40	28.71
Jervaulx	103.7%	99.6%	100.7%	101.6%	3.10	3.63	6.73
Lascelles	106.7%	100.6%	100.0%	100.0%	5.03	4.44	9.47
Littondale	95.3%	116.1%	94.6%	109.7%	4.72	2.87	7.59
Maternity Wards	101.5%	80.2%	98.1%	87.5%	15.25	3.78	19.03
Nidderdale	105.9%	80.2%	101.6%	98.4%	3.86	3.35	7.21
Oakdale	89.4%	102.2%	98.4%	121.0%	4.39	2.87	7.26
Special Care Baby Unit	93.4%	45.2%	88.7%	-	14.61	2.19	16.80
Trinity	99.7%	90.3%	100.0%	100.0%	3.67	3.87	7.55
Wensleydale	86.9%	129.0%	100.0%	112.9%	3.78	3.13	6.91
Woodlands	73.6%	106.5%	93.5%	100.0%	8.91	3.24	12.15
Trust total	**95.8%**	**102.3%**	**97.7%**	**105.5%**	**5.34**	**3.38**	**8.72**

Registered nursing and midwifery staff had an over-established fill rate on six wards for day shifts and on three wards for night shifts. The trust's overall fill rate was 95.8% for day shifts and an over-establishment of 102% on night shifts for nursing and midwifery staff.

The average fill rate on Trinity ward was 99.7% for registered nurses.

(Source: Safer Staffing Data – Trust website)

The ward was fully established for registered nurses following a successful recruitment drive. Nursing staff levels were good with planned versus actual qualified staffing levels near to planned staffing from July 2018 to September 2018. Staff told us they were never understaffed with registered nurses and planning included the requirement for at least two registered nurses and a total of four staff to be on shift at all times. This total could include therapy and support staff. Therapy staff and the multidisciplinary assistants worked between the ward and the community. There was one whole time equivalent (WTE) physiotherapist, one half time equivalent occupational therapist and 2.5 WTE multidisciplinary assistants. The therapy staff were managed by the community fast response and rehabilitation team which provided a seven-day service in the community. Therapy assistants were not included on the ward off duty rota.

We were told that the therapy fast response team was a priority and when there were fewer staff on duty or if the team had an increase in referrals it could result in the physiotherapist being unable to attend on the ward. Staff told us therapy staff were required to work weekends on fast response duties so they often took their days off during the week. However, staff told us and we

observed the therapy team worked together and supported each other well. There were therapy staff on shift throughout our inspection.

More nursing therapy support staff were being recruited to work in a multidisciplinary role to support and strengthen the multidisciplinary rehabilitation team.

A health care assistant had joint responsibilities for care support and administrative and clerical duties on the ward.

Staffing was planned based on the number of beds being used. The ward capacity was 16 beds and staff ensured a nursing ratio of 1:8 (one trained nurse for every eight patients) was consistently achieved as a minimum on all shifts.

A responsive acuity and dependency score was not used to assess the required number of nursing staff on a daily basis because staff told us their strict admission criteria and escalation process ensured no patients with additional nursing or medical needs were cared for on this ward.

On day shifts there were two registered nurses including the ward manager on duty and at least two healthcare assistants (HCA) on every shift. There was an additional registered nurse on an early shift on the MDT meeting day.

At this inspection nurse staffing was at establishment and the funded number of beds was at 16. Full establishment allowed Trinity ward to flexibly increase to 20 beds if these were required during the winter months. At the time of inspection this was not required so the standard number of beds were available.

A matron was responsible for the overall management of the ward and other services based at Ripon Community Hospital. They were not included in the numbers on the nursing rota.

Planned v Actual Establishment

Details of staffing levels within community health inpatient services by staff group are below.

Community inpatient services total

	April 17 - March 18			April 18 - June 18		
Staff group	Planned staff – WTE	Actual staff – WTE in month	Fill rate %	Planned staff – WTE	Actual staff – WTE in month	Fill rate
Nursing & Midwifery staff	12.0	11.1	92.2%	12.1	12	98.8%

From April 2017 to March 2018 the fill rate for nursing and midwifery staff was 92.2%, the latest snapshot of data for April 2018 to June 2018 shows the fill rate above 95%.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

From June 2017 to June 2018 the trust reported an overall vacancy rate of 20% within community inpatients compared to a trust target of 7%. A breakdown by staff group is below:

- Nursing and midwifery staff: 6.3%
- Support to doctors and nursing staff: 37%

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

There were no nurse staffing vacancies in September 2018 following successful recruitment.

Turnover

From April 2017 to March 2018 the trust reported an overall turnover rate of 15% within community inpatients compared to a trust target of 15%. A breakdown by staff group is below:

- Nursing and health visiting staff: 25%
- Support to doctors and nursing staff: 0%

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness

From April 2017 to March 2018 the trust reported an overall sickness rate of 7% within community inpatients compared to a trust target of 3.9%.

A breakdown by staff group is below:

- Nursing and health visiting staff: 8%
- Support to doctors and nursing staff: 5%

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

Nursing – Bank and Agency Qualified nurses

From July 2017 to June 2018 the trust reported bank and agency usage for qualified nurses in community health inpatient services as below:

Type	Total number of hours	Total %
Hours available	23,420	
Filled by bank	2,723	11.6%
Filled by agency	24	0.1%
Hours not filled	889	3.8%

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Nursing - Bank and Agency Non-Qualified nurses

From July 2017 to June 2018 the trust reported bank and agency usage for non-qualified nurses in community health inpatient services as below:

Type	Total number of hours	Total %
Hours available	25,887	
Filled by bank	0	0%
Filled by agency	145	0.6%
Hours not filled	1,972	7.6%

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Bank and agency usage in the service was variable and the information supplied to us from the trust showed that usage increased to cover sickness and absence. Staff told us they could usually

find staff from their own registered nurses to cover additional shifts but had to request bank or agency cover for HCA shifts.

Medical locums

From July 2017 to June 2018 the trust did not require any bank/locum usage for community inpatients services.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Medical cover was provided by general practitioners (GP) from the three local practices. A GP visited the ward on weekdays, usually in the morning. Trinity ward was nurse led and medical presence was not provided all day.

A consultant geriatrician from Harrogate District Hospital visited the ward once a week on a Wednesday to review all patients and attend the multidisciplinary team meeting. Alongside this medical cover, an Elderly Care Advanced Clinical Practitioner assisted the Consultant Geriatrician on a Wednesday and provided additional cover on a Friday. They were both contactable on an outreach basis if required.

Out of hours medical cover was provided by the out of hours GP service for North Yorkshire.
At our last inspection, staff told us there could sometimes be delays in a doctor attending the ward out of hours. However, at this inspection staff told us they experienced no problems in GP attendance and they would come in or give advice over the phone. Staff reiterated the escalation process and told us any patients requiring more comprehensive medical care would be transferred to the main hospital.

Patients who were admitted to the ward out of hours would be seen by the out of hours GP service if needed. Otherwise a GP from the surgery clerked new patients during the next day.
Trust staff completed medical assessments for all patients transferred from other wards before they left the main hospital site.

Suspensions and supervisions

During the reporting period from July 2017 to June 2018, there were no staff suspensions and no members of staff working under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

At our last inspection we had found patients notes were not always stored securely. However, at this inspection we found this had improved. Patients' medical records were stored in notes trolleys in the medicines room close to the nurses' station. Nursing and therapy notes were kept in an individual folder for each patient and were stored in a locked cupboard next to the nurses' station.

Good multidisciplinary team working was evident throughout patient notes. Therapists and nursing staff contributed to and shared information on patient care. There had previously been a lack of clarity regarding goal setting and planning for discharge but at this inspection rehabilitation aims and setting of goals were clearly recorded.

There was a clear record keeping audit cycle, planned over the year and records reviews showed good documentation and record keeping.

We reviewed eight sets of medical records and eight sets of nursing/therapy records and found staff completed and reviewed these regularly and consistently. Previously, we found there had been a lack of documented actions in the nursing and therapy records but at this inspection all records were up to date and actions were recorded.

We reviewed eight medical records and found that patients were clerked by a doctor within 24hours of arrival on the ward. All records were legible and completed fully.

Medicines

A pharmacy technician visited the ward regularly to carry out medicines reconciliation, stock rotation and returns of unused medicines to the trust pharmacy.

We found medicines were stored securely and appropriate emergency medicines were available. We checked the storage of controlled drugs and found records to be correct and checked daily.

The service used an electronic prescribing and administration system. This had been new to staff at our last inspection but staff had received training on the use of this system with support from the pharmacy team.

We observed a medication round being undertaken and saw that medicines were being administered according to the prescribed instructions and any omissions were recorded with an explanation.

Refrigerators used to store medicines were checked daily and records showed the minimum and maximum temperatures were not exceeded. Staff could describe the procedure if there was a recording that was out of the safe range.

A pharmacist attended the ward every Wednesday to attend the MDT, complete medicines reviews and support staff with discharge planning. The pharmacist was fully informed and involved in all medicines reviews. We observed staff sought advice and they provided medicines and general updates, such as investigations planned and completed, throughout the MDT.

There was no piped oxygen on Trinity ward. Large oxygen cylinders were stored in individual wheeled trolleys in a locked cupboard on the ward with the appropriate signage on the door. The hospital porter was responsible for checking the cylinders daily and completed a check list. The nurse in charge of the ward had access to the cupboard at all times. There were no patients using oxygen at the time of our inspection.

At our last inspection we reported patients who would be returning to their own homes were not offered the opportunity to manage their own medicines whilst on the ward. Staff told us at this inspection patients' own medicines were stored in individual locked cupboards at their bedside. However, staff had access to only one key so staff unlocked the medicine cupboards as part of the drugs round and medicines were given to patients to take themselves. Staff told us new cupboards had been identified as part of the refurbishment programme.

Incident reporting, learning and improvement

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2017 to July 2018, the trust reported no never events in its community health inpatient services.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include never events (serious patient safety incidents that are wholly preventable).

Serious Incidents (SIRI) – trust data

The trust reported two serious incidents (SIs) in its community health inpatient services from July 2017 to June 2018.

Both incidents were classified as pressure ulcer meeting SI criteria.

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Staff told us both pressure ulcers occurred while patients were receiving treatment on the ward. Both involved equipment including a tightly fitting face mask and strapping on a patient's foot and ankle which prevented adequate movement or positioning. Staff told us how the team had learned following these incidents to manage the use of pressure relieving materials to prevent future pressure ulcers.

Prevention of Future Death Reports (Remove before publication)

The trust has not had any deaths requiring Coroner's Inquest in the last 12 months for community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

Incidents were reported using the trust electronic recording system. Staff were trained how to identify an incident or a near miss and how to use the system. We found that staff were confident to report incidents.

Staff told us they were informed of incidents and outcomes during team huddles, the MDT and by e-mail bulletins.

The trust completed Root Cause Analysis (RCA) investigations on serious incidents. The ward manager undertook the investigations that related to Trinity ward and was required to do these within a set timescale. The matron and the ward manager supported staff in dealing with incidents and provided feedback to all the ward staff during daily rehab huddles and via email.

At our last inspection we did not see any evidence of cross directorate learning as a result of incidents that may have occurred elsewhere in the organisation. However, at this inspection the elderly care physician played a significant role in ward medical care and support and we saw learning was shared at MDT and in staff communications.

Staff we spoke with understood the term Duty of Candour and its meaning in practice, particularly the more senior members of staff. All staff were aware they needed to be open, honest and demonstrate transparent behaviour and to communicate with patients and families when incidents occurred.

Safety performance

Collection of safety performance information and sharing of lessons learned had improved since our last inspection. Staff met daily as a team in the rehab huddle. This had replaced the safety huddle and now included the therapy and nursing teams as one.

Staff completed the NHS safety thermometer monthly and displayed the results at the entrance to the ward. This measured the occurrence of new and old pressure ulcers, new and old catheter associated urinary tract infections, patient falls which resulted in harm or no harm and venous thromboembolism (VTE).

The ward patient safety board displayed incident information and there had been a gap of 85 days between patient falls in the months prior to our inspection. Staff explained patients were actively encouraged to mobilise safely as part of their rehabilitation and reported a new fall had occurred nine days before our inspection.

As at our last inspection, the ward were still hoping to purchase a sensor to prevent falls in high risk patients.

The service undertook VTE risk assessments on all patients, including those that transferred from other hospital settings. This is in line with the National Institute for Health and Care Excellence (NICE) guidance (clinical guideline CG92). GPs undertook VTE risk assessments on patients they admitted as a step-up from their own homes. There had been no instances of VTE on the ward since the VTE risk assessments had been introduced.

Is the service effective?

Evidence-based care and treatment

Trust policies and procedures reflected national best practice guidance e.g. The National Institute for Health and Care Excellence (NICE).

Nursing and therapy staff we spoke with were aware of best practice guidance and they told us that policies were easily accessible via the trust's intranet.

Staff completed a cycle of clinical audits including falls and pressure ulcers. Each team lead was responsible for at least one audit. They shared actions and outcomes from these and other trust audits in meetings and displayed results on staff noticeboards.

Staff carried out regular documentation audit of nursing records and we found no gaps in recording in any of the records we checked.

Staff followed national guidelines for falls and pressure ulcers and made specific efforts to reduce the incidence of both using outcomes from incidents as learning tools.

There was no named nurse or key worker system in operation because staff worked as a rehabilitation team. Patients and relatives we spoke with knew the ward staff and that all staff carried out essential roles in their care and treatment.

Staff developed clear individualised care plans with patients depending on their stage of rehabilitation. The main aim, from admission to discharge, was for patients to regain their physical baseline to return home or access an appropriate level of care support. Care plans set out clear and agreed outcome goals for patients.

Nutrition and hydration

Nursing teams used a nutritional assessment tool to assess if patients were at risk of malnourishment. The scoring system identified patients at risk and listed measures to be implemented. At our last inspection we observed that patients who had a score of 2 were not having measures implemented such as the red tray to indicate that a patient required assistance with eating and drinking. However, at this inspection we noted all records were completed fully and correctly and patients requiring additional support had their needs identified in notes, above their bed and on a chart at the nurses' station.

Staff told us if patients required a fluid balance chart it would be kept at the bedside. However, because of the strict admissions policy they rarely needed to provide additional nursing needs.

A nutrition assistant worked with staff and patients to ensure patients received support and any nutritional needs were identified.

Most patients were weighed on admission and weekly thereafter to ensure nutritional needs were being met. Staff told us the ward chef regularly met with patients to discuss their nutritional needs and preferences. Staff said patients were more likely to put on weight than lose it because of the quality of the food and team commitment.

Food and fluids were within patients' reach and all patients told us they enjoyed the food provided.

Observation of a lunch time showed that all patients received what they had ordered. The food was hot and appetising. Staff were available to give assistance if required. Meals were often served at the patient's bedside but the team had introduced a lunch club to encourage patients to eat at the dining table and aid their rehabilitation.

All meals and snacks were prepared in the kitchen on the hospital site. The chef made a variety of snacks for patients and staff encouraged patients to request snacks.

Pain relief

Although we found patient records and charts showed pain assessments were not completed regularly at our last inspection, we noted all records we viewed this time were completed and reviewed.

We observed staff ask patients about pain at medication rounds and that analgesia was prescribed and administered appropriately. Patients told us they had received pain relief when they required it.

Patient outcomes

Audits – changes to working practices

The trust did not participate in any clinical audits in relation to community health inpatient services as part of their Clinical Audit Programme.

(Source: Universal Routine Provider Information Request (RPIR) – P37 Audits)

At our last inspection, we found patients were not fully involved in their own rehabilitation, goal setting and discharge planning and discharge dates were not effectively communicated to the patients or their families. However, we noticed major improvements at this inspection. Patients were admitted with rehabilitation as their main goal. Admission criteria were strictly adhered to and patients were informed and fully involved in their own rehabilitation from the start with realistic goals agreed and set. The MDT met weekly and discussed every patient, their needs, aims and plans for discharge. The team agreed and recorded reviews and changes to plans.

Goal setting and individual needs, rates of recovery and independence scoring were considered at multidisciplinary meetings and were managed robustly, for example the pharmacist looked up test results and planned appointments during the meeting and staff agreed to follow up results or other services that would have ensured patient progress towards discharge.

Staff told us the ward objective was to provide a rehabilitation model to ensure a holistic package of care was provided to meet individual needs and ensure a return to either a previous level of independence or achievement of the optimum level of independence possible for that individual. The process of assessment, goal setting and rehabilitation planning by the team fully reflected this objective.

All records we reviewed had occupational therapy and physiotherapy input with very clear goals recorded.

Competent staff

Clinical Supervision

The trust provided the following information about their clinical supervision process: They do not currently record individual clinical supervision data at Trust level.

Medical
Consultants and SAS Doctors have time for reflection as part of SPA allocation and the appraisal and revalidation process.
Doctors in training have, mandated into their training, an educational supervision process with reflection.

Nursing
All registered nursing staff have time for reflection as part of the appraisal and revalidation processes. A number of clinical teams have formal clinical supervision which is managed locally.

AHP
Clinical supervision arrangements are in place for physiotherapists, occupational therapists and dieticians, utilising one to one, peer and group supervision. It is an active process and is evidenced in professional portfolios supporting personal development and professional reregistration.

Safeguarding Supervisions
The Trust operates the Morrisons 4x4x4 peer reflective supervision model for all staff involved in working with children and young people. The model is facilitated by senior staff who have two years' experience in child protection processes.

All staff
HDFT has supported the development of Schwarz Rounds. Each round is open to all staff. In addition, following significant events of high emotional impact, staff are supported through facilitated multidisciplinary team briefs.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clinical Supervision)

Staff told us all registered nursing staff had time for reflection as part of the appraisal and revalidation processes. The trust told us the ward manager worked with the nursing staff, developing clinical competencies and leadership skills.

Appraisal rates

From April 2018 to June 2018, 40% of staff within the community health inpatient services exceeded the trusts 90% completion target for appraisal completion. A breakdown by staff group is below:

Staff group	Individuals required (YTD)	Staff who have received an appraisal (YTD)	Appraisal rate %
Qualified nursing & health visiting staff (Qualified nurses)	3	0	0%
Support to doctors and nursing staff	2	2	100%
Grand Total	5	2	40%

No data was provided for medical and dental staff as there are no medical and dental staff that are solely assigned to this area. The appraisals of relevant staff are reported as part of another service. They met the target in the last financial year (April 2017 to March 2018) were they achieved 95%.

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

Staff appraisals were completed using the trust values. Support staff we spoke with had received an appraisal in the past year and staff undertaking appraisals had received the appropriate training. The ward manager was responsible for carrying out the three registered nurse appraisals and these were booked in to be completed before the end of the financial year.

Staff told us they were given opportunities to develop for example, a health care support worker was continuing to complete competencies for a joint nursing assistant and therapy assistant role.

Registered nurses had undertaken syringe driver training. This ensured they could provide pain relief and safe care to patients at the end of life. Funding was secured for all the Band 2 Care Support Workers to complete specialist end of life training at a local hospice

New staff, including bank staff, completed full trust induction and local induction, including mandatory training, trust information and emergency procedures.

Staff told us the trust supported staff to attend external courses but securing funding could sometimes be a problem. However, the trust told us several staff had attended external courses funded by the trust and Friends of Ripon Hospital. Some senior nursing staff were attending leadership courses and care support workers were completing specialist end of life care training. One care assistant had completed a rehabilitation assistant course. Staff told us they disliked traveling to the main hospital site for training courses but understood this was where the majority of staff were based. Some training was organised on site for end of life care, learning disabilities, continence and resuscitation

Non-registered nursing staff completed competencies in core skills such as record keeping and infection control as well as tissue viability, catheter management, tests and investigations, bowel care and topical medication administration.

Multidisciplinary working and coordinated care pathways

The ward team included registered nurses and healthcare assistants, physiotherapists, occupational therapists, a nutrition assistant, and multi-disciplinary therapy assistants. A

pharmacist and pharmacy technician visited the ward weekly and dieticians and speech and language therapists made visits to the ward when required. Staff could contact the tissue viability nurses for advice and they would visit the ward if required. The pharmacist attended the weekly MDT meeting.

Multidisciplinary team meetings took place once a week and involved the visiting consultant geriatrician, the nurse in charge and ward manager, a physiotherapist, an occupational therapist and social worker. MDT meetings were used to discuss patient progress, plan discharges and check care packages were in place. These meetings had previously lacked leadership, co-ordination and direction. However, the meeting we observed was well led by the consultant geriatrician and their specialty trainee. All staff were engaged and involved and discussed every patient, their progress and plans for discharge. Discussions were concise and decisions were recorded in patient notes.

We observed therapists and nurses working together with patients to support and encourage them to carry out therapy activities with confidence.

Staff recorded levels of independence for each patient on a board above each bed and also at the nurses' station so all staff were informed of patients' mobility and transfer needs.

Most patients were seen daily by the therapy team, mostly individually but some group activities had been introduced such as a lunch club, art workshops and games. We observed patients enjoying competitive games involving communication and dexterity such as dominoes.

However due to pressure in the community fast response team the amount of therapy input could be variable. Senior managers were aware of this and additional support was planned for the therapy staff.

Health promotion

Staff supported patients in all aspects of rehabilitation; physical, mental and social to enable them to have sufficient skills and confidence ensure a return to either a previous level of independence or achievement of the optimum level of independence possible for that individual.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trusts training compliance is RAG rated: Red is 0-49%, Amber is 50% - 74%, Green is 75% - 94% and Blue is 95% - 100%.

Trust level

Training is reported on a monthly rolling basis; a breakdown of compliance for MCA and DoLS courses as of July 2018 are shown by staff group below:

Staff group	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Qualified nursing & health visiting staff (Qualified nurses)	7	14	50%	Amber
Support to doctors and nursing staff	4	11	36%	Red

Following the introduction of MCA training level 1 in May 2018 compliance at July 1st 2018 was 50% for qualified nursing staff and 36% for support staff. This had increased to 86% for qualified nursing staff and 92% for support staff by November 2018.
(Source: Universal Routine Provider Information Request - P38 Training)

Nursing and medical staff undertook Mental Capacity Act (MCA) training via e-learning as part of the mandatory training schedule. GPs completed MCA training as part of their mandatory training packages. Managers told us all staff were allocated time to complete MCA and DoLS courses, some of which were planned for the second half of the year and staff would meet training compliance targets by the year end.

Staff we spoke with were aware of the Deprivation of Liberty Safeguards and the process for applying for this. There was one patient on the ward at the time of our inspection that had these measures in place and staff discussed their case at the MDT meeting regarding their condition, progress and support they would require at discharge.

Staff we spoke with had a good understanding of the Mental Capacity Act and how this worked in practice to support and protect patients who were unable to make decisions themselves.

The ward admission criteria was designed and upheld to ensure patients with severely reduced mental capacity were not accepted and would be cared for in a more suitable environment for their needs. Patients' capacity to consent was recorded in MDT assessments and patient notes. Some staff had received training on how to undertake this and a link nurse had been identified for the ward.

Staff provided audit information regarding DoLS applications including the number that had been made and those approved. Staff told us in most cases when an application was made an extension was also requested because local authority assessors rarely looked at applications before the first time period had passed.

Patients' agreement to rehabilitation was part of the admission criteria.
We observed staff requested and obtained verbal consent before and during personal care and interventions.

Is the service caring?

Compassionate care

We spoke to six patients and three visitors who told us the care they received from all staff was excellent. Patients said they felt safe and cared for during their stay. Staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered.

We observed nursing and therapy staff, doctors and GPs who all spoke to patients in a sensitive, caring and compassionate manner. Staff knocked on doors before entering private areas and used curtains when required.

We observed engagement between staff and patients in providing clarity in the rehabilitation programmes and patients told us that they were encouraged to be as independent as possible but staff provided appropriate assistance in a sensitive way.

Patients and visitors told us nursing and therapy staff were extremely caring and they had been treated with dignity. They also reported, and we observed, call bells were responded to quickly.

Ward meeting minutes from January 2016 indicated that staff should be using a peg, known as the peg of dignity, for curtains. We observed on our inspection that space around the bed when curtains were drawn was limited and the use of the peg helped.

As at our last inspection, some staff members and a patient reported a lack of compassion from some of the team. We did not see evidence of this at the time of our inspection but the ward manager assured us there were processes in place to deal with staff behaviours and they would address this immediately.

The trust carried out a bereavement survey in January 2018 and families of patients who received end of life care at Trinity ward provided mainly positive responses, one of which stated *"My mother died in a private room with my sister and I present. The nursing staff could not have been more helpful, kind, or supportive. I am left with a wonderful completeness because the Ripon hospital and all the relevant teams came together to ensure my mother had a calm and pain free end to her life. I regard our experience as outstanding."*

Emotional support

The ward had two beds dedicated to palliative care patients. The beds were located in a large bay, separate from the rest of the ward. Staff cared for patients at the end of life and supported families during this time.

Staff provided emotional support when patients displayed anxiety during rehabilitation activities.

Therapy staff listened to patients' concerns and explained what they were hoping to achieve.

We observed all staff provided support to keep patients calm and help keep themselves and other patients safe if they were agitated.

Staff told us volunteers visited the ward to support patients with their rehabilitation. These included someone who provided art and craft sessions. Patients had made poppies in preparation for Armistice Day and staff organised activities to celebrate national and sporting events. In addition to the volunteers, multidisciplinary assistants who were part of the Supportive Discharge Team assisted patients with distraction therapy such as knitting and painting.

Students from the local grammar school regularly visited the ward to talk to patients. We observed staff informing them about patients who might need some additional company.

A 'Pets as Therapy' (PAT) dog had visited the ward regularly and staff told us patients responded well to the dog being on the ward. However, the lady who brought her dog had not visited recently and the ward manager told us she intended to get back in touch to resume sessions.

Understanding and involvement of patients and those close to them

Patients we spoke with confirmed their care plans had been explained to them and they understood and agreed with the content.

The ward visiting times meant relatives and visitors could spend time and speak with staff, including doctors, about patients' care and treatment.

Is the service responsive?

Planning and delivering services which meet people's needs

Moves at night

The trust was asked to list ward moves between 22:00 and 08:00am for each core service for the most recent 12 months

From July 2017 to June 2018 the trust reported eight ward moves at night from Trinity Ward. These were all due to clinical deterioration and the patients were transferred to the main site for medical support in line with the escalation policy.
(Source: Universal Routine Provider Information Request (RPIR) Universal P44 – Moves at night)

Mixed sex breaches

Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. Whilst these are specifically for MH providers the same definitions apply to CHS and Acute providers from a CQC perspective. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children's and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children's unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported that there had been no mixed sex breaches in any community inpatient units from July 2017 to June 2018.

(Source: Universal Routine Provider Information Request (RPIR) P47 –Mixed sex)

The ward was appropriately segregated to meet the same sex accommodation requirements with separate toilets and washing facilities for male and female patients.

Staff told us they had reviewed the ward admissions criteria taking into account the focus on rehabilitation, location of the ward, medical cover and skill mix of staff. They had implemented a comprehensive policy and process, information for referrers, and checklists for staff dealing with requests for admissions.

At our previous inspection there had been three reported incidents related to requiring additional staff for patients who needed one to one support. At this inspection, staff told us they were confident the admissions criteria and risk assessment process prevented inappropriate admissions and ensured patients requiring elevated levels of support would be refused admission at the initial request or, if a patient's condition deteriorated, they would be transferred back to the acute setting. We saw no reported incidents where patients had been transferred back to the acute wards but we did see EWS scores were recorded and staff followed trust escalation processes.

We observed staff taking referral details and following the checklist before agreeing to an admission.

The criteria for admission to Trinity Ward included transfers from acute hospitals, palliative care (end of life care only) and step – up from community care. The criteria document had been updated within the last year. The criteria were used in conjunction with a flow chart that was available to staff across the Trust.

A discharge liaison nurse post was created in June 2018 to support the established nurses and wider MDT. As part of their role they attended the main site weekly to help identify patients suitable for transfer to Trinity. They attended the weekly MDT, acted as a central point of contact for social care and external agencies. They provided education and training to the MDT on social care and continuing health care assessments and supported patients and families with complex discharge needs. They ensured nursing documentation for discharge planning was completed in a timely manner.

A social worker attended the MDT to give information and advice regarding social care, access and availability of local authority and specialist resources and to ensure family involvement regarding discharge.

Meeting the needs of people in vulnerable circumstances

The ward environment was not appropriate for people living with dementia. Although the ward did not accept patients with late stage dementia, there were some patients with confusion. Staff had raised this to be included in plans for the ward refurbishment.

Patients with dementia, delirium or confusion were cared for in bays closest to nurses' station and ward manager had printed some dementia friendly coloured signs for the ward but no other changes had been made. Staff expected the whole ward refurbishment would meet dementia needs more readily. Staff had been fully involved in these plans and put forward requirements regarding dementia friendly environment.

Some staff had received additional training in dementia care provided by Age Concern and all staff had completed Dementia tier 1 training.

There were white boards at the entrance of each of the sides of the ward – one for the male side and one for the female side. These displayed the patient name for each bed in that section along with a colour indicating which GP practice was responsible for the patient's medical cover. Symbols showing specific patient needs were placed next to the patient's name for example a triangle was used to show if a patient was diabetic and a butterfly for patients living with dementia.

There were clocks and calendars on the ward and in the day room. There were televisions beside patients' beds and in the day room.

The day room had a limited range of books, games and puzzles which staff told us they had difficulty in keeping thoroughly clean. However, staff told us they had received funding to purchase a computer with a tablet and activity programmes suitable for rehabilitation patients.

We observed patients were encouraged to use the day room although this was not used all the time. There was a large table and dining chair as well as comfortable chairs. Patients were involved in craft activities and we observed patients enjoying a competitive and sociable game of dominoes.

There was a well maintained and accessible outdoor area for patients and relatives to and staff told us this was used much more regularly than previously noted. The large windows and frames

in the day room had been replaced and patients enjoyed looking out into the garden when bad weather prevented access.

We observed nurses and care assistants enabling and supporting patients and therapy staff answering calls for help and answering questions

The service had produced an information leaflet to give patients and their families on admission. This included contact information and visiting times and some brief details about rehabilitation and goals in terms of discharge. This was an improvement since the last inspection. There was a plentiful supply of trust leaflets and information relating to specific conditions. These were stored safely and were in good condition. We found no out of date information.

The ward had a link nurse for learning disability and staff could access specialist support for patients with sensory impairment and communication issues, including speech and language therapists for patients following a stroke. We observed staff recorded all outcomes of discussions at MDT and referrals to specialist services in patient records.

The palliative care bay was separate from the main ward areas. It had two beds and a bathroom and was regularly used to accommodate one patient and their family but staff told us it could be arranged to provide care for two patients. Two community palliative care nurses came to the ward to care specifically for palliative patients. They followed patients from community to the ward to provide for continuity and familiarity of care for those 'step up' palliative care patients.

Access to the right care at the right time

Accessibility

The largest ethnic minority group within the trust's catchment area is Polish with 0.9% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	Polish	0.9%
Second largest	All other Chinese	0.3%
Third largest	Hungarian	0.2%
Fourth largest	Tagalog/Filipino	0.2%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Staff could access translation services for any patients whose first language was not English.

Bed occupancy

The breakdown of average bed occupancy levels from July 2017 to June 2018 for community health inpatient services below:

Mean percentage bed occupancy (with leave)											
Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
86.1%	78.4%	73.1%	71.8%	77.7%	78.6%	95.5%	96.1%	95.5%	93.5%	93.1%	89.4%

(Source: Community Routine Provider Information Request (RPIR) Community CHS7 – Bed occupancy & LOS)

Average length of stay data

The breakdown of average length of stay from July 2017 to June 2018 for community health inpatient services below:

Average length of stay of patients (with leave) Days											
Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
25.8	24.3	27.8	27.2	28.5	18	15.4	26.2	22.9	18.1	20.4	18

(Source: Community Routine Provider Information Request (RPIR) Community CHS7 – Bed occupancy & LOS)

Staff told us the most recent average length of stay data showed this was 15 days and staff expected this to stabilise. Staff were confident the rehabilitation model and admission criteria enabled patients to be safely discharged within this shorter timeframe. At the time of our inspection, there were no patients on the ward who did not meet the admission criteria and staff told us this had been the case since they had introduced the admission checklists in the summer of 2018.

Referrals

The trust did not identify any community health inpatient services as measured on 'referral to initial assessment' and 'assessment to treatment'.
(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Patients were referred to the service by GPs for rehabilitation following illness or accident. There were also beds set aside for palliative care patients and one patient was admitted for end of life care during our inspection.

Patients recovering from illness or accidents at the main hospital site were referred by acute hospital teams. Patients had to be medically fit, stable and agree to rehabilitation.

Referrals from the acute hospital were received by fax and screened by the therapy, medical and nursing staff. This was done on a specific form which included the patient's diagnosis, treatment and other medical conditions. The ward manager had recently organised an improved fax facility to ensure timeliness of referrals, confidentiality and security of information. The nursing staff were responsible for making the arrangements for transfer taking a nurse to nurse handover from the discharging ward in the acute hospital.

A discharge care nurse had recently been appointed and they visited the main site every week to identify patients suitable for rehabilitation and transfer to Trinity ward. Staff reported a marked improvement in the quality of referrals, suitability of patients identified for admission and timely transfers, thus improving availability of beds in the acute wards.

Delayed discharges

From July 2017 to June 2018, there was a total of 170 discharges in community health inpatient services, none of which were delayed discharges.

(Source: Universal Routine Provider Information Request (RPIR) Universal P49 – DTOC)

The whole MDT worked together with safe and appropriate discharge as the main aim for all patients. The discharge care nurse liaised with families, care providers and social services to ensure patients were discharged appropriately and as soon as they were ready to do so.

Staff reported that discharges usually went well. There were sometimes delays in transport arriving to take patients home. We observed the discharge of a patient and there were no delays.

Learning from complaints and concerns

Complaints

From July 2017 to June 2018 there were three complaints about community inpatient services. The trust took an average of 90 working days to investigate and close complaints. This is not in line with the trust's complaints policy, which states that complaints should be dealt with within 25 working days.
(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From July 2017 to June 2018, the trust did not receive any compliments for community health inpatient services.
(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

There were leaflets available for patients and visitors about the Patient Experience Service in the trust which explained how to make a complaint, compliment or raise a concern.

Learning from complaints and concerns was cascaded to all staff through handover, rehab huddles, MDT and one to one meetings.

We spoke to some relatives who were concerned about their relative's dignity, lack of information about their medical needs, and the way a member of staff had spoken to their loved one. This was addressed immediately and sensitively by the ward manager and the consultant ensured they spent time with the family to explain care and rehabilitation plans.

We saw thank you cards and messages from patients and relatives that complimented the team.

Patients we spoke with discussed the positive behaviours of individuals.

Is the service well-led?

Leadership

At our last inspection the nursing leadership at ward level did not appear effective. However, a new ward manager had been appointed and we saw some new processes had been implemented and existing systems strengthened.

We met the matron who visited the ward at least once a week and contacted the team daily to discuss patients, staffing and any risks or problems.

Staff spoke highly of their matron, saying they were approachable and listened to them. Staff knew how to contact them if there was an emergency or problem out of hours.

Staff knew the chief executive, directorate leads and immediate line managers from face to face visits, emails and regular communication. Most staff we spoke with felt connected with the trust, especially since communications had improved with the acute wards through the discharge

planning nurse and the pharmacist attended MDT. However, a minority of staff reported they felt the community hospital was isolated and neglected at times.

Staff reported good senior leadership and robust processes at the trust board level. Senior leaders worked as part of the multidisciplinary management team and had good knowledge of service needs and aims and pressures on staff.

Medical leadership had been strengthened since our last inspection. The consultant for elderly medicine made themselves available to support the team, led the weekly MDT and encouraged the specialty trainee to present cases at the meeting. GPs were an integral part of the ward team, communicated well with staff and liaised with the full team about patient needs and care.

Therapists were led by the community therapy lead and the senior therapist on duty took responsibility for junior staff, therapy support workers and rehabilitation activities.

Vision and strategy

Staff we spoke with were aware of the trust's vision and values. We saw posters displayed in all areas we visited.

All staff were aware of and engaged in the ward's aims and purpose to provide an environment for rehabilitation for patients and a safe and peaceful setting for provision of end of life care.

People living in the area played an active role in making decisions about their own health care and their lives.

The care model for rehabilitation on Trinity ward had been implemented to increase the bed base in the community. Trinity ward was equipped to take up to 20 patients but this had never exceeded 16. There was also rehabilitation provision in a local authority care home in the area and the trust provided the therapy service to the patients in this setting.

Senior managers were clear that the rehabilitation unit and the Ripon community hospital site would continue to be part of the trust elderly care strategy.

Culture

Staff were happy in their work and several members of the team had worked there for many years.

Staff were confident to report concerns and incidents and to share this information.

Morale was good this seemed to be related to the recent appointment of new staff.

The cleaning, portering and catering staff were valued and proud of their work and contribution to team working and patient care on the ward.

Governance

There was a governance framework in place ensuring clear lines of accountability. Staff managed incidents, complaints and risks from ward level to senior management and the trust board. Staff received information and feedback from points raised. Lessons learned, actions and outcomes were recorded.

A previous Quality Review of Trinity ward had highlighted some actions including reducing the number of inappropriate referrals and being able to discharge patients home in a timely manner. Staff told us they had seen very good progress with these actions and now had data to show continued improvements.

The trust worked to support staff to learn from incidents and act to prevent recurrence. The matron and ward manager led Root cause analysis investigations on serious incidents and included other members of the team as appropriate.

Managers ensured they shared information and feedback to staff on themes or actions to be taken.

Management of risk, issues and performance

There was a risk register which recorded identified risks appropriately and rated them according to severity and impact. Risks were assessed and updated regularly and actions taken were recorded clearly, monitored and reviewed.

Staff recorded ward performance against targets through audits including the safety thermometer, IPC, monthly nursing and record keeping audits. Staff reported results to the matron and senior management team up to board.

Ward staff could contribute and influence the risk register directly. The risk register was discussed at their Quality of Care meetings to ensure a multidisciplinary approach. The trust told us the directorate lead for quality assurance spent time at Trinity with the ward manager and matron to ensure the risk register was live and updated appropriately.
The main risk on the register related to estates and staff were confident the ward refurbishment would address the main risks. In the meantime, there were effective processes in place to mitigate risks.

Information management

Staff could access and record electronic observations. Internet coverage by one bed space was intermittent so staff had to input observations away from the patient bed area. Staff had experienced frustration when the system had first been introduced in June 2017 because data inputted onto a tablet could not always be transferred to the main computer. This has been improved by the IT team inserting a booster so the internet connection and coverage was improved. The nurse in charge checklist included a check of patient observations, with a second checker ensuring observations had been uploaded.

Staff completed discharge summaries electronically and printed them out on the day of discharge, to be delivered with the patient to the receiving community team or GP and copies were filed in patient notes.

Engagement

Staff told us they had regular communication with senior managers and received information through emails and in face to face meetings. They also said that the matron and consultant were regularly present at the hospital site.

We reported there had previously been no ward based team meetings on Trinity ward in the past six months prior to our last inspection. Staff at this inspection told the ward manager had restarted regular staff meetings and staff felt informed and involved.

There was up to date guidance and information on display for staff to read in the medicines room. The staff notice board contained a mix of professional and work-related information such as training dates as well as fundraising activities.

Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered.

The trust carried out a bereavement survey in January 2018 and families of patients who received end of life care at Trinity ward provided mainly positive responses, one of which stated *"My mother died in a private room with my sister and I present. The nursing staff could not have been more helpful, kind, or supportive. I am left with a wonderful completeness because the Ripon hospital and all the relevant teams came together to ensure my mother had a calm and pain free end to her life. I regard our experience as outstanding."*

The community of Ripon valued their local service. The Friends of Ripon Hospital regularly raised funds for the ward. The most recent purchase was a computer to provide patient activities at a cost of £18,000. This had been fully funded by the Friends.

Learning, continuous improvement and innovation

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There were no services reported within community health inpatient services that have been awarded an accreditation.
(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Staff used the Alzheimer's Society Butterfly scheme to identify and provide effective care for people living with dementia.

A number of items to improve the environment had been provided such as the provision of televisions and wall art.

The trust had developed and implemented a single assessment tool and care plan which had been used in patient records we viewed. However, this tool did not include all risk assessments used on the ward so staff used additional documents to supplement this form. We found some assessments, and therefore effort, were duplicated because of this. The trust told us there was work ongoing to improve risk assessment documentation.

A Delirium Rapid Process Improvement Workshop was led by the matron and attended by the Trinity ward manager, Elderly Care Advanced Clinical Practitioner and General Manager. The trust told us the team had developed and were trialling a delirium nursing management plan and night needs document.

Creation of the Discharge Liaison Nurse role in June 2018 supported development of admission criteria, rehabilitation goals, the MDT and staff told us this role had also contributed to the reduction in length of stay.

The ward team had completed work with Bradford University to complete a study to support patient experience. The Study supported the lunch club, the Therapy dog and goal planning. The ward team had undertaken work to promote these ideas but the therapy dog had not visited the ward for some months and the lunch club had not been fully implemented at the time of our inspection.

The trust had participated in the National Intermediate Care audit which provided evidence of positive patient engagement relating to goal setting. All patients we spoke with had set goals for rehabilitation achievements.

Urgent care

Facts and data about this service

Community urgent and emergency care are provided in two minor injuries units (MIUs) based in Selby and Ripon. Both services deliver a nurse led walk in service, available without an appointment, for patients who suffer minor injuries which can be treated outside of an emergency department by Urgent Care Practitioners.

Both services are open 7 days per week but are not open overnight. A four-hour standard is adhered to and patients can access x-ray, wound assessment, dressings, casts and prescription of basic medicines.

Selby MIU is in the process of being re-launched as an urgent treatment centre which will also treat minor illness through the delivery of primary care bookable appointments in addition to the existing walk-in access.

Clinical leadership is delivered to Ripon MIU from Harrogate ED via regular consultant clinics and staff supervision. The leadership at Selby is provided in a similar way via a GP with ED experience who is substantively employed within the service.
(Source: Routine Provider Information Request (RPIR) – Context tab)

Both MIUs offered a seven-day service-Ripon currently opened from 8am-6pm, Selby was open 8am-8pm.

Between May 2018-October 2018 Selby MIU had 7494 attendances, Ripon MIU had 5043 attendances over the same period.

During this inspection we spoke with seven members of staff and five patients and family members. We reviewed 40 sets of records.

Is the service safe?

Mandatory training

The trusts training compliance is RAG rated: Red is 0-49%, Amber is 50%-74%, Green is 75% - 94% and Blue is 95% - 100%.

Training is reported on a monthly rolling basis; a breakdown of compliance for mandatory courses as of July 2018 for nursing and health visiting staff/ medical and dental staff within community urgent and emergency care is below:

Nursing and midwifery/health visiting staff

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Data Security Awareness (previously Information Governance)	80	82	98%	Blue

Health & Safety	80	83	96%	Blue
Medicine management training	76	80	95%	Green
Manual Handling Face to face & eLearning	131	157	83%	Green
Basic Life Support	65	79	82%	Green
Infection prevention & Control (no renewal and Level 2)	67	84	80%	Green
Fire Safety - Level 1 (annual)	59	83	71%	Amber

Nursing staff within community urgent and emergency care achieved two blue ratings and four green ratings for mandatory training.

Medical and dental staff

The community urgent care service is nurse led and there are no medical and dental staff within this service. There is therefore no training data for Medical and Dental staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding Training completion

The trust set a target of 95% for completion of safeguarding training.

Training is reported on a monthly rolling basis; a breakdown of compliance for safeguarding training courses as provided in the RPIR, as of July 2018 for Registered Nursing staff within Community urgent and emergency care is below:

Nursing and midwifery/health visiting staff
The trusts training compliance is RAG rated: Red is 0-49%, Amber is 50%-74%, Green is 75% - 94% and Blue is 95% - 100%.

Training is reported on a monthly rolling basis; a breakdown of compliance for safeguarding courses from June 2017 to July 2018 for nursing and health visiting staff/ medical and dental staff within community urgent and emergency care is below:

Nursing and midwifery/health visiting staff

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Rag rating
Safeguarding Children (Level 1)	71	77	92%	Green
Safeguarding Children (Level 2)	54	74	73%	Amber

Nursing staff within community urgent and emergency care achieved a green rating for safeguarding children level 1 and an amber rating for safeguarding children level 2.

The failure to achieve the target completion rate has been attributed to an unforeseen increase in patient attendances which has impacted on staff availability to attend and/or complete mandatory training modules

Medical and dental staff

The community urgent care service is nurse led and there are no medical and dental staff within this service. There is therefore no training data for Medical and Dental staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We spoke to seven members of staff who told us that extra time has been allocated to ensure completion of any outstanding mandatory training modules. We were shown the action plan which addressed the short fall in completion of mandatory training.

We observed rotas which highlighted designated training time.

We reviewed mandatory training forms that had been completed by staff which demonstrated that meaningful feedback was sought on the completion of the training provided.

All staff received appropriate training regarding the identification and treatment of sepsis.

Safeguarding

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Between July 2018 and June 2018, the trust reported two safeguarding referrals within community urgent and emergency care.
(Source: Routine Provider Information Request (RPIR) – Safeguarding referrals tab)

Of the seven members of staff that we spoke to across both departments each was conversant with the safeguarding referral process for both adults and children.

All staff we spoke with were aware how to manage patients presenting with complex safeguarding needs, for example involving mental health, domestic violence, learning difficulties and female genital mutilation (FGM).

Staff we spoke with knew how to recognize safeguarding concerns, they could make safeguarding referrals and they could describe in detail the types of incidents that they would refer to the safeguarding team. They could describe examples of safeguarding concerns they had been involved with, including what actions they had taken and the outcomes. The examples included support for victims of domestic violence. Learning from safeguarding was shared across the teams by the practice educator and team leaders.

The electronic patient record would identify children who were known to social services including those on the 'At Risk Register'. Information would be shared utilizing the computer systems ensuring that entries were made into the child's medical record and that the relevant GP was informed.

Cleanliness, infection control and hygiene

The MIUs were visibly clean including patient assessment rooms and toilet facilities. Disposable curtains were clearly labelled to show dates of when they were last changed and when they would next be routinely changed. Cleaning schedules were completed and signed by domestic staff and no omissions were found. Nursing staff were observed to clean equipment and trolleys between patient use.

When we last inspected in 2016 that there was no evidence that Selby MIU completed any infection prevention and control (IPC) audits, during this inspection we found that both MIUs participated in monthly infection control audits which we were able to review for the previous 12 months and both MIUs scored between 95-100% each month. The staff reported that the purpose of infection control audits was to set the standards for infection prevention and control practice, with the overall aim to optimise and assess infection prevention and control practices throughout the hospitals to reduce infection rates.

We observed all staff adhering to trust policy and with national standards for infection prevention and control. It was observed that all staff cleaned their hands between patient contact and we also observed all equipment being cleaning between patient use. Assessment areas were cleaned after each patient use. Cleaning records were completed regularly and fully. Hand basins were appropriately sited; soap and alcohol gel dispensers were working and were well stocked. Paper towels were available for hand drying. Sharps bins were available and were not over filled.

Mandatory training completion compliance for infection prevention and control (IPC) was 80% which was green in the trust's RAG rated system. There was an action plan in place for addressing mandatory training compliance which included IPC.

Staff had access to personal protective equipment (PPE) and staff were observed to use it as appropriate.

All staff were noted to be Bare Below the Elbow (BBE) in line with good practice and current guidelines.

Environment and equipment

Both MIUs were comprised of treatment areas for minor injuries.

Due to the size of both MIUs there was no facility to have separate waiting areas for children and adults

We found that all electrical equipment had undergone routine safety checks. All equipment had up to date tests.

Resuscitation equipment had checklists attached which were completed daily and signed off by staff checking them. All trolleys were stored securely and all equipment within the trolleys such as medicines were in date.

Assessing and responding to patient risk

At Ripon MIU all patients were booked in by a clinical support worker (CSW) and would be seen on an arrival time basis. However, if the CSW was concerned about a particular patient they would seek immediate advice from a nurse. We were told that the CSW received additional training before undertaking this role.

In Selby MIU they have introduced a triage nurse role who will complete the initial assessment and prioritise any patients who arrive within the department.

Both MIUs had clear pathways to follow for the assessment of a patient who may inappropriately attend with a condition that is beyond the scope of the MIU such as chest pain or shortness of breath. The pathways included early warning systems for both adult and paediatric patients. There is a specific pathway for those patients under the age of 1. All staff spoken to could describe occasions were this occurred and the pathways were followed. All patients are assessed within 15 minutes of arriving at Ripon MIU with an average wait time of 14 minutes, however, the average wait time at Selby was 30 minutes from arrival to initial assessment. We were told that with the introduction of triage nurses this would improve, however, there was no data to support this as the role has only recently been introduced.

We observed prompt assessment to treatment during inspection at both locations which included the newly developed triage nurse role at Selby.

Ripon MIU Initial assessment and treatment times

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Average
Arrival to Initial Assessment (minutes)	15	17	13	13	14	11	14
Initial Assessment to Treatment (minutes)	0	0	0	0	0	0	0

Selby MIU Initial assessment and treatment times

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Average
Arrival to Initial Assessment (minutes)	25	33	33	30	30	31	30
Initial Assessment to Treatment (minutes)	0	0	0	1	0	3	1

(Source: Information provided by the Trust-Data Request DR91)

We reviewed 40 sets of notes, however there were no cases within this sample of patients requiring assessment under the deteriorating patient pathways.

We observed and reviewed the departmental sepsis care pathway including adult and paediatrics which was in line with NICE and best practice guidelines. The pathway included a screening tool and an escalation process which all staff we spoke to were familiar with.

All staff are trained in Immediate Life Support (ILS) for both adults and paediatrics.

Staffing

Safer Staffing levels

Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). Mental health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means that in January 70% of the planned working hours for daytime nursing staff were actually ‘filled’.

The trust does not provide a safer staffing level breakdown for community urgent and emergency care.

Planned v Actual Establishment

Details of staffing levels within community urgent and emergency care by staff group are below.

	April 17 - March 18			April 18 - June 18		
Staff group	**Planned staff – WTE**	**Actual staff – WTE in month**	**Fill rate %**	**Planned staff – WTE**	**Actual staff – WTE in month**	**Fill rate**
Nursing & Midwifery staff	7.16	7.59	106%	8.57	6.86	80%

From April 2017 to March 2018 the fill rate for nursing and midwifery staff was 106%, the latest snapshot of data for April 2018 to June 2018 shows the fill rate decreased to 80%. There is no data available for medical and dental staff.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

From June 2017 to June 2018, the trust reported an overall vacancy rate of 6.1% in community urgent and emergency care services; this was better than the overall trust target of 7%.

Staff group	**Annual vacancy rate**
Qualified Nursing and Health Visiting Staff	7.2%
Support to Doctors and Nursing Staff	12.1%
Qualified Ambulance Service Staff	-0.8%

(Source: Routine Provider Information Request (RPIR) – Vacancies tab)

We were told on inspection that a recruitment process had recently been completed and that qualified staff had been appointed within both services and would commence employment imminently

Turnover

From April 2017 to March 2018, the trust reported an overall turnover rate of 25% in community urgent and emergency care services. This was worse than the trust's target of 15%.

Staff group	**Annual turnover rate**
Qualified ambulance service staff	43%
Qualified nursing & health visiting staff (Qualified nurses)	20%
Support to doctors and nursing staff	25%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness

From April 2017 to March 2018, the trust reported an overall sickness rate of 12% in community urgent and emergency care services. This was worse than the trust target of 3.9%.

Staff group	**Annual sickness rate**
Qualified ambulance service staff	5%

Qualified nursing & health visiting staff (Qualified nurses)	15%
Support to doctors and nursing staff	7%

(Source: Routine Provider Information Request (RPIR) P19 sickness)

Nursing – Bank and Agency Qualified nurses

From July 2017 to June 2018 the trust did not require any bank and agency usage in community urgent and emergency care services.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Medical locums

From July 2017 to June 2018, there was no medical locum usage for community urgent and emergency care services.
(Source: Routine Provider Information Request (RPIR) P21 Medical agency locum)

Consultant cover

From April 2017 to March 2018, there was no consultant cover reported for this core service.
(Source: Routine Provider Information Request (RPIR) – P22 Consultant cover)

Both units are staffed with qualified nurses and CSWs, there is no permanent medical cover due to both units being nurse led.

There has been recent recruitment of several Band 5 nurses to work within Selby MIU

Both units will assess and treat children but there are no paediatric nurses employed in either unit, however, there are additional training opportunities for staff to complete through the local university to develop paediatric competencies

Both units are not open 24 hours per day so staff work the same shift, therefore there is no formal handover system. During our previous inspection in 2016 it was found that there were periods at the beginning and end of the shifts that staff would be 'lone working'. This has been addressed and there are no periods during the working day in which staff would have to work alone.

Quality of records

All records are completed on the specialist computer system which allows for timely availability and sharing of patient records.

We reviewed 40 sets of notes across both MIUs-all were completed without error or omission.

Each patient record was electronically based.

Each record contained all relevant patient specific data.

Each record recorded consent and any safeguarding issues were flagged within the patient notes.

The patient records would alert staff to specific patient needs such as learning disability or dementia.

Medicines

All medicines including intravenous fluids were checked and found to be stored correctly and all were in date. All documentation that we reviewed regarding medicines were completed fully and without error or omission.

There was regular pharmacy involvement within the MIUs who maintained oversight of medicines.

We found all fridges had a daily temperature checklist which was completed and signed without omission. Staff we spoke to were able to describe the actions required if the temperatures moved out of range.

In our previous inspection it was found that Patient Group Directives (PGDs) were being utilised however, they were out of date and had not been subject to review. During this inspection PGDs were available in both hard copy and electronic formats. All were currently in date with evidence of planned and completed reviews.

Both MIUs were staffed by Independent Nurse Prescribers who would prescribe medication as necessary. All examples checked were clear and accurate. We were told that staff utilise peer review of medical notes including prescribing where appropriate.

There were local antimicrobial protocols displayed in both MIUs and the use of antimicrobials was audited.

All 40 records that we reviewed had the allergy status accurately recorded.

Safety performance

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care.

Incident report, learning and improvement

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018, the trust reported no incidents classified as never events within community urgent and emergency care.

(Source: NHS Improvement - STEIS (01/03/2017 - 30/02/2018))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) which met the reporting criteria in community services for urgent and emergency care, set by NHS England. From July 2017 to June 2018 the trust did not report any serious incidents within community urgent care services.

(Source: NHS Improvement - STEIS (01/03/2017 - 30/02/2018))

Serious Incidents (SIRI) – Trust data

From July 2017 to June 2018 the trust did not report any serious incidents within community urgent care services.

(Source: Routine Provider Information Request (RPIR) – Incidents tab)

All staff that we spoke with were aware of incident reporting and the trust's policy and incident reporting procedures. Staff could describe what an incident was and how they would report an incident. All staff reported that they were encouraged to report any incidents.

Due low numbers of reported incidents, staff were unable to give recent examples however, staff told us that information and learning from incidents is shared.

Staff understood about Duty of Candour and when it needed to be applied. There were no recent incidents that staff could tell us about where duty of candour had been applied. We were shown one example of a historic complaint in which duty of candour was applied

Is the service effective?

Evidence-based care and treatment

We observed evidence based clinical guidelines on the trust intranet which included Standard Operating Procedures (SOPs) and clinical pathways. We were told that local audits were being completed to confirm the appropriate usage. Staff reported being able to access this information as required and without issues.

Staff across the community urgent care service followed clinical guidance and could give examples such as the Ottawa foot, ankle and knees rules for x-ray and for sepsis identification and treatment.

Guidelines were reviewed and audits completed by a lead consultant from the main emergency department and the practice educator who worked across both sites.

The service policies and procedures reflected national best practice guidance e.g. The National Institute for Health and Care Excellence (NICE).

Pain relief

Within the notes we reviewed across both sites there was documented pain scores, pain relief being prescribed and administered as appropriate. Both units utilised scoring pain from 1-10. They also used the Wong Baker pain faces rating scale.

We spoke with 4 patients in both MIUs who reported being asked about their pain and we were told that they had been offered pain relief.

Patient outcomes

Unplanned reattendances

Data provided by the Trust after inspection showed that in the period May 2018-October 2018 Selby MIU had 7494 attendances with 2 unplanned reattendances equating to 0.02% of all attendances.

Ripon MIU had 5043 attendances over the same period with 68 unplanned attendances equating to 1.34% of all attendances.

4 Hour Target

Data provided by the Trust after inspection showed that in the period May 2018-October 2018 demonstrated that at Selby the 4-hour target was met in 99.6% of all cases and Ripon achieved 99.98% of cases completed.

Competent staff

Clinical Supervision

The trust does not currently record individual clinical supervision data at trust level however they provided the following information;

Medical
Consultants and SAS Doctors have time for reflection as part of SPA allocation and the appraisal and revalidation process.
Doctors in training have, mandated into their training, an educational supervision process with reflection.

Nursing
All registered nursing staff have time for reflection as part of the appraisal and revalidation processes. A number of clinical teams have formal clinical supervision which is managed locally.

AHP
Clinical supervision arrangements are in place for physiotherapists, occupational therapists and dieticians, utilising one to one, peer and group supervision. It is an active process and is evidenced in professional portfolios supporting personal development and professional reregistration.

Safeguarding Supervisions
The Trust operates the Morrisons 4x4x4 peer reflective supervision model for all staff involved in working with children and young people. The model is facilitated by senior staff who have two years' experience in child protection processes.

All staff
HDFT has supported the development of Schwarz Rounds. Each round is open to all staff. In addition, following significant events of high emotional impact, staff are supported through facilitated multidisciplinary team briefs.
(Source: Routine Provider Information Request (RPIR) – Clinical Supervision tab)

All qualified nursing staff have the required qualifications, skills and experience for the role that they are employed in.

We were told that there is a robust induction process for all staff including agency/locum staff which includes supervised practice prior to working independently.

We observed two staff undergoing induction during the inspection.

All staff completing triage, both qualified nurses and CSWs receive appropriate training and supervised practice to gain competency.

There is a Practice Educator who works across both units ensuring staff receive all additional training as required for their role. There are opportunities to undertake further academic study such as additional paediatric training.

Appraisals

Between April 2017 to March 2018, 90% of all staff within the community urgent and emergency care services had received an appraisal. However 2 staff became eligible for an appraisal between April 2018 - June 2018 (YTD at the time of the RPIR) within community urgent and emergency care service and neither had yet completed this.
(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

All staff within both MIUs confirmed that they had either received an annual appraisal or one had been scheduled within the current calendar year. Qualified nursing staff told us that they are supported in completing their professional revalidation. We were also told that additional training and study is encouraged. We observed the schedule for completion of any outstanding appraisals

Multidisciplinary working and coordinated care pathways

We observed very effective communication between staff.

Senior staff reported effective communication and access to consultant support as required, this was facilitated by telephone and by regular consultant led review clinics.

We observed coordinated care pathways on the trust intranet and on paper hard copy.

We saw examples of discharge arrangements which included referral to GP and to the district nurses.

Staff could tell us how to make referrals as required to local services such as community physiotherapy.

Health promotion

We observed multiple examples of health promotion displayed throughout the department covering a diverse range of topics such as domestic violence, excess alcohol, drugs awareness and healthy eating.

We observed patient information leaflets being readily available.

Staff were observed to give health promotion advice.

We did note that health promotion literature was only available in English.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards training

The trust set a target of 95% for completion for MCA and DoLS training.

Training is reported on a monthly rolling basis; a breakdown of compliance for Mental Capacity

Act training courses provided in the RPIR as of July 2018 for registered nursing staff within community urgent and emergency care is below. :

Nursing and midwifery/health visiting staff

Staff group	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	RAG Rating
Support to doctors and nursing staff	4	4	79%	Green
Qualified nursing & health visiting staff (Qualified nurses)	4	4	7%	Red

Nursing staff within community urgent and emergency care received a red rating for mental capacity act level 1 with 7%.

Medical and dental staff

The community urgent care service is nurse led and therefore there are no medical and dental staff with this service and in turn no training data for medical and dental staff in this core service

(*Source: Routine Provider Information Request (RPIR) – Training tab*)

Deprivation of Liberty Safeguards

As patients are not admitted to these services we would not expect any DoLS applications.

(Source: Routine Provider Information Request (RPIR) – DOLS tab)

We spoke with 6 members of staff about Mental Capacity Act and deprivation of liberty training and each confirmed they had completed mandatory training covering these areas.
We found that staff understood how and when to obtain consent. We observed staff as they obtained informed consent prior to assessment and treatment and documented this appropriately. Assessment and treatment was explained to the patient.

Staff we spoke with were aware of the rights of patients and their role in protecting the rights of patients in relation to the Mental Health Act. The requirements of legislation and guidance relating to mental capacity were understood by the staff we spoke with. Staff could explain assessment and treatment in several ways and stated that where they felt a patient lacked capacity they would act in the best interests of the patient and make safeguarding or GP referrals, as appropriate.

Staff we spoke to were very conversant around the issues of consent in children and young people. All staff were knowledgeable regarding Gillick competency and the use of Fraser guidelines to apply the principles.

Is the service caring?

Compassionate care

We observed staff communicating effectively with patients, to ensure that care, treatment and conditions were understood. Staff gave a clear explanation to the patient about their condition. Staff checked that patients had fully understood their care and treatment by asking whether they

had any further questions at the end of a treatment.

All staff treated patients with dignity, compassion and undertook their role in a caring way when we observed interactions in reception and during assessment and treatment.

We observed positive feedback cards and letters on display in the waiting area at Ripon.

Patients we spoke with gave positive feedback regarding their care.

Both units participated in the Friends and Family Test (FFT). In data provided by the Trust covering a period from May 2018-October 2018, Ripon achieved 96.02% and Selby achieved 100% recommendation

Emotional support

The staff we spoke to were able to describe in detail how they would support a patient emotionally, they were aware of the services available to refer onto including hospital chaplaincy. We were told of one example when a member of staff referred a patient who had recently been bereaved

Understanding and involvement of patients and those close to them

Staff gave patients advice about the services available and how to access them. Where a patient required further advice or support after treatment they were advised to contact their GP or facilitated referrals as required. Patients were encouraged to manage their own health care and wellbeing and self-care advice was given on discharge.

We observed staff communicating effectively with patients' relatives and including them as appropriate.

Is the service responsive?

Planning and delivering services which meet people's needs

Selby MIU was changing their care model from a MIU to an urgent care centre in order to assess and treat minor illnesses in order to provide a greater service to their local community. This followed engagement with the local Care Commissioning Group (CCG), patients and the local community.

The facilities and premises at Selby are appropriate the service being delivered with ample space in reception and waiting areas with appropriate treatment facilities. The facilities at Ripon are more limited due to the age of the building with a small waiting area and limited seating. The assessment and treatment facilities are suitable for the service delivered.

We saw examples of staff supporting patients with additional needs.

Both MIUs offered a seven-day service-Ripon currently opens from 8am-6pm, Selby is open 8am-8pm. There was clear information available at both locations on how to access services over night which included directions to the nearest main emergency department or to contact the 111 service.

Both units adhered to the national standard of 95% of patients attending an emergency department should wait no more than 4 hours to receive treatment and to be discharged. Selby achieved 99.6% and Ripon 99.98%.

Ripon had 1.34% unplanned reattendances (patients returning within 48 hours) and Selby 0.02%.

Meeting the needs of people in vulnerable circumstances

We found services were delivered in a way that accommodated the specific needs of patients. Where a patient was living with dementia or learning disability, they were prioritised to minimise distress and anxiety. Staff we spoke to had a good understanding of how to support patients with complex needs.

We discussed the care of patients with a learning disability with nursing staff. We were informed that patients usually arrived at the unit with a carer to support them and this made communication more effective.

We observed posters on display making patients aware of the use of chaperones.

Staff reported having access to both telephone and computer based interpretation support.

Bariatric equipment was available across both sites.

Access to the right care at the right time

Both units achieved in excess of the national 4-hour standard

Both units are open at times that enable patients to access them as required

There was no data available when asked regarding patients leaving prior to being seen

Selby has qualified triage nurses to ensure patients are prioritised due to clinical need

Both units displayed estimated waiting times and staff explain any delays

Referrals
From April 2017 to March 2018 there were no referrals relating to community urgent and emergency services.
(Source: Routine Provider Information Request (RPIR) – Referrals tab)

Learning from complaints and concerns

Complaints

From July 2017 to June 2018, the trust received one complaint relating to community urgent and emergency care services. The trust took 87days to close this complaint, this is not in line with the trusts policy which states complaints should be closed within 25 days.

The complaint was regarding the treatment of a blister by nursing staff.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We were told by senior staff that all complaints are dealt with by the clinical lead and nurse educator. Any learning from the complaint is taken and disseminated throughout the team in order to take any opportunity available to learn from the complaint. We were also told that they would utilise complaints received by the main department as training opportunities to further imbed learning.

Compliments
From July 2017 to June 2018 the trust did not receive any compliments relating to community urgent care services.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We saw active participation with seeking feedback as part of friends and family-staff were observed to give patients the opportunity to provide feedback, there were posters and other documentation within the department regarding feedback and recently received feedback was displayed prominently within the department.

We saw 2 occasions where staff actively sought feedback from patients.

Is the service well-led?

Leadership

At the last inspection it was found that both MIUs had a lack of senior leadership and that each unit worked in isolation to the other MIU and the main Emergency Department. Since the last inspection there has been clear developments in the nursing leadership and both sites now have designated leaders who are supported by Band 7 staff. There are two senior nurses who have overall responsibility for both units. There is also a close working relationship between both units and with the main emergency department.
There was strong leadership at a senior level that encompasses both units. Staff reported a very visible senior management team.

All leaders are aware of the challenges and priorities of the services provided across both sites

Vision and strategy

A clear vision and operational plan was in place for the continued development of the department.

There were clear plans for the management of winter pressures including reallocation of staff as required.

There was investment ongoing to improve both services with bodies of work being completed on strengthening the links between primary, secondary and community care.

Culture

The MIU's culture was clearly positive, which staff told us about. Staff we spoke with felt valued, appeared happy and enthusiastic and spoke positively about working in the department. Staff told us that they felt supported by management and by their peers.

There are no lone working arrangements in either unit and entry is restricted after 6pm using locked main doors with telephone access.

Governance

Information was used to monitor and manage the operational performance of the department, and to measure improvement. Service performance measures were monitored and reported.

Governance meetings for ED took place monthly and were done in conjunction with both MIUs and the main emergency department.

Governance meetings inform up to board level and feed down to the local teams.

Governance had been reported as being more effective with the appointment of senior leaders in the nursing teams across both sites.

Management of risk, issues and performance

The service had a local risk register. The senior management team had a good oversight of the risks currently on this risk register. There were monthly meetings to review current risks and existing risks were either up or downgraded as necessary with new risks being added as appropriate. There is a clear pathway for the escalation of risks to the trust corporate risk register. All senior staff could articulate what risks were on the register and could describe how they were captured.

Any complaints or serious incidents are raised to the senior leaders which are investigated with reports completed to highlight trends or patterns.

We were told of the process to support staff who are failing to meet the required standards.

Information management

The department collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. Information was used to monitor the performance of the department, and performance data was shared with staff.

All patient records are electronically based across both MIUs.

All computers are user specific password protected and all computers were observed to be locked when not in use.

Engagement

All staff we spoke with told us that engagement with staff and feedback to staff following engagement is continually improving. Staff feel that they could raise issues and questions and are confident that they are heard at a senior level. Staff report that their feedback is actively encouraged and is used in decision making processes. Staff feel that they are fundamental when planning and delivering services.

Patients that we spoke to told us that the community are involved by the trust when changes to services are being considered.

Staff report that the senior team are very visible with regular visits on site. The staff also report that they are approachable if required.

Learning, continuous improvement and innovation

There was evidence of quality improvements.

Since the last inspection a new role of ‘practice educator’ had been created and is currently held by a senior member of the nursing team. Staff report that this role has increased training opportunities and the ability to develop further due to having specific training support.

The practice educator had completed and implemented multiple care pathways and patient group directives.

A middle grade doctor undertakes weekly training sessions at Ripon.

Staff were encouraged to undertake non- mandatory training to support their practice development.

Staff were encouraged to work across sites to gain further experience.

There was designated training time with consultants from the main emergency department.

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust has reported that no services within community urgent and emergency services have been awarded an accreditation.
(Source: Routine Provider Information Request (RPIR) – Accreditations tab).