Calderdale and Huddersfield NHS Foundation Trust

Evidence appendix

The Royal Infirmary
Acre Street, Lindley
Huddersfield
West Yorkshire
HD3 3EA

Date of inspection visit:
6 March to 5 April 2018

Date of publication:
20 June 2018

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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 hospital and community sites at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Calderdale Royal Hospital, Salterhebble, HX3 0PW</td>
<td>Surgery, Urgent and emergency service, Services for children and young peoples, Gynaecology, Maternity, Medical care (including cardiology), Adults Community, Children, Young People and Families</td>
<td>Calderdale &amp; Huddersfield</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Huddersfield Royal Infirmary, Lindley, HD3 3EA</td>
<td>Surgery, Urgent and emergency service, Services for children and young peoples, Gynaecology, Maternity, Medical</td>
<td>Calderdale &amp; Huddersfield</td>
</tr>
</tbody>
</table>
We inspected the trust in March 2016 and visited Huddersfield Royal Infirmary, Calderdale Royal Hospital, Community services including adult community services, community services for children, young people and families and community end of life care.

We rated the trust as requires improvement overall. We rated safe, effective, responsive and well led as requires improvement and caring was rated as good. We rated the Huddersfield Royal Infirmary and Calderdale Royal Hospital as requires improvement and community services as good. We found the trust was in breach of regulations and issued four notices which required the trust to develop an action plan for how they would comply with the regulations where breaches had been found.
The trust has a financial turnover of £365m. The trust did not achieve its financial plan for 2017/18. The trust reported a deficit of £47.68m for 2017/18. This was £17.83m below the planned deficit of £29.84m. The Trust made savings in line with its cost improvement programme, however did not meet the stretch target set by the regulator of a further £2m.

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. The trust scored better than the England average for recommending the trust as a place to receive care for most of the time period from December 2016 to November 2017.

Is this organisation well-led?

Leadership

Of the executive board members at the trust, 14.0% are Black and Minority Ethnic (BAME) and 37.5% are female. Of the non-executive board members there were no BAME members and 25.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>14.0%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>6.3%</td>
<td>31.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

The trust board consisted of:

- The Chair (appointed in April 2018)
- Chief Executive Officer (appointed in May 2012)
- Director of Nursing / Deputy Chief Executive (appointed in June 2016)
- Medical Director (appointed in July 2014)
- Chief Operating Officer (appointed in January 2016)
- Director of Finance (appointed in November 2017)
- Director of Planning, Estates and Facilities (appointed in May 2006)
- Director of Workforce and Organisational Development (appointed in February 2018)
- Seven Non-executive Directors

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The board of directors’ portfolios covered all key areas. There had been a stable leadership team with most board members in place since the last inspection. The director of finance and director of workforce and organisational development had been appointed within the last six months. The new chair commenced employment in April 2018 and there was a handover process in place with the outgoing chair.

The director of nursing was also the governance lead for the trust and was supported by the assistant director for quality and safety. The trust also had appointed a director of transformation and partnerships in 2013, who had overall responsibility for the trust’s reconfiguration plan but was not an executive voting member of the board.
The non-executive directors were knowledgeable, competent and had the appropriate skills and experience relevant to their roles. They had worked in leadership and management positions in the NHS, education, voluntary and private sectors. They had a background in a range of areas including business planning, law and accountancy. The non-executive directors provided appropriate challenge and were positive about trust leadership. They demonstrated a clear awareness of the financial challenges faced by the trust and were clear that patient care and safety took priority over financial performance.

Senior leaders demonstrated an understanding of the priorities and challenges facing the trust, such as financial performance, workforce and the realisation and delivery of the trust reconfiguration plan. These challenges were articulated in the strategy and operational plan and were also recognised in the corporate risk register and Board Assurance Framework.

The leadership team were able to describe how they addressed patient safety and quality performance risks. However, we found that individual executive and non-executive directors did not have a collective view on addressing the key challenges the trust faced including financial performance and the delay to the trust reconfiguration plan.

We carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive and non-executive directors in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We looked at six executive and non-executive director employment files, which were completed in line with the FPPR regulations.

The council of governors approved the appraisal process for the chair and non-executive directors. Performance appraisals for non-executive directors went to the nominations and remuneration committee, which held meetings on an annual basis. There was a structured competency based recruitment process for senior directors and the trust used an external recruitment organisation to produce detailed reports to help inform recruitment and selection. Newly appointed executive and non-executive directors underwent formal induction, which included mandatory training and a local induction plan specific to their role.

The workforce strategy was launched in January 2017 and this identified leadership development and succession planning as a key activity.

There were processes in place for leadership development and succession planning across the senior and divisional management levels. The Compassionate Leader in Practice (CLIP) programme was launched in June 2017. The programme ran for eight months and included masterclasses, individual coaching and action learning sets. The programme was delivered by an external organisation that specialise in developing leadership programmes within health and care settings. Since its launch, 45 staff had participated in the programme with further training cohorts were planned during 2018.

The Work Together, Get Results (WTGR) programme was a two-day change management programme comprising a ‘toolkit’ of techniques and interventions and was open to all staff. The trust also had specific development programmes for nurses, matrons, ward managers and theatre staff.

Most staff reported that the leadership team were visible and approachable. The executive and non-executive directors undertook a scheduled programme of walkabouts across the directorates and reported these back at board meetings. The chief executive also engaged with staff through regular informal talks and responded to staff queries through the use of an online portal.
Vision and strategy

The trust’s vision was “Together we will deliver outstanding compassionate care to the communities we serve”. The vision was underpinned by the following four ‘pillars’ of behaviours. These were; we put the patient first; we go see; we do the must dos and we work together to get results.

The trust’s five year strategic framework 2015 – 2020 and one year plan 2017/18 outlined the following four goals:

- Transforming and improving patient care
- Keeping the base safe
- A workforce for the future
- Financial sustainability

The overall responsibility for the delivery of each strategic goal was assigned to a named executive director and a board committee. The goals were underpinned by 14 strategic objectives and these had been developed in line with the NHS Five Year Forward View and the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP). The trust’s two year operational plan (2017/18 and 2018/19) outlined how the trust would deliver the strategic plan. Progress was monitored by the trust board and the strategic objectives were periodically reviewed and updated throughout the year.

The five year strategic framework was developed in 2015 and there was involvement and engagement with a wide range of staff and external stakeholders in the development of the strategic framework, the values and the four pillars. The strategic plan was supported by a number of other core plans, strategies and framework documents. These included the workforce strategy, nursing strategy, quality Improvement strategy, risk management strategy, dementia strategy (draft), end of life care strategy and the trust reconfiguration plan.

The vision and values were shared with staff across the trust. The 2017 NHS staff survey indicated most staff across the trust (97%) had some level of awareness of the four pillars. Individual staff objectives were aligned to the trust’s overall objectives through the appraisal process.

Sustainability and transformation plans (STP) were part of a national programme where the NHS, local authorities and social care form partnerships to improve health, the quality of social care and efficiency of services in a geographical ‘footprint’. The STP processes would inform part of the overall long-term strategy for the trust in terms of service configuration. Calderdale and Huddersfield NHS Foundation Trust was part of the West Yorkshire and Harrogate STP. The trust did not have its own separate STP future implementation plan but provided input and representation into the STP’s formal programmes of work, as well as its corporate and strategic decision making governance.

The trust contributed to the ongoing and future operational work of the STP through the West Yorkshire Association of Acute Trusts (WYAAT). This association had a Committee in Common (CiC) of all the acute trusts in West Yorkshire with an underpinning memorandum of understanding (MoU) and was the vehicle through which the STP delivered its planned acute collaboration programme. The Chair and CEO were members of the CiC. There were six on-going WYAAT programmes and work streams and senior staff were involved in each of these.

The hospital pharmacy transformation programme (HPTP) was aligned to the five year strategic framework and outlined the transformational change to achieve infrastructure balance and financial viability across the pharmacy services by 2020 as highlighted in the 2016 Carter report. The key deliverable was the provision of a seven-day clinical pharmacy service which would result in improved patient care. There was a formal written strategy which was based on the hospital
pharmacy transformation plan. The chief pharmacist was aware of the challenges to the quality and sustainability of the pharmacy service. They told us the strategy needed a review to include more detail and expected completion dates for key milestones.

The director of nursing was the executive lead for mental health across the trust. The trust was in the process of developing an overarching mental health strategy. A draft strategy was due to be completed by June 2018. The strategy was being developed in response to the publication of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report Mental Health in General Hospitals: Treat as one (2017) report.

The trust was in the process of setting up a mental health working group to oversee the development of the strategy and implementation of the development NCEPOD guidance. The role of the group included completion of the self-assessment checklist, implementation of audits using the NCEPOD audit tool every three months and to provide training and raise awareness among staff. An action plan was developed and this was monitored by the executive management team on a monthly basis.

Staff in the emergency department and ward areas were able to seek advice about mental capacity, Deprivation of Liberty Safeguards and other issues related to mental health from the safeguarding team, the onsite psychiatric liaison and first response teams provided by the local mental health trust during out of hours. There were good working relationships with the liaison team. Staff told us they received a timely response to referrals to the service and could also ring and ask for advice and information at any time.

Culture

There was a positive culture across the trust with a focus on delivering safe care for patients. The trust’s vision and ‘four pillar’ values were cascaded across the trust and staff demonstrated these values in practice. Most staff were motivated and showed pride in working for the trust and within their teams. We found there was effective multidisciplinary working and teamwork across the services we inspected.

Staff we spoke with described an open and inclusive culture. They felt they received good support and were encouraged to develop their skills to enable the delivery of safe care and treatment to patients. Staff told us they felt able to discuss issues or concerns with their leaders and they were confident they would be listened to. Medical staff reported a good level of clinical input with the ability to improve services. Nursing staff and junior doctors told us they received good support and were encouraged to participate in quality improvement projects and clinical audits.

The chief executive and board members were described as being visible, open and approachable. The board members, senior management team and divisional management teams worked well together. The non-executive directors and council of governors demonstrated a culture of constructive challenge and mutual respect.

The trust had an appointed guardian of safe working hours. The current guardian was appointed in October 2017 for a one-year term. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. The guardian oversaw exception reporting and highlighted any identified concerns or trends in relation to junior doctor’s working hours, rotas, and breaks or missed training. The guardian worked with the education supervisor to identify actions, explore any immediate solutions and implement remedies.

The guardian of safe working hours reported to the medical director and submitted a report to the trust board every three months. There was a junior doctor’s forum held every three months, where representatives from all specialities at a variety of grades could attend to discuss and share ideas. However, the guardian of safe working hours reported that attendance at the last three forum
meetings had been poor despite timely communication to junior doctors. The guardian of safe working hours and medical education team planned to improve engagement with junior doctors and their supervisors by engaging with doctors in training prior to their teaching sessions and increasing email communications.

Junior doctors spoke positively about working for the trust. They told us they received good support and that registrars and consultants were available when needed. Most junior doctors felt their workload was balanced and they told us they had received adequate training and support in the use of the electronic patient record system.

The guardian of safe working hours annual report for the period December 2016 to December 2017 highlighted that 67% of exception reports were from the general surgical directorate and over 95% of these were from foundation year 1 (FY1) doctors. Actions to improve this were developed locally within the department. There had been an overall reduction in the number of exceptions reported across the trust since the beginning of the year and additional measures such as use of bank or agency staff had helped to improve this. The report highlighted a positive culture of reporting exceptions and the electronic exceptions reporting system was being rolled out across all the divisions.

The trust had an appointed Freedom to Speak up Guardian who was one of the non-executive directors. We had concerns that the NED may not have the capacity to undertake the full aspects of their role due to their limited working hours in the trust. The Freedom to Speak up Guardian reported to the chief executive and was supported by the Freedom to Speak up Champion (who was the Executive Director of Workforce and Organisational Development) and 15 ambassadors. The ambassadors had been appointed from different departments and staff grades across the trust to allow them to be independent and impartial when reviewing cases.

There was a Freedom to Speak Up: raising concerns (whistle blowing) policy (June 2017) that outlined the responsibilities for staff, managers, directors and the trust board if a concern had been raised. The policy stated that staff should raise concerns with their line manager in the first instance, and then escalate to the Freedom to Speak up Guardian and the executive team if their concerns had not been addressed.

The Freedom to Speak up Guardian submitted an annual report to the trust board. The 2017 report showed there had not been any concerns raised with the trust or the Freedom to Speak up Guardian. There were two whistle blower concerns reported directly to the Care Quality Commission by staff during early 2017. These related to staffing concerns and we saw evidence that the trust had taken appropriate actions to address the concerns raised.

The Freedom to Speak up process was communicated through engagement, newsletters and other promotional materials to raise awareness among staff. The Guardian told us staff survey results showed approximately 80% of staff were aware of the policy but felt the Freedom to Speak process was still being embedded across the trust. The recruitment for Freedom to Speak Up ambassadors had recently completed and plans were in place for the ambassadors to engage with staff and raise awareness of the process. There were plans to set up a network meeting every three months from April 2018 onwards. The trust also planned to implement an online reporting tool during 2018.

Staff we spoke with during the inspection did not highlight any concerns in relation to the whistle blower policy or Freedom to Speak process. Staff felt they were able to raise concerns through other means such as through the ‘Ask Owen’ portal that allowed staff to post queries and concerns to the chief executive.

There was an open culture and staff were encouraged to report incidents involving medicines. The medicines safety officer (MSO) was aware of areas of low incident reporting and had a strategy to
improve this. Staff in the pharmacy teams received meaningful appraisals which included conversations about personal and professional development.

The trust had a Duty of Candour policy in place. We found staff demonstrated a good understanding of Duty of Candour requirements during the inspection. Duty of Candour states the trust must act in an open and transparent way about the care and treatment patients receive and notify them, as soon as is reasonably practicable, after becoming aware that a notifiable safety incident has occurred, firstly in person and then in writing.

The trust had been compliant with the statutory and contractual Duty of Candour requirements for all incidents reported during 2017. Performance was reported on a monthly basis and presented at the trust’s quality committee. The trust reported that 100% of Duty of Candour correspondence was sent within 10 days of the incident between January 2017 and January 2018. This was an improvement from 2016/17 where compliance of 97.9% was reported. We looked at six serious incident reports during the well led inspection and Duty of Candour requirements were fulfilled in each case.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
<th>Nursing and Health Visiting staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3.9%</td>
<td>3.29%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.27%</td>
<td>0.10%</td>
<td>0.42%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.32%</td>
<td>0.07%</td>
<td>1.39%</td>
</tr>
<tr>
<td>Black</td>
<td>0.28%</td>
<td>0.12%</td>
<td>0.68%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.23%</td>
<td>0.0%</td>
<td>0.02%</td>
</tr>
<tr>
<td>Other</td>
<td>0.45%</td>
<td>0.0%</td>
<td>0.38%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.61%</td>
<td>0.12%</td>
<td>0.48%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity)

The trust did not have a standalone equality and diversity strategy. An overarching equality and diversity strategy capturing the trust’s approach for staff, patients and the public was being developed at the time of our inspection. Aspects of equality and diversity such as implementing the workforce race equality standard (WRES) had been incorporated into the quality priorities 2017 - 18 and the workforce strategy 2016 - 2021.

The trust’s equality and diversity objectives 2016 – 2020 set out the four equality priorities for the trust to focus on. Progress against the equality objectives was routinely monitored by the trust board and an annual report was produced. The priorities included the implementation of a strategy; engagement with staff, patients, carers and the public to help develop and achieve equality and diversity objectives; engagement and support for staff identified with a protected characteristic and implementation of national requirements, such as the implementation of NHS accessible information standard, workforce disability equality standard and the workforce race equality standard.

The trust’s integrated performance dashboard showed 95.4% of staff across the trust had completed equality and diversity training (updated every three years).
There were two senior managers within the Trust who had responsibility for leading on equality and diversity, along with a staff network group for black, asian and minority ethnic (BAME) staff that held meetings every three months. The trust reported that further work was required as part of the equality and diversity strategy to establish other staff network groups, such as for staff with a disability and lesbian, gay, bisexual and transgender (LGBT) staff.

The trust had started recently started to review the Workforce Disability Equality Standard (WDES) and staff had attended an NHS employer information and good practice workshop in March 2018.

The trust reported a number of improvements in engagement with patients and the local communities during 2017/18 as part of the Equality Delivery System 2 (EDS2) framework. The trust planned to further improve engagement with people identified with a protected characteristic during 2018/19. The trust also had plans to incorporate accessible information standards into electronic appointment letter systems and to support and further develop engagement champions across the trust.

The trust held a regional engagement event to raise awareness of LGBT patients receiving care in the NHS and LGBT staff working in the NHS during 2017. Feedback from the event highlighted that imagery used across the trust lacked diversity and the trust planned to improve this. A further LGBT event was also planned in a community setting to identify further improvements to services. The trust had also sought local expert advice to help improve staff practice when asking transgender patients about being pregnant when attending for x-ray.

The trust used an electronic equality impact assessment (EQUIP) process. Staff carried out assessments against core business policies, improvement projects, reports and risk assessments. These identified if there was likely to be any impact on any of the protected characteristics (such as age, gender, race and sexual orientation) for patients and staff and to mitigate the likely impact.

The trust had a dementia lead and the dementia strategy was being updated at the time of our inspection. The draft strategy included key objectives around improving staff knowledge, the quality of care and the care environment for patients living with dementia. The trust carried out a survey of relatives and carers of patients with dementia to identify improvements to the dementia service. Some wards had trialled the use of coloured plates, cups and pans for patients living with dementia.

There was a learning disabilities lead matron in place. The learning disability action plan 2017/18 included eight actions that were either completed or on-going in relation to improving the care received by patients with a learning disability. The trust carried out two easy read surveys for patients with a learning disability during 2017. Feedback from surveys was positive and no specific improvement actions were highlighted from the feedback.

### NHS Staff Survey 2017 – results better than average of acute trusts

The trust has one key finding that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding 11. Percentage of staff appraised in last 12 months</td>
<td>95%</td>
<td>86%</td>
</tr>
</tbody>
</table>

### NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has five key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:
### Key Finding

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding 17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.63</td>
<td>3.76</td>
</tr>
<tr>
<td>Key Finding 4. Staff motivation at work</td>
<td>3.88</td>
<td>3.92</td>
</tr>
<tr>
<td>Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.84</td>
<td>3.91</td>
</tr>
<tr>
<td>Key Finding 32. Effective use of patient / service user feedback</td>
<td>3.61</td>
<td>3.71</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The NHS staff survey (2017) had recently been published and the trust had 2434 staff take part in this survey. The staff response rate for the 2017 staff survey was 43%. This was comparable to the average of acute trusts in England (44%), but was slightly lower than the response rate of 45% in the 2016 survey.

The staff survey was made up of 32 key findings. The trust had improved in 11 key findings and declined in 21 key findings since the 2016 survey. The chief executive and executive directors highlighted and had anticipated that staffing shortfalls, increased workload for staff following implementation of the electronic patient record system and the trust reconfiguration plans may have contributed to the 2017 NHS staff survey findings.

The findings of the 2016 staff survey had four main themes: colleague engagement; reward and recognition; health and wellbeing and learning and development. An action plan was developed and a number of improvements were implemented following the 2016 survey. This included the launch of trust-wide reward and recognition schemes, updated appraisal processes, the launch of the compassionate leadership in practice (CLIP) programme and support for staff to improve their health and well-being, such as stress risk assessments.

The 2017 staff survey findings were reviewed by the director of workforce and organisational development and a summary was presented to the workforce well led committee in March 2018. Initial improvement actions identified by the trust included communicating the findings from the survey, identifying areas of strength at trust and divisional level, refreshing the 2016 staff survey action plan, feedback sessions with divisional lead to analyse the survey results, engagement with the black, asian and minority ethnic (BAME) network, colleague engagement network and staff management and to share areas of good practice across the organisation.

### Workforce race equality standard 2016

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.
Of the four questions above, two questions do not show a statistically significant difference in score between White and BME staff (KF25 and 26). The other two (KF21 and Q17b) have not had statistical analysis undertaken as the number of BME respondents was less than 50.

(Source: NHS Staff Survey 2016)

The trust held several focus groups with black, Asian and minority ethnic (BAME) staff in early 2016 and the feedback received was used to support the development and delivery of the workforce race equality standard (WRES) action plan during 2016/17. The trust established the BAME Network in September 2016 and the network supported the delivery and implementation of WRES action plans.

The 2017/18 WRES action plan included four specific action points to improve the trust’s compliance with the standard. These included; to improve the existing equality training to include cultural awareness, to develop and mentor BAME staff (band 8 and above) in leadership roles, to support BAME staff (band 2 and 7) to aid career progression and to develop guidelines and standards of behaviours deemed to be acceptable / unacceptable.

The action plan was due for completion by June 2018 and an executive director lead was appointed with overall responsibility for each action point. Actions completed so far included the launch a one year development programme aimed at senior BAME staff (band 8a and above) in
July 2017 and the placement of 10 BAME staff (bands 5 – 6) on a development programme managed by a neighbouring NHS trust. The first cohort graduated in October 2017 and was well received. The trust was looking at opportunities to continue the programme in 2018. A leaflet had also been produced with a draft proposal for staff behaviours around equality and diversity. There was a plan to engage with all staff about the behaviours identified by the end of June 2018.

BAME staff we spoke with in focus groups were very positive about the level of engagement and involvement from the trust leadership and particularly the support they received from the chief executive. The majority of staff told us they had not experienced any discrimination but they felt cultural awareness training would be useful to support an equality and diversity culture across the trust. Most staff told us they were supported and encouraged to develop and progress their careers within the trust. A number of clinical and non-clinical staff that attended the BAME focus group told us they had been promoted to management roles.

The trust did not have specific recruitment targets for staff from BAME groups to enable the workforce to reflect the local population. The trust had reviewed the local demographic against the workforce and BAME staff we spoke with felt the workforce was diverse and reflective of the local population. They were aware of the balance between increasing the representation of BAME staff and preserving meritocratic recruitment practices.

**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.

The trust scored better than the England average for recommending the trust as a place to receive care for most of the time period from December 2016 to November 2017.

(Source: Friends and Family Test)
The Friends and Family Test (FFT) responses were generally positive across the trust and consistently better than the England average during 2017. Response rates showed a large variation between wards and departments, with lower response rates seen in outpatients, community services and the accident and emergency care department.

Actions taken to improve FFT response rates were managed at divisional level and monitored through the quality committee. Actions to improve response rates included increased focus and awareness among staff and engagement with patients through daily interactions and focus groups.

**Sickness absence rates**

The trust’s sickness absence level from September 2016 to August 2017 is similar to the England average.

![Graph of sickness absence rates]

(Source: NHS Digital)

The average sickness absence rate across the trust from April to December 17 was 4.06%. This had improved from the same point in 2016 (4.41%), but was still worse than the trust target of 4%. Long term sickness absence accounted for 2.56% of the overall sickness absence rate and short term sickness absence accounted for 1.50%. Targets were in place for each division with monthly reports showing progress against the target.

The trust reported that anxiety/stress/depression/other psychiatric illness was the main reason for sickness absence in December 2017. Human resources (HR) advisors held drop-in sessions to provide attendance management support for managers. There was a focus on completing return to work interviews to identify individual reasons for sickness.

There were a number of initiatives in place to improve sickness and absence, such as fitness classes and knitting / crochet classes held by the occupational health department to improve staff well-being. The trust had also commenced an audit into moving and handling musculoskeletal (MSK) injuries to staff during 2017 to determine the nature and types of injuries and to identify improvements.
In the 2016 General Medical Council Survey the trust performed worse than expected for one indicator (Induction) and the same as expected for the remaining 13 indicators.

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>This Trust</th>
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<tbody>
<tr>
<td>Overall Satisfaction</td>
<td></td>
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<tr>
<td>Clinical Supervision</td>
<td></td>
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<tr>
<td>Clinical Supervision out of hours</td>
<td></td>
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<tr>
<td>Handover</td>
<td></td>
</tr>
<tr>
<td>Induction</td>
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<tr>
<td>Adequate Experience</td>
<td></td>
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<tr>
<td>Supportive environment</td>
<td></td>
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<tr>
<td>Work Load</td>
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<tr>
<td>Educational Supervision</td>
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<tr>
<td>Access to Educational Resources</td>
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<td>Feedback</td>
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<tr>
<td>Local Teaching</td>
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<tr>
<td>Regional Teaching</td>
<td></td>
</tr>
<tr>
<td>Study Leave</td>
<td></td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)

The trust reported that the indicator for induction had improved from 'worse than expected' in 2016 to 'same as expected' in the 2017 General Medical Council Survey. The content of the corporate induction for doctors in training was routinely monitored and feedback was sought during the induction days. College tutors were responsible for delivering departmental inductions and updates from college tutors were shared at the medical education committee meetings held every three months.

The three areas the trust scored below expected in the 2016 survey were anaesthesia, cardiology and ophthalmology. Improvement actions were put in place in each of these areas. Anaesthetic departmental induction was made cross site and on line resources to support induction made available. Improvement was demonstrated in the 2017 survey. A cardiology specific induction was developed for 2017 and the department planned to produce a cardiology handbook for staff. An ophthalmology induction booklet was given to all the trainees before their posting so they could familiarise with the working practices in the department. The college tutor and the educational supervisor conducted a departmental full day Induction at the start of the trainee rotation. Improvement in the induction indicator was demonstrated in the 2017 survey.

**Governance**

There was a clear governance structure that supported the escalation of information and key risks to the trust board through various committees and assurance groups. The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately.

The main subcommittees of the board were:

- Quality committee (monthly)
- Finance and performance committee (monthly)
- Workforce well led committee (every two months)
- Audit and risk committee (every three months)
- Nominations and remuneration committee (at least once annually)
- Charitable funds committee (every three months)
• Council of Governors (every three months)

All subcommittees of the board were chaired by a non-executive director (NED) and had clear terms of reference. The NED’s were engaged in quality governance. They were sighted on most issues and provided appropriate challenge. The trust board and sub-committees received timely, detailed, high quality information through periodic reports, summary briefings and integrated dashboards to inform planning and decision-making.

There was also an additional executive led committee that fed into the board of directors, the electronic patient record transformation board. Trust executive board meetings took place on a weekly basis to focus on strategy, recovery and delivery of key business cases at executive level. One meeting per month focused on performance.

The trust had commissioned an independent review of governance against the NHS improvement well led framework in October 2015. The review did not highlight any significant concerns. There had been 22 recommendations for improvement following the review in areas such as leadership, risk management and data quality. An action plan was put in place and all 22 actions had been completed and approved at the November 2016 board meeting.

The medicines management group was a sub-group of the patient safety group, which reported to the quality committee. The chief pharmacist reported told us the governance structure was currently under review as existing committees had not delivered the objectives in their terms of reference. A new medicines and compliance committee was planned from the end of April 2018 which would report directly to the quality committee.

The chief pharmacist reported that progress against the hospital pharmacy transformation plan (HPTP) was monitored every three months by the pharmacy board. A medicines management assurance tool was completed by each ward manager. In the future, the results would be reported to the new medicines and compliance committee. The pharmacy department employed a medicines management nurse who took part in medicines safety initiatives in partnership with the medicines safety officer and the wider trust.

The safeguarding committee met on monthly basis and was chaired by the deputy director of nursing. The safeguarding committee reported in to the quality committee. There was an annual safeguarding report and a Trust Board update every six months.

The overall responsibility for safeguarding adults and children across the trust had been delegated to the deputy director of nursing. There were named safeguarding professionals for both adults and children who were supported by a specialist practitioner and a paediatric liaison sister. The Head of Safeguarding met with the deputy director of nursing on a monthly basis. The safeguarding leads met with the deputy director of nursing on a monthly basis to review policy, lessons to be learned from reviews both locally and nationally and the safeguarding agenda. There were audit programmes to ensure that safeguarding systems and processes were functioning effectively. A safeguarding annual report was received at the quality committee with a six-monthly update.

The trust reported that safeguarding training compliance across the trust was 87.3% in January 2018. This had improved from 83% compliance in December 2017. This showed the majority of staff had received safeguarding training but compliance was below the trust target of 95%. The deputy director of nursing was aware of safeguarding training compliance and was able to describe the steps being taken to improve this, such as weekly monitoring of training compliance and sending written correspondence directly to individuals that had not completed training.

The trust board received an annual safeguarding report. Each division also produced a quality report with operational safeguarding information. There was a safeguarding subcommittee that reported to the quality committee and was chaired by the deputy director of nursing. There was a
clear structure to recognise and support safeguarding concerns within the trust. There were effective support mechanisms with other agencies, such as the Police, local authorities and the local mental health providers.

There was a clear governance structure in place for infection prevention and control processes across the trust. The medical director was the director for infection and prevention control (DIPC). An annual Infection prevention and control (IPC) report was prepared by the DIPC and submitted to the trust board. The DIPC also produced an IPC performance report every three months. The IPC committee was chaired by an infection control doctor and meetings took place every three months with input from associated groups (such as antimicrobial prescribing). The DIPC chaired a monthly IPC performance board and the IPC committee also reported in to the quality committee.

The IPC team included a mix of nursing and medical staff with infection control expertise. The DIPC told us the trust had four microbiologists and a nominated infection control doctor. All the microbiologists contributed to the infection control service and provided advice and guidance.

There was a sepsis management group that linked in to the IPC committee. The DIPC highlighted the environment at Huddersfield Royal Infirmary and sepsis management as key infection risks. The DIPC told us that by managing sepsis there was an associated increased risk of Clostridium difficile (C. Diff) incidence from increased use of antibiotics to treat patients with sepsis, which may have contributed to the increase in numbers.

**Board assurance Framework**

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of these is below.

- Transforming and Improving Patient Care
- Keeping the Base Safe
- A Workforce for the Future
- Financial Stability

*(Source: Trust Board Assurance Framework)*

The board assurance framework (BAF) and corporate risk register set out the strategic risks that could impact on the delivery of the trust's objectives. The BAF and corporate risk register were reviewed by the trust board and the executive team to provide assurance that the strategic risks and the controls in place to mitigate the risk were appropriate and effective. Individual risks on the BAF were also reviewed by sub-committees of the board for oversight. The board undertook a review of all BAF risks every three months.

The board assurance framework linked key risks to the strategic goals. Each risk had a numerical rating (likelihood versus consequence) and was red, amber, green (RAG) rated. The highest rated risks related to financial performance, staff recruitment and achieving the transformation plan. Each identified risk included details of controls, positive assurance as well as gaps in assurance and controls. Each risk was assigned to a responsible executive lead and an associated board subcommittee.

**Management of risk, issues and performance**

The risk management strategy 2018 – 2019 articulated the trust's approach to managing risks. The strategy was approved in January 2018 and outlined the roles and responsibilities of the trust board, board sub-committees and divisional and specialty-level staff in identifying, managing and monitoring risks to the organisation. The board of directors were accountable for risk management.
and were responsible for reviewing organisational risks through the corporate risk register and strategic risks through the board assurance framework.

The audit and risk committee was responsible for assuring the board that systems were in place for effective and timely risk escalation and effective systems were in place to manage and report on the board assurance framework. Board committees were responsible for oversight and assurance of strategic risks within the board assurance framework. Each board committee was also responsible for undertaking a self-assessment of performance annually and share these assessments with the audit and risk committee.

The monthly risk and compliance group was chaired by the director of nursing reported to the audit and risk committee. The role of the group was to promote effective risk management and to establish and maintain a dynamic board assurance framework and risk register through which the trust board could monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality. The information governance group held meetings every three months and also reported to the audit and risk committee.

There was a clear process for identifying and escalating risks from ward to board. Risks scored at seven or below were identified and reviewed at ward specialty / department level at least annually. Risks scored at eight or greater were escalated for review at monthly divisional patient safety and quality boards and to the risk and compliance group. Divisional risk registers were reviewed on a monthly basis. High level risks graded at 15 or greater were reviewed by the executive board, audit and risk committee and monthly by the trust board.

Performance information and data was routinely reported to the board committees and the trust board. This included performance dashboards, progress updates and reports relating to incidents, workforce data (such as training and recruitment and retention), and financial performance and improvement projects. This allowed the trust board to identify and take actions to mitigate risks. For example, where performance data highlighted poor performance, a ‘deep dive’ review was carried out to carry out a detailed analysis and identify improvement actions. Examples of deep dives included reviews of corporate risks and integrated performance metrics. Findings from these reviews were reported at the finance and performance committee.

The audit and risk committee received audit schedules and update reports from the internal audit team and approved audit plans for external organisations, such as finance and governance consultancy contractors. The clinical effectiveness and audit group was a sub-group of the clinical outcomes group. The clinical outcomes group was chaired by the medical director and met monthly. This group reported to the quality committee.

We found poor compliance with medicines management guidelines in the critical care and urgent and emergency care services during our core service inspection. This included omissions and errors in controlled drug log books, expired medicines and instances where medicine fridge temperatures were not recorded or escalated when fridge temperatures exceeded expected ranges. We checked whether improvements had been made in the urgent and emergency care services during the well-led inspection and our findings had not been fully addressed. This highlighted that the local level governance and quality monitoring processes were not effective as these concerns had not been identified and addressed by the senior staff within these areas. Our findings also showed a lack of monitoring and support from the pharmacy teams supporting these areas.

We also had concerns relating to person-centred care plans, nursing care and the management of patient risks following our inspection of the community inpatient service (community place) based at Calderdale Royal Hospital. We raised our concerns with the trust during the unannounced inspections and were given assurance that our concerns had been addressed. We were
disappointed to find during the well led inspection that no significant improvements had been made across both these services.

We felt there was a lack of management oversight in the community inpatient service because the concerns we had raised were not addressed in a timely manner and these concerns had not previously been identified through the trust’s own monitoring processes. The trust voluntarily closed the service immediately following the inspection and transferred the existing patients to other wards in the hospital to mitigate any on-going patient risks.

There was an executive-led process in place for the weekly tracking and escalation of performance against referral to treatment times, cancer wait times and emergency care standard targets. The trust reported they were one of the best performing trusts nationally for achieving patient access targets. We found the trust achieved most targets for cancer wait times and referral to treatment during 2017/18. The trust did not fully meet the emergency care 95% four hour wait standard but consistently performed better than national average over the past year.

The workforce performance report for February 2018 showed an overall staff vacancy rate of 5.9% across the trust. The medical and dental staff vacancy rate was reported as 11.8% across the trust and registered nurse vacancy rate was 9.5%. The shortfalls in medical and nursing staff reflected our core service inspection findings. Safe staffing levels were maintained through the use of flexible staff working and use of bank, locum and agency staff.

The chief nurse reported monthly on nurse staffing, in line with the NHS Hard Truths (2013) and National Quality Board Report (2013) requirements. The quality and performance report from January 2018 showed safe staffing levels were maintained across the majority of wards. The report highlighted the actions taken on wards with identified staffing shortfalls to minimise patient safety risks.

There was an on-going recruitment programme for nursing and medical staff across the trust. The director of nursing had been involved in a programme to recruit international nurses and two nurses had joined the trust in February 2018 with a further nine nurses pending commencement of employment. The trust also introduced 20 nurse associate roles during 2018 to support divisions with their nurse staffing supply in the future and the nurse associate programme was planned to continue as an annual programme to support workforce planning.

A review of the trust’s model hospital data during October 2017 reported that nursing and midwifery staff costs of weighted activity unit (WAU) were higher than the national average. The director of nursing commissioned an internal quantitative review and an external qualitative review to identify areas for improvement. The key findings of the reviews concluded that nurse staffing levels were safe and in line with national guidelines. The review found there were no excessive staffing levels but agency spend costs could be reduced.

A nursing and midwifery workforce steering group was set up to oversee a programme of activities with key work-streams across the nursing establishment to deliver improved nursing utilisation, reduced temporary staffing demand and a reduction in variable pay expenditure. The group planned to meet monthly and reported to the workforce well led committee.

Consultant recruitment was on-going and consultants had been appointed in respiratory medicine and anaesthesia. A new consultant microbiologist had also been appointed in January 2018. The trust has been working with Bradford Teaching Hospitals NHS Foundation Trust to try and appoint a consultant interventional radiologist. Health Education had agreed to use the trust as a pilot site for certificate of eligibility for specialist registration (CESR) development. Participation in the programme would enable the trust to develop consultants of the future.

The workforce and organisational development team submitted mandatory training and appraisal compliance data to the workforce well led committee. The report for January 2018 showed the
overall staff appraisal rate was 96% across the trust compared with a trust target of 100%. The April 2018 report showed the year end mandatory training compliance ranged from 92.8% to 95.3% for the five prioritised mandatory training topics. This showed the majority of staff across the trust had completed mandatory training in line with the trust’s 95% target. Mandatory training performance was monitored on a weekly basis and each division had actions in place to improve compliance, such as identifying and prompting individuals that had not completed their training.

There were nine mandatory training subjects. The trust had prioritised five mandatory topics for completion by all staff during 2017/18 due to the pressures on staff during / after the implementation of the electronic patient record (EPR) system. These were; safeguarding (adults and children), data security awareness, fire safety, infection control and moving and handling training.

The quality improvement strategy 2018-2021 set out the three year plan on how the trust planned to continually improve the service offered to patients. The strategy had four strategic aims; to improve outcomes for acutely ill patients, to implement the end of life care strategy, to provide safe care and to improve community services and to demonstrate engagement and co-design. There was an implementation plan and progress was reported to the trust board every three months. A number of quality improvement projects took place across the trust, including the mortality review programme, learning from complaints and harm free care, falls prevention, sepsis, pressure ulcers, hospital-acquired venous thromboembolism (HA-VTE), medicines safety and safe discharges.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£350.2m</td>
<td>£375.3m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£21m)</td>
<td>(£16.1m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£371.1m</td>
<td>£391.3m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£23.0m)</td>
<td>(£16.2m)</td>
</tr>
</tbody>
</table>

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

The delivery of the financial plan was a strategic objective and the trust board identified financial performance as the top risk to the organisation. This was reflected in the board assurance framework and the corporate risk register. The board had a good understanding of the current financial position and the challenges and risks to the trust in the current year and during 2018/19. Financial performance was reviewed on a monthly basis at the finance and performance committee, which was chaired by a non-executive director.

The trust did not achieve its financial plan for 2017/18. The trust reported a deficit of £47.68m for 2017/18. This was £17.83m below the planned deficit of £29.84m. On a control total basis the year end deficit was £23.91, which was £7.97m below the planned year end control total deficit of £15.94m.

The trust’s cost improvement programme (CIP) plan was to deliver £20m of efficiencies during 2017/18. The trust was able to achieve £17.91m in cost improvements. This was £2.09m below
the target. The £17.91m cost improvements delivered included £9.02m of recurrent savings and non-recurrent savings of £8.89m. The non-recurrent savings will not carry forward into next year.

Agency staff expenditure during 2017/18 was within the agency spend ceiling of £16.86m. However, this was achieved because of non-recurrent benefits of £0.82m relating to 2016/17 agency costs. The high level of agency costs reflected our findings in relation to staffing vacancies and use of agency staff during the core service inspection. Capital expenditure for 2017/18 was £15.62m, which meant the trust spent £1.23m above the plan of £14.39m. This additional expenditure was approved with the Trust’s regulators in line with the Trust’s SFI.

The trust had submitted a case for the reconfiguration and consolidation of clinical services across the two hospital sites in order to achieve long term clinical and financial sustainability. A public consultation process concluded in 2016 and there had been regular engagement with staff across the trust in relation to the proposed reconfiguration plan. The trust was waiting for a decision from the Secretary of State regarding next steps and timescale.

The Trust's longer term financial sustainability was reliant upon long term strategic change enabled by the Trust's reconfiguration plans; and the future opportunities from working collaboratively across the region.

The trust benchmarked its productivity and performance against other trusts in the region and the Carter review recommendations (2016) and the model hospital concept. The trust had also sought external advice from financial consultancy services and NHS improvement (NHSi).

The chair of the finance and performance committee highlighted that the cost base of the trust was not significantly above the average and that there had been a number of one-off costs, such as the electronic patient record system, that had impacted the financial position of the trust. The trust planned to focus on improving elective and private venture activities to improve income.

A quality impact assessment (QIA) was completed for all improvement programmes and for projects that were likely to directly or indirectly impact on quality of services. The QIA took into account risks to patients and staff. We reviewed three completed quality impact assessments and these identified key risks and mitigating factors. All quality impact assessments were reviewed by the company secretary, director of nursing and medical director.

**Trust corporate risk register**

The trust provided a document detailing their 26 highest profile risks. Each of these have a current risk score of 15 or higher. But the risk profiles below are nine highest profile risks between 20 and 25.

<table>
<thead>
<tr>
<th>ID</th>
<th>Date risk opened</th>
<th>Objectives</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6967</td>
<td>April-2017</td>
<td>Financial sustainability</td>
<td>The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during</td>
<td>25</td>
<td>15</td>
<td>Sep-2017</td>
</tr>
</tbody>
</table>
EPR implementation phase and unplanned revenue costs
- inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans
- income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets
- Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance
- expenditure in excess of budgeted levels
- agency expenditure and premium in excess of planned and NHS Improvement ceiling level.

<table>
<thead>
<tr>
<th>Date</th>
<th>Financial sustainability</th>
<th>Risk Description</th>
<th>Probability</th>
<th>Likelihood</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6968</td>
<td>Apr-2017</td>
<td>Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.</td>
<td>20</td>
<td>15</td>
<td>Sep-17</td>
</tr>
<tr>
<td>6969</td>
<td>Apr-2017</td>
<td>Risk that the Trust will have to suspend or curtail its capital programme for 2017/18 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. Following a mandate from NHS Improvement to reduce Capital expenditure for 2017/18 due to national funding pressures, the Trust's Capital Programme has been severely curtailed and a number of capital schemes have had to be removed. This has increased the risk to the development and sustainability of services and has the potential to impact on clinical, safety and performance</td>
<td>20</td>
<td>12</td>
<td>Sep-17</td>
</tr>
<tr>
<td>Issue Number</td>
<td>Date Range</td>
<td>Category</td>
<td>Description</td>
<td>Impact</td>
<td>Frequency</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>6903</td>
<td>Dec-2016</td>
<td>Keeping the base safe</td>
<td>Collective ICU &amp; Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access granted to estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients &amp; staff.</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>7049</td>
<td>Aug-2017</td>
<td>Financial sustainability</td>
<td>Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in Outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity &amp; mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff. Increased costs to ensure timely and appropriate response to clinical &amp; operational risks</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>5806</td>
<td>May-2015</td>
<td>Keeping the base safe</td>
<td>There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>2827</td>
<td>Apr-2011</td>
<td>Developing our workforce</td>
<td>The inability to recruit sufficient middle grade and consultant</td>
<td>20</td>
<td>12</td>
</tr>
</tbody>
</table>
emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps.

Risks:
1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents
2. Risk to the emergency care standard due to risk above and increased length of stay
3. Risk of shifts remaining unfilled by flexible workforce department
4. Risk to financial situation due to agency costs

It should be noted that risks 4783 and 6131 should be read in conjunction with this risk.

There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG’s resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards, Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust’s underlying deficit. Delays in being able to reconfigure services will impact on The Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's
reputation. It should be noted that risks 2827 and 4783 should be read in conjunction with this risk

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Description</th>
<th>Impact</th>
<th>Severity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6345</td>
<td>Jul-2015</td>
<td>Keeping the base safe</td>
<td>20</td>
<td>9</td>
<td>Sep-2017</td>
</tr>
</tbody>
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Staffing Risk
Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to:
- lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models)
- Inability to adequately staff flexible capacity ward areas
- difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology
- dual site working and impact on medical staffing rotas
- lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams resulting in:
  - increase in clinical risk to patient safety due to reduced level of service / less specialist Input
  - negative impact on staff morale, motivation, health and well-being and ultimately patient experience
  - negative impact on sickness and absence
  - negative impact on staff mandatory training and appraisal
  - cost pressures due to increased costs of
interim staffing
- delay in implementation of key strategic objectives (eg Electronic Patient Record)

(Source: Trust Corporate Risk Register)

The risk and compliance group was chaired by the director of nursing on a monthly basis and reported to the audit and risk committee. The role of the group was to promote effective risk management and to establish and maintain the board assurance framework and corporate risk register through which the trust board could monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality. High level risks escalated from the divisions were reviewed by risk and compliance group for placement on the corporate risk register.

A review of the board assurance framework and high level risk register took place in September 2017. The purpose of the review was to ensure that risks were aligned to the trust’s five year strategic framework and one year plan and risks to all trust objectives were captured. There was also clarification around the difference between the board assurance framework and the high level risk register and the relationship between the two. This led to proposals to remove areas of duplication and identify new risks relating to the following areas that were not currently captured on either the board assurance framework or the high level risk register.

We reviewed the corporate risk register and found this was up to date and completed appropriately. The risk register included a summary section showing changes to risk ratings and a detailed section where the risk, controls and actions taken to address the risk were recorded. Risks included date of addition to register and review dates. Each risk was assigned to a board committee, an executive director and an operational lead. The mitigating actions were frequently updated to record the activities taken to mitigate risks. Risk scores were updated and appeared to be consistent with the level of risk and mitigating actions recorded. The risks detailed in the register were reflective of those highlighted to us by staff and broadly correlated with our findings during the inspection.

Information management

The board and its sub-committees received suitable information in order to gain assurance on implementing the trust’s strategic objectives and operational and financial performance. Board and committee papers provided detailed information through a combination of progress reports, meeting minutes and integrated performance dashboards.

The trust had developed a series of performance dashboards to enable appropriate oversight and challenge. The trust wide quality and performance report was discussed at the weekly executive board (WEB) prior to submission to board subcommittees and to the trust board on a monthly basis.

The quality and performance report consisted of a performance summary, Carter dashboard and a summarised commentary where adverse performance was observed. Key indicators were linked to the CQC domains. There was a RAG (red, amber, green) rating system for key indicators and a performance chart showing trends over the past 13 months. Many of the indicators were benchmarked either nationally or locally to help monitor and improve performance and outcomes.

The divisional integrated performance reports (IPRs) were produced in a similar format to the trust wide report and also included directorate level information with current month and year to date indicators. These were reviewed at divisional and directorate level monthly performance review meetings.
The pharmacy department had developed a separate dashboard and has increased the number of pharmacy indicators in the Divisional IPR to provide better measures of performance. The chief pharmacist reported that progress against the hospital pharmacy transformation plan (HPTP) was monitored every three months by the pharmacy board. A medicines management assurance tool was completed by each ward manager. In the future, the results would be reported to the new medicines and compliance committee. The pharmacy department employed a medicines management nurse who took part in medicines safety initiatives in partnership with the medicines safety officer and the wider trust.

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 or the NHS strategic executive information system. Staff across the trust could access information through meetings, updates, newsletters and through the trust's intranet site. Policies and procedures were available on the trust intranet.

The trust launched an electronic patient record (EPR) system in May 2017. This was developed in partnership with Bradford Teaching Hospitals NHS Foundation trust and joint programme board meetings were held each month. There was a comprehensive implementation plan and support functions available during the implementation to ensure the EPR system was implemented across most areas of the trust without significant problems. The system enabled staff within the trust and externally (such as community staff and GP’s) to access patient records remotely. The EPR system also included electronic prescribing. Staff accessed the system using secure key card access.

The trust aimed to operate as a paperless organisation. However, there were still some services (such as critical care) that operated paper-based records or legacy IT systems in use in conjunction with the EPR. The consultant’s focus group highlighted that EPR did not include all patients’ complete medical history. This meant staff had to rely on legacy IT systems to access some information. Consultants told us the legacy systems were slow to access and increased the workload. The medical director was aware of this and told us that the Trust was continuing to progress plans to resolve this.

Our discussions with staff during focus groups and core service inspections highlighted that most staff were positive about using the system. They felt the initial training did not fully prepare them to use the EPR system but the quality of training had improved since then. The EPR system had reporting functionality which allowed staff to generate reports covering a range of information, such as performance data and patient access and flow information. Where EPR reporting functionality was not available, staff were able to obtain the relevant information manually.

The trust had a director of informatics and digital health in place. The implementation of the EPR system was overseen by the EPR operational group, which held monthly meetings chaired by the chief operating officer. An IT infrastructure strategy 2017-22 was in development and the draft strategy had five strategic goals linked to the overarching five year strategic framework. These were; usability, cyber security, sustainability, mobility and identity and accessibility.

The trust had completed the NHS England digital maturity self-assessment tool and an external digital maturity review was carried out in February 2018. The external assessment identified that the rationale provided by the trust supported the self-assessment response for most questions.

The trust had completed the information governance (IG) toolkit submitting a 73% satisfactory rating in March 2018. The toolkit requirements had designated ‘owners’ each taking responsibility for maintenance and where possible improvement in their specialist area. Data security awareness training compliance for staff across the trust was 82% in January 2018. The trust had processes in place for the reporting and management of cyber security risks. The trust reported two information governance breaches to the Information Commissioner's Office (ICO) during 2017/18 and both
incidents had been resolved. Remedial actions taken following the breaches included a review and update of procedures in the access to health records department and voluntarily inviting the ICO to conduct an audit of the trusts processes.

**Engagement**

Most staff reported that the leadership team were visible and approachable. The executive and non-executive directors undertook a scheduled programme of walkabouts across the directorates and reported these back at board meetings. The ‘Ask Owen’ portal allowed staff to post queries and concerns directly to the chief executive. The trust reported that 200 queries to the ‘Ask Owen’ portal had been responded to since its launch in 2015.

The national NHS staff survey (2016) showed the trust scored 3.80 (out of five) for an overall indicator of staff engagement. This was slightly below average (3.81) when compared with other trusts of a similar type. The national NHS staff survey (2017) findings showed the trust scored 3.82 for staff engagement, which was slightly worse than the previous survey and was below (worse than) average when compared with trusts of a similar type (3.79).

Staff engagement took place through a variety of methods, including focus groups, staff surveys, listening events, correspondence updates and a weekly newsletter. The colleague engagement network was a trust-wide multidisciplinary group. This group was responsible for developing a new staff engagement programme and accompanying surveying tool for implementation during 2018. The trust used feedback from leaver’s surveys in order to inform and improve policies, procedures or training for existing staff.

The reward and recognition group identified a range of employee benefit schemes available for staff including flexible working, staff discounts, health and wellbeing initiatives, staff long service awards, pensions, salary sacrifice schemes and child and family support initiatives.

There were a number of initiatives in place to recognise and celebrate staff achievements. This included ‘thank you’ postcards that were available to all staff to send to anyone else in recognition of good work. A ‘Star Awards’ monthly recognition scheme was in place for teams and individuals going “above and beyond”. This attracted up to 20 entries each month and awards were presented by the chief executive. The trust also had an annual programme of nominations and submissions that was open to all staff with an annual ‘Celebrating Success’ event and awards night dinner.

Feedback from staff focus groups and interviews showed that most nursing, medical and support staff spoke positively about the level of engagement and support they received. We received a mixed response from the consultant’s focus group about the level of engagement from the medical director. The trust appointed two associate medical directors to improve this.

Board members actively engaged with the governors and members of the trust. Governors we spoke with were actively involved with the trust and received regular updates on how the trust performed. Governors were invited to attend board meetings and walkabout visits. There was a staff side committee in place. Members we spoke with told us they had a good working relationship with the executive team and they felt they were listed to. Members told us they met regularly with executive directors.

The patient experience and caring group met eight times per year and reported to the quality committee on activities related to patient experience, involvement and engagement. The group developed an annual programme of priorities linked to the trust strategy and based on feedback from surveys. The group was chaired by the assistant director for quality and safety and included multidisciplinary staff representation as well as quality improvement, complaints and patient and carer representatives.
There were a number of patient and public engagement initiatives being delivered by the trust. Examples included:

- The children’s and women’s patient experience group held focus groups to capture patient and family experiences of services. The group developed a promotional video about the children’s ward.
- Planned patient involvement in designing an information leaflet for patients who had undergone insertion of urological stent.
- The Trust's patient experience and caring group used Experience Based Co-design (EBCD) as an opportunity for patients and staff to come together to design, monitor and improve services. The trust held two events during 2017 related to the reconfiguration of respiratory and frailty medical services.
- New chairs had been purchased following a trial by parents to help promote skin to skin with babies on the neonatal unit.
- The diabetes Team introduced a new program of diabetes education sessions for young patients with type 1 diabetes.
- A roadshow was held in June 2017 following a new food provision contract. This included a food tasting session and a competition to design a regional dish. Positive feedback was received regarding the quality of the food and a new finger food menu was introduced as a result of the feedback.
- The patient reporting and action for a safe environment (PRASE) tool for assessing patient experience using volunteers was launched in 2017 on the Children’s Ward.
- The trust introduced graffiti boards to capture patient experiences and a “mood board” for younger patients. This had identified improvements such as adolescent patients we introduction of more age-appropriate activities and a teenage room following patient feedback.
- The chaplaincy department had carried out engagement activities with the local South Asian communities to improve inter-faith relations and to improve strategies of care.
- A wheelchair patient was involved in the redesign of the public toilets to ensure accessibility issues were taken into account.
- As a result of the feedback from lymphoedema patients the clinic was relocated to an accessible venue.

The trust routinely engaged and collaborated with other healthcare providers. The trust was a member of the West Yorkshire and Harrogate Sustainability and transformation plan (STP) and worked with other trusts within the West Yorkshire Association of Acute Trusts (WYAAT). There were regional collaborative groups for information management and technology (IM&T), imaging, pharmacy and pathology services. The electronic patient record (EPR) had been developed and implemented as a joint product with Bradford Teaching Hospitals NHS Foundation Trust.

The trust engaged with local commissioners, NHS improvement and local GP service representatives. The trust had also worked with Healthwatch to get feedback from the public on outpatients and stroke services. Feedback from stakeholders we spoke with demonstrated there was positive engagement from the trust.

**Learning, continuous improvement and innovation**

The quality improvement strategy 2018-2021 set out the three year plan on how the trust planned to continually improve the service offered to patients. The strategy had four strategic aims; to improve outcomes for acutely ill patients, to implement the end of life care strategy, to provide safe care and to improve community services and to demonstrate engagement and co-design. There was an implementation plan and progress was reported to the trust board every three months.

A number of quality improvement projects took place across the trust, including the mortality review programme, learning from complaints and harm free care, falls prevention, sepsis, pressure
ulcers, hospital-acquired venous thromboembolism (HA-VTE), medicines safety and safe discharges. The trust implemented the Getting It Right First Time (GIRFT) programme in order to reduce unwarranted variations, bring efficiencies and improve patient outcomes.

The maternity services carried out a number of engagement activities to improve the services following our last inspection. This helped staff to identify improvements. The survey of patients and birth partners helped to develop the “Getting Ready for Birth” lesson plan. The Trust included a session in the junior doctors’ induction programme called “Walking in the Woman’s Shoes” to ensure the privacy and dignity issues are addressed. The bedrooms on the neonatal intensive care unit (NICU) were updated following parents’ feedback to create a more pleasant, less clinical environment for parents.

The trust actively learned from other organisations in order to improve services. We saw several examples where staff had learnt from other NHS providers as part of the ‘we go see’ pillar of behaviours. The trust also invited external organisations to review their processes to identify improvements. Examples included Royal College’s reviews, Healthwatch and financial consultancy organisations.

The trust shared examples of continuous learning, improvements and innovations. This included:

- Introduction of daily safety briefs between critical care and theatre teams
- One stop prostate clinic for urology patients
- Follow up clinic for critical care patients post discharge – the first in West Yorkshire
- Operating services Band 6 development programme
- Visual impairment forum – first of its type started by healthcare assistants
- Development of the frailty service
- Cardiology and respiratory reconfiguration
- One stop rapid access arrhythmia clinic
- Patient engagement work in children and maternity – graffiti boards, fruit rounds, children’s ‘welcome to the children’s ward’ video

**Mortality Review Process Overview**

There was evidence of learning from the death of patients, and support given to families and carers through any investigation process. The trust had a ‘learning from deaths’ policy (September 2017). The mortality surveillance group was chaired by the medical director and held monthly meetings to oversee the mortality review process and share learning. Reports about mortality were submitted to the trust board every three months.

Learning from individual deaths was either by initial screening review (ISR) or by a structured judgement review (SJR). The SJR process was started in April 2017 and reviews were carried out by a team of trained consultants. Initial screening reviews were performed by consultants, doctors and senior nurses. The trust reported that 395 (23.4%) of patient deaths had been reviewed using the initial screening review tool in the last 12 months. Where care was assessed as poor or very poor care this triggered further investigation using the SJR process. Any deaths having a second level review that showed strong evidence of avoidability, or definite avoidability were reported as a ‘red’ incident and considered at the weekly serious incident panel for investigation as a risk. A total of 73 deaths have been escalated for SJR since April 2017, of these 70 had been completed. We reviewed a selection of mortality investigation reports, initial screening reviews and structured judgement review during the inspection and these were completed appropriately.

The mortality surveillance group reviewed performance against mortality indicators on a monthly basis. The Summary Hospital-level Mortality Indicator (SHMI) placed the trust in the “as expected” category with an outcome of 101 for the twelve months from October 2016 to September 2017. The Hospital Standardised Mortality Ratio (HSMR) was 85 in the 12 months from February 2017 to January 2018. This placed the Trust in the “better than expected” category. This had been
steadily improving during 2017. The trust reported that improvement in the HSMR and SHMI mortality indicators was due to a number of initiatives, such as the care of the acutely ill patient (CAIP) process, which was monitored at the clinical outcomes group. There had been no prevention of future death letters received from the Coroner during the last 12 months.

**Serious incident Process Overview**

There were clear processes in place for the reporting, investigation and learning from incidents. Reported incidents, complaints and patient deaths were reviewed at weekly and monthly divisional meetings. Serious incidents that required formal investigation were reviewed by divisional directors and senior risk managers. Serious incident investigations were allocated to independent medical or nursing staff that had received root cause analysis training. The division in which the incident occurred reviewed the report and actions, confirming leads and timescales and the actions to address any issues identified. Monitoring of actions was carried out at monthly divisional patient safety quality boards.

A monthly serious incidents report was submitted to the quality committee. This listed the serious incidents raised during the previous month along with identified trends and details of improvement actions taken. Incidents were also reviewed by the serious incident review group chaired by chief executive and met every two months to share cross divisional learning. This group reported to the quality committee.

There was a deep dive presentation to the trust board on serious incidents in December 2017 at the request of the board as there were concerns about the timeliness of report completion and subsequent learning. Incidents with overdue actions were monitored weekly and managed through routine divisional meetings and by the quality committee.

We looked at six serious incident investigations completed during 2017. These were completed to a good standard and contained appropriate information, action plans and evidence of learning and improvement. There was evidence of comprehensive investigations having been undertaken with root cause analysis, chronology (timeline of events) and a review of business continuity arrangements recorded. The incident reports detailed the involvement and support provided for staff involved in the incident as well as support for patients and relatives (such as duty of candour principles). The reports included a section which highlighted good practice identified during the investigation. Action plans had lead responsibilities and completion dates recorded.

Learning from incidents was shared across the trust in a variety of ways; through the incident reporting system, through alerts and staff newsletters. Learning was also discussed on an individual basis with those who may be directly involved with incidents and with a range of staff through routine team, directorate and divisional level meetings.

**Complaints process overview**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>25 working days</td>
<td>52%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>There is no additional target date; we are guided by the 25 or 40 day targets. Complaints are closed once a complaints response has been sent or a meeting held and the</td>
<td>N/A</td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
complainant is satisfied that the complaint has been resolved. Some complaints are closed following a telephone call, once the complainant is satisfied.

<table>
<thead>
<tr>
<th>If you have a slightly longer target for complex complaints please indicate what that is here</th>
<th>40 working days</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months? *</td>
<td>1,548</td>
<td>November 2016 to October 2017</td>
</tr>
</tbody>
</table>

* Without formal process is defined as a complaint which has been resolved without a formal complaint being made. This may include for example complaints resolved by the Patient Advice and Liaison Service (PALS) or by mediation.

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)

Number of complaints made to the trust

The trust received 590 complaints from November 2016 to October 2017. Medical care (including older people’s care) core service received the most complaints with 143.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Proportion of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>143</td>
<td>24.2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>142</td>
<td>24.1%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>95</td>
<td>16.1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>68</td>
<td>11.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>43</td>
<td>7.3%</td>
</tr>
<tr>
<td>End of life care</td>
<td>29</td>
<td>4.9%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>17</td>
<td>2.9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>17</td>
<td>2.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>15</td>
<td>2.5%</td>
</tr>
<tr>
<td>Adults Community</td>
<td>11</td>
<td>1.9%</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>9</td>
<td>1.5%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>590</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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

The performance report for January 2018 showed 50.1% of complaints had been closed within target timeframe. There were 31 overdue complaints at the end of January 2018; compared to 40 at the end of December 2017 (23% decrease). There were weekly complaints panels in place with divisions with overdue complaints. There was a plan to clear the backlog of overdue complaints with staff aiming to close 15 overdue complaints per week.

Complaints were reviewed on a weekly basis at divisional governance and risk operational team meetings. The integrated performance dashboard was reviewed monthly at the quality committee and included a breakdown of complaint numbers by division, an analysis of complaint reasons, timeliness of complaint responses, complaint outcomes and details of lessons learnt from complaints.

Learning from complaints was shared with staff through newsletter and local and divisional team meetings. The trust carried out featured learning following significant complaints or trends. These
were presented as patient stories and shared with staff at divisional meetings. A complaints report was also presented at the patient experience and caring group (reporting to the quality committee). These reports focussed on performance, local benchmarking and learning. An annual complaints and Patient Advice and complaints report was also reviewed by the trust board.

**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 table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacMillan Quality Information Service (MQIS)</td>
<td>Currently accredited at level 4</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Head and Neck: self-assessment data submitted May 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Urology: self-assessment data submitted April 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Breast: self-assessment data submitted May 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Colorectal: self-assessment data submitted April 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Specialist ear surgery: self-assessment data submitted June 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Acute Oncology: self-assessment data submitted May 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Skin 2016: self-assessment data submitted April 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Unknown primary: self-assessment data submitted April 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Invasive cardiology: self-assessment data submitted May 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Lung cancer: self-assessment data submitted April 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>NICU - visit Nov 17, awaiting final report</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber Paediatric Critical Care Network (peer review)</td>
<td>Paediatric HDU - July 16 (partial compliance)</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Paediatric oncology: self-assessment submitted Feb 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Cancer: Teenager and young adults: self-assessment data submitted May 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>Gynaecology cancers: self-assessment data submitted April 17</td>
</tr>
<tr>
<td>Quality Surveillance Programme (peer review)</td>
<td>HIV: self-assessment data submitted May 17</td>
</tr>
<tr>
<td>Critical care peer review</td>
<td>Network peer review Feb 17 (partial compliance)</td>
</tr>
<tr>
<td>National bowel cancer screening programme</td>
<td>Calderdale, Kirklees &amp; Wakefield bowel screening centre - Nov 15 (partial compliance)</td>
</tr>
<tr>
<td>National bowel cancer screening programme</td>
<td>Pathology Nov 15</td>
</tr>
<tr>
<td>Accreditation</td>
<td>Organisation/Date</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>National AAA screening programme</td>
<td>CHFT - Nov16 (partial compliance)</td>
</tr>
<tr>
<td>National antenatal and newborn screening programme</td>
<td>QA Public Health Nov 15 (partial compliance)</td>
</tr>
<tr>
<td>HFEA Human fertilisation and embryology authority</td>
<td>Yorkshire Fertility: May / June 2017</td>
</tr>
<tr>
<td>Stroke peer review (SQuINS): BSP/RCP/Stroke Association Peer Review of Stroke Services</td>
<td>Full accreditation given at last peer review carried out Nov 15, report received Feb 16</td>
</tr>
<tr>
<td>British Society of Urinary Unit Accreditation</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Diabetes external peer review and self-assessment (Royal College of Paediatric &amp; Child Health)</td>
<td>Mar-14</td>
</tr>
<tr>
<td>Human Tissue Act (Cellular Pathology CRH)</td>
<td>May 15 (re-submission Sept 17)</td>
</tr>
<tr>
<td>&quot;MHRA compliance with Blood Safety &amp; Quality Regulations 2005 Haematology &amp; Blood Transfusion</td>
<td>CRH - March 15; HRI - April 10</td>
</tr>
<tr>
<td>Neonatal and newborn screening quality assurance visit. Microbiology and Haematology</td>
<td>Microbiology &amp; Haematology Nov 15</td>
</tr>
<tr>
<td>Pennine Breast Screening QA Visit 2016</td>
<td>Pathology Sept 16</td>
</tr>
<tr>
<td>Quality Assurance Reference Centre (QARC)</td>
<td>Cytology CRH Full - 2013</td>
</tr>
<tr>
<td>UNICEF UK BFI Accreditation</td>
<td>Apr-15</td>
</tr>
<tr>
<td>Investors in People</td>
<td>Bronze award status August 16</td>
</tr>
<tr>
<td>Information Governance Toolkit</td>
<td>Mar-17</td>
</tr>
<tr>
<td>British Association Cardiovascular Prevention and Rehabilitation</td>
<td>BACPR/NACR Certification – In 2017 the Team awarded the minimum standards certification. This last for 3 years.</td>
</tr>
<tr>
<td>I CAN Accreditation</td>
<td>The SALT therapy team at Ashbrow Nursery maintained their ICAN Accreditation at annual review - 2017</td>
</tr>
<tr>
<td>Soil Association Food for Life Catering Mark Silver Accreditation</td>
<td>Catering department at ISS for the Ingleton Falls restaurant at Calderdale following an assessment - Ja Accreditation to the Cleaning Industry Management Standard (HRI) - Aug 2017nuary 2017</td>
</tr>
<tr>
<td>British Institute of Cleaning Science professional cleaning qualifications</td>
<td>Accredited Training Organisation approved by BICSc for the training and assessment of all staff in the cleaning team - October 2015</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations)
Acute services at Calderdale Royal Hospital

Urgent and Emergency Care

Facts and data about this service
The trust provides urgent and accident and emergency services at the Huddersfield Royal Infirmary and Calderdale Royal Hospital.

The accident and emergency department at Calderdale Royal Hospital provides a 24 hour, seven day a week service to the local population. Between April 2017 and March 2018, there were 148,929 accident and emergency department attendances at Huddersfield Royal Infirmary and Calderdale Royal Hospital. This equates to an average of 408 patients a day across urgent and emergency care services at the trust.

The accident and emergency department at Calderdale Royal Hospital is a not a designated trauma unit.

There is no separate paediatric accident and emergency department at Calderdale Royal Hospital but between 1 March 2017 and the 28 Feb 2018 there had been 18,087 paediatric attendances.

The accident and emergency department had four resuscitation bays, one of which was dual equipped for adults and children. There were 13 cubicles to treat patients with major injuries and illnesses, four cubicles to treat minor injuries, an eye room, an ambulance assessment room for rapid assessment, an adult triage room, a GP triage room, a paediatric triage room, a paediatric treatment room, a small waiting room in majors and a five bedded clinical decisions unit split in to bays of three beds and two beds, for single sex accommodation. The clinical decisions unit also had a side room that was used as a small seated waiting area.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. There was an out of hours GP in the department which ran between the hours of 6.30pm and 9.45pm Mondays to Friday and 9am to 10pm at weekends. The out of hour’s service was managed by Local Care Direct. Where patients were triaged and deemed suitable to be streamed to the GP, they would be sent there from triage. There was paediatric triage and streaming in the department between the hours of 1pm and 9pm, five days per week.

We inspected the whole core service and looked at all five key questions. In order to make our judgements, we spoke with 13 patients and carers and 18 staff from different disciplines. We observed daily practice and viewed five sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Details of emergency departments and other Urgent and Emergency Care services
- Calderdale Royal Hospital - Ward AECDU
- Calderdale Royal Hospital – A&E Department

(Source: Routine Provider Information Request (RPIR))

Activity and patient throughput

Total number of urgent and emergency care attendances at Calderdale and Huddersfield
There were 151,354 attendances from April 2016 to March 2017 at Calderdale and Huddersfield NHS Foundation Trust as indicated in the chart above.

(Source: NHS England)

Total number of urgent and emergency care attendances at Calderdale and Huddersfield NHS Foundation Trust April 2017 – March 2018

Between 1 April 2017 and 31 March 2018 there were 148,929 attendances at both Huddersfield Royal Infirmary and Calderdale Royal Hospital. Emergency attendances across the trust dropped significantly in quarter 4 January 2018 – March 2018.
### Total Attendances Per Quarter

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 Apr - Jun 17</td>
<td>38024</td>
</tr>
<tr>
<td>Quarter 2 Jul 17 - Sept 17</td>
<td>38057</td>
</tr>
<tr>
<td>Quarter 3 Oct 17 - Dec 17</td>
<td>37808</td>
</tr>
<tr>
<td>Quarter 4 Jan 18 - Mar 18</td>
<td>35040</td>
</tr>
<tr>
<td><strong>Total Attendances Per Annum</strong></td>
<td><strong>148929</strong></td>
</tr>
</tbody>
</table>

(Source: NHS England A&E Attendances and Emergency Admissions 2017-18)

### Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased by 0.4% from 2015/16 to 2016/17. In 2016/17, the rates were lower than the England average.

(Source: NHS England)
Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>33,785</td>
</tr>
<tr>
<td>Discharged*</td>
<td>90,928</td>
</tr>
<tr>
<td>Referred*</td>
<td>13,160</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>4,647</td>
</tr>
<tr>
<td>Died in department</td>
<td>127</td>
</tr>
<tr>
<td>Left department#</td>
<td>7,247</td>
</tr>
<tr>
<td>Other</td>
<td>304</td>
</tr>
<tr>
<td>Not known</td>
<td>83</td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

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 trust set a target of 95% for completion of mandatory training. After the inspection the trust provided updated mandatory training figures.

This division focused on five core mandatory training modules prioritised by the trust, which were:

- Fire safety
- Safeguarding (Adult and children)
- Infection control
- Moving and handling
- Data security awareness

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Data Security Awareness</th>
<th>Fire Safety</th>
<th>Infection Control</th>
<th>Manual Handling</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
<th>ALS</th>
<th>ILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>Additional Clinical Services</td>
<td>93.33%</td>
<td>100.00%</td>
<td>93.33%</td>
<td>86.67%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>-</td>
<td>46.15%</td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical</td>
<td>71.43%</td>
<td>85.71%</td>
<td>85.71%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Estates and Ancillary</td>
<td>0.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>50.00%</td>
<td>50.00%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Medical and Dental</td>
<td>100.00%</td>
<td>89.47%</td>
<td>94.74%</td>
<td>89.47%</td>
<td>68.42%</td>
<td>78.95%</td>
<td>-</td>
<td>63.16%</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery</td>
<td>90.41%</td>
<td>91.78%</td>
<td>86.30%</td>
<td>83.56%</td>
<td>79.45%</td>
<td>84.93%</td>
<td>64.29%</td>
<td>68.42%</td>
</tr>
</tbody>
</table>

(Source: Data Request UEC3 supporting narrative)

End of year position

<table>
<thead>
<tr>
<th>CQC Core Service</th>
<th>Data Security Awareness</th>
<th>Fire Safety</th>
<th>Infection Control</th>
<th>Manual Handling</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Urgent and emergency services</td>
<td>94.58%</td>
<td>94.09%</td>
<td>94.58%</td>
<td>95.07%</td>
<td>88.77%</td>
<td>90.91%</td>
</tr>
</tbody>
</table>

(Source: Data source CQC REQUEST ALL1 UPDATE)
The trust was had not met all mandatory training targets at the time of inspection, however had a trajectory to hit the target by the end of March 2018. After the inspection the trust submitted trust wide updated year-end figures which showed they had met one target of 95% in manual handling, and were very close to the 95% target in data security, fire safety and infection control. However they did not meet safeguarding training targets with safeguarding adults training at 88.77% and safeguarding children training at 90.91%.

The trust had a detailed action plan for the completion of mandatory training. The emergency department had actions in place to identify non-compliant staff and allocate protected time to enable these staff to complete their training before the deadline. Weekly compliance lists were issued to the ward manager for monitoring and compliance.

The trust appointed a clinical practice educator to the emergency department in 2017 and as a result of this post; the monitoring and completion of mandatory training had improved.

The trust had planned that all band 6 and band 7 staff complete intermediate life support (ILS) and paediatric intermediate life support (PILS) training. The clinical practice educator was working with the electronic staff record (ESR) team to include basic paediatric life support training onto mandatory fields for the emergency department staff. As part of the band 5 ‘new starters’ induction day, the nurse consultant provided a session on paediatric life support in the simulation suite at Huddersfield Royal Infirmary, which included basic life support.

Advanced life support training by consultants and middle grade doctors was overseen through the appraisal process and by the clinical director for emergency medicine.

For nursing staff advanced life support (ALS)/intermediate life support (ILS) was not mandatory, however the trust recognised that it is good practice and since the introduction of the clinical practice educator have trained the following percentage advanced life support (ALS) 61.54%, intermediate life support (ILS) 100%.

Mandatory training was monitored at directorate and divisional level by the senior management team.

Junior doctors were able to transfer mandatory training completed at regional inductions where evidence was provided. However, this did not include fire safety, manual handling and elements of safeguarding which needed to be completed locally. These elements were included in the trust induction and are to be completed through the electronic staff record (ESR).

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training, although some courses were not provided with a target. Mandatory training was identified as: fire safety, safeguarding (adult and children), infection control, moving and handling and data security awareness. Data below was requested prior to the inspection and the trust submitted up to date data post inspection which is detailed above.

**Trust-wide**

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing staff in urgent and emergency care is shown in the table below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>77</td>
<td>83</td>
<td>92.8%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td></td>
<td>76</td>
<td>83</td>
<td>91.6%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td></td>
<td>76</td>
<td>83</td>
<td>91.6%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>75</td>
<td>83</td>
<td>83</td>
<td>90.4%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>75</td>
<td>83</td>
<td>83</td>
<td>90.4%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>74</td>
<td>82</td>
<td>90.2%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>73</td>
<td>82</td>
<td>89.0%</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td></td>
<td>67</td>
<td>79</td>
<td>84.8%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>63</td>
<td>75</td>
<td>84.0%</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td></td>
<td>63</td>
<td>78</td>
<td>80.8%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>66</td>
<td>83</td>
<td>79.5%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>66</td>
<td>83</td>
<td>79.5%</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td></td>
<td>65</td>
<td>83</td>
<td>78.3%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
<td>56</td>
<td>76</td>
<td>73.7%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td></td>
<td>56</td>
<td>77</td>
<td>72.7%</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td></td>
<td>39</td>
<td>54</td>
<td>72.2%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td></td>
<td>55</td>
<td>77</td>
<td>71.4%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>57</td>
<td>82</td>
<td>69.5%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>53</td>
<td>83</td>
<td>63.9%</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td></td>
<td>36</td>
<td>83</td>
<td>43.4%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The trust’s overall mandatory training completion rate for nursing staff in urgent and emergency care was 80%.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care is shown below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Genital Mutilation</td>
<td></td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td>29</td>
<td>35</td>
<td>82.9%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>27</td>
<td>35</td>
<td>77.1%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>24</td>
<td>35</td>
<td>68.6%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td></td>
<td>21</td>
<td>33</td>
<td>63.6%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>16</td>
<td>35</td>
<td>45.7%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>15</td>
<td>35</td>
<td>42.9%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td></td>
<td>15</td>
<td>35</td>
<td>42.9%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>14</td>
<td>34</td>
<td>41.2%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td></td>
<td>14</td>
<td>35</td>
<td>40.0%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>12</td>
<td>31</td>
<td>38.7%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>95%</td>
<td>13</td>
<td>35</td>
<td>37.1%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>11</td>
<td>33</td>
<td>33.3%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td></td>
<td>9</td>
<td>33</td>
<td>27.3%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>8</td>
<td>35</td>
<td>22.9%</td>
</tr>
<tr>
<td>NGT Elearning 2017</td>
<td></td>
<td>6</td>
<td>35</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical staff in urgent and emergency care was 46%.

Calderdale Royal Hospital

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing
staff in urgent and emergency care at Calderdale Royal Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>68</td>
<td>74</td>
<td>91.9%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td></td>
<td>67</td>
<td>74</td>
<td>90.5%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td></td>
<td>67</td>
<td>74</td>
<td>90.5%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>66</td>
<td>74</td>
<td>89.2%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td>66</td>
<td>74</td>
<td>89.2%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>65</td>
<td>73</td>
<td>89.0%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>65</td>
<td>73</td>
<td>89.0%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>60</td>
<td>72</td>
<td>83.3%</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td></td>
<td>60</td>
<td>72</td>
<td>83.3%</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td></td>
<td>59</td>
<td>72</td>
<td>81.9%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>58</td>
<td>74</td>
<td>78.4%</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td></td>
<td>57</td>
<td>74</td>
<td>77.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>57</td>
<td>74</td>
<td>77.0%</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td></td>
<td>38</td>
<td>51</td>
<td>74.5%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td></td>
<td>53</td>
<td>72</td>
<td>73.6%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
<td>52</td>
<td>72</td>
<td>72.2%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>51</td>
<td>73</td>
<td>69.9%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td></td>
<td>50</td>
<td>72</td>
<td>69.4%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>48</td>
<td>74</td>
<td>64.9%</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td></td>
<td>33</td>
<td>74</td>
<td>44.6%</td>
</tr>
</tbody>
</table>
The trust’s overall mandatory training completion rate for nursing staff in urgent and emergency care at Calderdale Royal Hospital was 79%.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care at Calderdale Royal Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Genital Mutilation</td>
<td></td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>12</td>
<td>17</td>
<td>70.6%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>11</td>
<td>17</td>
<td>64.7%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td></td>
<td>9</td>
<td>15</td>
<td>60.0%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>95%</td>
<td>8</td>
<td>17</td>
<td>47.1%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>8</td>
<td>17</td>
<td>47.1%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>8</td>
<td>17</td>
<td>47.1%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>95%</td>
<td>8</td>
<td>17</td>
<td>47.1%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>7</td>
<td>16</td>
<td>43.8%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>7</td>
<td>17</td>
<td>41.2%</td>
<td></td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>5</td>
<td>15</td>
<td>33.3%</td>
</tr>
<tr>
<td>NGT Elearning 2017</td>
<td></td>
<td>5</td>
<td>17</td>
<td>29.4%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>5</td>
<td>17</td>
<td>29.4%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>4</td>
<td>15</td>
<td>26.7%</td>
<td></td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>3</td>
<td>15</td>
<td>20.0%</td>
<td></td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical staff in urgent and emergency care at Calderdale Royal Hospital was 47%.
Safeguarding

Staff understood and were able to explain how to raise a safeguarding concern if they thought a patient maybe at risk of harm.

Nursing and medical staff we spoke with were able to explain the process for when they were concerned a patient was at risk of harm and provided us with specific examples as to when they would do this. We saw that staff were able to access the trust safeguarding guidelines, which were readily available on the intranet.

Junior staff told us any safeguarding concerns were escalated to a senior nurse and doctor.

Staff told us they could access the trust’s internal safeguarding team for advice and guidance if they were unsure about whether an issue was a safeguarding concern.

Staff were aware of safeguarding processes for child exploitation and female genital mutilation (FGM). There was a clear focus on safeguarding and there was a bespoke safeguarding training programme for the emergency department. Staff understood ‘the hidden child’ and gave examples of when they had identified and actioned safeguarding around domestic abuse.

The trust had a paediatric liaison sister that reviewed every admission for patients 17 years old and under to provide a safety net and ensure that any child safeguarding concerns were not missed and referrals could be made where applicable.

Safeguarding training completion rates

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>Additional Clinical Services</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Estates and Ancillary</td>
<td>50.00%</td>
<td>50.00%</td>
</tr>
<tr>
<td></td>
<td>Medical and Dental</td>
<td>68.42%</td>
<td>78.95%</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery Registered</td>
<td>79.45%</td>
<td>84.93%</td>
</tr>
</tbody>
</table>

The trust submitted updated safeguarding training figures post inspection, however all levels had been combined as one percentage per staff group. Staff who had not yet completed training but were eligible were being booked on to the next available courses. The trust had not met its 95% completion target.

The trust set a target of 95% for completion of safeguarding training.

Trust-wide

A breakdown of compliance for mandatory safeguarding courses from April 2017 to November 2017 for nursing staff in urgent and emergency care is shown in the table below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>54</td>
<td>59</td>
<td>92%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td></td>
<td>53</td>
<td>58</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>53</td>
<td>58</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>20</td>
<td>23</td>
<td>87%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>95%</td>
<td>20</td>
<td>24</td>
<td>83%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td></td>
<td>19</td>
<td>24</td>
<td>79%</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the safeguarding training modules for which qualified nursing staff in urgent and emergency care were eligible.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care is shown in the table below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding</td>
<td></td>
<td>5</td>
<td>9</td>
<td>56%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>16</td>
<td>33</td>
<td>48%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>12</td>
<td>33</td>
<td>36%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td></td>
<td>3</td>
<td>24</td>
<td>13%</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the safeguarding training modules for which medical staff in urgent and emergency care were eligible.

**Calderdale Royal Hospital**

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing staff in urgent and emergency care at Calderdale Royal Hospital is shown in the table below:

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<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>17</td>
<td>18</td>
<td>94%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>50</td>
<td>55</td>
<td>91%</td>
</tr>
</tbody>
</table>
The 95% target was not met for any of the safeguarding training modules for which medical staff in urgent and emergency care at Calderdale Royal Hospital were eligible.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care at Calderdale Royal Hospital is shown in the table below:

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<tr>
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<td></td>
<td>49</td>
<td>54</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>49</td>
<td>54</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>95%</td>
<td>17</td>
<td>19</td>
<td>89%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td></td>
<td>15</td>
<td>19</td>
<td>79%</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the safeguarding training modules for which qualified nursing staff in urgent and emergency care at Calderdale Royal Hospital were eligible.

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

**Cleanliness, infection control and hygiene**

The accident and emergency department appeared clean and tidy. Cleaning services were provided by domestic staff. The lead nurse told us they had a good working relationship with the domestic supervisor who did a monthly walk around the department with the infection prevention and control lead, to ensure standards were maintained.

Recent environmental audits showed that the department did not always meet targets set for 12 out of 12 key areas. However there was an action plan for the department which detailed environmental issues for resolution and the lead nurse was undertaking a piece of work to review and rearrange storage in the department to maximise space and make the storeroom more efficient.
Staff completed core training related to their roles including: WDD waste management training, infection prevention (level 1) and WDD infection control level 2 - beyond the basics.

The accident and emergency department completed hand hygiene audits, however audits were not submitted for Calderdale Royal Hospital.

**Environment and equipment**

In the department doors were unobstructed. In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to sufficient seating. There was a small paediatric waiting area, from which the paediatric triage room had direct access. There was no separate entrance between the small paediatric waiting area and the adult waiting area; however there was a small play area for children to use with toys and books and chairs for parents.

The reception area had separate male, female and disabled toilets. We identified potential ligature points in the toilets and this was escalated whilst on site, however when we returned these had not been removed. Each toilet had a pull cord to alert staff if help was needed.

The accident and emergency department was close to car parks and had a drop off area and separate entrance for ambulances.

Equipment we reviewed had been PAT tested and was the next test date was recorded.

Panic buttons were checked monthly, but staff told us that checks were not documented.

There was a cubicle (cubicle nine) utilised to assess patients with mental health needs, however, it was not suitable for patients presenting with mental ill-health. The area used at Calderdale Royal Hospital did not meet the RCEM guidelines for a suitable environment for dealing with mental health emergencies in the emergency department. The area used was a cubicle next to the nurses’ station and it was not free of ligature points. The trust had plans to undertake some work.
to refurbish a room in the department to make it suitable for using with patients presenting with mental ill-health.

Cubicle 13 in the major’s area was set up for and used to treat paediatric patients.

We found that equipment checks were not consistently undertaken in the paediatric resuscitation bay, at the time of our inspection the paediatric bay had not been checked nine times over the previous three weeks.

We found out of date consumables in the paediatric resuscitation area. We found a tracheal intubation stylet (expiry October 2017), a single use laryngeal mask (expiry December 2017) and a paediatric blood collection – coagulation (expiry January 2018). These issues were escalated on site and the lead nurse immediately disposed of the out of date consumables and restocked the areas accordingly.

**Assessing and responding to patient risk**

The accident and emergency department had a clear triage and screening process. Patients attending by ambulance would be brought to the rapid assessment ambulance triage room where blood cultures and fluids could be commenced. There was a healthcare assistant in the department that could commence blood tests or an ECG to aid rapid diagnosis and treatment.

We found staff were able to identify and respond appropriately to patients who were at risk of deteriorating. A national early warning score system for acutely ill patients was used.

We checked five adults’ records and found all five had NEWS scores completed. Pain scores recorded in three out of five records, two patients did not have pain so there was no score recorded. VTE assessments had not been recorded. However, assessments of pressure areas were completed and documented in patient records.

There was no ‘separate’ paediatric A&E at Calderdale Royal Hospital however there was a small paediatric waiting area, a paediatric triage room and a paediatric treatment room in the department. Between 1 March 2017 and the 28 Feb 2018 there had been 18,087 paediatric attendances at Calderdale. Paediatric emergencies attended by ambulance would be routed to Calderdale Royal Hospital. There were three registered paediatric nursing staff in the emergency department. Paediatric streaming was undertaken in the department between 1pm and 9pm, five days per week, when the highest number of paediatric attendances would take place. Paediatric nurses were not in the department overnight so the department would ask for assistance from the nurses on the paediatric ward at night, if necessary.

Some nursing staff in the emergency department were trained in paediatric life support, however not all eligible staff were trained as the table below documents. Medical staff worked cross site and 94.1% of medical staff were trained in advanced paediatric life support.

<table>
<thead>
<tr>
<th>Nursing Staff</th>
<th>CRH Staff required</th>
<th>CRH Staff completed</th>
<th>CRH Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>APLS</td>
<td>14</td>
<td>2</td>
<td>14.30%</td>
</tr>
<tr>
<td>PILS</td>
<td>33</td>
<td>18</td>
<td>54.40%</td>
</tr>
<tr>
<td>PBLs</td>
<td>60</td>
<td>20</td>
<td>33.30%</td>
</tr>
</tbody>
</table>
The department used a comprehensive emergency department safety checklist that helped to identify any changes to the patient and monitor for deterioration. The checklist was on paper and detailed steps and prompts staff should take in the 1\textsuperscript{st}, 2\textsuperscript{nd}, 3\textsuperscript{rd}, 4\textsuperscript{th}, 5\textsuperscript{th} and 6\textsuperscript{th} hour. There was also a section for relevant referrals and risk assessments such as: adult safeguarding, child cause for concern, mental health ReACT (to assess patients for risk of harm to themselves), mental health referral, MARAC (domestic abuse) and frailty team.

Named nurses used the SBAR tool to facilitate effective communication in patient handovers. An SBAR can be used very effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover.

Patients presenting with mental ill-health would undergo a ReACT assessment and a referral to the psychiatric liaison team would be made. The team attended within an hour to assess the patient. The area used to accommodate and assess patients with mental ill-health was unsuitable for this purpose, however this was a known risk and work was being undertaken to have a room in the department refurbished to meet national standards. There were not enough staff in the department to provide one to one care to patients with mental ill-health at risk of absconding and self-harm. To mitigate risks in the area used to accommodate patients, the department had invested in ligature cutters that were placed centrally for staff to access. There were also guidelines on EM Beds (Guidance for Environmental Safety of Patients at Risk of Injury to Themselves or Others In the Emergency Departments at CHFT) around making an area safer for high risk patients which gave steps to follow, such as considering the removal of oxygen piping/tubing in the area. The department had a ‘missing patients’ policy. There was a SOP flow chart for patients who did not wait to be seen and this covered vulnerable patients, such as those presenting in crisis. The trust had a document available on EM Beds called ‘Guidance for Environmental Safety of Patients at Risk of Injury to Themselves or Others’ which provided clear guidance on making a room safer for patients presenting with ill-mental health.

The department also had a flowchart for the management of paediatric and adolescent patients presenting with mental ill-health. Patients that fitted these criteria were assessed using a paediatric mental health pro-forma and the department contacted CAMHS to attend and assess the patient.

The department had a comprehensive sepsis management policy and staff we spoke to were confident they could recognise and treat sepsis. There was also a ‘sepsis six’ display board on the wall outside of the resus area, which further educated staff on the signs to look out for.

The department had ‘point of care testing’ which provided results within minutes. Point-of-care tests are simple medical tests that can be performed at the bedside. Staff told us this was incredibly beneficial.
The department conducted four medical huddles each day; nursing safety huddles took place twice a day.

**Emergency Department Survey 2016**

The trust’s scored “About the same as” other trusts for all of the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey September 2016)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The target time for initial assessment is 15 minutes. The data the trust has submitted shows a decline in performance since the introduction of the EPR in May 2017. The trust stated there has been deterioration in performance against all standards including initial assessment for patients arriving by ambulance. The trust understood this was because of a data capture issue due to the current inability to accurately record the time of starting the initial assessment on the EPR system for the following reasons:

“Following the introduction of dedicated ambulance assessment areas (after the launch of EPR); there was a demonstrable improvement in ambulance turnaround times on both sites. Despite this improvement, there was no associated improvement in reported times to initial assessment (ambulances are turning around quicker than before EPR but this is not reflected in a shorter time to initial assessment). This supports the interpretation of an ongoing flaw in the ability of EPR to accurately record the time of commencement of initial assessment. The Directorate are working with EPR team to address the data capture issue.”

(Source: Data request UEC7 supporting narrative)

The below chart shows the previous six months validation data for ambulance wait and turnaround times.
The median time from arrival to initial assessment was worse than the overall England median in seven months over the 12 month period from January 2017 to December 2017. The chart is below.

**Ambulance – Time to initial assessment from January 2017 and December 2017 at Calderdale and Huddersfield NHS Foundation Trust**

In December 2017, the median time to initial assessment was 12 minutes compared to the England average of 9 minutes.

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Calderdale Royal Hospital

From January 2017 to December 2017 there was an overall upward trend in the monthly
percentage of ambulance journeys with turnaround times over 30 minutes at Calderdale Royal Hospital.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Calderdale Royal Hospital**

![Graph showing the number of ambulance journeys with turnaround times over 30 minutes from January 2017 to December 2017.]

In December 2017, 58% of ambulance journeys had turnaround times over 30 minutes.

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

In past six months the trust had six black breaches, one at Calderdale Royal Hospital and five at Huddersfield Royal Infirmary. These breaches occurred in October 2017, December 2017 and four in January 2018.

Root Cause Analysis was completed for the October and December breaches and the main findings were:

- The triage nurses’ comprehensive assessment could have occurred without the ambulance service being present.
- Staff working in the rapid assessment area are expected to escalate delays to the nurse in charge.
- Communication with patients and/or next of kin regarding any anticipated delays and ensure their comfort and safety is maintained.
- On-going plan to continue to feedback performance through the safety huddles to the clinical teams so they understand the importance of timely handover to patients.
- SOP in place and reviewed following the black breaches.

(Source: UEC8 black breaches supporting narrative)

The findings were shared with the teams through the safety huddles and the changes to the SOP added to the emergency department newsletter (November 2017).

Four further black breaches in January 2018 were down to winter operational pressures, volume and exit block from the department; therefore no formal RCA’s were completed. The trust planned to conduct a deep dive into the pressures to identify any learning for next year’s winter planning.
The deep dive would investigate whether there were other mitigations that could be implemented going forward when no bed capacity/discharges are predicted.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From September 2016 to October 2017 the trust reported nine “black breaches”, with a steady trend over the period.

(Source: Routine Provider Information Request (RPIR))

Nurse staffing

Managers acknowledged that staffing had historically been a challenge, but there were improvements and new staff had been recruited. There had been a large intake of new band 5 nurses and the trust was interviewing for band 6 sisters at the time of our inspection. No one we spoke with felt that staffing was unsafe or a risk to patient safety.

Staffing was planned on an electronic system by senior staff in the accident and emergency department. Agency and bank staff were used to fill vacant shifts where possible.

Nurse staffing was over three shifts: early, late and night shifts. We were satisfied that staffing had been planned in a safe and effective manner.

Nursing numbers were displayed in the department with the planned and actual numbers. Paediatric streaming was staffed by one of three registered paediatric nurses employed in the department and took place between 1pm and 9pm, five days per week.

The trust reported their registered nursing staff numbers as below as of October 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual staff – WTE in month</th>
<th>Actual staff – whole number / headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>69.6</td>
<td>79</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>7.7</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77.3</strong></td>
<td><strong>88</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Vacancy rates

As at October 2017, the trust reported a vacancy rate of 11% in urgent and emergency care. The vacancy rates by site were:

- Calderdale Royal Hospital – vacancy rate of 17%

(Source: Routine Provider Information Request (RPIR))

Turnover rates

As at October 2017, the trust name reported a turnover rate of 12% in urgent and emergency care. The turnover rates by site were:

- Calderdale Royal Hospital – turnover rate of 12.9%

(Source: Routine Provider Information Request (RPIR))
Sickness rates
As at October 2017, the trust name reported a sickness rate of 5% in urgent and emergency care. The sickness rates by site were:

- Calderdale Royal Hospital – sickness rate of 5%

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

Bank and agency staff usage

Agency staff usage by site. Nursing and Medical.

Hours per site Medical

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>742.25</td>
<td>706.25</td>
<td>526</td>
<td>1974.5</td>
</tr>
<tr>
<td>HRI</td>
<td>1159.5</td>
<td>994.5</td>
<td>908.5</td>
<td>3062.5</td>
</tr>
<tr>
<td>Total</td>
<td>1901.75</td>
<td>1700.75</td>
<td>1434.5</td>
<td>5037</td>
</tr>
</tbody>
</table>

Hours per site Qualified Nursing

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>437.25</td>
<td>500.75</td>
<td>660.25</td>
<td>1598.25</td>
</tr>
<tr>
<td>HRI</td>
<td>375.5</td>
<td>576.25</td>
<td>564.83</td>
<td>1516.58</td>
</tr>
<tr>
<td>Cross Site</td>
<td>632</td>
<td>766.5</td>
<td>65</td>
<td>1463.5</td>
</tr>
<tr>
<td>Total</td>
<td>1444.75</td>
<td>1843.5</td>
<td>1290.08</td>
<td>4578.33</td>
</tr>
</tbody>
</table>

The trust provided data showing the previous three months agency usage at all sites. Calderdale Royal Hospital used a total of 1592.25 hours’ worth of agency nurses in the previous three months December 2017 to February 2018.

From November 2016 to October 2017, the trust reported that 391 shifts were filled by bank staff and 1,189 shifts by agency staff with 391 shifts unfilled. They did not provide details of all shifts available, so we were unable to provide this data as a percentage.

(Source: Routine Provider Information Request (RPIR))

Medical staffing
There was consultant cover in the accident and emergency department between 8am and 10pm on Monday to Friday and from 9am on Saturday and Sunday for between four to six hours. This did not meet the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. There were not enough whole time equivalent consultants to staff a full weekend rota so this was undertaken on a voluntary basis. Outside of these hours, consultants were available on call. There were two middle grade doctors available in the department overnight.

The trust was undertaking work to recruit two further consultants to work in the department.

The department was recruiting for a paediatric consultant to work in the department and treat children. Two paediatric consultants worked in the department for five sessions a week on paediatric streaming.

The trust reported their medical staff numbers as below as of October 2017.
Vacancy rates

As at October 2017, the trust reported a vacancy rate of 28% in urgent and emergency care. The vacancy rates by site were:

- Calderdale Royal Hospital – vacancy rate of 23%

(Source: Routine Provider Information Request (RPIR))

Turnover rates

As at October 2017, the trust name reported a turnover rate of 15% in urgent and emergency care. The turnover rates by site were:

- Calderdale Royal Hospital – turnover rate of 15%

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

Sickness rates

As at October 2017, the trust name reported a sickness rate of 1% in urgent and emergency care. The sickness rates by site were:

- Calderdale Royal Hospital – rate of 2%

(Source: Routine Provider Information Request (RPIR))

Bank and locum staff usage

Agency staff usage by site. Nursing and Medical.

Hours per site Medical

<table>
<thead>
<tr>
<th></th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Total</th>
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<td>Total</td>
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<td>1843.5</td>
<td>1290.08</td>
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</tr>
</tbody>
</table>
The trust provided data showing the previous three months agency usage at all sites. Calderdale Royal Hospital used a total of 1974.5 hours' worth of locum medical staff in the previous three months December 2017 to February 2018.

From November 2016 to October 2017, the trust reported that 547 shifts were filled by bank staff and 1,368 shifts by locum staff with 132 shifts unfilled. They did not provide details of all shifts available, so we were unable to provide this data as a percentage.

(Source: Routine Provider Information Request (RPIR))

Staffing skill mix

As of October 2017, the proportion of consultant staff reported to be working at the trust were similar the England average, and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 30 whole time equivalent staff working in Urgent and Emergency Care at Calderdale and Huddersfield NHS Foundation Trust.

(Source: NHS Digital Workforce Statistics)

Records

Patient records were held on an electronic patient record system (EPR).

We reviewed five sets of patient records. We reviewed the record keeping for information inputted by nursing and medical professionals and found that it recorded relevant information. Records were appropriately completed and had allergies completed (where applicable), were dated and the name of the clinician reviewing the patient was clear.

Discharge summaries were sent to GPs electronically, where possible, otherwise they were sent via the post or with the patient.

Medicines
We were not assured that medicines were always managed and stored in a safe way. We found that controlled drugs in the resuscitation area had not been checked nine times since the 9 February 2018. Controlled drugs should be checked daily. We found one patient’s own medication (morphine sulfate 10mg/5ml) in the controlled drugs cupboard. The stock was noted in the controlled drugs register but the medication had not followed the patient to the clinical decisions unit and had not been disposed of.

We found issues with the controlled drugs register where entries on the 5 March 2018 and 6 March 2018 had been crossed out, not bracketed and footnoted which is the process for recording mistakes in line with trust policy. When we returned on the well led inspection, the controlled drugs register was reviewed and 13 anomalies were identified following the previous inspection on the 22 March 2018. The anomalies included crossing out, writing over entries and the amount received/given/wasted drugs was not always recorded.

We found expired Ventolin (expiry February 2018) for infusion 5mg/5ml in the resuscitation drugs cupboard.

We found issues with the recording of fridge temperatures and escalation of out of range temperatures. Where fridge temperatures that had been recorded as out of range, there was no evidence of escalation by staff. We reviewed fridge temperature records for the resuscitation area and records from 1 March to 6 March 2018 showed that temperature checks had not been recorded on two consecutive occasions.

After escalating these issues the trust has taken action around monitoring expired medication, this included: redesigning the top-up expiry check log, expiry checks to be undertaken every two months and items with an expiry date within six months to be documented, a standard operating procedure for stock topping up to be updated by end March 2018 and compliance to be reported quarterly to the pharmacy board from June 2018.

The department used patient group direction (PGD’s) and a list of these was available on the EM Beds system. A patient group direction (PGD) allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

**Incidents**

Staff recognised significant incidents and knew how to report them. Incidents were discussed by senior management at their monthly quality improvement forum and learning shared with staff. Learning from incidents was also fed back at the daily cross-site safety huddle meeting. Staff could access the briefing on the shared drive and add on information to be shared on both sites.

Incidents that trigged specific levels of harm went through an orange or red panel. Orange panel incidents were reviewed at divisional level and red panel incidents were reviewed at trust wide level. Incidents could be downgraded once they had been thoroughly investigated at the panel and learning was shared with staff.

Staff used an electronic system to report incidents. Staff were encouraged to report incidents, so that trends could be flagged and learnt from.

Most of the staff we spoke with were aware of the statutory duty of candour principles, however, some staff were less familiar with the principles. The accident and emergency department had a system to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. 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.

**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 February 2017 to January 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(*Source: NHS Improvement - STEIS*)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from February 2017 to January 2018.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with four (31% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (15% of total incidents)
- Slips/trips/falls meeting SI criteria with two (15% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (15% of total incidents)
- Apparent/actual/suspected self-inflicted harm meeting SI criteria with one (8% of total incidents)
- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with one (8% of total incidents)
- Medication incident meeting SI criteria with one (8% of total incidents)

(*Source: Strategic Executive Information System (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 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.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, 13 falls with harm and no new catheter urinary tract infections from March 2016 to December 2017 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Calderdale and Huddersfield NHS Foundation Trust**
Total falls (13)

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

There were a range of pathways that complied with the National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments. These aimed to promote early treatment and improve patient outcomes. We saw evidence of the sepsis pathway in use at the time of our inspection.

The department had a website called EM Beds which was used as a repository for the standard operating processes (SOPs), patient pathways, policies and guidelines in use across both hospital sites. The website had been designed in-house by a consultant working in the emergency department. It was regularly reviewed and updated by a member of the ED team who linked with the trust communications team to ensure any changes were updated. This ensured the most up to date information was available. New staff were able to access the website prior to commencing employment, so they could familiarise themselves with the way the department worked and the key processes and policies in place. Staff told us this was useful for locum and agency staff as well as new permanent members of staff. Staff were overwhelmingly positive about the SOPs in place, they stated that they helped them work consistently and effectively across both sites and there was no ambiguity around how something was undertaken as they SOPs were clear and could be picked up by anyone in the department and followed.

(Source: data request UEC35 EM Beds)

We saw evidence that NICE guidelines and RCEM best practice were discussed at meetings, including the quality improvement forum, so changes to guidance could be applied to systems and processes within the accident and emergency department.
The department also took part in national audits, such as those identified by the Royal College of Emergency Medicine. The department undertook local audits to review and improve practice, including mortality, x-rays and audits of under 1yr olds (infants) senior review.

**Nutrition and hydration**

Patients could access food and drinks. Sandwiches were always available on the unit and soup was offered at mealtimes by the housekeeper. Patients on the clinical decisions unit (CDU) could order a hot meal in advance of mealtimes. Dietary and cultural requirements could be accommodated in the food choices offered.

There were vending machines in the waiting areas. These offered hot and cold drinks and a selection of snacks. At the time of our inspection, the vending machines were stocked and in use.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey September 2016)

**Pain relief**

Staff used a pain score tool to assess if a patient had pain. Three different pain scoring tools were used in accident and emergency, so there were appropriate tools available for a diverse range of people, including children.

We saw evidence that pain scores had been recorded in the records we reviewed.

Pain relief was prescribed in a timely manner and recorded on the EPR, where applicable. Patients told us that they had been given pain relief when they had requested it.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey September 2016)

**Patient outcomes**

We saw that the trust had participated in national audits, such as those identified by the Royal College of Emergency Medicine. The results were used to benchmark and compare with other trusts nationally. There was a clinical audit lead in place for the department and they would lead on audit completion and compliance.

The trust undertook national audits alongside local audits, such as mortality, x-ray and under 1’s senior sign off reviews. The department also took part in trauma audits; the TARN trauma audits fed into the trauma group and trauma network and were jointly reviewed through the peer review process.

There were audit action plans in place to improve future outcomes across the local and national audit programme.
The trust had introduced the rapid assessment and treatment area to aid rapid assessment and undertake tests prior to the patient being seen by a doctor, to aid prompt diagnosis and treatment. There were plans to roll out this area at Calderdale Royal Hospital as it had benefitted the emergency department at Huddersfield Royal Infirmary in a positive way.

The department had a positive quality improvement programme. Staff told us about a quality improvement project undertaken by a registrar around paediatric wrist fractures which has now been developed into a new pathway to improve care for patients who must no longer have a plaster cast fitted.

The frailty team had a presence in the emergency department every day to work with elderly and frail patients who attended the department. The team used dashboards to monitor and review their performance.

Mortality was reviewed on the department by a middle grade doctor within 48 hours of the death and was reviewed by consultants in line with the trust policy. Mortality reviews were also shared at the quality improvement forum.

**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

The audit lead told us that an initial review of the RCEM asthma audit suggested significant deficiencies in recording vital signs and administration of steroids in the emergency department. First-hand experience of the emergency department senior team suggested that this was likely due to a flaw in the data collection process rather than a true picture of the outcomes. In order to ensure appropriate actions were undertaken a brief re-audit was undertaken to provide assurance that observations were undertaken, and steroids are administered.

20 patients diagnosed asthma in the ED at CHFT in Feb 2018. Review of notes demonstrated:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obs recorded on arrival</td>
<td>95%</td>
</tr>
<tr>
<td>Repeat Obs recorded within 1 hour</td>
<td>40%</td>
</tr>
<tr>
<td>Prednisolone administered within 1 hour</td>
<td>55%</td>
</tr>
<tr>
<td>Prednisolone administered within 4 hours</td>
<td>75%</td>
</tr>
</tbody>
</table>

This gave assurance that the key outputs from the RCEM audit were due to flaws in audit data capture. The trust planned to formally develop an action plan and re-audit to measure changes in data capture.

**Calderdale Royal Hospital**

In the 2016/17 Moderate and Acute Severe Asthma report, Calderdale Royal Hospital met the target for one of the seven standards:

- **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed according to guidelines.

Calderdale Royal Hospital was in the upper UK quartile for three standards:

- **Standard 1a:** O2 should be given on arrival to maintain sats 94-98%. Hospital: 72%; UK: 19%.
- **Standard 3:** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 40%; UK: 25%.
- **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed according to guidelines. Hospital: 100%; UK: 52%.

Calderdale Royal Hospital was in the lower UK quartile for three standards:
• Standard 2a: As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Hospital: 0%; UK: 26%.

• Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  o Standard 5a: within 60 minutes of arrival (acute severe). Hospital: 0%; UK: 19%.
  o Standard 5b: within 4 hours (moderate). Hospital: 0%; UK: 28%.

Calderdale Royal Hospital’s result for the remaining metric was between the upper and lower UK quartiles:

• Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 87%; UK: 77%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17
There was an action plan in place to improve results following the RCEM audit and plans to re-audit to measure whether actions taken had improved results.

Calderdale Royal Hospital
In the 2016/17 Consultant sign-off audit, Calderdale Royal Hospital failed to meet any of the standards.

Calderdale Royal Hospital was in the lower UK quartile for three standards:

• Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 5%; UK: 11%.
• Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Hospital: 0%; UK: 8%.
• Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 5%; 12%.

Calderdale Royal Hospital’s result for the remaining standard was between the upper and lower UK quartiles:

• Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 5%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17
There was an action plan in place to improve results following the RCEM audit. The department had re-audited in November 2017 which showed an improvement in results in standards: 1, 2, 3a, 3b, 4a, 4b, 5a and 7b. No change in standard: 6a and worse results in standards: 5b (78% to 70%), 6b 92% to 80%, 7a (29% to 20%) and 8 (27% to 0%). However for standard 8 the trust stated “NB for all patients that receive IV fluids EPR automatically initiates fluid balance measurement”.
### AUDIT OF RECM STANDARDS

<table>
<thead>
<tr>
<th>RCEM Standard</th>
<th>2016/17 National results</th>
<th>CRH ED 2016/17 51 CASES</th>
<th>CRH ED Nov-17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STANDARD 1</strong> Completion of observations. RR, O2 Sats, O2 Therapy, Temp, B/P, AVPU or GCS &amp; BM on arrival</td>
<td>100%</td>
<td>50% - 91%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>STANDARD 2</strong> Senior Review before leaving ED</td>
<td>100%</td>
<td>52% - 76%</td>
<td>76%</td>
</tr>
<tr>
<td><strong>STANDARD 3</strong> O2 was initiated to maintain Sao2 &gt; 94% (unless there is a documented reason not to)</td>
<td>50%</td>
<td>10% - 59%</td>
<td>30%</td>
</tr>
<tr>
<td>3a – 50% within 1 hour of arrival</td>
<td>50%</td>
<td>10% - 59%</td>
<td>30%</td>
</tr>
<tr>
<td>3B – 100% Within 4 hours of arrival</td>
<td>100%</td>
<td>11% - 60%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>STANDARD 4</strong> Serum lactate measured within 4 hours of arrival</td>
<td>50%</td>
<td>37% - 72%</td>
<td>25%</td>
</tr>
<tr>
<td>4a – 50% within one hour of arrival</td>
<td>50%</td>
<td>37% - 72%</td>
<td>25%</td>
</tr>
<tr>
<td>4b – 100% within four hours of arrival</td>
<td>100%</td>
<td>60% - 89%</td>
<td>59%</td>
</tr>
<tr>
<td><strong>STANDARD 5</strong> Blood cultures obtained</td>
<td>50%</td>
<td>25% - 62%</td>
<td>59%</td>
</tr>
<tr>
<td>5a – 50% within 1 hour of arrival</td>
<td>50%</td>
<td>25% - 62%</td>
<td>59%</td>
</tr>
<tr>
<td>5b 100% within 4 hours of arrival</td>
<td>100%</td>
<td>36% - 79%</td>
<td>78%</td>
</tr>
<tr>
<td><strong>STANDARD 6</strong> Fluids – first IV crystalloid fluid bolus (up to 30ml/kg) given</td>
<td>75%</td>
<td>25% - 57%</td>
<td>20%</td>
</tr>
<tr>
<td>6a – 75% within 1 hour of arrival</td>
<td>75%</td>
<td>25% - 57%</td>
<td>20%</td>
</tr>
<tr>
<td>6b – 100% within four hours of arrival</td>
<td>100%</td>
<td>59% - 89%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>STANDARD 7</strong> Antibiotics administered</td>
<td>50%</td>
<td>28% - 58%</td>
<td>29%</td>
</tr>
<tr>
<td>7a – 50% within 1 hour of arrival</td>
<td>50%</td>
<td>28% - 58%</td>
<td>29%</td>
</tr>
<tr>
<td>7b – 100% within 4 hours of arrival</td>
<td>100%</td>
<td>70% - 91%</td>
<td>88%</td>
</tr>
<tr>
<td><strong>STANDARD 8 – Urine output measurement/ Fluid balance Chart instituted within 4 hours of arrival</strong></td>
<td>100%</td>
<td>6% - 38%</td>
<td>27%</td>
</tr>
</tbody>
</table>

(Source: Data request UEC4 ED sepsis audit Nov 17)
Calderdale Royal Hospital

In the 2016/17 Severe sepsis and septic shock audit, Calderdale Royal Hospital was in the upper UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 77%; UK: 65%.

The hospital was in the lower UK quartile for three standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 65%; UK: 69%.
- Standard 4: Serum lactate measured within one hour of arrival. Hospital: 26%; UK: 60%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 20%; UK: 43%.

The hospital’s results for the remaining four metrics were all between the upper and lower UK quartiles:

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 30%; UK: 30%.
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 59%; UK: 45%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 29%; UK: 44%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 28%; UK: 18%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

Calderdale Royal Hospital

In the 2015/16 Vital signs in children audit, Calderdale Royal Hospital met the target for three of the six standards.

The hospital was in the upper England quartile for one of the fundamental standards and two of the developmental standards:

- Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 100%; England: 70%.
- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 100%; England: 73%.
- Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Hospital: 100%; England: 60%.

The hospital was between the upper and lower England quartiles for one fundamental standard and two developmental standards:

- Standard 1. All children attending the ED with a medical illness should have a set of vital
signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:

- Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 44%; England: 38%.
- Standard 1b (developmental). Capillary refill time. Hospital: 38%; England: 23%.
- Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Hospital 6.5%; England: 4.4%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Procedural sedation in adults 2015/16**

**Calderdale Royal Hospital**

In the 2015/16 Procedural sedation in adults audit, the hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the lower England quartile for four fundamental standards and two developmental standards:

- **Standard 1 (fundamental):** Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  - Standard 1a. ASA grading
  - Standard 1b. Prediction of difficulty in airway management
  - Standard 1c. Pre-procedural fasting status
    - Hospital: 0%; England: 7.6%.
- **Standard 2 (developmental):** There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Hospital: 10%; England: 52%.
- **Standard 3 (fundamental):** Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 41%; England: 90%.
- **Standard 4 (fundamental):** Procedural sedation requires the presence of all of the below:
  - Standard 4a. A doctor as sedationist
  - Standard 4b. A second doctor, ENP or ANP as procedurist
  - Standard 4c. A nurse
    - Hospital: 4%; England: 41%.
- **Standard 6 (developmental):** Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 12%; England: 41%.
- **Standard 7 (fundamental):** Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - Standard 7a. (fundamental): Return to baseline level of consciousness.
  - Standard 7c. (fundamental): Absence of respiratory compromise.
  - Standard 7d. (fundamental): Absence of significant pain and discomfort.
  - Standard 7e. (developmental): Written advice on discharge for all patients.
    - Hospital: 0%; England: 2.6%.

The hospital was between the upper and lower England quartiles for one fundamental standard:

- **Standard 5 (fundamental):** Monitoring during procedural sedation must be documented to have included all of the below:
  - Standard 5a. Non-invasive blood pressure
Standard 5b. Pulse oximetry
Standard 5c. Capnography
Standard 5d. ECG
Hospital: 10%; England: 24%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

Calderdale Royal Hospital

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit the hospital met one of the two audit standards

The hospital was in the upper England quartile for both of the standards:

- Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. Hospital: 100%; England: 100%.
- Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Hospital: 24%; England: 2%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From January 2017 and December 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5%, and consistently better than the England average.

In August 2017 the trust’s rate was 0%, which is almost certainly a data error. In December 2017, the trust’s performance was 7.2% compared to an England average of 7.9.

Unplanned re-attendance rate within 7 days - Calderdale and Huddersfield NHS Foundation Trust

(Source: NHS Digital - A&E quality)

Unplanned re-attendance rate within 7 days – Calderdale Royal Hospital
Data submitted after the inspection showed that Calderdale Royal Hospital had unplanned re-attendance rates of between 5% (February 2018) and 6.16% (May 2017) against a trust target of 5% over the year.

(Source: Data request UEC 6 & 7 - Copy of AE Indicators April to Feb 2018)

Competent staff

There was a dynamic clinical education programme in the department. The accident and emergency department employed a clinical practice educator. The clinical practice educator was supernumerary to the planned staffing on the unit, so was able to allocate their weekly hours to the training, development, coaching and mentoring of staff in the department. The clinical practice educator provided an outstanding approach to training, development and retention of staff on the unit.

New staff received a planned six week trust induction which included a two week supernumerary clinical training programme that was delivered in-house. The clinical nurse educator would work with staff that required additional support to ensure they felt confident and comfortable working in the accident and emergency department; this could include in-situ simulation training, support in resus or other areas of the department.

There was a bespoke emergency department safeguarding training programme run in-house. It was comprehensive, in-depth and covered all aspects of adult and children’s safeguarding.

The training programme was comprehensive and covered areas including: an introduction to ESR, oxygen competency, mental health, paediatric training, cannulation and venepuncture, caring for the dying patient, introduction to triage and minor injuries skills, paediatric life support, trauma, safeguarding, ECG training, blood transfusions, alcohol and drugs, organ donation, domestic abuse and MAJAX (major incident) and CBRN (chemical, biological, radiological and nuclear defence).

Band 5 nursing staff were given a ‘National Curriculum and Competency Framework - Emergency Nursing (Level 1) - June 2017’ workbook to work through and band 6 nursing staff were given a ‘National Curriculum and Competency Framework - Emergency Nursing (Level 2) - June 2017’
workbook. These books provided clear guidance and a comprehensive competency framework for staff to work to and be measured on.

New staff to the department received a new starters pack that outlined key contacts in the department, alongside important information and expectations of new staff.

New staff also completed a drug administration competency assessment to provide assurance that they were capable and competent at administering medicines to patients via different routes.

Band 6 staff received development pack which covered the role, key focuses, expectations, reviewing progress, an action plan to plot further development and what to move on to next.

Staff also undertook specific ‘TaRTS - Trauma and Resuscitation Team Skills’ trauma training, as there were patients who presented with serious trauma injuries, so staff were competent and able to deal with trauma injuries.

Appraisal rates
At the time of our inspection the trust provided updated appraisal data and explanation around rates below the 100% target. Where the rate is below 100%, this is attributed to new staff coming out of their probationary periods, staff returning from maternity leave and sickness. Members of staff have a date booked in for their appraisals to be completed. Three medical staff appraisals had also not yet been completed, but there was a plan in place to ensure that these appraisals were completed by the end of March 2018.

The updated figures showed an improvement on appraisal rates than the figures provided when the provider submitted their RPIR.

Staff we spoke to told us they received appraisals and found them useful. There were plans to further develop staff by introducing a cascaded approach to appraisals where appraisals would start with the matron appraising the band 7 staff, the band 7 staff would appraise the band 6 staff and the band 6 staff would then appraise the band 5 staff. This would provide development opportunities for staff at all levels and allow them to utilise management and coaching skills.

Appraisal rate for Emergency Care Directorate

<table>
<thead>
<tr>
<th></th>
<th>Appraisal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

Calderdale Royal Hospital

<table>
<thead>
<tr>
<th></th>
<th>Appraisal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>100.0%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>80.0%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>88.1%</td>
</tr>
</tbody>
</table>

Medical staff appraisal (work cross site)

<table>
<thead>
<tr>
<th></th>
<th>Number of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Appraisals</td>
<td>12 (75.0%)</td>
</tr>
<tr>
<td>Appraisals out of date due to sickness (rescheduled)</td>
<td>1 (6.25%)</td>
</tr>
<tr>
<td>Milestone for appraisals not yet completed – dates agreed</td>
<td>3 (18.75%)</td>
</tr>
</tbody>
</table>
From 1 April 2017 to November 2017, 86% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 100%.

A split by staff group and location can be seen in the tables below:

**Trust wide**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who have had an appraisal</th>
<th>Staff eligible for appraisal</th>
<th>Completion rate</th>
<th>Met trust target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>65</td>
<td>67</td>
<td>97%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>3</td>
<td>17</td>
<td>18%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>104</td>
<td>121</td>
<td><strong>86%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: data request UEC5 - Appraisals - supporting narrative)

Multidisciplinary working

The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There was a palliative care team that offered in-reach support and respiratory nurses could offer support with non-invasive ventilation (NIV) patients.
For paediatric patients that presented at the accident and emergency department there were close links with the paediatric wards at Calderdale and the accident and emergency department at Huddersfield Royal Infirmary, who would transfer paediatric patients to Calderdale when necessary.

We also observed excellent multidisciplinary working within the department. The frailty team worked in the clinical decisions unit and had access to therapists to aid patient recovery. Medical staff worked across emergency departments at both sites.

There were daily cross site safety huddles that were conducted via video link so both sites could take part and share issues and learning.

There was a paediatric liaison sister working across both sites to review all attendances of patients 17 years of age and under, staff told us they had an excellent working relationship.

Staff also worked with a domestic abuse support worker employed by another organisation and described them as ‘part of the team’.

**Seven-day services**

The accident and emergency department was operational 24 hours a day, seven days a week. The x-ray department facilities were in the department and could be accessed easily from the unit, 24 hours a day, seven days a week.

There was consultant cover in the accident and emergency department between 8am and 10pm on Monday to Friday on Monday to Friday and from 9am on Saturday and Sunday for between four to six hours. However there were not enough whole time equivalent consultants to staff a full weekend rota so this was undertaken on a voluntary basis. Outside of these hours, consultants were available on call. There were two middle grade doctors available in the department overnight.

There was access to medication for discharge seven days a week, 24 hours a day. Outside of the pharmacy operating hours the emergency department could dispense medication and the trust would collect prescription costs from the patient after discharge.

**Health promotion**

The accident and emergency department did not have any specific displays to promote health to patients; however patients were given information about their treatment and condition. There were a large number of leaflets to support this which were printed from the EM Beds website to ensure patients always received the most up to date leaflet.

There was a large display of leaflets, in collaboration with Macmillan, to offer support and advice on being diagnosed with cancer. These leaflets and booklets covered a wide range of cancer diagnoses and patients were able to take as many away with them as needed.

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

We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Some staff we spoke to understood the basic principles of the act and were able to explain how the principles worked in practice in the accident and emergency department. However not all staff we spoke to felt confident in treating patients with mental ill-health or capacity issues and we were not assured they fully understood all the principles of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards.

Staff had access to the principles of the Mental Capacity Act (MCA) 2005 on the EM Beds system which outlined the actions staff should take if they are assessing whether a patient has capacity. All staff had access to the EM Beds system.
We did not see any evidence of mental capacity assessments being completed. Two staff members stated that a doctor would carry out a capacity assessment if it was required. One member of staff stated that they would always imply consent when writing their notes for example ‘gave meds with consent’ but they would not carry out a specific capacity assessment with regards to this. We spoke to another member of staff and they said they used both implied and verbal consent, for example, when taking blood they would seek verbal consent from the patient to do so.

Staff undertook bespoke safeguarding training specific to the emergency department setting, this training covered consent in depth and assessing competence using the Fraser guidelines and Gillick competence guidance.

**Mental Capacity Act and Deprivation of Liberty training completion**
As part of a focus on the Mental Capacity Act, the trust had previously purchased MCA prompt cards and these were given to every member of staff across the trust.

The trust had introduced, as part of the essential skills framework for staff, specific Mental Capacity Act and Deprivation of Liberty training. Prior to this it was delivered as part of the mandatory adult safeguarding training and was within the trust E-Learning packages. As part of the Level 3 MCA/DoLS training, the training covered the Mental Health Act and how this is similar and different to the Mental Capacity Act.

Updated training results were submitted post inspection and showed that 68.48% of staff had undertaken Mental Capacity Act and deprivation of liberty safeguards training.

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>Additional Clinical Services</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical</td>
<td>33.33%</td>
</tr>
<tr>
<td></td>
<td>Estates and Ancillary</td>
<td>50.00%</td>
</tr>
<tr>
<td></td>
<td>Medical and Dental</td>
<td>58.82%</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery Registered</td>
<td>69.64%</td>
</tr>
<tr>
<td></td>
<td>Overall</td>
<td>68.48%</td>
</tr>
</tbody>
</table>

(Source: Data request UEC21 MCA DOLS training)

The trust reported that from April 2017 to November 2017, Mental Capacity Act (MCA) training has been completed by 72% of staff in urgent and emergency care.

Deprivation of Liberty training has been completed by 68% of staff in urgent and emergency care.

(Source: Routine Provider Information Request (RPIR))

**Is the service caring?**
Compassionate care
We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed. We observed a number of interactions between staff, patients and relatives. Staff were polite, respectful and professional in their approach. We observed staff responding compassionately to patients’ pain, discomfort and emotional distress in a timely and appropriate way.

Confidentiality was respected in staff discussions with people and those close to them.

Staff spoke about patients with mental ill-health in a respectful way and demonstrated a non-judgemental attitude.

Friends and Family test performance
The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was generally about the same as the England average from December 2016 to November 2017. The exception was May 2017, where the trust’s performance was noticeably worse than the England average.

In November 2017, the trust’s performance was 86%, compared to the England average of 87%.

A&E Friends and Family Test Performance - Calderdale and Huddersfield NHS Foundation Trust

Emotional support
There was a room for relatives to use if needed. There was support available for the bereaved from the chaplaincy service.

We observed staff supporting patients emotionally and providing assurance to anxious and distressed patients. Staff also told us they supported each other emotionally during difficult shifts and distressing events.

Understanding and involvement of patients and those close to them
Patients told us staff explained their care and treatment to them in a way they could understand. We observed staff communicating in a way that people could understand and was appropriate and
respectful. Patients and relatives told us they were kept informed of what was happening and understood what tests or treatment they were waiting for.

The department did not have a dedicated viewing room for patients who passed away in the department. The ambulance triage room had been used previously and most recently a room where a healthcare assistant was based was used. There was no access to any spiritual or religious materials that families using the room may require in these rooms. However, the staff could facilitate requests to wash and prepare the deceased, where families requested this due to cultural or religious beliefs. Staff had access to a book that outlined numerous cultural and spiritual beliefs and practices. They could familiarise themselves with the customs and traditions that may be requested if a patient was dying or passed away in the department, in order to honour cultural traditions after death.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG trusts</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The A&E department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day via the psychiatric liaison team. The psychiatric liaison team operated a 24 hour service across both hospital sites. They would attend the emergency department within an hour of receiving a referral, which is the trust target. Referrals to the psychiatric liaison team were made by telephone and all referrals were seen within the agreed timeframe, unless the referral was inappropriate, for example the referral was to provide support in the community and not at the hospital.

There was no separate room to assess patients with mental health needs. The area used at Calderdale Royal Hospital did not meet the RCEM guidelines for a suitable environment for dealing with mental health emergencies in the emergency department. The area used was cubicle 9 in the majors area and it was not free of ligature points. However there was a direct line of sight in to the cubicle from the staff station in the centre of the department. The trust had plans to undertake some work to refurbish a room in the department to make it suitable for use with patients presenting with mental ill-health.

The nearest section 136 suite was located on site at Calderdale Royal Hospital, however not in the emergency department and was managed by local mental health trust. A section 136 suite is a place of safety for patients detained under Section 136 of the Mental Health Act.

There was an alcohol liaison nurse that visited the emergency department daily and referrals could be made via the EPR system or on paper.

**Meeting people’s individual needs**

There were dedicated disabled toilets available in the department.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were never used for interpreting. It is best practice not to use family members for a number of reasons, including reliability of translation and patient confidentiality and staff understood this. We asked staff on both sites what their most requested languages were for translation and both sites answered with the same languages, which showed they understood the demographic of the local population.

The department did not have a viewing room for families of recently deceased patients, however they could facilitate requests from family members to wash and prepare the body in line with cultural, religious and spiritual beliefs.

On the wall outside of the paediatric waiting area, there was a display called ‘Ted’s Journey’. The innovative display showed pictures of Ted, a small soft toy, making his way around the A&E department with pictures of staff and Ted, in real life scenarios to help explain what to expect to children. The display was comprehensive and used pictures of Ted with real equipment and good
explanations as to what was happening which would help to allay any fears children may have of the ‘unknown’.

Young people who presented under the influence of alcohol or drugs would be referred to the local adolescent substance misuse service, if appropriate.

**Emergency Department Survey 2016**

The trust scored “better than” other trusts for all three of the Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey September 2016)*

**Access and flow**

The department had a rapid assessment ambulance triage room where patients arriving by ambulance would be taken. This meant that tests and assessments could be undertaken rapidly to aid the flow through the emergency department.

The department had a paediatric streaming service that was staffed by paediatric nurses between 1pm and 9pm, five days per week, when paediatric attendances were at their highest.

The directorate team had been working closely with colleagues in Local Care Direct to put in place a new referral criteria and a SOP for the emergency department staff to follow, to ensure that patients in the department were identified in a timely manner to ensure that all the Local Care Direct slots were utilised effectively. The new process is due to be rolled out in April 2018.

The accident and emergency department used emergency nurse practitioners (ENPs) in the minor’s area. Staff told us that this had helped identify and treat more minor injuries, resulting in better flow and greater patient satisfaction.

The trust held bed meetings three times per day. Representatives from the emergency department attended and flow through all departments was discussed. Breaches were discussed alongside bed issues to aid movement through the department.

There was a monitor in the waiting room that informed patients of how long they would be waiting to be triaged and how long it would take to see a doctor. The monitor also displayed how many patients had attended the department and helped to address patient expectations with regards to waiting times and time to treatment.

There was an admission avoidance team who worked with the emergency department in Calderdale. The team comprised of a senior middle grade doctor and a senior nurse. The team would review patients who would normally be admitted to hospital and decide whether they could be treated via outpatients with additional social support, if required.

The department had an emergency department tracker role that covered the department until midnight. The ED tracker could help chase test results, undertake administrative work to free up
the nurse in charge, answer the phones and book porters, therefore aiding flow through the department.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for seven months over the 12 month period from January 2017 to December 2017. In August 2017, the median time to treatment was 0 minutes, compared to the England average of 53 minutes. This could be a data issue.

In December 2017, the median time to treatment was 73 minutes, compared to the England average of 62 minutes.

**Ambulance – Time to treatment from January 2017 to December 2017 at Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing median time to treatment from January 2017 to December 2017 at Calderdale and Huddersfield NHS Foundation Trust.](source)

*(Source: Source: NHS Digital - A&E quality indicators)*

**Median total time in A&E per patient – Calderdale Royal Hospital**

Data submitted after the inspection shows that Calderdale Royal Hospital median time spent from arrival at A&E to treatment was under the target of one hour for two months out of an 11 month period, at its lowest at 49 minutes in January 2018 and its highest at 1 hour and 28 minutes in May 2017.

![Graph showing median total time in A&E per patient at Calderdale Royal Hospital.](source)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should
be admitted, transferred or discharged within four hours of arrival in the ED.

The trust met the standard three times from January 2017 to December 2017. The trust breached the standard nine times from January 2017 to December 2017. The trust's performance has, with one exception, been better than the England average.

**Four hour target performance - Calderdale and Huddersfield NHS Foundation Trust**

(Source: NHS England - A&E Waiting times)

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

From January 2017 to December 2017, Calderdale and Huddersfield NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average.

Performance against this metric showed a trend of improvement over the period.
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from January 2017 and December 2017, there were no patients that waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2017 (292) and February 2017 (171).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-17</td>
<td>292</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>171</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>93</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>59</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>82</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>59</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From January 2017 to December 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was, with the exception of August 2017, worse to the England average. The figure of 0% in August 2017 could indicate a data issue.

In December 2017, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 0%.
care services before being seen for treatment was 5.9%, compared to the England average which was 3.5%.

**Percentage of patient that left the trust without being seen - Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing percentage of patients leaving without being seen](image)

(Source: Source: NHS Digital - A&E quality indicators)

**Percentage of patient that left the trust without being seen – Calderdale Royal Hospital**

Data submitted after the inspection shows that the percentage of patients that left Calderdale Royal Hospital without being seen peaked at 8.46% in May 2017 and was at the lowest in April 2017 at 3.62% and January 2018 at 3.90%.

(Source: Data request UEC 6 & 7 - Copy of AE Indicators April to Feb 2018)

**Median total time in A&E per patient (all patients)**

From May 2017 to December 2017, the trust’s monthly median total time in A&E for all patients was, with the exception of August 2017, consistently worse than the England average. The figure of 0 minutes in August 2017 could indicate a data issue.
In December 2017, the trust’s monthly median total time in A&E for all patients was 176 minutes, compared to the England average of 159 minutes.

**Median total time in A&E per patient - Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing median total time in A&E per patient](image)

(Source: NHS Digital - A&E quality indicators)

**Total time in A&E per patient - Calderdale Royal Hospital 95th Percentile of time from arrival to Departure**

![Graph showing total time in A&E per patient](image)

(Source: Data request UEC 6 & 7 - Copy of AE Indicators April to Feb 2018)

**Total time in A&E per patient - Calderdale Royal Hospital 95th Percentile of time from arrival to Admission (Admitted)**
Total time in A&E per patient - Calderdale Royal Hospital 95th Percentile of time from arrival to discharge (Non-Admitted)

Learning from complaints and concerns

Staff told us that complaints made whilst patients were in the department would be handled by the nurse in charge. Where possible complaints would be dealt with in the department and staff would listen and try and diffuse the situation and resolve the issues. Staff told us that complaints were recorded on the electronic incident system, as this also helped to flag trends to managers and disseminate learning to staff. Staff who were the subject of patient complaints were encouraged to reflect on their practice and use it as a learning experience.

Complaints could be made via telephoning or emailing the trust the Patient Advocacy and Liaison Service (PALS) and staff told us that they made patients aware of this service when they wanted to raise a formal complaint. Staff told us that PALS would contact the lead nurse or matron with
concerns or complaints when these were raised. Complaints were investigated by the matron and directorate general manager.

Complaints and learning from complaints were discussed at the quality improvement forum on a regular basis. Themes were identified and learning cascaded to staff. We reviewed a report that detailed complaints from February 2018. We also reviewed a document that showed the learning from complaints and the actions taken by the trust.

**Summary of complaints**

From November 2016 to October 2017 there were 95 complaints about urgent and emergency care services. The trust took an average of 41 working days to investigate and close complaints, this is in line with their complaints policy, which states that whilst they have no additional target date, the trust is are guided by the 25 and 40 day targets.

There were 55 complaints for Calderdale Royal Hospital.

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

**Is the service well-led?**

**Leadership**

The emergency care directorate sat within the division of medicine, which was split in to five directorates.

The local directorate structure was as the below diagram shows:

![Emergency Care Directorate Diagram]

**Clinical Director**

**Divisional Accountable Officer**

**General Manager**

**Directorate Matron**

ED & CDU – HRI & CRH

Resus Team

**Operational Manager**

**Medical Teams/Nursing Teams**

Emergency Departments

Clinical Decisions Unit

Resuscitation Training Officers
A triumvirate of a clinical director, a directorate general manager and a directorate matron led the directorate of integrated medicine. The emergency department had a lead nurse who provided local leadership. The directorate matron provided strategic and managerial support for the emergency department and supported the lead nurse in the management of the department. This structure provided direct nursing and medical leadership.

The nursing and medical team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. Junior staff told us that they were well supported in their roles and had a clear understanding of their responsibilities. They said leaders were visible and approachable. Staff told us that senior managers were aware of the local challenges the department faced.

The directorate managers knew about the quality issues, priorities and challenges the division faced and worked collaboratively site-wide to try and deliver solutions and pilot new ways of working. We observed that managers were proactive and their positivity and motivation was inspiring.

The directorate leadership team demonstrated a clear approach to assessing and managing patient flow and safety within the emergency department. The lead nurses led a ‘safety huddle’ every morning and they discussed cross site issues using one template filled in by staff on both sites. This ensured messages and information were relayed with consistency, including staffing, complex cases and patient flow.

There was a clear commitment and focus by leaders to predict and respond to patient demand and flow issues within the emergency department, and this was supported by the other departments in the hospital, particularly around the management of medical and surgical outliers on the clinical decisions unit.

**Vision and strategy**

The trust had a clear vision and strategy that was quality driven and which looked to transform patient access to urgent and emergency care. There was a strong vision in place for transformation of the delivery of urgent and emergency services to the local population.

As part of the departmental vision and strategy for 2017/18, there were plans to implement a CESR Programme to mitigate middle grade doctor gaps and allow the trust to grow their own consultants. The leadership team told us the department was receiving training from Health Education England for 10 further middle grade doctors due to the consistently excellent results from the GMC survey. There was a focus on recruitment and workforce modelling, recruiting advanced clinical practitioners (ACPs) to mitigate low middle and junior doctor numbers. The trust was carrying out focussed recruitment for consultants and band 5 nurses, to attract high quality candidates to roles at the trust. Investment and recruitment of a clinical practice educator would help to ensure a competent, supported nursing workforce with on-going development opportunities. The trust were also working with the EPR team to improve reporting capabilities with the system.

The department also had an education strategy for emergency nursing with a focus on educating, developing and growing a strong and competent nursing workforce.

**Culture**

We found the culture of the accident and emergency department open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders. We asked staff about
the morale of the department and they all said that morale was generally good and they worked collaboratively as a team. Staff felt there were still some pressures around staffing, but the service had much improved since the last inspection and staff were proud to work there.

Staff felt supported in their work and there were opportunities to develop their skills and competencies, which was encouraged by senior staff.

Staff we spoke with wanted to provide effective care and treatment to patients and put patients at the centre of the experience. We observed staff working well together and there were positive working relationships within the multidisciplinary teams.

**Governance**

The accident and emergency department had governance, risk management and quality measures to improve patient care, safety and outcomes. The governance system supported the strategy and provided continuing assurance up to board level, with the clear focus on patient safety.

The governance structure was effective at providing a comprehensive governance framework to the department:

(Source: Data request UEC13 CHFT Emergency Department Governance Structure)
We reviewed the minutes from the quality improvement forums. The comprehensive agenda items were split into CQC domains such as safe, effective, caring, responsive and well-led. Items for discussion included: mortality reviews, x-ray audits, safeguarding, medicines management, infection prevention and control, training and development, sepsis, audits, NICE guidance, CQUINs, friends and family test, learning from incidents, complaints, initial assessment times, did not wait, RCEM best practice, paediatric forum and trauma network.

The department held regular meetings and we reviewed minutes from the emergency department sisters meeting (chaired by the matron), the emergency care network directorate board meeting, the cross site staff meeting and the paediatric emergency care forum.

We identified some issues around the governance of the recording, storage and management of controlled drugs, medicines and consumables in the department. Managers assured us that processes had been changed and checks would be completed on a daily basis. We saw evidence of daily checks when we returned on the well-led inspection and issues that had been escalated and remedied immediately, for example missing signatures. However we identified some further issues with the recording of controlled drugs and managers accepted that there was a need to provide additional training to staff in the department.

Management of risk, issues and performance

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. The leadership team were well sighted on the departmental risks and had plans in place to help manage and mitigate risks which were detailed on the risk register.

Incidents were discussed by senior management at their monthly quality improvement forum and learning shared with staff. Learning from incidents was also fed back at the daily cross-site safety huddle meeting. Staff could access the briefing on the shared drive and add on information to be shared on both sites to ensure a consistency in messages cascaded to staff.

The service undertook local and national audits to monitor and benchmark its performance at a local and national level. There were audit action plans in place to improve future outcomes across the local and national audit programme.

The service used dashboards which covered governance, quality and safety. We reviewed the integrated performance report which was made up of a series of dashboards covering the safe, effective, caring and responsive domains and benchmarked performance in key areas against other local trusts and the England average.

Information management

Staff were able to access patient information using an electronic system, EPR. Staff we spoke to was positive and engaged with the electronic patient record system. The accident and emergency department used an electronic system to track patients from presentation to discharge.

The department had an outstanding bespoke website called EM Beds that held all of the departmental policies, standard operating processes, leaflets, guidelines and pathways. Staff were able to access EM Beds internally and externally and they were overwhelmingly positive about its use. Documents held in EM Beds were updated regularly so there was always the most recent version available.

We observed good practice in relation to information security. Staff locked their computers and did not leave records open and unattended on screen.
Engagement

The accident and emergency department participated in the friends and family test and the NHS and CQC surveys.

In the past six months, the trust had initiated a number of measures to improve its engagement with local service users.

Work undertaken to increase engagement and involve the public had included:

- The department had involved patients in their governance meetings.
- The department won a trust Celebrating Success Award in 2017 with Team Lucy (care to a specific patient that attended emergency department).
- The trust planned to appoint a public engagement nurse for 15 hours a week and provided a job description for the role.
- Each emergency department had a ‘You said, We did’ board’ displayed for patients to see.

The emergency department team had completed a number of measures to increase its Friends and Family Test response rates and looked at the responses received which has since increased the percentage of patients that would recommend the service.

Following learning from a complaint, a member of the public came to talk to new starters regarding their experience in the emergency department and how they felt in whilst they were in the emergency department. This was used as an insight for staff to understand and empathise with patients who may attend the emergency department.

Learning, continuous improvement and innovation

The leadership had used some innovative approaches to recruiting and retaining new and talented medical staff to the accident and emergency department, including introducing a CESR programme to grow their own consultants from substantive middle grade doctors employed by the trust.

The trust had introduced a rapid assessment area. This has been introduced in to support ambulance turnaround times. At Huddersfield Royal Infirmary the trust had invested in a new six bedded area in the old plaster room to deliver this service. Ambulance turnaround times had improved the team were working with the local ambulance service to improve turnaround times further.

The department had an education strategy for emergency nursing with a focus on educating, developing and growing a strong and competent nursing workforce.

The department had successfully recruited to key roles to support the running of a high quality service. Roles recruited to included:

- Advanced Care Practitioners (ACPs) – The trust was successful in recruiting ACP’s at various stages in their training and had an educational strategy to support them joining the junior and middle grade doctors rota’s once qualified.
- Medical Training Initiative (MTI) – The trust had worked in partnership with the Deanery and had their first MTI in post with a second candidate in the recruitment process.
- Consultant – The trust had successfully recruited two new consultants into the department.
- Clinical practice educator – The trust successfully recruited a practice educator in the department ensuring a competent, supporting nursing workforce with on-going development opportunities.
The department had introduced trauma training, TaRTS training was in place supported by the clinical practice educator.

The trust had introduced safety huddles to support communication, patient and staff safety and pass on operational pressures to all team members. Safety huddles were held four times a day by medical staff and twice daily for the nursing staff. All groups of staff utilised a shared agenda to ensure consistency.

The directorate team had been working closely with colleagues in Local Care Direct to put in place a new referral criteria and a SOP for the emergency department staff to follow, to ensure that patients in the department were identified in a timely manner to ensure that all the Local Care Direct slots were utilised effectively. The new process is due to be rolled out in April 2018.
Facts and data about this service

The trust has 19 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Calderdale and Huddersfield NHS Foundation Trust and England

This trust

![Pie chart showing bed type distribution for this trust]

England

![Pie chart showing bed type distribution for England]

(Source: NHS England)

Huddersfield Royal Infirmary has one critical care ward; Ward HICU.

Calderdale Royal Hospital has one critical care ward; Ward CITU.

(Source: Routine Provider Information Request (RPIR))

The Calderdale Royal Hospital site has a combined intensive care unit (ICU) and high dependency unit (HDU). This provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care.

The unit has a total of five bed spaces with the capability to flex to six, including two single rooms. At the time of inspection the unit was funded for five beds. These flexed between level two and level three beds as required. Cross site there was a maximum capacity of nine level three and four level two patients. Staffing was dependent on the level of patient care and additional staff could be sent from the Huddersfield site if required.

A critical care outreach team provides a supportive role to the wards caring for deteriorating patients and support to patients discharged from critical care. The team is available seven days a week from 7.30am to 8pm.

The critical care service is part of the West Yorkshire Critical Care Network. Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 30 September 2017 at this site, there were 105 admissions with an average age of 55 years. Eighty four percent of admissions were non-surgical, 12% were planned surgical admissions and 4% were emergency surgical admissions. The average length of stay on the unit was two days.
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 trust set a target of 95% for completion of mandatory training. There were 12 mandatory training topics to be undertaken by all staff. Further staff training data was seen on site and requested after the inspection. Staff rotated between the units at Calderdale and Huddersfield; the training data below is for all 93 ICU and critical care outreach nursing staff as it could not be broken down by site. The training figures represent expected compliance rates by March 2018.

<table>
<thead>
<tr>
<th>Course title</th>
<th>Compliance by March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>93%</td>
</tr>
<tr>
<td>Data security awareness (Information governance)</td>
<td>96%</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>100%</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>87%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>98%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>98%</td>
</tr>
<tr>
<td>Health safety and welfare</td>
<td>98%</td>
</tr>
<tr>
<td>Infection control</td>
<td>95%</td>
</tr>
<tr>
<td>Manual handling</td>
<td>84%</td>
</tr>
<tr>
<td>Mental capacity</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding children</td>
<td>99%</td>
</tr>
</tbody>
</table>

In addition to the above training there were also role specific training modules to undertake, included in this was intermediate life support training. This had a target of 50%, compliance was 54% at the time of inspection and more staff were booked on to training courses later in the year.

During our inspection we saw the ‘productive ward’ database. This was available by department and was accessed via the trust intranet. This gave an overview of the unit’s mandatory training, clinical skills and specialist skills training. This was managed by the clinical educator for ICU.

Managers were aware that manual handling training was below the trust target. Four staff members had gained competence to provide this training. This meant they could train staff on the unit rather than then having to leave to attend training. It also meant the training was bespoke to ICU.

Training was provided on sepsis as part of other training courses such as intermediate life support and critical care competencies. For medical staff it formed part of their induction training.

We requested mandatory training data for consultants working in ICU. Again this could not be provided per site as staff worked across both sites. Compliance was just below the trust target of 95% at 94% in all areas with the exception of infection control.

Safeguarding

Safeguarding training completion rates

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for...
nursing staff in critical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Course title</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>62</td>
<td>72</td>
<td>86.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>7</td>
<td>19</td>
<td>36.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>5</td>
<td>19</td>
<td>26.3%</td>
<td>No target</td>
</tr>
</tbody>
</table>

We were provided with more recent safeguarding training data following the inspection. The data could not be broken down by site as staff rotated between the ICU at Calderdale Royal Hospital and Huddersfield Royal Infirmary.

Adults and children’s safeguarding training compliance for the 93 nursing staff exceeded the trust target of 95%.

We requested data on medical staff training compliance for adults and children’s safeguarding this was just below the trust target at 94%.

Trust protocols and guidance on safeguarding were easily accessible and staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. There was also a safeguarding team who were available for advice, as well as safeguarding champions in the unit. Senior nurses reported feeling confident that staff would escalate any concerns. We were given a recent example of a situation where concerns had been identified and appropriate action had been taken.

**Cleanliness, infection control and hygiene**

Ninety five percent of nursing staff and 88% of consultants had completed infection control training against a trust target of 95%. Seventy two percent of nursing staff had completed infection control ‘beyond the basics’ training, this training was undertaken every two years but had no target attached. Seventy eight percent of nursing staff had also completed training on aseptic non-touch technique. This training only needed to be completed once, there was no target attached to this.

Hand hygiene points were at the entrance to the unit with signs encouraging its use. Infection control information was displayed to staff and visitors on the unit. The latest information was from January 2018 which showed hand hygiene was 100%, the units cleaning score was 99% and the units environment audit score was 91%.

All areas on the unit were visibly clean, tidy and free from clutter. There was a cleaning schedule for the unit and the bedside charts included daily checks on bed space cleaning. Hand wash facilities were available in each bay and alcohol gel was available at every bed space. There were appropriate waste segregation and disposal systems in place.

We observed staff interactions with patients and found they were compliant with key trust infection control policies, for example, hand hygiene and the use of personal protective equipment (PPE). The unit had facilities for respiratory isolation.

Intensive Care National Audit and Research Centre (ICNARC) data showed there had been no unit acquired infections in blood per 1000 patient bed days between 1 April and 30 September 2017. This was better than similar units. For the same time period there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA) or *clostridium difficile*.
Environment and equipment

The unit was a purpose build 5 bedded unit; access was via intercom with a security camera. At the time of our inspection there were five beds in use with access to single rooms as required.

The unit was spacious and compliant with health building notice (HBN) 04-02. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance. To maintain patients’ privacy the bed spaces were separated by curtains.

There was adequate equipment in the unit to meet the needs of patients. There was a rolling programme for equipment replacement including beds and ventilators. Specialist equipment was available for patients with a high body mass index (BMI) when required. We checked 20 pieces of equipment for evidence of in date electrical testing stickers. We found these to be in place and in date on all the equipment checked.

Training for new equipment introduced to the unit was provided by the manufacturer, then cascade training was utilised. Equipment training was part of role specific training and recorded on the productive ward training database. This included equipment such as ventilators and hemofiltration.

Resuscitation equipment was centrally located on the unit. We inspected resuscitation equipment and found that from August 2017 to March 2018 monthly checks had been completed. However the tamper proof seal was not signed on the trolley itself. This meant staff could not be fully assured that items had not been removed between the monthly checks.

We also observed a weekly resuscitation equipment checking sheet which had only been completed on the 26 February 2018 and a daily defibrillator check which had not been completed since the 15 January 2018.

The weekly checklist for the transfer ventilator had not been completed since 23 December 2017. We checked the contents of the transfer bag. There was a laminated sheet to show what should be contained however no records of checks were undertaken. This meant staff could not be assured all the contents were present and ready for use in an emergency. During our checks we found that the pneumothorax kit was past its expiry date.

We spoke about the different checklists and with staff during our inspection. We were told the documentation would be reviewed and any changes shared with the team.

Assessing and responding to patient risk

The critical care outreach team (CCOT) provided cover seven days a week from 7.30am to 8pm at Calderdale Royal Hospital. Overnight cover was provided by the hospital out of hours programme (HOOP) team. At the previous inspection in 2016 it was identified that handover and sharing of information between the two teams could be improved. During this inspection we found there was a standard operating policy (SOP) in place with a handover checklist. This ensured the HOOP team were aware of those patients who may deteriorate, or those who had been unwell during the day. The CCOT told us information sharing between the teams was more effective and concise and it took place at dedicated times.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They also reviewed patients who were discharged from ICU to ward areas.

The trust used the national early warning score system (NEWS) as a tool for identifying deteriorating patients. There was a clear escalation policy in place for when patients had an elevated NEWS score.
The wards had an electronic system for recording patient observations. This allowed the CCOT to remotely view any patients with elevated NEWS scores. This system had key information that could be inputted about the patient such as past medical history and current concerns, which gave the team an overview of the individual patient. Since the implementation of electronic patient records (EPR) the CCOT told us (and showed us on the system) that ward staff were no longer inputting the key information alongside the patient observations and NEWS scores. Whilst the information could be extracted from the EPR system it was not as quick and readily available.

We were provided with the draft terms of reference for the deterioration, recognition, response and prevention programme group. The purpose of this group was to improve patient outcomes with regards to the various aspects of deteriorating conditions. We were told real time audit data was to be collected from February 2018 on the response and treatment for patients with an elevated NEWS score of five or more. We requested details of this audit data but the trust did not provide it.

During our time on the unit we sat and observed care at the nurse’s station. For a period of just over an hour we observed a level three patient left unattended on five occasions for between one and three minutes. Whilst there were other staff close by with other patients we did not see that it was clearly communicated to them that the nurse was going to leave the bed area. Guidelines for the Provision of Intensive Care Services 2015 (GPICS) states level three patients require a minimum nurse to patient ratio of one to one care.

We observed staff complete daily bedside safety checks for each patient. Staff completed relevant risk assessments and care bundles, for example, venous thromboembolism (VTE) and intravenous devices. These were completed in the four sets of records we reviewed.

The EPR included a screening tool for sepsis. This would flag automatically for a patient on the wards if they had a NEWS of five or more. Sepsis care and treatment bundles were in place and we found evidence of this in the records we reviewed. However we did find it difficult to locate them in patient records. Some staff also commented that not everyone knew how to access the screening tool within the EPR.

Sepsis data was collated in the department’s quality and performance report. It was also noted in the September 2017 report that the EPR screening prompts were causing some confusion, and whilst screening was occurring, the evidence was not being captured in the correct part of the EPR. In response to this a clinical working group looked at this issue and shared the correct process at the sepsis group.

Data from quarter two in 2017 showed the division of surgery and anaesthesia, of which ICU was part, was not achieving the 90% target for timely screening and treatment of sepsis.

- 19% Eligible patients were screened for Sepsis in Emergency Admissions and 6% Eligible patients screened for Sepsis Inpatients (LOS >0).
- 82% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Emergency Admissions.
- 86% of patients with severe red flag/ septic shock that received IV antibiotics < 1hr in Inpatients (LOS >0).

There were also some gaps where data had not been collected, for example in August and September 2017. The division was part of the sepsis improvement group and received weekly updates on compliance to enable targeted work to be undertaken. We asked the service leads about sepsis; they stated the EPR was creating some challenges and processes were taking time to become embedded.
The unit did not accept paediatric admissions. The anaesthetist or consultants would attend in an emergency and stabilise the patient until the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Staff we spoke with knew how to access the mental health liaison team and told they responded in a timely way to any referrals.

**Nurse staffing**

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate in critical care of 0.4%. The trust did not provide a vacancy target percentage. More recent data provided on site gave a vacancy rate within critical care of 3.13%.

(Source: Routine Provider Information Request (RPIR))

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate in critical care of 4%. The trust did not provide a turnover target percentage.

(Source: Routine Provider Information Request (RPIR))

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate in critical care of 6.4%. This is higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR))

**Bank and agency staff usage**

Data from September 2017 to February 2018 showed that a total of 37 shifts were covered by agency staff. This met the GPICS standard of units not utilising greater than 20% of registered nurses from bank or agency on any one shift, when they are not the units own staff.

From November 2016 to October 2017, the trust reported a bank and agency shift total of 351 in critical care for qualified nurses. There were also 49 qualified nursing shifts not filled.

A breakdown of bank and agency staff by staff type is shown in the table below:

<table>
<thead>
<tr>
<th>Bank/agency/unfilled</th>
<th>Nursing Assistant</th>
<th>Qualified Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>0</td>
<td>118</td>
<td>118</td>
</tr>
<tr>
<td>Agency</td>
<td>1</td>
<td>233</td>
<td>234</td>
</tr>
<tr>
<td>Not filled</td>
<td>7</td>
<td>49</td>
<td>56</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Nurse staffing was based on guidance and standards from D16 NHS standard contract for adult critical care and GPICS. Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients' ratio for level two patients.
At this site there was no supernumerary co-ordinator, this was in line with GPICS standards as the unit had less than six beds. The guidance suggests in such units to consider having a supernumerary co-ordinator for peak periods such as the early shift, however this was not in place. Between the two sites there would always be a band seven nurse working Monday to Friday.

The nursing handover was led by the nurse in charge who then allocated staff to patients to ensure continuity of patient care and skill mix was considered. Nurses then completed a one to one handover at the bedside.

Planned and actual staffing numbers were displayed. Planned staffing levels for the unit was four nurses and one health care support worker during the day and four nurses at night.

Nursing staff rotated across both sites. Electronic rostering was in place which incorporated the safe care staffing tool. One rota was produced which covered both sites. This was managed by one of the band seven sisters.

One key aspect of creating the staffing rota was the system for managing annual leave. This was done with a spreadsheet which all staff could access, which calculated how much annual leave could be taken each week. This meant that annual leave was spread throughout the year and stopped too many staff being on leave at once which would result in difficulty in covering shifts.

There was also a spreadsheet for managing staff sickness. Senior nurses reported good support from human resources as well as a raised awareness amongst staff about sickness management.

We viewed eight weeks of staffing rotas. When the rotas were produced there were 34 unfilled shifts. These shifts were covered by bank staff, existing staff working additional hours or the movement of staff from the Huddersfield site.

A change in ICU staffing had been introduced which positively impacted nursing staff. If there were empty beds and not all staff were required, historically staff would be moved to support the wards. This had changed and nursing staff were given the option to go home rather than be moved to a ward area. This flexible approach to staffing meant at busier times staff who had chosen to do this could be brought in to work to provide additional support.

The previous inspection highlighted a high vacancy and staff turnover rate. A significant amount of work had been done to improve this. This included reviewing information from exit interviews and providing additional support for newly qualified nurses. As a result of this work the staff turnover rate had reduced from 20% in 2016 to 3% in January 2018.

The critical care outreach team (CCOT) consisted of seven staff who worked cross site. With one nurse on each site seven days a week from 7.30am to 8pm. Data provided by the trust showed that there was only one shift from September 2017 to February 2018 where the CCOT were unavailable due to staffing shortages. There were escalation plans in place if this happened.

The CCOT were identified on the divisional risk register as any sickness could significantly impact the service due to the size of the team. The situation was monitored on a daily basis with additional support available from anaesthetic staff. The hospital had a central venous access devices (CVAD) team who had recently had a staffing uplift of two whole time equivalent staff. This team supported the CCOT by undertaking tasks relating to the care and management of central lines. This helped reduce some of the workload on the CCOT.

**Medical staffing**

Critical care had a designated clinical lead. Since the last inspection a further consultant post had been appointed to and it was hoped that by April 2018 this would allow for a change in rota which
would then meet GPICS standards. At the time of inspection the standards of care must be led by a consultant in intensive care medicine; a consultant in intensive care medicine must be immediately available twenty four hours a day, seven days a week; and, consultants must be freed from all other clinical commitments when covering intensive care, were not being met.

It was also identified that consultant work patterns at Calderdale did not provide continuity of patient care as block working was not in place. This did therefore not meet GPICS standards.

We discussed this with the service leads as this had been noted at the previous inspection and had been on the divisional risk register since 2015. The team recognised that there was now increased demand at the Calderdale site. This was due to a reconfiguration of services which meant patients with respiratory problems were cared for at this site.

The team felt confident the new consultant appointment would help support the changes needed to meet GPICS standards and that ongoing monitoring would continue. However they acknowledged progress had been slow as significant changes needed to be made.

In the four patient records we reviewed we saw that daily consultant led ward rounds took place in line with GPICS standards. The consultant to patient ratio did not exceed the recommended 1:8 to 1:15.

From September 2017 to February 2018 there had been no use of medical locums in critical care.

**Records**

Since the last inspection electronic patient records (EPR) had been introduced. Within ICU there were still some nursing paper records in use such as nasogastric tube management plans and hemofiltration observation charts, which led to some duplication of records. This was on the divisional risk register with assurance processes in place to reduce the impact of the risk.

The ICU observation charts were also paper based. The electronic system for recording observations was not used on the unit, however once a patient was ready to transfer to a ward their most recent observations would be added to the system.

The paper records were stored securely in trolleys at the end of each bed. Information provided by the trust showed 96% of nursing staff and 94% of medical staff in the service had completed information governance training against a target of 95%.

Mobile computers were used during ward rounds to record discussions and treatment plans.

We reviewed four sets of nursing and medical records in detail with the help of a member of staff to help navigate the EPR. We looked at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Medical records were completed in line with trust and professional standards. There was evidence of consultant review on admission to critical care and daily review from the multidisciplinary team.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital.

The physiotherapy team completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness) requirements during a patient’s stay in critical care.

The critical care module for the EPR had not been purchased by the trust. This was why some paper documents were still used. Some adoptions had been made to the systems in terms of where information was recorded to make it more user friendly and easy to access for ICU patients records. Staff were generally positive about the transition to EPR. The ability to review patient
information remotely was a benefit for the outreach team and when looking at potential admissions to the unit.

**Medicines**

There were electronic and paper prescription charts in use. The ICU specific infusions and medicines were on paper prescriptions. Staff on the unit told us they were used to having two prescription charts for patients, as ICU specific drugs had always been on separate charts, so no concerns were raised about this.

We reviewed incident data from December 2017 to February 2018 and found no incidents related to a dual system being in place. The risk was also identified on the divisional risk register; through reviews and training the risk has been reduced.

We reviewed four electronic prescriptions and found them to be fully completed. Prompt systems were in place on the EPR when antibiotics were prescribed to ensure course duration and review date was entered. However when we reviewed the paper prescription charts for the same four patients we found a number of gaps and omissions. For example, the allergy status was not completed on one chart, there were eight infusions with a second signature missing and there were four infusions with the drug batch number not recorded.

We observed information on a staff notice board from January 2018 on an EPR audit. This highlighted the unit had not performed well with regards to second signatures for intravenous drugs being administered. We were not aware of any specific plans to address this.

Regular monthly audits took place asking six questions around fridge temperature recording, controlled drugs and the storage of medicines. We were provided with data from January 2017 to February 2018. The data showed a decline in performance in four of the areas from December 2017 to February 2018. These related to; daily checks of controlled drugs, in the month of December 2017 these had been completed 67% of the time, this had further dropped to 50% in February 2017; medicines being in date, medicines being kept locked and bedside medicine cabinets being locked.

In response to this audit data there was a focus on medications stored at the patient’s bedside and controlled drugs with information shared with staff. During our inspection we found stock medicines within the unit were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records and saw that daily balance checks had been completed in line with the trust policy during March 2018 up to the time of the inspection. Audits were also completed by the pharmacist every six months.

Training was provided on medicines management and the safe use of insulin. Training compliance figures at the time of inspection were 96% and 99% respectively.

Microbiology input could be accessed however attendance at the multidisciplinary ward round was variable.

**Incidents**

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 February 2017 to January 2018, the trust reported no incidents classified as never events for critical care.
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from February 2017 to January 2018.

The unit at Calderdale reported 15 incidents between December 2017 and February 2018. Twelve of these were graded as green (no harm/near miss) the remaining three were graded as yellow (low harm). The yellow incidents all related to pressure damage. There were no incidents reported with moderate or severe harm.

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. However none could give an example of a recent incident they had reported. With the small number of incidents reported by the unit we lacked some assurance that all incidents and near misses were being reported.

There were various systems in place to feedback learning from incidents. Face to face feedback, either on an individual basis or at team meetings was given. Information was also sent via email.

We saw the ‘bite-sized’ learning file which contained brief summaries on a number of different topics and what learning or action was taken. For example infection control issues and what to do in response to an unwitnessed fall.

We also observed information displayed in staff areas on learning from specific incidents. This was information on a page about the incident trigger, conclusions, root cause and lessons learnt. The staff we spoke with were aware of the one displayed during our inspection which related to pressure damage and could told us about the importance of documentation following this incident. We were not provided with any other examples of incidents or learning from staff on the unit.

The electronic incident reporting system included a prompt on the duty of candour. This 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. We saw information displayed in general areas on the duty of candour. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

We reviewed the learning from deaths policy this outlined the mortality review process. This included a standard operating policy (SOP) which detailed the specialty specific initial mortality initial screening review process, which included critical care. The policy stated all reviews must take place within four weeks and any that scores one or two would be subject to a structured judgement review.

There was a four tiered process to mortality reviews which included a trust wide mortality surveillance group, divisional, team and individual levels.

At divisional level, any deaths that were incident reported were reviewed at the divisional orange panels and divisional patient safety and quality board (PSQB).

Medical staff told us mortality and morbidity was sometimes discussed at monthly audit sessions, however this would not always be just ICU patients. We reviewed several meeting agendas and minutes and saw that mortality and morbidity was not always discussed and that is was not specific to critical care. This was not in line with GPICS standards.
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.

Data from the Patient Safety Thermometer showed that the trust reported 11 new pressure ulcers, no falls with harm and no new catheter urinary tract infections from March 2016 to December 2017.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing prevalence rate of pressure ulcers](image)

(Source: NHS Digital)

We did not see safety thermometer data displayed on the unit. Staff told us since the implementation of EPR they were not sure if this data was still being collected.

Safety information was displayed on the ward information board which included information on the last fall and pressure ulcer on the unit. However we lacked assurance about the data on this as it stated the last pressure ulcer was in December 2014. Incident data showed there had been two pressure ulcers in January 2018 and one in February 2018. We therefore lacked assurance that staff were aware of up to data safety performance within the unit.

We reviewed safety thermometer data for the unit which was variable this was due to the number of beds on the unit. We reviewed data from January 2017 to January 2018, the percentage of harm free care varied from 0% to 100%.

Is the service effective?

Evidence-based care and treatment

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Policies and guidance were accessed on the trust intranet which was easy to navigate. We reviewed ten polices and found them to be in date with an author and version control. At the previous inspection a number of out of date paper copies of guidelines were found on the unit. We did not find this during this inspection. For example in the reference file for the use of bridles and mittens the protocols within it were current.

The trust was part of the West Yorkshire Critical Care Operational Delivery Network (WYCCODN). This group met six times a year to representatives from each trust in the network. They shared...
and reviewed critical care specific guidance from their units. This included areas such as pain, sedation, delirium, prone positioning and nutrition.

Each area was marked against a standard framework and given a score. The unit with the highest score shared their guidance with the rest of the group. If it was identified that there was a particular area or topic for which there was not guidance available, the group would develop some.

Within the WYCCODN group it was identified that the trust was not fully compliant with the ventilator associated pneumonia (VAP) care bundle as sub-glottic suction endotracheal/tracheostomy tubes were not routinely used. There were plans in place to trail some tubes and it was expected the unit would be compliant by May 2018.

We saw evidence of screening for delirium in the four records we reviewed in line with NICE guidance. This was also included on the ICU chart as a daily reminder for staff.

The physiotherapy team delivered care on the unit in line with NICE CG83 rehabilitation after critical illness.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in the four patient records we reviewed.

The unit had an emergency feeding protocol in place. This provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

Ninety two percent of staff had completed training in nasogastric tube competency and 55% of staff had gained competency to insert nasogastric tubes.

We found that nasogastric tube management plans were duplicated, as there were paper copies and records within the EPR. However we found these to be both completed and updated.

There was access to a dietitian however they would not attend the ward each day. Staff told us if a referral was sent they would come and review patients. There were no plans to increase the level of dietetic input at this site.

During our inspection we saw that water was available for those patients able to drink and assistance was given with meals as required for those able to eat. Fluid balance charts were fully completed in each of the four records we reviewed.

**Pain relief**

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was reviewed as part of the ward round.

From the notes we reviewed we found evidence of pain scores being done and appropriate action taken in response to any indicating a patient was experiencing pain.

The patients and relatives we were able to speak with reported pain control being effective.

We were provided with a pilot ward assurance tool which had been implemented since the launch of EPR. There were five questions in this related to pain management, such as had pain scoring being completed and are there care plan in place. Data collection had started in September 2017. Results had been variable during this time with some months scoring 100% in each area, some scoring between 60% and 80% and some gaps where data was not collected. These issues were being addressed through a task and finish group.

**Patient outcomes**
The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. More recent quarterly data may be available online. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

For the Intensive Care Unit at Calderdale Royal Hospital, the risk adjusted hospital mortality ratio was within expected limits in 2016/17.

We reviewed data from the 1 April 2017 to 30 September 2017 quarterly quality report, this showed the risk adjusted hospital mortality was 0.97, this was within the expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC))

For the Intensive Care Unit at Calderdale Royal Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was within expected limits for 2016/17. We reviewed data from the 1 April 2017 to 30 September 2017 quarterly quality report, this showed the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.76, this was within the expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICNARC data from the same period showed the unit had an unplanned readmission in 48 hours rate of 1.4%. This was in line with similar units’ rate of 1.3%.

We spoke with the critical care outreach team about data they collected. Staffing within the team meant that whilst the clinical responsibilities could be covered there was no allocated time for additional tasks such as audit. We requested data on the national critical care outreach activity outcome data set. This included 19 areas of data collection, such as the number of cardiac arrest calls and the number of individual patients referred to the CCORT. Some data was being collected, for example by the site coordination team and the resuscitation team. Other data was contained within the electronic patient observation record. However this information was not being collated to provide an overview of the activity and performance of the team.

The physiotherapy team completed a national rehabilitation outcome measure called the ‘Chelsea Critical Care Physical Assessment Tool’, a scoring system to measure physical morbidity in critical care patients.

Competent staff

Appraisal rates

From April 2017 to November 2017, 96.3% of staff within critical care had received an appraisal, compared to a trust target of 100%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Number of staff members who have received an appraisal (YTD)</th>
<th>Number of staff required to receive an appraisal (YTD)</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>--------</td>
</tr>
<tr>
<td>Qualified Nursing Staff</td>
<td>69</td>
<td>72</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We requested appraisal data for medical staff. This showed that 84% had undergone a recent appraisal. However we did find that 33% of those had taken place more than 12 months since their last appraisal.

Information provided by the trust showed that 61% of nurses in the service had a post registration award in critical care nursing. This was a significant improvement from the last inspection where it had been 39%. This met the GPICS minimum recommendation of 50%.

A trust wide and local induction was completed by all new staff. There was an eight week preceptorship programme in place and new staff would be allocated mentors to work alongside.

Staff on the unit were working to complete the national competency framework for adult critical care nurses. Information on progress with this was captured in the productive ward database. Also included in this was compliance in areas such as transfer training, specialist tracheostomy and airways training, and supporting learning in practice (SLIP) training. The unit had introduced development days for staff to attend each year where this additional training would be provided.

The clinical educator had oversight of all training and managed the database. At the previous inspection there had been 1.5 whole time equivalent (wte) clinical educator in post to support the number of newly qualified staff to the service. At this inspection this had been reduced to one wte as staff retention had significantly improved.

The clinical educator provided cross site cover and worked flexibly depending on which site staff were working who required support.

We spoke with staff who were relatively new to the unit who told us they felt well supported. We spoke with some staff who had worked on the unit for over ten years. They did not feel that their educational needs were valued as much as those of new staff. However the trust had developed an education and training strategy and we were provided with a copy of this. In this document were career development and personal development training pathways for each grade of staff. It was also stated the amount of time and funding which the trust agreed to support for different types of training.

We spoke with the CCOT who also felt their educational needs had not been an area of focus. At the time of the previous inspection they were delivering training for staff this was no longer the case. The team were also concerned that competency assessments for the team were not in place.

The team were keen to address this although current capacity within the team meant there was no allocated time for this. The team had completed a gap analysis against National Outreach Forum (NOF) and WYCCODN competencies and standards. We were provided with a copy of this following the inspection. This identified 23 standards of partial compliance and 10 standards of none compliance. These were all focused around education, training and development within the team. This information was due to be presented to the senior management team.

**Multidisciplinary working**

Staff we spoke with told us, and we observed good multidisciplinary team working. We saw evidence of this in the four patient records we reviewed. There was access to speech and language therapy, a specialist nurse in organ donation and other nurse specialists when required.
There were clear internal referral pathways to therapy and psychiatric services. Multidisciplinary staffing was generally in line with GPICS standards; however, it did not meet the full recommendations. There was not always full attendance during ward round however we saw from reviewing records there was daily input from the pharmacy and physiotherapy team. Microbiology and dietitian input was variable. However they were available as needed, but this may have been by telephone rather than in person. This was also seen in the patient records we reviewed.

We reviewed the units’ admission and discharge policy. This had recently been updated and clearly outlined the criteria for admission to the unit. We observed handovers taking place and the completion of transfer documents for patients going to ward areas. This was in line with NICE CG50 acutely ill adults in hospital.

**Seven-day services**

We saw from patient records daily consultant led ward rounds took place. A consultant in intensive care medicine was available during the day. However, as discussed in the medical staffing section, out of hours the service was not compliant with GPICS standards. It was hoped the service would soon be in line with GPICS standards when rotas were reviewed.

A pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients’ medicines. There was access to pharmacy provision on call at other times.

Physiotherapists provided treatment seven days a week with an on-call service was available overnight.

X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

**Health promotion**

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

The unit had developed partnership working with improving access to psychological therapies (IAPT), as part of critical care follow up clinic.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust has not provided any targets for the completion of Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for nursing staff in critical care at the hospital is shown below:

<table>
<thead>
<tr>
<th>Course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD MCA &amp; DoLS Level</td>
<td>2</td>
<td>5</td>
<td>19</td>
<td>26.3%</td>
</tr>
<tr>
<td>----------------------</td>
<td>---</td>
<td>---</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>Grand Total</td>
<td>52</td>
<td>72</td>
<td>72.2%</td>
<td>No target</td>
</tr>
</tbody>
</table>

MCA training had been completed by 88.7% of nursing staff in critical care and DoLS training by 26.3% of staff. The trust had not set targets for either of these courses. Further data was received following the inspection which showed training compliance on mental capacity for nursing staff across both sites was 90%. Eighty eight percent of medical staff were compliant with training in mental capacity.

It was recognised that gaining consent within the unit could be difficult due to the patients they cared for. However staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients.

In the records we reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. This are used to measure the agitation, sedation or delirium levels of a patient. We saw that where appropriate these had been completed and appropriate actions taken.

We spoke with staff about the use of restraint. Staff told us where possible this would be avoided, however staff were clear about the process they would follow for the use of restraint and where they would document this. There was a file on the unit with up to date polices and care plans, as well as information on consent and best interest decisions. If restraint was required a patient’s mental capacity would be assessed and regularly reviewed. We saw evidence of this in one of the sets of notes we reviewed where restraint was being used. An Independent Mental Capacity Advocate (IMCA) had been involved in the decision to represent the views of the patient.

### Is the service caring?

**Compassionate care**

We observed all members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious and unconscious.

Staff maintained patients’ privacy and dignity when care and treatment was being delivered by pulling curtains round.

All the patients and relatives we were able to speak with were very complementary about the care they had received from staff. High praise was given for the team.

We did not see thank you cards displayed however we were told the ward clerks collected them each month and they were shared with staff.

**Emotional support**

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. We saw various contact cards on the nurses station.

The critical care outreach team said part of their role when reviewing patients on the ward following discharge from the unit was providing psychological support.

Staff we spoke with felt able to provide support to relatives as well as to patients and felt this was an important part their role.
Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life.

At the time of the inspection patient diaries were being completed for some patients. Evidence has shown these can provide comfort for patients following a stay on an ICU as they can fill in gaps and help patients understand what they have experienced. The involvement of families can also have a positive influence. If completed patient diaries were shared at the follow up clinic.

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

Staff we spoke with told us about the use of advocates and involving carers and relatives to aid communication. There was evidence of patient and family involvement in the records we reviewed. Relatives reported a flexible approach to visiting, one family lived a distance away and very much appreciated this approach.

Staff encouraged patients (where able) to wash themselves and get dressed, to promote independence where possible, this helped with their recovery.

We observed wards rounds in which time was taken to explain what was happening to individuals and their relatives so they understood the care and treatment.

Patients we spoke with told us all staff introduced themselves they felt involved in the decisions made about their care.

We saw evidence in the records we reviewed where patients and their relatives had been involved in making decisions about their care and treatment.

Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Since the last inspection a follow up clinic for patients had been established. This was nurse led with a consultant sometimes in attendance. The clinic had been shortlisted as a finalist in the trusts celebrating success awards. The clinics took place once a month with any patients able to attend. This was in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standard.

The critical care outreach team reviewed all patients on the wards who were discharged from intensive care. Patients received a minimum of two visits from the team.

The service did not have a critical care patient and relative support group. The unit had previously been involved with a network coffee morning which patients who had used critical care services had been invited to. There were plans to look at holding another locally but no timeframes had been set for this.

There was space for relatives to stay overnight in a separate area at the entrance to the unit. We were told new furniture had been ordered for this. There was also a coffee room for relatives and a quiet room on the unit where private discussions could take place. Hot drinks were available in this area.

Critical care provision on the unit flexed to meet the differing needs of level two and level three patients. The additional bed spaces on the unit also meant there was access to single rooms when
The unit also had the ability to open an additional bed (if this did occur a bed would be closed at Huddersfield). As critical care nurse staffing was cross site there was the ability to also flex staffing if the unit became busier.

**Meeting people’s individual needs**

The unit was accessible for people who used a wheelchair or walking aids. There was also an accessible toilet and shower room.

Staff we spoke with knew how to access translation services for patients whose first language was not English. Translation could be provided face to face or over the telephone.

Staff we spoke with felt confident to care for patients with a learning disability or living with dementia. We saw evidence in patient records that care plans included assessment and interventions for patients with dementia, learning disabilities and delirium.

Staff recognised the importance of relatives and carers for any patients with additional needs. We observed how a family was involved and helped staff with caring for a young person with a life limiting condition.

Staff would seek support from the nurse in charge if they had any concerns, or they could access specialist nurses.

The unit reported good links with the specialist matron for learning disabilities and described how they could provide further support for staff as often the patient may already be known to them.

The patient records that we reviewed reflected that individual needs were assessed and care planning was informed by this.

Feedback from patients identified that often they made have several appointments following discharge from hospital. To help reduce the burden of this, patients were offered a telephone follow-up as an alternative to attending the clinic.

**Access and flow**

During the period from December 2016 to November 2017, Calderdale and Huddersfield NHS Foundation Trust has seen adult bed occupancy fall. From January 2017 to November 2017, the trust’s performance was better than the English average.

**Adult critical care Bed occupancy rates, Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing bed occupancy rates](image)

Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*
Delayed discharges

For the Intensive Care Unit at Calderdale Royal Hospital, there were 1,825 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was similar to the national average.

(Source: Intensive Care National Audit Research Centre (ICNARC))

We were provided with the most recent ICNARC quarterly quality report. This showed that between 1 April 2017 and 30 September 2017 the bed days of care post eight hour delay rate was 0.6% this was much better than similar units which had an average of 3.1%.

We observed the process when a patient was declared fit to transfer to a ward and that staff were very proactive in managing this. Times for escalating were clearly documented to try and ensure the standard was met. If delays were encountered consideration was given to mix sex breaches and this is when the additional single rooms may be utilised.

Non-clinical transfers

For the Intensive Care Unit at Calderdale Royal Hospital, there were 191 admissions in 2016/17. Compared with other units this unit was within expected limits.

ICNARC data from 1 April 2017 to 30 September 2017 showed that of 108 admissions to this unit there were no non-clinical transfers, this was better than similar unit’s rates which were 0.9%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

At the previous inspection it was highlighted that there were a high percentage of transfers occurring out of hours (between 10pm and 7am).

For the Intensive Care Unit Calderdale Royal Hospital, the proportion of admissions that were non-delayed, out-of-hour’s discharges to the ward was within expected limits in 2016/17, based on 126 admissions. These are discharges which took place between 10pm and 6:59am.

The unit had an admission and discharge policy which had recently been updated. The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. From the eight sets of notes we reviewed all the patients had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.

The reconfiguration of services meant there was no surgical activity at this site. The majority of patients on the unit were non-surgical, 84%.

There had been no instances in the last 12 months where a level three patient had been cared for outside of critical care.

Learning from complaints and concerns

From November 2016 to October 2017 there was one complaint about critical care. This complaint was made in reference to clinical treatment provided at Calderdale Royal Infirmary. The trust took six days to investigate and close this complaint. The trust does not use a target for responding to complaints though they did provide the following statement:

“There is no additional target date. We are guided by the 25 or 40 day targets. Complaints are closed once a complaints response has been sent or a meeting held and the complainant is satisfied that the complaint has been resolved. Some complaints are closed following a telephone call, once the complainant is satisfied.”
(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Information was available to patients and relatives on how to make a complaint. Staff were aware of the policy for managing concerns. However all staff said they would try and resolve any concerns at the time they arose. Often this may be dealt with by the nurse in charge.

We saw information displayed on a patient feedback poster. This included comments such as, ‘leaving ICU and going to the ward was scary for me’. Senior staff identified this as a possible theme from patient feedback but we were not provided with any specific plans to address this.

Is the service well-led?

**Leadership**

Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. There was a lead consultant and a lead nurse for critical care.

Management responsibilities across the two critical care units were shared between four band seven nurses. One of these nurses would always be present each day.

Additional support had been provided to the CCOT during the winter period. This support was provided by an identified anaesthetist on a separate rota. The critical care outreach team did not have a band seven lead practitioner. Management oversight was provided by the band seven on the critical care unit. The team felt this was having an impact on the development of their service. They had lost links with the network and felt the professional development of team members had also been affected. Positive action had been taken by the team with the submission of a gap analysis for the service.

From discussions with the leadership team it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. There were plans in place to address gaps and areas of non-compliance with GPICS standards. It had been recognised in areas such as medical staffing progress had been slow.

There was a focus on developing and training for staff at all levels to ensure effective leadership. There were plans in place for succession planning. This included band six development posts and there were plans to look at implementing band seven development posts although no time frames had been set for this. The service was developing staff by looking outside of unit to gain a wider experience, this included areas such as working with the site coordination team. The focus on training and development of staff was captured in the new education and training strategy.

The leadership team and senior staff were visible and approachable. There was strong nursing and medical leadership on the unit. From our observation and from speaking with staff, it was clear that staff had confidence in the leadership at all levels. Staff reported feeling very supported by their teams and managers and able to escalate any concerns.

Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

**Vision and strategy**

The trust vision was “Together we will deliver outstanding compassionate care to the community we serve”. This was reflected in the care we observed and staff were clearly patient focused.
The trust identified four pillars of behaviour “we put the patients first” “we go see” “we work together to get results” and “we do the must do's”.

The vision for the unit was ultimately dependent on the long term reconfiguration of critical care services and the plans to move to a single site service by 2021. This process was ongoing with final plans still undecided. Whilst this did leave some uncertainty amongst staff they were positive about the plans.

We spoke about the strategy for the service with the senior management team and were provided with the critical care objectives for 2017/2018. The goals were focused around four areas. These were transforming and informing patient care, keeping the base safe, a workforce for the future and financial sustainability.

The objectives were focused around developing and embedding existing processes and working towards compliance in all areas of the GPICS standards. However there were also objectives focused on transforming care by using new initiatives and focusing on patient experience and learning from feedback.

The service had recently had a network review and from this had produced a detailed action plan Against the GPICS standards with designated leads and identified time frames.

**Culture**

At the previous inspection some concerns were identified over low morale within the nursing team. We found generally this had improved, the majority of staff we spoke with reported high levels of staff morale. The exception was within the CCOT this was felt to be due to a lack of leadership within the team.

We also found that health care support workers had been excluded from the flexible working agreement within the unit. Where staff nurses had the option to go home rather than be moved to a ward this was not the case for health care staff. This had led to some dissatisfaction within this group of staff.

Staff told us they felt proud of their work and the care they provided to patients and their relatives.

We observed a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other’s opinions.

Staff of all we spoke with told us they felt able to raise concerns and were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care. However we lacked assurance about incident reporting within the team so could not be fully assured that staff would always recognise when this happened.

**Governance**

The service was in the division of surgery and anaesthesia. Governance processes had strengthened since the last inspection. Monthly, surgery and anaesthetic patient safety and quality board meetings took place, with an update provided for each service.

Monthly cross site critical care management meetings took place with had a business element and clinical governance element. We reviewed meeting minutes which had standing agenda items related to risk, incidents, complaints and network updates.

The information was disseminated to staff via team meetings, however it was identified that attendance at these meeting had been poor. Senior staff were looking at how meeting could be arranged to try and improve the number of staff attending. Whilst there had been plans to introduce safety huddles this practice was not embedded.
**Management of risk, issues and performance**

There was a divisional risk register which contained 63 risks; ten of these were specific to critical care. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Each of the risks had evidence of recent review and had a description of existing controls, any gaps and further actions required. The risks related to the electronic patient record (EPR) system, staffing and capacity within teams and specific items of equipment.

From our discussions with the leadership team they were clear about any risks to the service and mitigating actions and the risk register reflected this. The team spoke about a planned pressure ulcer prevalence audit in response to the incidents reported. They had identified that the pressure damage reported was different to that of other units and on this site had trailed a mouth care product for oral cleansing and suctioning.

There was a task and finish group in place which was developing a ward assurance tool. This audited various aspects of clinical care and showed compliance rates for each area. This was still in a pilot phase and ongoing development was in place to ensure the accuracy of the data collected.

The service was involved in the regional critical care operational delivery network. There was a programme of internal clinical audit and a quality and performance report which enabled quality and performance to be monitored.

**Information management**

Staff could access information relating to polices and guidance electronically, and the system was easy to navigate.

The admission, discharge and transfer documentation was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients’ bedside.

**Engagement**

Friends and family test data as for all critical care units was limited, so results could not be collated or analysed.

One of the critical care objectives was to ‘ensure learning from patient experience is shared across the team’. However we saw limited examples of how patient feedback had helped inform or influence the service.

Some feedback was gained from the follow up clinics and through patient diaries. However as discussed not all patients had these completed.

The senior team recognised that further work was needed in this area and there were plans to hold an afternoon tea session for patients who had used the service later in the year with a hope that further feedback would be gained.

In the minutes from the surgery and anaesthetics patient safety and quality board, patient stories were a standing agenda item. The minutes we reviewed showed at some meetings the patients presented this information which prompted discussion and reflection among the team.
The staff we spoke with felt involved and informed about what was happening in the trust. We reviewed meeting minutes which evidenced discussions around incidents, training and staffing with senior staff. However more local departmental meetings had poor attendance so information sharing at this level was not as effective. We did see a number of notice boards however that were used to share information on a wide range of topics.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network.

It was recognised further work was required with regards to the critical care outreach team.

A significant amount of work had been done to improve the retention of staff. This included reviewing information from exit interviews and implementing changes such as band six development roles.

There had been a focus on training and education; this was supported by a new strategy document.

Significant work with the universities had meant the number of staff who had completed the post registration award in critical care exceed the 50% outlined in the GPICS standards. This made the trust the best performer in the WYCCODN.

The establishment of monthly follow up clinic services ensured patients received a high standard of rehabilitation following their stay on intensive care. This included developing partnership working with improving access to psychological therapies (IAPT), as part of the clinic.
Maternity

Facts and data about this service

The trust has 61 maternity beds across five wards at two locations. Of these beds, 55 are located within three wards and a birth centre (CBC) at Calderdale Royal Hospital (CRH). The three wards are consultant led and the CBC is midwife-led.

The remaining six beds are located in one midwife-led birth centre (HBC) at Huddersfield Royal Infirmary (HRI).

(Source: Trust Provider Information Request – Acute sites)

From October 2016 to September 2017 there were 5,066 deliveries at the trust. A comparison from the number of births at the trust and the national totals over the most recent 12 months period is shown below.

Number of babies delivered at Calderdale and Huddersfield NHS Foundation Trust – Comparison with other trusts in England.

A profile of all deliveries from October 2016 to September 2017 is shown below.

<table>
<thead>
<tr>
<th></th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td>5,003</td>
<td>98.8%</td>
</tr>
</tbody>
</table>
### Multiple

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>63</td>
<td>1.2%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

### Mother’s age

<table>
<thead>
<tr>
<th>Age range</th>
<th>Deliveries</th>
<th>(%)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>178</td>
<td>3.5%</td>
<td>3.1%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,959</td>
<td>78.1%</td>
<td>75.1%</td>
</tr>
<tr>
<td>35-39</td>
<td>760</td>
<td>15.0%</td>
<td>17.9%</td>
</tr>
<tr>
<td>40+</td>
<td>169</td>
<td>3.3%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

### Total number of deliveries

<table>
<thead>
<tr>
<th></th>
<th>Deliveries</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,066</td>
<td></td>
<td>607,089</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The gestation period of babies born at the trust from October 2016 to September 2017 is shown in the table below.

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>333</td>
<td>6.6%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>4,673</td>
<td>93.3%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

Total number of deliveries with a valid gestation period recorded

<table>
<thead>
<tr>
<th></th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,009</td>
<td></td>
<td>498,097</td>
</tr>
</tbody>
</table>

The gestation period of babies born at term (between 37 and 42 weeks) was 93.3%, which was above the national average (91.8%).

Trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at Calderdale and Huddersfield NHS Foundation Trust by quarter

Delivery numbers by quarter for the period October 2015 to September are shown in the graph below.
The number of deliveries at the trust showed little variation from October 2016 to December 2017. There was a notable decrease in deliveries in Q4 2016/17, and since then the number of deliveries has increased slightly over time.

During the inspection, we visited the labour ward, a theatre, birth centre, 2 post-natal wards, and the antenatal day unit. We spoke with x members of maternity services staff, and 18 patients and their companions. We observed staff delivering care, and we reviewed trust policies and performance information from, and about, the trust.

**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**

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to November 2017 for the qualified nursing/midwifery staff in maternity is shown below.

We saw there was additional mandatory training for midwifery staff which complied with the midwifery specific mandatory training policy. The training policy was reviewed on an annual basis and will be next reviewed January 2019.

The Maternity specific mandatory training policy (January 2018) and associated training programme, detailed that feedback from colleagues had informed the development of a new for 2018-2019 three-day midwifery training programme. It stated that roster managers will work with the lead midwife for patient safety and quality to block three days in one calendar week for midwives to complete maternity specific mandatory training.
<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>209</td>
<td>210</td>
<td>99.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>207</td>
<td>210</td>
<td>98.6%</td>
<td>No target</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>206</td>
<td>210</td>
<td>98.1%</td>
<td>No target</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>171</td>
<td>175</td>
<td>97.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>205</td>
<td>210</td>
<td>97.6%</td>
<td>No target</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>155</td>
<td>164</td>
<td>94.5%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>194</td>
<td>210</td>
<td>92.4%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>97</td>
<td>108</td>
<td>89.8%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>188</td>
<td>210</td>
<td>89.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>187</td>
<td>210</td>
<td>89.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>139</td>
<td>160</td>
<td>86.9%</td>
<td></td>
</tr>
<tr>
<td>Information Governance</td>
<td>182</td>
<td>210</td>
<td>86.7%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>141</td>
<td>164</td>
<td>86.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>71</td>
<td>83</td>
<td>85.5%</td>
<td>No target</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>175</td>
<td>210</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td>35</td>
<td>43</td>
<td>81.4%</td>
<td>No target</td>
</tr>
<tr>
<td>Maternity Obstetric Emergency Training (PROMPT) - 1 Year</td>
<td>39</td>
<td>51</td>
<td>76.5%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td>138</td>
<td>181</td>
<td>76.2%</td>
<td>No target</td>
</tr>
<tr>
<td>CPR</td>
<td>145</td>
<td>210</td>
<td>69.0%</td>
<td>No target</td>
</tr>
<tr>
<td>SABINE - Externally supported (Perinatal Institute) on line training</td>
<td>20</td>
<td>30</td>
<td>66.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95</td>
<td>171</td>
<td>55.6%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td>108</td>
<td>210</td>
<td>51.4%</td>
<td>No target</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>86</td>
<td>210</td>
<td>41.0%</td>
<td>95%</td>
</tr>
<tr>
<td>CO Monitoring (Community Midwives)</td>
<td>11</td>
<td>27</td>
<td>40.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Smoking Cessation (Community Midwives)</td>
<td>11</td>
<td>27</td>
<td>40.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Training module</td>
<td>Trained staff (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate (YTD)</td>
<td>Trust Target</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>WDD - BFI Infant Feeding for Hospital and Community Maternity staff</td>
<td>16</td>
<td>47</td>
<td>34.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Antenatal Newborn Screening - 1 year</td>
<td>4</td>
<td>30</td>
<td>13.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Perinatal Mental Health (Midwives) - 1 Year</td>
<td>1</td>
<td>51</td>
<td>2.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Fetal Monitoring Programme</td>
<td>0</td>
<td>29</td>
<td>0.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
</tbody>
</table>

**Calderdale Royal Hospital**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>132</td>
<td>133</td>
<td>99.2%</td>
<td>No target</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>131</td>
<td>133</td>
<td>98.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>113</td>
<td>116</td>
<td>97.4%</td>
<td>No target</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>129</td>
<td>133</td>
<td>97.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>129</td>
<td>133</td>
<td>97.0%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>51</td>
<td>53</td>
<td>96.2%</td>
<td>No target</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>99</td>
<td>107</td>
<td>92.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>82</td>
<td>92</td>
<td>89.1%</td>
<td>No target</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>118</td>
<td>133</td>
<td>88.7%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>118</td>
<td>133</td>
<td>88.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>117</td>
<td>133</td>
<td>88.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>21</td>
<td>24</td>
<td>87.5%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>116</td>
<td>133</td>
<td>87.2%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>92</td>
<td>107</td>
<td>86.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Information Governance</td>
<td>112</td>
<td>133</td>
<td>84.2%</td>
<td>95%</td>
</tr>
<tr>
<td>Maternity Obstetric Emergency Training (PROMPT) - 1 Year</td>
<td>20</td>
<td>24</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td>20</td>
<td>24</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td>100</td>
<td>124</td>
<td>80.6%</td>
<td>No target</td>
</tr>
<tr>
<td>Training module</td>
<td>Trained staff (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate (YTD)</td>
<td>Trust Target</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>CPR</td>
<td>95</td>
<td>133</td>
<td>71.4%</td>
<td>No target</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>63</td>
<td>110</td>
<td>57.3%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td>76</td>
<td>133</td>
<td>57.1%</td>
<td>No target</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>55</td>
<td>133</td>
<td>41.4%</td>
<td>95%</td>
</tr>
<tr>
<td>SABINE - Externally supported (Perinatal Institute)</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Antenatal Newborn Screening - 1 year</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD - BFI Infant Feeding for Hospital and Community Maternity staff</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Fetal Monitoring Programme</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Perinatal Mental Health (Midwives) - 1 Year</td>
<td>0</td>
<td>24</td>
<td>0.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
</tbody>
</table>

With the exception of one module completed by staff at Huddersfield Royal Infirmary, the qualified nursing and health visiting and the qualified nursing midwifery staff failed to meet any of the training targets for mandatory training. Whilst most completion rates were there was a target were around 85% or higher, the Manual Handling – People module had a completion rate of only 41%.

Calderdale Royal Hospital had an overall 75% mandatory training completion rate against the trust target of 95%.

Staff told us the trainer was responsible for the completion of their electronic training records and that it was not always completed in a timely way. We saw evidence of completed mandatory training and evidence the electronic staff record (ESR) system had not yet been updated to reflect this.

We reviewed information we received from the trust about rates of completion for maternity specific training for staff across Calderdale and Huddersfield sites. As of 7 March 2018, data we received showed that:

Maternity obstetric emergency training (Practical Obstetric Multi-Professional Training) (PROMPT) included training on human factors in healthcare, shoulder dystocia, vaginal breech, cord prolapse, massive obstetric haemorrhage, eclampsia, and recognition of severely ill pregnant women (which included topics on sepsis) and modified early warning scores (MEWS). Of the 308 nursing and medical staff available for PROMPT training, 284 had attended training during 2017-2018. Rates of completion for 2017/18 were 92.2%, and were better than NHS guidance (90%). Data showed 24 members of staff had not had the PROMPT training. This included junior doctors who were to have the CHFT training by the end of March 2018.

Removing this group of junior doctors from the data gave 95% attendance achieved of total staff available. We saw the calculation of this figure was in line with the maternity mandatory training
policy (dated January 2018). The policy stated the PROMPT training should be completed annually, within the first six months following appointment and compliance rates should exclude staff in the first six months following appointment.

The rate of completion for the 2017-2018 growth assessment protocol (GAP) e-Learning was 100% amongst midwifery staff across the service. The GAP e-learning was part of the NHS England Saving babies lives in the north of England programme / Perinatal Institute stillbirth reduction care bundle.

Seventy five percent of staff had completed the prevention of third and fourth degree perineal tears training; this was part of the Royal College of Gynaecologists (RCOG), Royal College of Midwives (RCM) and the obstetric anal sphincter injuries (OASI) care bundle quality improvement programme.

Data showed that 91% of applicable nursing and medical staff had completed all four components of the monitoring fetal wellbeing which included intermittent auscultation and cardiotocograph (CTG) training programme which are techniques used to measure the babies heart beat; set out in the standard operating policy, Mandatory Fetal Wellbeing Policy (June 2017).

During our visit we saw a database was used to show staff monitored fetal wellbeing and recorded compliance rates. The data included details of when individual members of staff had completed training and training renewal dates.

The rate of completion for 2017-2018 new born resuscitation (NLS) training was 96.6% among midwives across the trust. This exceeded the 95% compliance target set by the trust.

The trust supported up to eight midwives a year to undertake Newborn Infant Physical Examination (NIPE) training at the University of Huddersfield. The trust provided information that showed 44 of midwives were NIPE trained and this accounted for 20% of their midwifery workforce. Twenty seven of the NIPE trained midwives worked on wards and the maternity assessment centre at CRH. The remaining 17 worked in the birth centres and in the community.

**Safeguarding**

The service had two early intervention midwives. Their role was to identify women at risk and have a plan in place to support women who had vulnerability factors identified at booking their pregnancy. This included those women on the perinatal mental health pathway and teenage pregnancies. In addition, the service had specialist midwives in substance misuse, domestic abuse, and a named midwife for safeguarding. As part of the safeguarding midwife role, they held multidisciplinary team meetings with a focus on vulnerable women and babies. In line with the national reporting system, safeguarding concerns such as abuse were reported to the trust safeguarding team, the local authority and police. We saw two examples on the EPR system of multidisciplinary agency working which included safeguarding plans and legal actions to follow following the birth of the baby. The records were in date and included the safe planning for the hospital admission and the postnatal period.

The named midwife for safeguarding represented the trust on Calderdale and Kirklees local safeguarding children’s board sub committees. This meant the midwifery service was part of the safeguarding development with the two local authorities. The named midwife took part in multi-agency ‘learning lessons’ sessions which explored the root causes of a specific case where plans had not gone well for a child.

At the time of our inspection, there were no ongoing serious case reviews involving midwifery services. However, the team were aware of national cases and those cases where their findings could be relevant.
The named midwife attended multi-agency risk assessment conference (MARAC) over the two local authorities. This is a victim focused information sharing and risk management meeting attended by key agencies and where high-risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to keep people safe.

The named midwife worked closely with other safeguarding team members across the trust and there was cross cover for annual leave.

There were processes in place to support staff in the completion of family court statements and court attendances.

Safeguarding policies for adults and children were in date and assessable to staff via the trust internet. Staff we spoke with understood their responsibilities for identifying and reporting concerns and knew the procedures to follow.

Since September 2014, acute trusts are legally obligated to provide a monthly report to the Department of Health the number of patients who have experienced female genital mutilation (FGM), or who have a family history of FGM.

At CHFT, the safeguarding midwife collated this information. From March 2017 to February 2018, 47 known cases of FGM were reported across the trust. All staff we spoke with had received training on female genital mutilation (FGM) and some had completed the statutory reports required. The World Health Organisation defines FGM as “procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons”.

The trust had a guideline to support staff in the identification of those at risk of FGM.

Risk assessments and pathways of care were in place to identify women and children at risk.

There was a perinatal mental health professional in post who gave advice to staff and they were aware of how to contact the mental health team.

The named midwife was responsible for the safeguarding supervision of midwifery and midwifery support staff. A nationally recognised safeguarding supervision tool was used. Staff had protected time for their individual safeguarding supervision which was every three months for community staff and annually for acute staff. Some midwives had supervision training and were competent to assist in the supervision programme.

The trust commenced a new way of recording attendance at safeguarding supervision in November 2017. As a result, the staff who had their training prior to this date and had annual supervision were recorded as non-compliant in November 2017. The compliance year reset to run from November 2017 to November 2018. The trust reported supervision compliance rates were monitored at their monthly confirm and challenge meeting process and at directorate and ward manager performance reviews.

<table>
<thead>
<tr>
<th>Specialism</th>
<th>Compliant</th>
<th>Required</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH Birth Centre</td>
<td>20</td>
<td>14</td>
<td>34</td>
<td>59%</td>
</tr>
<tr>
<td>CRH Maternity Unit</td>
<td>39</td>
<td>52</td>
<td>91</td>
<td>43%</td>
</tr>
<tr>
<td>Ward 1D ANPN CRH</td>
<td>9</td>
<td>6</td>
<td>15</td>
<td>60%</td>
</tr>
<tr>
<td>Ward 9 Ante/Postnatal CRH</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>60%</td>
</tr>
</tbody>
</table>

Safeguarding training completion rates
The table below shows compliance for safeguarding training courses from April 2017 to November 2017. The information relates to maternity qualified nursing and midwifery staff groups at Calderdale Hospital.

### Trust wide

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>174</td>
<td>200</td>
<td>87.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>151</td>
<td>178</td>
<td>84.8%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>156</td>
<td>187</td>
<td>83.4%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>156</td>
<td>189</td>
<td>82.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>No target</td>
</tr>
</tbody>
</table>

### Calderdale Royal Hospital

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>106</td>
<td>119</td>
<td>89.1%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>106</td>
<td>119</td>
<td>89.1%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>106</td>
<td>126</td>
<td>84.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>90</td>
<td>108</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>10</td>
<td>14</td>
<td>71.4%</td>
<td>No target</td>
</tr>
</tbody>
</table>

Calderdale Royal Hospital had an overall 86% safeguarding training completion rate. The trust set a target of 95% for completion of safeguarding training. Qualified midwifery and medical staff were required to complete level three safeguarding children training as outlined in the Intercollegiate Document 2014. All midwifery staff we spoke with had completed this. Training was face to face over one day with other disciplines to give depth and an understanding of roles in the safeguarding process. The staff who had not completed safeguarding training had a date to complete their training by the end of April 2018.

Three consultants were non-compliant for safeguarding training. This included one in adult safeguarding and two consultants needed to complete children’s level three training. All consultants had a date booked to attend the training by the end of April 2018. The service would then have a compliance rate of 100% for all their 15 obstetric consultants.
The five middle grade doctors had all completed level three training (100% compliance) in adults and children’s safeguarding.

At the time of our inspection, there was a new group of junior doctors to undertake training (17). We saw that 52.9% of these had received the appropriate safeguarding training and had training plans for the remaining staff.

**Cleanliness, infection control and hygiene**

The areas we visited were visibly clean and tidy. There were no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within obstetrics in the last 12 months.

We observed hand towel and soap dispensers adequately stocked. There was a sufficient number of hand wash sinks and visible poster showing the correct hand washing technique. Hand gels were located at entrances to wards, and patient and clinical areas. Signage was clearly displayed encouraging their use.

All staff we saw adhered to infection control guidelines of ‘bare below elbow’ where the use of jewellery, watches or long sleeves is prohibited to reduce the spread of infection.

The divisional reporting of audit data was done each month and discussed at the infection prevention and control committee. This included areas such as hand hygiene, dress code and insertion of peripheral cannulas.

We saw cleaning schedules on the wards and departments. In the main, these were up to date.

We were shown the log of the deep clean of the birthing pools between patients which were up to date.

There were suitable arrangements for safe disposal of waste. Infected, clinical and domestic waste was segregated in colour-coded bags and managed appropriately. Sharps such as needles and blades were disposed of in approved receptacles.

In the 2017 CQC maternity survey, the trust scored nine out of a possible 10 for the cleanliness of rooms and ward; this was similar to the England average.

**Environment and equipment**

There were seven rooms on the birth centre and two rooms had birth pools with hoists which could be used to evacuate patients in an emergency situation.

The labour ward had one birth pool and a hoist. The hoists were in a good state of repair. Records showed the hoists were in working order and checked within the last six months.

On the labour ward and birth centre there was a variety of equipment to offer comfort in labour. This included birth balls and dimmable lighting.

During our inspection of the maternity assessment unit, the labour ward and birth centre, we found the clean utility rooms were organised and equipment checks were present in the three months prior to our inspection.

Calderdale hospital had a dedicated birth centre, which was suitable for women assessed as low risk. The birth centre reflected a ‘home from home’ environment aimed to help women and families feel as relaxed and comfortable as possible during the birth experience. The unit had two permanent birth pools which were cleaned, tested and maintained. Two obstetric theatres were available for labour ward. Elective theatre lists were staffed by dedicated teams. This helped to avoiding unnecessary delays to the elective theatre activity.

There was adequate equipment available for use including, fetal heart monitors (CTGs), blood gas analysers and resuscitation equipment.
We reviewed the child abduction policy; this was generic for all groups of children and young people. We considered that it was not specific to the vulnerabilities of young infants and situations where families might seek to remove an infant from the ward.

Access to the labour ward and birth centre was via an intercom video system, which enabled staff to monitor people visiting these areas. However, we observed on the postnatal ward, other visitors following family members into the unit without being challenge. This meant that staff could not be assured as to who was on the unit at any one time. We saw this concern was on the risk register and to help mitigate the risk of abduction of a baby a business case to purchase equipment for electronic tagging had been submitted.

We were told that community midwives carried their own baby scales. There was a process for these to be calibrated annually.

**Assessing and responding to patient risk**

The antenatal booking visit took place before 12 weeks of pregnancy in line with the trust policy and guidance. An initial maternity booking and referral form was completed by the community midwives to determine whether individuals were high or low risk. The antenatal assessment included detailed obstetric, medical, mental health and social risk assessments.

The trust had produced a patient information leaflet to ensure the differences between the service delivery options and locations were explicit.

Midwives also completed venous thromboembolism (VTE) risk assessments and this was included in the elective and emergency caesarean section patient care plans.

A modified early warning score (MEWS) tool was used in maternity. This assessment tool enabled early identification of women who required additional medical support or closer monitoring. In the ten sets of records we reviewed we found these had been accurately completed, with any raised scores being escalated. A monthly audit of these showed that labour ward and Calderdale birth centre consistently scored 100% for appropriate completion in the three months prior to our inspection.

Midwifery staff identified women at high risk by using an early warning assessment tool, known as the maternity early warning score (MEWS). This was to assess the health and wellbeing of women identified as being at risk. The assessment tool enabled staff to identify and respond with additional medical support where needed. All records we inspected contained completed MEWS tools.

We saw there was a sepsis policy and clear guidelines for its use on the wards, maternity assessment unit, labour ward and the birth centre.

We saw the use of the sepsis bundle in patient records. The sepsis bundle is a group of medical interventions to treat patients with a serious infection. Training was provided on sepsis as part of the PROMPT training days. Staff we spoke with told us how they would recognise this. We saw that patients who had developed sepsis had their case discussed at the maternity governance meetings. This was to ensure actions taken relating to their care and treatment was appropriate.

We reviewed a clinical guideline ‘appropriate management of a pregnant woman who presented at accident and emergency services.’ The purpose of the guideline was to recognise the deteriorating pregnant woman and ensure there was no delay in care when a specialist medical service are required.

There was a process which identified those women who had a risk factor which made them unsuitable for delivery at Calderdale midwife led, birth centre. This included a range of medical
conditions. To reduce the risk of an unsafe choice in the birth centre, these risks were discussed with the pregnant women and the additional care that could be provided in the obstetric unit. This ensured women had an informed choice in their planned place of birth. [NICE 2007 amended 2014]. Staff we spoke with told us the guidance was clearer and it was rare for women to plan their place of delivery against advice. Where this was the case and the women presented at the midwifery unit against advice, there was guidance for staff to follow and a multi-disciplinary plan to help mitigate the risks.

We saw that there was a system where CTG (fetal heart monitoring) recordings were reviewed by the labour ward co-ordinator or another senior midwife. This allowed for objectivity of the recording and where appropriate, professional challenge when care was assessed.

The World Health Organisation (WHO) devised a safer surgery checklist which included steps to be completed when anyone had an operation. This was adapted to include obstetric procedures.

Staff we spoke with in the antenatal clinic felt confident using the electronic patient system to document assessments. An audit of electronic patient records of women admitted to Calderdale took place between October 2016 and August 2017. The audit showed women received the appropriate frequency and number of antenatal appointments; an appropriate risk assessment took place in all cases.

**Midwifery and nurse staffing**

The trust has reported their staffing numbers below as of 31 October 2017.

<table>
<thead>
<tr>
<th>Site/location</th>
<th>Staff group</th>
<th>Actual staff - WTE</th>
<th>Actual staff - headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>NHS infrastructure support</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>7.2</td>
<td>8.0</td>
</tr>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>118.6</td>
<td>138.0</td>
</tr>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Support to doctors and nursing staff</td>
<td>40.8</td>
<td>50.0</td>
</tr>
<tr>
<td>Cross-Site</td>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Cross-Site</td>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>61.4</td>
<td>70.0</td>
</tr>
<tr>
<td>Cross-Site</td>
<td>Support to doctors and nursing staff</td>
<td>8.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>7.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>9.5</td>
<td>12.0</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Support to doctors and nursing staff</td>
<td>12.0</td>
<td>15.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>265.8</strong></td>
<td><strong>311.0</strong></td>
</tr>
</tbody>
</table>

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of -1.2% in maternity;

- Calderdale Hospital; -4.6%
- Cross site staff; 8%
The negative percentages mean that the trust currently has more whole time equivalent (WTE) staff in position than they had originally budgeted for.

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

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 7.7% in maternity;

- Calderdale Royal Hospital; 7.6%
- Cross site staff; 9.7%

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

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 4% in maternity;

- Calderdale Royal Hospital; 3.7%
- Cross site staff; 5.4%

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

**Bank and agency staff usage**

From November 2016 to October 2017, the trust reported 260 shifts were filled by bank staff, two shifts were filled by agency staff and this left a total of 361 shifts unfilled.

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

**Midwife to birth ratio**

The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG), recommend a ratio of 1:28. This meant one midwife to 28 births.

As of September 2017, the trust had a ratio of one midwife to every 27 women. This is similar to the national average and has improved slightly over time.

The trust informed us they used their escalation policy to move staff flexibly across the service to meet women’s needs, and as such, they were not able report midwife to birth ratio by site.

Data provided by the trust showed that from March 2017 to February 2018, there were 5248 deliveries at the trust, and 5303 babies were delivered. Of the 5248 women who delivered at the trust, data showed that 5135 (97.8%) received 1:1 care in labour.

Senior staff explained midwifery colleagues used Birth-rate Plus tool in conjunction with the intrapartum scorecard (NPSA). The NPSA scorecard is a tool for monitoring and improving patient safety in maternity units. Data collected using the scorecard was used to demonstrate maternity staffing and activity levels. This informed planning of staffing and activity and/or escalation procedures. Senior staff confirmed their two hourly use of the tool in the birth centre. It helped them to monitor staffing levels and understand the range of issues when considering the escalation procedure. The managers told us that activity was discussed on a day-to-day basis and data analysed quarterly to examine skill mix provision.
Red Flag maternity staffing guidance was published by NICE in February 2015, and highlights signs that may indicate there are not enough midwives available. For example, a delay of two hours or more between a woman coming in for induction of labour and the process starting. Data provided by the trust showed from March 2017 to February 2018 there were 117 maternity staffing related incidents across the trust, and 80 of these were recorded as ‘red flag’ incidents.

**Medical staffing**

The Trust provided 96 hours cover for Obstetrics and Gynaecology. This cover was in line with the Safer Childbirth minimum standards for the organisation and delivery of care in labour (2007). There were 14 full time obstetrician and gynaecology consultants in post at the time of our inspection.

There was a consultant presence on the CRH site during weekdays from 8 am - 11 pm, and from 8.30am - 7.30pm on a Saturday and Sunday. Outside of these hours, a consultant provides on-call cover from home and contactable by telephone. The travelling time for the consultant on-call to travel from home to site, is less than 30 minutes. This was in line with the trust on-call procedure.

Daytime cover was provided by the ‘hot-week’ consultant Monday to Friday 8am-6pm.

The on call consultant took over at 6pm, and was resident on site Monday to Friday 6pm-11pm and on call from home after 11pm.

A consultant led safety brief, handover and ward round took place at 8.30am, seven days a week and additionally at 8.30pm, Monday to Friday.

Consultant obstetrician cover on the central delivery suite was 40 hours a week, from 8.30am until 5pm each day. This cover was better than recommended in the Safer Childbirth minimum standards for the organisation and delivery of care in labour (2007). On-call consultant cover was in addition to these hours and was from 5pm to 8.30am daily.

**Consultant Anaesthetist cover for Maternity**

**Calderdale Royal Hospital**

Monday to Friday, 8am – 6pm a consultant physician supported the LDRP and two sessions a month were covered by a senior middle grade anaesthetist. Outside of these hours a consultant was on-call, from 6pm – 8am Monday to Friday and on a Saturdays and Sundays. A consultant anaesthetist covered the daily lower segment caesarean section (LSCS) list in all cases.

Following a recommendation from the CQC inspection in 2016, two registrars are on duty out of hours. Most staff told us this had improved safety although it depended on the level of expertise the second doctor had. If they required significant supervision then this could be seen as a difficulty.

**Vacancy rates**

The trust did not provide any data for medical staff in maternity

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

**Turnover rates**

The trust did not provide any data for medical staff in maternity

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

The trust did not provide any data for medical staff in maternity

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

Bank and locum staff usage

The trust did not provide any data for medical staff in maternity

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

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average, and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 38.6 whole time equivalent staff working in maternity at Calderdale and Huddersfield NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>39%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>3%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ 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)

Records

The service had moved from a paper-based system to an electronic patient record system. Patients still kept their hand-held records. The service had a maternity electronic patient record (EPR) lead who they could contact them for support and advice. A business continuity plan was also available and informed staff what to do in case of a system failure. This included the use of contemporaneous paper-based documentation. The unit aimed to be paper-light and not paper-free. Staff had their own password with which to log on the EPR system. We saw that staff logged out when the system was not required. This helped ensure there were no breaches of confidentiality from unauthorised personnel accessing the system.

We reviewed ten sets of electronic records. They were individualised, up to date, and reflected the care provided. Record keeping was of a good standard. The staff, who showed us the records,
told us that they felt confident and competent in using the system and considered that it was a positive development.

Staff told us they were able to generate pdf documents from the electronic systems, and would offer a copy to women to keep in their hand-held notes (for example, their birth plan).

We reviewed three electronic training files these demonstrated staff had received training and support for using the system

The service used a situation, background, assessment, recommendation (SBAR) transfer record. This was used when handing over care between staff. The tool was used in maternity services where there may be multiple handovers between staff and it assisted in improving communication.

We saw that themes and evidence of learning from record keeping audits were ‘captured’ on a monthly basis. The information related to the hospital, and community based services. For example, the audit themes for November and December 2017 included antenatal steroid administration and management plans (held within the EPR system).

Medicines

The storage and checking of medicines, including the medicines refrigerator temperatures were taking place in line with policies and procedures.

We checked the controlled drugs cupboards on the wards, delivery suite and Calderdale birth unit. The stock was in date and correlated with the register in the cupboard.
We observed a controlled drug being prepared by two midwives in accordance with trust policy.

We found the medicines on the emergency trolleys were securely stored and in tamperproof packaging. Daily checks were recorded and this ensured the medication was in date and available for use.

We saw the midwife on ward 9 who administered medication wore a tabard, which identified that she should not be distracted.

Ward 1d and ward 9 had completed their own self-assessments on the safe storage of medicines against 16 standards and both wards were compliant. The self-assessments were undertaken annually and if areas for improvement identified, these were reviewed after a period of three months.

We reviewed ten prescription charts which were fully completed. We reviewed an epidural infusion which was signed by two midwives and then by the anaesthetist when it was in place. This was highlighted as good practice. Medication allergies were appropriately indicated on prescription charts.

We observed that insulin which was in use was being stored in the drug fridge on labour ward. Insulin, which was in use for a patient should have been stored at room temperature and staff seemed to have been unaware of this. This was highlighted to staff at the time.

Medical gas cylinders at Calderdale hospital maternity unit and birth centre were appropriately stored in secure brackets/trolleys/chains according to trust policy.

Patient group directives (PGDs) were in use in maternity. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We reviewed a file of two PDGs at Calderdale birth centre and found these appropriately signed and dated by individual staff with authority to administer the medicine
The wards and birth unit had the support from the hospital pharmacy service. A midwife told us the staff had a very good relationship with the clinical pharmacy team and this included access to a pharmacist out of hours if needed.

Medicine incidents were communicated to staff in ward meetings and through newsletters.

**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 February 2017 to January 2018, the trust reported zero incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

The quality assurance midwife told us that the unit learnt from incidents in other areas. For example from NPSA alert and safer insulin Awareness Training of care of patients with diabetes requiring insulin and learning from Incidents reported via the Central Alerting System - from failure to obtain and continue flow from oxygen cylinders.

Learning was discussed at the Trust Risk and Compliance group and Divisional Patient Safety and Quality Board. Learning was shared via email to all Matrons for them to share and discuss with their teams.

**Breakdown of serious incidents reported to STEIS**

There was an Incident reporting management policy (incorporating the serious incident process). Incidents were reviewed and discussed at the weekly orange panel meeting and weekly maternity governance meeting.

Three serious incidents (SI’s) had been reported for maternity services between March 2017 and March 2018. At the time of our inspection, one of these had been investigated completed, one was due for review at the divisional orange panel and trust serious incident panel, and been referred to the coroner and was under investigation.

Of these, the most common type of incident reported was that which met the maternity/obstetric SI criteria: ‘baby only’ (this includes foetus, neonate and infant) a total of three (which was 75% of the total incidents). The other serious incident reported was screening issues meeting SI criteria (25% of total incidents).

Data provided by the trust showed from March 2017 to February 2018, 98 incidents in maternity services where harm was caused were recorded.

The trust informed us that all stillbirths and neonatal deaths received a first level review using national guidelines. All cases were discussed at the weekly maternity governance meeting and weekly orange panel meeting. Cases where there may have been failures in care proceed to a level two review; an ‘orange investigation’ or a serious incident investigation.

We reviewed a selection of weekly maternity governance meetings from 2017 to 2018 and found these were attended by senior staff. We saw evidence of the review of clinical outcomes and lessons learned.
We also reviewed perinatal mortality and morbidity meeting minutes for the last 12 months, which showed appropriate sharing of information about incidents, and lessons learned.

The trust reported there had been one serious incident investigation related to stillbirths and neonatal deaths during the past 12 months.

Level two (orange) investigations had been commissioned for two of 15 stillbirths that had occurred at the trust between January 2017 and December 2017.

We reviewed the associated root cause analysis to these incidents which had been completed robustly and had clear actions for identified staff. We were told that key staff had training to complete incident investigations.

The trust provided information that showed feedback from staff indicated that they preferred face to face discussion rather than email. They also preferred learning to be distributed from the weekly governance meeting in a newsletter rather than email. Following this feedback, the service had recently begun issuing weekly learning lessons newsletter from the weekly governance meeting. The trust reported that the newsletter was well received.

Staff we spoke with told us there was a good incident reporting culture. They were encouraged and supported to report incidents without fear of recrimination, and received appropriate feedback. They also described that multi-disciplinary debriefs took place after a clinical incident had occurred.

The duty of candour is a regulatory duty that relates to openness and transparency. It 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.

Duty of candour was evidenced in the serious incident investigations we reviewed. The staff we spoke with said they were open and honest with women if things went wrong.

We observed examples of the weekly ‘safer maternity care’ newsletter, which demonstrated shared learning. One newsletter focussed on instances of retained placenta and guideline recommendations.

**Safety thermometer**

The maternity safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm-free care. This was in use and data collected each month on perineal and abdominal trauma, retained placenta, post-partum haemorrhage, and infection. We saw that this information was displayed in wards and departments and discussed at maternity clinical governance meetings. We saw where there were concerns those issues had been discussed and the proposed actions and timescales were recorded.

**Is the service effective?**

**Evidence-based care and treatment**

The care and treatment provided to women was based on guidance from the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives, and evidence based practice.
Nutrition and hydration

We saw that women who had just given birth were offered light refreshments such as tea and toast. On the wards there was a meal ordering system which offered patient choice.

Breastfeeding support was provided in line with the United Nations children’s fund baby friendly initiative (UNICEF BFI) guidelines.

Calderdale hospital was a UNICEF baby friendly hospital. Data provided by the trust from March 2017 to February 2018 showed an average breastfeeding initiation rate of 76%; this is lower than the England average of 81%.

Breast feeding information leaflets and posters displayed in patient areas, showing contact details for support groups in the local community.

Four women we spoke with had felt well informed about the benefits of breastfeeding however they chose not to do so. They stated they had received information with which to bottle feed safely. Six women we spoke with had told us they had chosen to breast feed their baby and felt staff were supportive.

Pain relief

Women in labour had a choice of pain relief, which included birthing pools, pethidine (opiate) injections, nitrous oxide and oxygen (Entonox) and epidurals. Women could choose to use TENS (transcutaneous electrical nerve stimulation). Women we spoke with told us that options had been discussed with them in the ante natal period.

We spoke with ten women who told us that they felt pain relief had been adequate in labour and had been given in a timely way. Two women had requested epidurals and these had been given without a delay.

We saw that women had been prescribed pain relief after labour. We were told this was given as requested and where appropriate, prescribed to take home.

In the birth centre women could have Entonox, pethidine, meptid and TENS machines. They could choose to hire a home birth pool if considered appropriate.

There were arrangements in place for women who had planned a home delivery to receive pain relief. This was mainly Entonox, pethidine and Meptid, and TENS.

Patient outcomes

National Neonatal Audit Programme

In the 2016 National Neonatal Audit, Calderdale Royal Hospital’s performance was as follows:

- Do all babies <32 weeks gestation have their temperature taken within an hour after birth?
  - There were 43 babies born at <32 weeks included in this audit measure for the unit. 98% of these babies had their temperature measured within an hour of birth; this was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

- Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids?
  - There were 134 eligible mothers identified for inclusion in this audit measure for the unit. 81% of these mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.
What proportion of babies < 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home from a neonatal unit?
  
  - There were 51 babies born at < 33 weeks who met the criteria for inclusion in the unit. 51% of these babies were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was below the national average, where 59% of eligible babies were receiving any mother’s milk at the time of their discharge from neonatal care.

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

Standardised Caesarean section rates and modes of delivery

From July 2016 to June 2017 the total number of caesarean sections was lower than expected. The standardised caesarean section rates for elective and emergency sections were similar to expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

In relation to other modes of delivery from July 2016 to June 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Proportions of deliveries by recorded delivery method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery method</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
</tr>
<tr>
<td>Total deliveries</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

The data shows that the proportion of caesarean sections performed at the trust from July 2016
to June 2017 was 4.4% lower than the national average, the proportion of instrumental deliveries was about the same as the national average (0.7% difference), and the proportion of non-interventional deliveries was 5.3% greater than the national average.

The trust provided us with monthly data about instrumental (assisted) delivery rates from March 2017 to February 2018. Data showed that 11% of births (585) were instrumental deliveries; of these instrumental births, 432 (74%) were forceps deliveries and 153 (26%) were ventouse (vacuum) deliveries. This was a slight improvement on the previous year. Of the 5508 women who delivered at the trust between March 2016 and February 2017, 677 (12%) had an assisted delivery. There had been previous concerns raised in the Royal College of Obstetricians and Gynaecologists (RCOG) report of a high rate of forceps deliveries compared to ventouse. The trust was actively addressing this by way of training and awareness. We saw this was discussed in the clinical governance meetings.

The risk that anomalies identified on scans in pregnancy may not be seen within the time frames set by the National Screening Committee was added to the maternity risk register in July 2017. The risk was initially graded as low risk and subsequently upgraded to moderate. The risk identified the trust had one fetal medicine consultant who had one clinic per week, with limited capacity. Recommended timescales are that the woman should be seen within three days locally or five days at a specialist tertiary unit.

An update in February 2018 detailed that an audit was planned for March 2018. This audit would identify any maternity cases not referred to the fetal medicine consultant in a timely manner. It would also have the options of increasing fetal medicine capacity at CHFT and of automatic referral to the tertiary center if the time frame cannot be met were being considered. Data provided by the trust showed from April 2017 to March 2018, 116 fetal anomalies were diagnosed; of these 17 (15%) women were cared for at CHFT, and 101 (85%) were cared for at LTHFT. Reasons for transfer outside of CHFT most commonly included identification of multiple anomalies, capacity issues at CHFT, and the presence of rhesus antibodies.

**Maternity active outlier alerts**

As of January 2018 there were no active maternity outliers.

**Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE Audit)**

The MBRRACE UK report (published October 2017) showed the trust’s stabilised and risk-adjusted extended perinatal mortality rate (per 1000 births) for January to December 2015 was 5.5, almost 6% higher than the comparator group average (5.19); and slightly worse than the perinatal mortality rate from January to December 2014 (5.41). Recent data showed the trust had made significant improvements in its stillbirth rate since our last inspection. Data we reviewed showed that the unadjusted (total) stillbirth rate had fallen from 0.36% (20 of 5595 births) for the period March 2016 to February 2017 to 0.26% (14 of 5303 births) for the period March 2017 to February 2018.

(Source: Maternity Dashboard – Indicators)

Senior staff we spoke with told us that CHFT was a pilot site for the new MBRRACE Perinatal Review Tool, and will be using this from April 2018.

A risk of more women who birth at the trust having a measured postpartum blood loss of over 1500mls, experiencing a third and fourth degree tear, or undergoing delay in manual removal of
placenta was entered on the maternity risk register in March 2016, the risk was initially categorized as moderate and was subsequently downgraded to low.

Data provided by the trust showed from March 2017 to February 2018, there were 5248 deliveries booked at the trust, and 5303 babies were delivered.

The trust reported that of the 5248 women who delivered at the trust from March 2017 to February 2018, 97 (1.8%) experienced a third or fourth degree tear. This is an improvement on the previous year; of the 5508 women who delivered at the trust between March 2016 and February 2017, 164 (3.0%) experienced a third or fourth degree tear.

The trust reported 197 women (3.8%) who birthed at the trust between March 2017 to February 2018 had postpartum blood loss of more than 1500mls. This was about the same as the previous year; of the 5508 women who delivered at the trust between March 2016 and February 2017, 203 (3.7%) had postpartum blood loss of more than 1500mls. However, the method of measuring loss was more accurate which staff told us accounted for rates which appeared higher.

Data provided by the trust showed manual removal of placenta in 129 (2.5%) of 5248 women who delivered at the trust between March 2017 and February 2018. We saw entry space for delay in manual removal of placenta (over 1hr post-diagnosis to transfer) in the maternity dashboard, but could not see that any data had been entered for this time period.

(Source: Maternity Dashboard – Indicators)

Competent staff

Appraisal rates

From April 2017 to November 2017, 96.2% of staff within maternity at the trust had received an appraisal compared to a trust target of 100%.

Consultants told us that they now had their appraisals from another senior colleague but not necessarily in their own speciality. Staff we spoke with told us that overall this was positive as allowed the supervisor and supervisee to see a wider perspective.

Midwifery and support staff we spoke with had all received their appraisal and felt the process was much improved.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff who have received an appraisal</th>
<th>Staff who require an appraisal</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>179</td>
<td>186</td>
<td>96.2%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>61</td>
<td>64</td>
<td>95.3%</td>
</tr>
</tbody>
</table>

Calderdale Royal Hospital
A preceptorship package was available for newly registered midwives. One preceptorship midwife told us they felt the programme prepared and supported their development for their next step up to a band six midwife post.

New starters were given an induction period incorporating mandatory training. This was initially for a month but adjusted to suit individual staff needs.

Several midwives had undertaken the New-born and Infant Physical Examination (NIPE) course so they could discharge low risk babies following birth. The framework within which they practised was clear including a detailed list of neonates (babies up to 28 days old) they could review and those who needed referring to a neonatologist. The trust provided information that detailed 44 midwives at the trust were NIPE trained, this accounted for 20% of the midwifery workforce. The trust informed us that 27 of NIPE trained midwives worked on wards and the maternity assessment centre at CRH. The remaining 17 worked in birth centres and in the community. The trust noted they supported five to eight midwives a year to undertake NIPE training at a local university.

The rate of completion for 2017-2018 new-born resuscitation (NLS) training was 96.6% among midwives; which exceeded the 95% compliance target set by the trust.

Staff we spoke with told us that it was up to the trainer to update training completion records (on the electronic staff record (ESR) system) and this was not always timely; we saw evidence of mandatory training that had been completed but was not yet captured on ESR.

Midwives and medical staff undertook training in obstetric and neonatal emergencies on a regular basis such as, management of a post-partum haemorrhage and shoulder dystocia. This included emergency removal of a woman from birthing pools.

The maternity unit had a number of specialist midwives who had received extra training to provide advice for staff. This included substance misuse, safeguarding, bereavement, domestic abuse and early intervention which included teenage pregnancies and learning disabilities.

We spoke with medical and midwifery staff who told us that they had been supported with their professional revalidation.

A maternity specific mandatory training policy was in place at the trust. Midwifery staff were required to maintain a record of mandatory training for the purposes of appraisal. It was the responsibility of line managers to undertake regular staff performance reviews and appraisals; including discussion about mandatory training.

In 2016, the trust was selected from 49 maternity providers who submitted applications to become one of six trusts to pilot the new A-EQUIP (advocating for education and quality improvement) model of midwifery supervision. Senior midwives were moving from the previous model of supervision to EQUIP. There was an ongoing programme for midwives to attend a local university for the course. We spoke with six senior midwives who considered this had been a positive development.

<table>
<thead>
<tr>
<th>received an appraisal</th>
<th>an appraisal</th>
<th>rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>112</td>
<td>117</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>39</td>
<td>42</td>
</tr>
</tbody>
</table>
We saw the unit was an active learning environment. Junior staff told us there were daily teaching activities incorporated into handovers and audit sessions with opportunities for professional challenge. This correlates to the findings of the most recent published local General Medical Committee (GMC 2015) which quoted a junior doctor stated it was the best handover on labour ward they had ever experienced.

The trust provided us with information about bereavement training rates in maternity, and told us that all midwives now participate in this training as part of the service induction programme. The trust reported 26% of applicable maternity staff (57 of 219) were currently trained. Four band 6/7 midwives were trained to obtain consent for post-mortem. The trust informed us that in 2018, they will begin to deliver a second mandatory training day, and bereavement training will be included and led by the newly appointed bereavement lead.

Information provided by the trust detailed that the rate of completion for 2017-2018 new-born resuscitation (NLS) training was 96.6% among midwives across the trust.

In October 2017, we saw in the maternity risk register an entry for possible risk of failure to identify small for gestational age babies after 32 weeks gestation. This was due to a lack of clinically trained obstetricians/ultra-sonographers at the trust as was recorded as being a moderate risk. The trust had mitigated this by providing full time training for a specialist doctor at a local university.

An update in February 2018 detailed that a permanent specialty doctor was currently undertaking a specialised training programme (one year full-time university course) and the trust were advertising for an NHS locum consultant with these skills. Midwifery support workers had received training to take blood specimens.

**Multidisciplinary working**

We observed good multidisciplinary working on the wards, Calderdale birthing unit and maternity assessment unity. This included timely sharing of information and plans of care.

Multidisciplinary training was positively encouraged within maternity services (for example, through PROMPT); to enhance skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.

Live skill drills were facilitated in the immediate management of obstetric and neonatal emergencies in clinical practice. These drills encouraged multi professional working with obstetricians, neonatal paediatricians, obstetric anaesthetists, midwives and support workers.

We saw specialist care available for women who had ongoing health needs such as diabetes and epilepsy. We saw evidence in a record that there had been joint working between the obstetrician and medical staff delivering care to a woman with complex care needs.

There was collaborative work which included quarterly meetings between antenatal screening, paediatrics, microbiology and the scan department. Joint work had included identification of some scans over bank holidays which was rectified.

Complex patients who also required care from genito-urinary medicine were discussed with their consent at bi–monthly meetings between departments in order to develop the best care plans.

There was a perinatal mental health worker in the maternity unit who was a source of advice for staff and patients.
We saw effective communication between hospital staff and community midwives and general practitioners (G.P’s). There were regular workshops in the community ‘getting ready for baby’ which was a joint initiative by community midwives; children centre staff and health visitors.

There was close communication with social work teams where there was safeguarding plans or concerns around a baby.

We observed a multidisciplinary handover meeting on the labour ward. This was thorough and allowed for risks to be discussed and professional challenge.

Staff we spoke with had a good understanding and training in the ‘human factors’ which made up effective multidisciplinary working.

**Seven-day services**

Community midwives provided a seven day service with antenatal clinics in community settings; all postnatal visits took place either in the home or local authority children centres.

Midwifery and medical cover were available on the wards 24 hours per day. There was consultant on call out of hours.

Calderdale birth unit had midwifery cover 24 hours per day. There was access to the two obstetric theatres and staff 24 hours per day.

The maternity assessment unit was open 24 hours a day. Staff told us the unit had cut down on unnecessary admissions to the ward areas.

**Health promotion**

We saw a wide range of up to date leaflets and posters in the unit which addressed the risks such as smoking and alcohol.

Women could access ‘get ready for labour’ workshops with their partner or birth support partner. We spoke with three women who had found these informative and reduced their anxiety about labour.

Breast feeding was actively encouraged by staff and support given. Where women had decided to bottle feed, information was available to support safe preparation and use. There was a workshop available in the community ‘Nurturing and feeding your new-born.’ This information in the workshop made an early link between breastfeeding, attachment and infant brain development.

Key health promotion messages were in the parent held records (the red book) such as safe sleeping. We saw this was reinforced on the wards by the midwives and we observed that a midwife showed a mother how to safely place her baby in the cot.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2017 to November 2017, Mental Capacity Act (MCA) and Deprivation of Liberty training had been completed by 82.9% of staff in within maternity.

<table>
<thead>
<tr>
<th>Course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>206</td>
<td>244</td>
<td>84.4%</td>
</tr>
<tr>
<td>CHFT MCA &amp; DoLS Level 1 2017</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>WDD MCA &amp; DoLS Level 3</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
</tr>
</tbody>
</table>
Staff we spoke with showed an understanding of the concepts of Gillick competencies framework, which is used for young people under 16 consenting for their own treatment, and Fraser guidelines which includes the prescribing of contraception to that age group. There were laminated sheets in staff areas with clear information for staff to refer to.

The trust informed us that six band 6 and 7 midwives were trained to obtain consent for post mortem; and four of these were trained during 2017.

**Is the service caring?**

Add headings, text, graphs and diagrams

**Compassionate care**

**Friends and Family test performance**

**Friends and family test performance (antenatal), Calderdale and Huddersfield NHS Foundation Trust**

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

In October 2017 performance for antenatal was 97% compared to the England average of 96%. This had increased to 98% in January 2018

**Friends and family test performance (birth), Calderdale and Huddersfield NHS Foundation Trust**

From November 2016 to October 2017, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.
In October 2017, performance for birth was 100% compared to an England average of 96%. In January 2018 this had increased to 99%.

**Friends and family test performance (postnatal ward), Calderdale and Huddersfield NHS Foundation Trust**

From October 2016 to October 2017, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

In October 2017, performance for postnatal wards was 98% compared to the England average of 94%. In January 2018 this had increased to 99%.

**Friends and family test performance (postnatal community), Calderdale and Huddersfield NHS Foundation Trust**

From October 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

In October 2017 performance for postnatal community provision was 99% compared to the England average of 98%. This had decreased in January 2018 to 97%.

*(Source: NHS England Friends and Family Test)*

After our previous inspection in 2016, the trust invited Health watch to review maternity services with regards caring and responsive issues. At this inspection we saw the trust had addressed many of these issues.

We spoke with a woman who was admitted for a planned epidural caesarean section. The person said they felt reassured as they were able to meet the anaesthetist before the procedure and discuss their fear of having the epidural analgesia. The anaesthetist was able to reassure the woman about her concerns and was able to answer all her questions. This gave her the time she needed to feel at ease.
CQC Survey of women’s experiences of maternity services 2017

The trust performed similar to other trusts for all of the 15 questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.82</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.07</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.41</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>9.23</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.28</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.31</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.74</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.54</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.41</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>9.24</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.43</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>7.84</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>8.12</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>9.01</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>8.81</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Emotional support

We observed good emotional support to women in the ante-natal period, labour and postnatal period. We heard staff speaking in a respectful manner to women and their families.

We spoke with ten women and six partners who were very positive about the care they had received One woman and her husband told us that they thought the care they had received was ‘amazing’ and staff had been kind and approachable. One woman told us that she had to undergo an emergency caesarean section, but that staff had explained everything to her, and were supportive in a frightening situation.
Another woman told us she had delivered her baby at Calderdale some years ago and that this recent experience had been totally different in a positive way; she had felt listened to this time.

We saw that wards and the birth centre had a ‘guest book’ where women and their families could write comments. We saw the books were accessible to people using the service and on discharge, there was encouragement to fill them in. We observed positive comments about care.

There was a ‘little footsteps’ bereavement suite on the labour ward. The facility allowed families a quiet, secure and private place where they can spend time together. The room was seen to be cosy and homely, even with the clinical adaptations available; the suite can be configured as a birthing room, when needed. A separate sitting room was available, should the bereavement suite be in use. The service had the use of a cold cot, which enables the baby to stay with the family whilst on the unit. We were also informed another two cold cots were available, if needed. Women who experienced child loss had access to a specialist midwifery bereavement team.

There were policies and guidelines in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death. As well as clinical pathways, the policy outlined approaches for creating memories and the involvement of children/siblings, and options for registration of death, investigations, coroner involvement, funeral arrangements, and religious considerations.

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

We saw in the handover on labour ward that attention was paid to the psychological needs of women. Where there were particular anxieties, both medical and midwifery staff took time despite the busy environment to offer support.

Following our inspection in 2016, the service recognised that obtaining and acting on feedback from women was a challenge. Following the inspection, the trust approached Healthwatch Kirklees and Healthwatch Calderdale about leading an engagement project to look at how the trust could improve the opportunities for parents and expectant parents to give feedback on their experiences.

At the time of our recent inspection, there was a maternity patient experience group in place at the trust. The groups remit was to provide assurance to the maternity forum that maternity patients were receiving a positive patient experience, where this feedback/data was not positive to develop plans and solutions to address this, and to celebrate positive patient experiences across the directorate.

The responsibilities of the group included reviewing all patient feedback (for example, from the national maternity patient survey, FFT, complaints, incidents, and local patient surveys), and identifying a minimum of three key themes/trends per quarter to action over the following quarter, and monitoring these. The group also had responsibility for developing, implementing and monitoring an annual patient experience improvement work plan.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Bed Occupancy**

From April 2016 to September 2017 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

![Chart showing bed occupancy levels]
Data provided by the trust for the period March 2017 to February 2018 showed monthly figures for the number of maternity beds available, the number occupied at midnight, and the proportion occupied. Data showed a 56% average occupancy rate across maternity services at the trust over the period.

We saw how the service had adapted to meet the needs of the community. For example, the trust now tests all women for sickle cell anaemia and thalassemia due to the increase in numbers identified.

**Meeting people’s individual needs**

Women reported that they had all been provided with clear information about their treatment and care by medical and midwifery staff, with opportunity available to ask further questions for clarification.

Women and their families could pre-book a tour of the maternity unit prior to admission. The trust had an interpreting policy which gave clarity about the risks of using family members for interpreting unless in an emergency. We saw there was access to telephone interpreters, or where planned, face to face interpreting via a third party service.

We saw information on the trust maternity website about antenatal workshops and how they could be downloaded in a wide variety of languages. We saw signage and posters in languages other than English. The Family and Friends Test (FTT) was available in a range of languages.

Where possible, women had a choice to deliver within the birth unit, obstetric unit or book for a home delivery. These were offered within the confines of safety. There was a clear process for women who chose a home birth or in the birth unit where risk factors were identified.

Women who accessed the birth centre were allowed any number of birth partners if the woman wished and was appropriate. On the labour ward this was confined to no more than two due to environmental factors. Food and refreshments were available for partners out of hours.
Women who had a learning disability had access to a midwife with specific skills in this area. There was a draft protocol around looking after women with a learning disability, which was pending approval. We saw that there were easy to read resources on wards and departments. Support was also available for patients on the autistic spectrum.

All wards and departments had access to the hearing loop for women and their families where hearing loss was an issue. The trust also had access to interpreters for the British Sign Language.

We saw in the minutes of the maternity governance meeting, dated 12 March 2018, that there was a discussion around only the labour ward staff were to answer the emergency call buzzer. There had been an occasion when other staff had responded to the call and the woman had been alarmed at the number of staff in the room.

**Access and Flow**

The service had achieved 91.33% when booking ante natal care before 13 weeks gestation between February 2017 to January 2018. This is higher than the national figure of 90%. The information shared by the trust detailed that the community matron to determine reasons for the late booking reviewed all maternity cases not booked by 12+6 weeks. The most common reasons identified for late bookings included, the woman was outside of the United Kingdom, undecided with regards to a termination of pregnancy, or had transferred from another area and had unbooked in the other area.

There were processes in place to follow up women who did not attend appointments at the hospital or in the community. This was to ensure the well-being of those women and their babies.

The ante-natal clinic at Calderdale was open from 08.30 until 16.30 p.m. Ten minute appointment were allocated for routine ante natal clinic visits, although these sometimes went over time. We spoke with three women who told us they had waited sometime after their booked appointment and staff had kept them informed; they did not perceive this as a problem. Medical staff told us that sometimes clinic appointment times could be delayed by the treatment of more complex patients and occasionally the need to break bad news.

An entry on the maternity risk register (opened July 2017), described there was a risk that current antenatal clinic capacity exceeded demand leading to overbooking of clinics resulting in longer waits and poor experience for women and workload management difficulties for staff.

It was recorded that this risk had been exacerbated by gaps in the medical workforce during 2017-2018, and the risk has been escalated via an incident report. The possible impacts of the risk included, poor experience for women (including long waiting times due to overfull and overrunning clinics), and poor experience for staff arising from frustration caused by excessive workload. Actions taken to mitigate the risk included capacity and demand mapping, increased room capacity at CRH and HRI sites (by one room each) for diabetes clinics, which had the largest throughput of patients. The review of the pathways for women attending antenatal clinics, and exploration of alternative options were marked as ongoing. The risk was initially categorised as high and was subsequently downgraded to moderate.

Clinic delays were on the directorate risk register. The directorate undertook a capacity and demand review and had plans in place to mitigate delays which included better utilisation of clinics on both sites and to review ante natal administration staffing arrangements. The risk was initially categorised as high, and was subsequently downgraded to moderate.

The maternity assessment unit was open on a 24-hour basis for women over a gestation of 16 weeks and up to six weeks after having their baby. The unit provided a triage system either by
telephone or face to face. The unit had minimised admissions to the ward for processes such as fetal heart monitoring.

The birth centre at Calderdale had seen a decreased rate of births from previous years. We were told that this was due to a more pro-active approach to encourage women who were high risk to deliver on the labour ward.

Information provided by the trust described CHFT as not a tertiary centre for fetal medicine. A service level agreement was in place with Leeds Teaching Hospitals NHS Foundation Trust (LTHFT) until March 2019 to provide specialised care. The trust reported, following diagnosis of a fetal anomaly, women were offered an appointment locally with the CHFT fetal medicine consultant; with the exception of certain conditions, which were referred directly to LTHFT in the first instance (for example, cardiac anomalies).

The local consultant provided one clinic per week at CFHT, with availability for six patients. The service offered scanning, amniocentesis, forward planning for the remainder of the pregnancy, liaison with paediatricians and the Forget Me Not Children’s Hospice.

Women transferred to labour ward from the birth centre because of clinical reasons, could choose to return before discharge if they felt safe and appropriate. Women would normally stay on the birth unit for approximately six hours before discharge.

We saw from weekly and monthly maternity governance meetings that where there were delays in planned induction of labour due to the acuity and pressures of labour ward, these were discussed. They considered if actions taken during this time were appropriate.

We saw that discharges were timely and community midwives were informed by the electronic patient records.

**Learning from complaints and concerns**

**Summary of complaints**

From November 2016 to October 2017 there were 43 complaints about maternity. A breakdown of complaints is shown in the table below;

<table>
<thead>
<tr>
<th>Clinical Treatment</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>6</td>
</tr>
<tr>
<td>Communications</td>
<td>5</td>
</tr>
<tr>
<td>Patient Care</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Provider Information Request P55)

The trust took an average of 38 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days.

We saw that complaints and resulting actions had been discussed in the weekly and monthly governance meetings. For example, a delay in a routine induction of labour had resulted in a complaint. Staff were reminded to ensure the possibility had been discussed with women prior to the induction being booked and given a leaflet, which explained this.

There was a trust complaints policy and procedure in place, which staff were aware of; and we saw patient advice and liaison service (PALS) information leaflets on display in the areas we visited. Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform the ward or birth centre manager or co-coordinator.
Is the service well-led?

Leadership

Inpatient, outpatient and community obstetrics were in the family services division. The management structure in place had clear lines of responsibility and accountability. A triumvirate of a divisional clinical director, a director of operations and a divisional head of midwifery led the division. We observed strong, supportive and cohesive local and senior leadership.

The head of maternity services sat on the trust board and had direct access to the board when maternity was under consideration.

The head of midwifery was the professional and management lead for midwives, and responsible for developing the strategic direction of the service; they worked closely with the divisional director and the director of operations to meet the trust’s identified strategic objectives.

The service had two matrons in post who divided responsibility for wards and departments led by ward managers.

At ward level, staff were positive about their managers, saying they were supportive and approachable. They told us they knew who the senior leadership team were and they were visible day to day.

We saw that there was a leadership programme internally and staff were encouraged to shadow senior managers for their development.

Senior staff were supportive of the new arrangements of the supervision of midwives and had attended or planned to undertake the bridging programme to gain the Professional Midwifery Advocate (PMA) role. This new model of supervision was supported by NHS England and Health Education England.

Vision and strategy

The trust’s stated vision and values included ensuring that the work it carried out always “puts the patient first”, and the plan identified a vision that “together we will deliver outstanding compassionate care to the communities we serve.”

Key priorities for maternity services included delivering maternity care integrated with specialist services and which provided choice for mothers. This included extended ante-natal, intra partum and post-natal care (provided in the community, where possible) and increased choice for women where to deliver, with midwifery led maternity available on both hospital sites.

The maternity service had a clear vision for the future, ‘driving patient experience and safety though a holistic family approach’. All staff were clear about the governance and management structure within the service and risk management was embedded.

The community midwifery manager had a vision for the service, which was developed and communicated with staff. This included the provision of services for vulnerable women, which included asylum seeking families.

Culture

We observed positive relationships between medical staff, midwives and between teams. Staff spoke to each other in a respectful way. We were told the culture of the service had improved significantly and had followed a number of changes within the leadership team.
We saw the culture in the labour ward had been on the risk register in the previous 12 months before our inspection. There were concerns staff did not feel comfortable to challenge senior staff, which may affect patient safety.

The trust provided us with information that demonstrated different methods they had developed to better understand and improve the culture within maternity services to enable teams to deliver compassionate care. These included a ‘team working and safety culture survey.’ The survey was validated with a tool recommended by the improvement academy (IA). The IA analysed data collected and provided verbal and visual feedback to teams, and each team developed a local action plan based on their own survey results. The clinical managers of each area manage the action plans, and we saw evidence of updated reports and action plans dated to March 2018.

The trust reported the survey will be repeated in April-May 2018, as part of the trust’s wave two maternal and neonatal safety collaborative work.

The divisional senior management team also commissioned a ‘work together to get results breakthrough workshop’, facilitated by the chief executive (July 2017). Workshop attendees were invited because they had on occasion witnessed (or heard about) questionable behaviour between colleagues. These may be based on issues linked to race, gender or status or other forms of diversity. Twelve members of staff attended with representation from the chief executive, head of midwifery and midwives, director of operations, college tutor, and trainees. Four key areas were identified: excellence reporting, verbal positive comments (good mouthing), challenging inappropriate behaviour, and cultural mandatory training.

We saw on labour ward at this inspection, that staff were confident to challenge other professional opinions without fear of recrimination. We spoke with junior medical staff on labour ward who told us, that although there were pressures on the unit, it was a positive place to work and learn. We heard there had been opportunities for labour ward staff to consider their roles during team building exercises and had received human factors training. The service had also worked with the Royal College of Midwives to raise awareness of experiences and the impact of undermining behaviour in the maternity assessment unit.

**Governance**

The directorate had a clear governance structure and there were regular governance meetings with a clear action plan. This identified responsible individuals and defined actions. Assurance had to be gained before any areas could be marked as complete.

Where community midwives were called into support the hospital as part of the escalation plan they were placed in low risk areas of work such as the birth centre and antenatal and postnatal wards.

The maternity risk register detailed that all transfers were reviewed through the weekly maternity governance meeting process, with monthly audit of birth centre transfers reported to the maternity clinical performance and improvement group (maternity CPAIG), with escalation to the patient safety and quality board (PSQB) if required.

Information provided by the trust described that CHFT is not a tertiary centre for fetal medicine; and a service level agreement was in place with Leeds Teaching Hospitals NHS Foundation Trust (LTHFT) until March 2019 to provide specialised care. The trust reported that following diagnosis of a fetal anomaly, women were offered an appointment locally with the CHFT fetal medicine consultant; with the exception of certain conditions, which were referred directly to LTHFT in the first instance (for example, cardiac anomalies). The local consultant provided one clinic per week at CFHT, with availability for six patients. The service offered scanning, amniocentesis, forward
planning for the remainder of the pregnancy, liaison with paediatricians and the Forget Me Not Children’s Hospice.

The risk that anomalies identified on scans in pregnancy may not be seen within the time frames set by the National Screening Committee was added to the maternity risk register in July 2017; the risk was initially graded as low risk and subsequently upgraded to moderate. The risk identified that the trust have one fetal medicine consultant who has one clinic per week, with limited capacity. Recommended timescales are that the woman should be seen within three days locally or five days at a specialist tertiary unit. An update in February 2018 detailed that an audit was planned for March 2018 to highlight any cases that were not referred in a timely manner; and options of increasing fetal medicine capacity at CHFT and of automatic referral to the tertiary centre if the time frame cannot be met were being considered.

Data provided by the trust showed that from April 2017 to March 2018, 116 fetal anomalies were diagnosed; of these 17 (15%) women were cared for at CHFT, and 101 (85%) were cared for at LTHFT. Reasons for transfer outside of CHFT most commonly included identification of multiple anomalies, capacity issues at CHFT, and the presence of rhesus antibodies.

Management of risk, issues and performance

There was a family services risk management strategy; this was currently under review to incorporate the new professional midwifery advocate role. This outlined the processes for managing and escalating risks as well as individual responsibilities.

We reviewed the risk register, which had thirteen risks identified for Calderdale hospital and the birth centre. These risks related to staffing, availability of stenographers, bathroom facilities on ward 1d, and security arrangements on the wards. The risks correlated with information we had been told by staff and in the minutes of departmental meetings. We saw that there were actions to be undertaken by identified individuals and these were time limited.

The service had a maternity dashboard, which reported performance data. These were benchmarked against the regional averages. This enables the service to monitor outcomes and performance. The dashboard was discussed at maternity clinical governance meetings. We saw that clinical risk such as post-partum haemorrhage and the management of third and fourth degree perineal tears had been discussed as a priority and actions plans to address these were in place. This included a review from the Royal College of Obstetrics and Gynaecology in response to our previous inspection.

Information management

Community midwives had an agile working policy, which, ensured they could access electronic antenatal notes in GP practices and on laptops. However, connectivity in the local area was not always possible.

Staff showed us they could access information relating to polices and guidance electronically. The system was easy to navigate.

Staffs received training on information governance and were aware of the importance of managing confidential patient information.

We observed on wards and departments’ information boards with the names of staff were regularly updated.

Engagement
We saw that the senior and local leadership engaged all staff in the development of services and that staff was good despite the challenges of a busy environment.

There was clear information for women and their families on the hospital website. This included ‘Stork Talk’ which invited women to discuss any fears and anxieties they may have.

We saw daily ‘rounding’ by matrons and clinical managers had been implemented; these provided a visible presence for women and staff, and women and staff were encouraged to talk about their experiences and concerns. Matrons aimed to protect the first hour and an half of every day to enable them to visit all clinical areas early in their shift.

Maternity services had recently devised an anonymous, online survey (launched January 2018) so that they could learn more about staff experiences and their recommendations. The first survey had 27 responses from staff across grades and roles. Feedback included, colleagues preferred face to face discussion rather than email and preferred learning to be distributed from the weekly governance meeting in a newsletter rather than email. As a result of this feedback, the service had implemented a weekly learning lessons newsletter from the weekly governance meeting, and reported that this had been well received.

**Learning, continuous improvement and innovation**

Since our last inspection, we saw evidence of the different ways in which leaders and staff within maternity services had strived for continuous learning, improvement and innovation.

The trust’s stillbirth rate was the lowest in the region during quarter one of 2017 to 2018 (2.4 per 1000), and that this was a considerable achievement considering five years ago the trust’s stillbirth rate was above the national average. Each year a day was allocated as ‘stillbirth day’ to share learning and consider new developments. A world expert in this specialised area planned to visit the next session. We observed maternity services were participating in research project. Information about an upcoming study around decision making in labour was advertised in areas we visited. CHFT is one of two NHS trusts taking part in the study, ‘VIP: Voices in partnership, video-informed practice’; hosted by a local university and funded by the National Institute of Health Research. The recently launched study aims to video or audio-record women in labour to capture conversations between women and care providers, to inform interactional practices of decision making during childbirth in maternity units.

The trust also used standardised improvement tools and methods, such as participation in the MBRRACE UK audit. Senior staff we spoke with told us that CHFT was a pilot site for the new MBRRACE Perinatal Review Tool, and will implement this from April 2018.

The screening midwife worked closely with the local hospice in order to provide a package of care where an abnormality had been found which was incompatible with life. This included bereavement work with siblings. The screening midwife and the hospice nurse had been nominated for a national award for this work.

Following out inspection in 2016, the trust invited the Royal College of Obstetricians and Gynaecologists to undertake a review of their maternity services. A number of recommendations came from this. A maternity service improvement plan was developed to address the recommendations made.

The unit had been a reference site for NHS digital after securing a business case. This was a national development and meant that IT issues could be resolved more quickly.

Shortly after our inspection, the trust informed us NHS Digital advised them that they had been awarded funding to implement an electronic patient health record (ePHR) for maternity. The award
means that from the end of April 2018 women receiving care at CHFT will be able to access their maternity notes and pregnancy information via their personal smart phones, tablets and computers.

Additional information received from the trust outlined upcoming maternity services initiatives. These included an event planned for May 2018 to review and co-design a new pathway for women who have had diabetes in pregnancy or have diabetes in pregnancy; to be undertaken in conjunction with the trust patient experience team.

We saw participation in and learning from external reviews; for example, those undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) and local Healthwatch groups.
Services for children and young people

Facts and data about this service

Calderdale and Huddersfield NHS Foundation Trust (CHFT) provides hospital services in West Yorkshire at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI). The distance between the two hospitals is approximately five miles.

The trust employs around 6000 staff and has an expenditure of £375M.

The children’s service is located at both hospital sites; however, the majority of children’s services, which include inpatient medical, and surgery takes place on the Calderdale Royal Hospital site. Children's Outpatient and Child Development services, a Children's Diabetes Team and a Community Children's Nursing Team are also available which offered support to all areas in the organisation where children were seen.

The trust had 64 inpatient paediatric beds across two sites:

- Calderdale Royal Hospital - 56 beds were located within two wards
- Huddersfield Royal Infirmary - eight beds were located within one ward

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The neonatal intensive care unit (NICU) provided level two services at CRH with flexible use of intensive care, high dependency and special care cots in accordance to British Association of Perinatal Medicine Guidelines (2011) and network guidance.

EMBRACE provided regional transfers to appropriate centres for children and neonates who required specialist and / or intensive care. Inter-hospital transfers between Huddersfield Royal Infirmary and Calderdale Royal Hospital were made by local ambulances with parent, nurse or medical escort as required based on the patient’s clinical condition.

During our inspection of children’s services, we visited the neonatal unit, the children’s outpatients department, ward 3 the children’s ward, which included a two-bed high dependency unit and the child development, centre.

We spoke with 14 medical staff, 27 nursing staff including managers, eight members of the multi-disciplinary team and nine parents, which included one grandparent and one carer. We reviewed seven children's records.

The trust had 7,391 admissions otherwise known as spells from October 2016 to September 2017. Emergency spells accounted for 94% (6,972 spells), 4% (327 spells) were day case spells, and the remaining 1% (92 spells) were elective.
Percentage of spells in children’s services by type of appointment and site, from October 2016 to September 2017, Calderdale and Huddersfield NHS Foundation Trust

![Percentage of spells in children's services by type of appointment and site](image)

Total number of children’s spells by Site, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>7,111</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>272</td>
</tr>
<tr>
<td>This trust</td>
<td>7,391</td>
</tr>
<tr>
<td><strong>England total</strong></td>
<td><strong>1,102,315</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

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 Trust was committed to ensuring all staff completed their required mandatory training and had set a 95% target for 2017/18. Compliance was monitored by the Executive Board and the Workforce (Well Led) Committee. There were 10 mandatory training subjects. For 2017/2018, the Trust had decided that due to the implementation of the Electronic Patient Record (EPR) staff would concentrate on five mandatory training subjects and this would be monitored and measured for compliance. These sessions were Fire Safety, Infection Prevention and Control, Information Governance, Manual Handling and Safeguarding (Adults and Children).

The trust had RAG (Red, amber and green) rated compliance against its mandatory training records. The statistics submitted identified a target of 95% by the end of March 2018.

From 142 nursing staff all but one nurse had completed mandatory training.

Mandatory training figures for consultants (16 in total) showed all but one consultant who started work in the trust in February 2018 had completed mandatory training.
Middle grade doctors (four doctors) had nearly achieved 100% mandatory training compliance with the exception of one individual. The junior doctors commenced their rotation in February 2018 and of the 24 staff compliance ranged between 16.67% for the completion of safeguarding adults to 100% for completion of the female genital mutilation training.

Discussions with senior staff confirmed staff attendance at online mandatory training sessions. Staff told us these sessions had to be completed before the staff member received a yearly incremental pay rise. To-date, the neonatal unit local records confirmed 89.72% of nursing staff had completed their team mandatory training for 2017/18. We reviewed neonatal staff training records and noted compliance was achieved, for example, dementia awareness, waste management and safeguarding. Senior staff said the remaining staff had been booked onto their mandatory training, which meant the unit should achieve mandatory training compliance by the 1 April 2018.

Staff told us they completed mandatory training on ward three from March through to the summer yearly. Each staff member was allocated a day where they completed their online mandatory training in the morning and had their appraisal in the afternoon. Staff of all grades confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, fire safety, manual handling, infection control, and safeguarding.

We saw evidence of staff attendance at mandatory training on electronic documents. The records showed that the majority of staff had completed their mandatory training for 2017 / 2018. Reason’s for non-completion was due to staff sickness or maternity leave.

**Mandatory training completion rates**

The trust set a target of 95% for completion of some mandatory training. However, the majority of courses did not have a target given.

**Trust-wide**

A breakdown of compliance for mandatory courses from April to November 2017 for nursing staff in children’s services care is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>115</td>
<td>119</td>
<td>96.6%</td>
<td>No target given</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>115</td>
<td>119</td>
<td>96.6%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>109</td>
<td>115</td>
<td>94.8%</td>
<td>No target given</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>112</td>
<td>119</td>
<td>94.1%</td>
<td>No target given</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>112</td>
<td>119</td>
<td>94.1%</td>
<td>No target given</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>107</td>
<td>117</td>
<td>91.5%</td>
<td>No target given</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>97</td>
<td>109</td>
<td>89.0%</td>
<td>No target given</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>104</td>
<td>117</td>
<td>88.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Course name</td>
<td>Trained staff (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate (YTD)</td>
<td>Trust Target</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>95</td>
<td>109</td>
<td>87.2%</td>
<td>No target given</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>98</td>
<td>119</td>
<td>82.4%</td>
<td>No target given</td>
</tr>
<tr>
<td>Information Governance</td>
<td>96</td>
<td>119</td>
<td>80.7%</td>
<td>No target given</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>96</td>
<td>119</td>
<td>80.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>96</td>
<td>119</td>
<td>80.7%</td>
<td>95%</td>
</tr>
<tr>
<td>CPR</td>
<td>90</td>
<td>115</td>
<td>78.3%</td>
<td>No target given</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>82</td>
<td>109</td>
<td>75.2%</td>
<td>No target given</td>
</tr>
<tr>
<td>Clinical Pathways for Sick Children</td>
<td>42</td>
<td>61</td>
<td>68.9%</td>
<td>No target given</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>66</td>
<td>110</td>
<td>60.0%</td>
<td>No target given</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>59</td>
<td>106</td>
<td>55.7%</td>
<td>No target given</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,691</strong></td>
<td><strong>2,021</strong></td>
<td><strong>83.7%</strong></td>
<td>95%</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for nursing staff in children’s services was 83.7%. The target was not met for the four modules for which it was specified. The remaining 15 modules had no target set.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in children’s services care is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>38</td>
<td>43</td>
<td>88.4%</td>
<td>No target set</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>28</td>
<td>40</td>
<td>70.0%</td>
<td>No target set</td>
</tr>
<tr>
<td>Information Governance</td>
<td>28</td>
<td>43</td>
<td>65.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>24</td>
<td>42</td>
<td>57.1%</td>
<td>No target set</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>24</td>
<td>43</td>
<td>55.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>21</td>
<td>43</td>
<td>48.8%</td>
<td>No target set</td>
</tr>
<tr>
<td>Course name</td>
<td>Trained staff (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate (YTD)</td>
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</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>7</td>
<td>15</td>
<td>46.7%</td>
<td>No target set</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>20</td>
<td>43</td>
<td>46.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>20</td>
<td>43</td>
<td>46.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>20</td>
<td>43</td>
<td>46.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>17</td>
<td>40</td>
<td>42.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>16</td>
<td>43</td>
<td>37.2%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>14</td>
<td>40</td>
<td>35.0%</td>
<td>No target set</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>15</td>
<td>43</td>
<td>34.9%</td>
<td>95%</td>
</tr>
<tr>
<td>CPR</td>
<td>13</td>
<td>43</td>
<td>30.2%</td>
<td>No target set</td>
</tr>
<tr>
<td>NGT Elearning 2017</td>
<td>4</td>
<td>43</td>
<td>9.3%</td>
<td>No target set</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>309</strong></td>
<td><strong>650</strong></td>
<td><strong>47.5%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical staff in children’s services was 47.5%. The target was not met for the five modules for which it was specified. The remaining 11 modules had no target set.

**Calderdale Royal Hospital**

A breakdown of compliance for mandatory training courses from April 2016 to November 2017 for qualified nursing midwifery staff at Calderdale Royal Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>102</td>
<td>106</td>
<td>96.2%</td>
<td>No target set</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>102</td>
<td>106</td>
<td>96.2%</td>
<td>No target set</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>100</td>
<td>106</td>
<td>94.3%</td>
<td>No target set</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>99</td>
<td>106</td>
<td>93.4%</td>
<td>No target set</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>99</td>
<td>106</td>
<td>93.4%</td>
<td>No target set</td>
</tr>
<tr>
<td>Course name</td>
<td>Trained staff (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate (YTD)</td>
<td>Trust Target</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>95</td>
<td>104</td>
<td>91.3%</td>
<td>No target set</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>95</td>
<td>104</td>
<td>91.3%</td>
<td>95%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>92</td>
<td>104</td>
<td>88.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>90</td>
<td>104</td>
<td>86.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>88</td>
<td>106</td>
<td>83.0%</td>
<td>No target set</td>
</tr>
<tr>
<td>Information Governance</td>
<td>86</td>
<td>106</td>
<td>81.1%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>85</td>
<td>106</td>
<td>80.2%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>85</td>
<td>106</td>
<td>80.2%</td>
<td>95%</td>
</tr>
<tr>
<td>CPR</td>
<td>82</td>
<td>106</td>
<td>77.4%</td>
<td>No target set</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>77</td>
<td>104</td>
<td>74.0%</td>
<td>No target set</td>
</tr>
<tr>
<td>Clinical Pathways for Sick Children</td>
<td>42</td>
<td>61</td>
<td>68.9%</td>
<td>No target set</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>61</td>
<td>102</td>
<td>59.8%</td>
<td>No target set</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>56</td>
<td>103</td>
<td>54.4%</td>
<td>No target set</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>No target set</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,536</strong></td>
<td><strong>1,847</strong></td>
<td><strong>83.2%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

The overall completion rate for mandatory training modules by qualified nursing / midwifery staff in children’s at Calderdale royal hospital was 83.2%. Qualified nursing staff did not meet the trust targets for four of the 19 mandatory training modules. The remaining 15 modules had no trust target set.
Safeguarding

The executive lead for safeguarding children and adults was the chief nurse whose responsibility was to ensure robust and effective arrangements for safeguarding adults and children within Calderdale and Huddersfield Foundation Trust (CHFT). There was safeguarding reporting arrangements in place to ensure safeguarding processes were monitored trust wide.

The trust fulfilled its statutory requirements by having a named doctor for safeguarding children and named nurses for safeguarding children and adults. The head of safeguarding represented the trust at local safeguarding adults and children’s boards.

The head of safeguarding was responsible for key safeguarding staff within the trust and reported directly to the deputy chief nurse. The head of safeguarding provided strategic support and direction to the governance and safeguarding arrangements for CHFT.

CHFT hosted two designated doctors for safeguarding children, two designated doctors for ‘looked after children’ and a designated and named nurse for ‘looked after children’ in the Calderdale area. The designated nurse for Kirklees was employed by another provider. These roles are directly commissioned through the clinical commissioning group (CCG). A consultant paediatrician is the SUDIC lead.

Named and designated safeguarding nurses in post-attended sub-groups of the local ‘Safeguarding Children and Adults Boards’ and contributed to multi-agency collaboration and partnership working. The safeguarding team linked closely with other key departments such as risk and governance, human resources, and also patient safety and quality boards within the divisions.

The safeguarding committee had two sub-groups, learning and audit, and training and policy. Staff told us that a serious case review group was also in place. Safeguarding subgroups provided a forum to bring together key senior professional and operational managers across all divisions. The individual groups reported directly to the safeguarding committee and supported the chief nurse in discharging their responsibilities in relation to safeguarding and strengthening accountability.

The safeguarding committee reported directly to the ‘Quality Committee’ and provided twice-yearly updates for the meeting. This raised the profile of safeguarding within the trust and ensured lines of accountability were aligned directly with the trust board.

The electronic patient record system had flags to alert staff of children and young people who were under child protection plans or were looked after children. The trust incident reporting system alerted senior management and safeguarding team of any incidents or near misses involving a child.

Policies and procedures within the trust included references to multi-agency policies and procedures. CHFT had a safeguarding children’s policy, a domestic abuse policy, a female genital mutilation (FGM) guideline and a mental capacity act and deprivation of liberty policy. Non-adherence to policy was reported through the trust incident reporting system.

Safeguarding procedures were communicated to staff through training attendance, safeguarding supervision, safeguarding newsletters, monthly virtual notice board trust wide and safeguarding champions.

Staff demonstrated knowledge of the safeguarding guidance to follow. They knew what to do and who to contact should a concern be raised. Staff confirmed that feedback was received and lessons learnt from individual safeguarding incidents.
The female genital mutilation (FGM) guideline referenced mandatory reporting. CHFT have developed and implemented the collection and collation of data of known cases of FGM. This data was captured by staff using a data collection form within the FGM guideline and reported monthly at the safeguarding committee meeting. In addition, quarterly FGM data is submitted to the Department of Health.

Female Genital Mutilation (FGM) was flagged on the new-born/child’s electronic record (Cerner) as a “risk of FGM” if a mother or female relative had been identified as a survivor of FGM. Health records of any female babies that were born to survivors of FGM was documented in the child’s red book and information was shared with health visitors and GP through the discharge summary.

Systems were in place to support the teenagers. Meetings took place between the named nurse for children’s safeguarding and the named midwife for safeguarding. The safeguarding team liaised with the specialist midwifery team when a pregnant young woman were admitted to the antenatal maternity service.

All staff were required to complete safeguarding adults and children training every three years at the required level of training as per the draft intercollegiate document for ‘Safeguarding Adults’ and the intercollegiate document for ‘Safeguarding Children’. Staff attended child safeguarding training, initially at trust induction and then during annual mandatory training. The trust confirmed that the level three safeguarding module included information on sexual exploitation and a bespoke workshop was available for staff to access. Female genital mutilation (FGM) was discussed within all levels of safeguarding training for both adults and children. FGM training was also an essential skill for specific members and groups of staff that may meet survivors of FGM as a once only e-learning package introduced in January 2017. Paediatric staff confirmed they had undertaken this training. FGM was included in the safeguarding training for both adults and children. Ad-hoc training was delivered on request.

Training statistics provided by the trust confirmed that 89.44% of nursing staff had completed safeguarding children training and 97.18% had completed safeguarding adults training. Level two children’s safeguarding training was completed by 100% of nursing staff, whilst 87.5% had completed level three training sessions. Fourteen nursing staff remained to complete safeguarding level three training. Thirteen places were booked before the end of March 2018 and one staff member was due to attend the level three safeguarding training in quarter one of 2018/19.

Training statistics for medical staff confirmed 100% completion of safeguarding adults and children’s training. Consultant and middle grade staff had completed level three safeguarding training. Medical staff identified three paediatricians were to complete level four child safeguarding training. Gaps in attendance existed for junior doctors at both training sessions, 16.67% (four junior doctors) had completed safeguarding adults and 75% had completed safeguarding children training. Eight or 66.67% of junior doctors had also completed children’s level two training.

Staff completed annual safeguarding supervision. The safeguarding supervision policy (v4) identified that a minimum of one session in a 12-month period.

**Safeguarding training completion rates**

**Trust-wide**

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2016 to November 2017 for medical staff in children’s services is shown below:
<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>19</td>
<td>26</td>
<td>73.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>21</td>
<td>29</td>
<td>72.4%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>15</td>
<td>40</td>
<td>37.5%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>15</td>
<td>40</td>
<td>37.5%</td>
<td>No target given</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>146</td>
<td>51.4%</td>
<td>95%</td>
</tr>
</tbody>
</table>

At trust-wide level, the 95% target was not met for three of the five safeguarding modules for which medical staff was eligible from November 2016 to November 2017 also two of the five modules had no targets given. Trust-wide completion rate for medical staff was 51.4%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>97</td>
<td>109</td>
<td>89.0%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>97</td>
<td>109</td>
<td>89.0%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>93</td>
<td>108</td>
<td>86.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>32</td>
<td>44</td>
<td>72.7%</td>
<td>No target given</td>
</tr>
<tr>
<td>Total</td>
<td>325</td>
<td>376</td>
<td>86.4%</td>
<td>95%</td>
</tr>
</tbody>
</table>

At trust-wide level, the 95% target was met for one of the five safeguarding modules. It was not met for two of the five safeguarding modules for which qualified nursing staff was eligible from November 2016 to November 2017. Two of the safeguarding modules did not have any targets given, and trust-wide completion for qualified nursing staff was 86.4%.

**Calderdale Royal Hospital**

There is no data to support the breakdown of safeguarding training for medical staff for Calderdale Royal Hospital.

A breakdown of compliance for safeguarding training courses from April 2016 to November 2017 for qualified nursing staff for children’s services at Calderdale Royal Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>92</td>
<td>104</td>
<td>88.5%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>92</td>
<td>104</td>
<td>88.5%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>89</td>
<td>103</td>
<td>86.4%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>30</td>
<td>42</td>
<td>71.4%</td>
<td>No target given</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>304</strong></td>
<td><strong>354</strong></td>
<td><strong>85.9%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by qualified nursing staff in children’s services at Calderdale Royal hospital was 85.9%. Qualified nursing staff met one of the safeguarding completion targets. They did not meet the trust targets for two of the three safeguarding training modules for which there was a target. In addition, the rest of the modules did not have a set completion target.

**Cleanliness, infection control and hygiene**

The clinical areas were visibly clean. Hand gel pumps and washbasins were located throughout the clinical environment including entry and exit points to clinical areas.

Good infection control practices were observed by staff throughout the children’s and neonatal service. These practices included handwashing, bare below the elbow and the use of hand gel between patient contacts.

In the neonatal unit, we saw a bin placed to keep the door open. The room had a contact precautions sign displayed. We asked whether the infection control team had agreed this practice. Staff told us infection control were aware, however, there was no formal written agreement in place showing this was an acceptable practice.

Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available.

We saw cleaning schedules in place, which identified the tasks and frequency of cleaning in each area. These cleaning schedules were completed with signatures and dates to confirm the respective tasks were completed. 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.

Staff received infection prevention and control training as part of their induction and as part of the annual mandatory training. Staff confirmed completion of yearly online infection control training. The children’s service training statistics confirmed 95.77% of nursing and midwifery staff, 93.75% of consultant staff, 100% of middle grade doctors and 41.67% of junior doctors have attended this training to-date.

Senior staff from neonates confirmed that all staff with the exception of four had completed infection control training. Non-attendance of staff was due to sickness and leave.

Children’s toys were cleaned by the play specialist or nursing staff. We saw a toys cleaning log completed in the children’s outpatient department.

The January 2018 safety information displayed on the neonatal compassionate care board identified that they had no *Clostridium Difficile* infections and the last *Multi Resistant Staphylococcus Aureus* infection was in May 2017.
The trust did not regularly complete surgical site infection surveillance in children and young people.

The neonatal unit confirmed that weekly infection prevention and control checks had taken place. Audit scores for January 2018 confirmed 100% compliance in hand hygiene for the neonatal unit and ward 3. Cleaning scores were 98% and 95% respectively for neonates and ward 3.

We reviewed infection control audits from March 2018, for ward 3 and children’s outpatient clinic. The infection control audit generally showed compliance against areas measured. Where breeches were found these were identified. However, we were unable to ascertain whether the changes identified had been actioned, as the document did not identify this.

The Infection Prevention Quality Improvement Audit on ward 3 (29 March 2018) scored cleaning – 94%, overall infection control score – 88%, estates – 90% and matrons total 91%. The compliance rating given was a green rating. Green compliance ratings were awarded when the score is between 91-94%.

Hand hygiene audit compliance was 100% for the children’s outpatient department from 1 March 2017 to 28 February 2018.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.94 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)

**Environment and equipment**

Clinical areas were secure. Entry to clinical areas was either by swipe card or by pressing a bell to alert staff to open the door. Swipe cards were required to exit clinical areas.

Equipment suitable for babies, children and young people was seen in all clinical areas.

Throughout our inspection, we undertook checks on clinical equipment and noted the majority were serviced and this was denoted by the presence of a sticker. We found some equipment’s test dates in the neonatal unit out of date, for example, blood machine dated January 2018, therefore, approximately two months out of date. We also found portable appliance tests out of date on the Trans incubator; breast pump, heated cot (CD015395), scales (CD019950) and the thermometer (CD016315) had no check label present. This was escalated when found.

Twice daily checks of the neonatal transport incubator had taken place.

The children’s unit comprised of 32 beds, which included a two-bed high dependency unit. A dedicated adolescent room was available where young people could go.

From the 1 March 2018, the neonatal unit operated 22 cots following a review of the unit layout. Included within the cot numbers were two side rooms, a three-bed intensive care unit and three-bed high dependency unit.

The children’s outpatient department (COPD) had four consultation rooms, a parent / quiet room, waiting areas, baby change room and treatment room.

Staff from the children’s outpatient department (COPD) told us that they shared a children’s resuscitation trolley with the children’s ward. The children’s ward (ward 3) was located adjacent to the COPD separated by a corridor. Staff said that the resuscitation trolley was located in the
treatment room of ward 3c. We walked across to the treatment room on ward 3c and found no resuscitation trolley. We later found a children’s resuscitation trolley in the treatment room of ward 3b.

Staff from the children’s outpatient department (COPD) showed us they had access to oxygen and suction, which was, located in the COPD treatment room and resuscitation drugs kept in the drugs cupboard.

We reviewed resuscitation equipment on the children’s ward and noted daily equipment checks took place. We reviewed three months of checks, October 2017, December 2017 and February 2018 and found that the majority of daily checks had taken place. One check was missed on the 9 October 2017.

Staff confirmed and we saw that resuscitation equipment was located in the two-bedded paediatric high dependency area and the treatment rooms located on ward 3a and 3b. One adult resuscitation trolley was also located on ward 3.

We observed that the resuscitation trolleys were sealed. Random checks of resuscitation equipment showed all equipment to be in date. One piece of equipment was due to expire, which was highlighted.

The neonatal ward environmental audit for January 2018 scored 92%.

**Assessing and responding to patient risk**

The service had identified guidelines and protocols to assess and monitor patient risk and react to changes in risk level.

Calderdale and Huddersfield Foundation Trust (CHFT) had invested in an electronic track and trigger system (Nerve centre). This is an electronic observation system, accessed through iPods and laptops across hospital sites.

The paediatric advanced warning score (PAWS) was used to monitor children at risk of deterioration by grading the severity of their condition and prompted nursing staff to get a medical review at specific trigger points. If the child’s observations scored, above three, this showed deterioration in condition and relevant staff were alerted so appropriate actions were taken. PAWS audit data from April 2017 to February 2018 ‘Ward 3 Obs on Time’ showed compliance from 65 to 80%. In response, the children’s service matron and ward managers had undertaken monthly audits of five records to identify PAWS compliance as part of the trust’s ward assurance framework. This would continue until an improvement was maintained. The Paediatric PAWS action plan dated 1 March 2018 identified one set of actions, which included undertaking PAWS audits, staff education and the allocation of a band 6 sister to work on the ‘EPR Going Forward’ incentive.

Risks to babies on the neonatal unit were identified during initial assessment and documented within care plans. Ongoing reviews of babies’ risks took place. At shift handovers, safeguarding issues and specific risks were discussed with incoming staff.

Retrieval services for children and neonates were provided by EMBRACE whose role was to transfer sick babies and children to the paediatric and neonatal intensive care units based in Leeds and other centres.

Two high dependency unit (HDU) beds were located on ward three. Senior staff said band five and six nursing staff who worked in the HDU area were advanced paediatric life support (APLS) and high dependency trained. This group of nursing staff were managed and supported by a band seven nurse who had completed the high dependency course and APLS training.
The lead nurse for sepsis had led training sessions on the education and implementation of sepsis bundles. The service adhered to NICE guidelines for management of sepsis in children and guidelines were in place for the management of infection in neonates. Staff told us that an alert was generated through the EPR system when sepsis was detected.

The trust confirmed daily surgical safety check audit data was given to the operating services manager. Discussions of this data took place monthly at directorate team meetings, the surgical patient safety and quality board (PSQB) and Calderdale and Huddersfield Foundation Trust (CHFT) integrated performance meetings. Performance had been static across all operating services over the last 12 months at 99% average across all theatre teams.

Incomplete compliance was tracked back to the theatre team involved by the operating services manager, which included feedback to the relevant speciality team. Analysis of findings identified the third part of the World Health Organisation (WHO) checklist could be problematic due to the timing of the process and activity in theatre at this time. Work was ongoing to ensure that this part of the process was always led by the surgeon to drive a sustained change across all areas to 100% compliance. As part of ongoing quality assurance processes theatre, team managers performed regular observation of practice and WHO compliance audits.

During our inspection, we tracked one child through theatre and observed the surgical safety checks were completed appropriately.

In the CQC Children and Young People’s Survey 2016, the trust scored 7.61 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 9.69 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.

Staff told us that the trust major incident plan would be followed. The trust confirmed that on 24 January 2018, children’s services undertook a facilitated table top exercise (TTE) relating to business continuity management and service managers. The aims of the TTE was to test the business continuity plan, raise awareness, review the plan and criticise the requirements for any changes regarding service disruptions and delivering business group part of critical infrastructure.

During the exercises, emergency preparedness, resilience and response (EPRR) tools were identified to use, apply and implement responses strategies to initial operational recovery. The additional purposes were to embed integrated emergency responses. Feedback was that “The Group were really positive staff, engaging, skilled and loyal to delivery of patients safety was very obvious”

The staff we spoke with was not aware of any major incident simulation or table top exercises having taken place. The Paediatric directorate had business continuity plans in place for the 3 core elements of the service: neonatal intensive care unit / special care baby unit, paediatric wards and Child Health.

### CQC Children and Young People's Survey 2016 questions, safe domain, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
</table>

CQC Children and Young People's Survey 2016 Questions, Safe Domain, Calderdale and Huddersfield NHS Foundation Trust
How clean do you think the hospital room or ward was that your child was in?

<table>
<thead>
<tr>
<th></th>
<th>0-15 adults</th>
<th>About the same as other trusts</th>
<th>S1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>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)?</td>
<td>0-15 adults</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

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

Nurse staffing

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).

Staffing within the children’s service was considered safe by the senior management team and staff who worked throughout the service. Where shortfalls existed, bank and / or agency staff were sourced.

The nursing service delivered a seasonal workforce model, which reflected seasonal variation in activity. This resulted in reduced beds during the summer period and some weekends to reflect service need and safe staffing. Escalation by the nurse in charge to the General Manager/Matron who made this decision.

Three workforce models were used to manage staffing throughout the service. These models were referred to as base, summer and winter. The base model was used from March to July and from September to November; the summer model was used from July to August and the winter model was used from November to February. The workforce model was reviewed annually and signed off at trust level to ensure safe staffing.

The paediatric service had two band seven nurses (1.92 whole time equivalent hours) who worked across both hospital sites. The band seven nurses worked 50% clinical: 50% management.

Staff told us that patient numbers were recorded four hourly and that collection of this data had helped dictate staffing levels.

Staff said that additional ward rounds took place when patient capacity had increased and additional support was accessed either through a senior manager or at night the site manager.

These workforce strategies allowed flexibility in workforce planning so that times of high capacity were planned for and staff in place. During periods of lower capacity, staff education and training took place.

We were shown the figures for funded and actual staffing establishments in paediatrics. The establishments were fully recruited into.

We reviewed a paediatric staffing rota from 7 March 2018 and noted there was no band six cover throughout the 24-hour period. Staff told us that band seven nursing staff when not working clinically could be approached for support and advice. Band seven nurses were also allocated to clinical shifts.

Rosters covering the periods of November 2017 and February 2018 for Wards 3 and 18 were reviewed. Staffing for both wards was built on one roster. The roster system used (Allocate)
allowed reports to be run to filter advanced paediatric life support (APLS) trained nurse cover only. The APLS rota shows full APLS cover with one exception: Night shifts 6th Feb and 2nd March had only one APLS trained nurse due to late notice sickness; these were reported through the trust incident reporting system.

During the past six months, the following bank and agency staff have worked within children’s services: Bank – 71 individuals used (predominantly trust employees with bank contracts - 74% of total uncontracted workforce) and agency – 25 individuals used (26% of total uncontracted workforce).

Medical and nursing staffs within the children’s service were asked to take up a bank contract. To ensure safety, roster managers reviewed rosters to identify individuals working in excess of the ‘European Working Time’ directive.

Sickness was monitored to identify relationships between additional hours worked and absence. See sickness rates provided by the trust below:

The advanced paediatric nurse practitioner (APNP) role was introduced to the service. Seven APNP work on both hospital sites. Predominantly the APNP role supports the Huddersfield hospital site. The paediatric nurse practitioners support the children’s workforce from a medical and nursing perspective.

Children’s and neonatal areas had a ‘staff on duty today’ board, which identified planned and actual staffing numbers on shift.

Band five and six staff nurses who were advanced paediatric life support (APLS) and high dependency trained worked within the high dependency area, supported by a band seven nurse.

Staff told us they worked with the children’s and adolescent mental health service (CAMHS) team to provide nursing support for the child or young person with mental health needs.

Staff said safety huddles attended by the multi-disciplinary team took place twice daily. The matron also under took daily safety huddles in the morning. We saw a completed safety huddle document, which identified a list of alerts for discussion, for example, deteriorating patients with PAWS above six, absent patients, safeguarding / vulnerable patients. The document was used as a tool to ensure a full and effective handover between medical and nursing staff.

**Neonatal staffing**

Senior nursing staff confirmed that neonatal staffing funded establishment met the British Association of Perinatal Medicine (BAPM) Guidelines (2011). The actual staffing establishment identified some vacancies, for example, the funded establishment was 14.47 band six qualified in speciality staff, in post-currently 12.8 band six staff. This left a vacancy of 1.67 qualified in speciality nursing staff. A vacancy of 0.73 wte band five staff was identified against qualified staff not qualified in speciality group.

Senior staff said interviews for trained and untrained staff on the neonatal unit were taking place on the 9 March 2018, which, if successful would fill any vacancies.
We reviewed staffing information on the electronic badger system with a senior staff member. This showed where BAPM guidelines were met and any shortfalls. From 1 January 2017 to 28 February 2018, we noted some shortfalls. Staff absence contributed to these shortfalls as one staff member was on maternity leave and from October 2017 to January 2018, four staff were on long-term sick. From July 2017 to February 2018 the percentage of qualified staff in speciality (QIS) ranged from approximately 64% (November 2018) to 100%. The QIS staff at 64% was reflective on one occasion, the majority of the time QIS staffing was above 90%. The neonatal staffing report showed that 81.6% shifts were QIS to toolkit. The national average was 74.89% shifts QIS to toolkit.

The neonatal report dated from 01 January 2017 to 28 February 2018 showed 61.65% of shifts staffed to BAPM recommendations. The national average was 61.74%.

We reviewed two random neonatal duty rotas for weeks commencing 1 December 2017 and 2 April 2018 and noted that all day and night shifts were covered by band six qualified in speciality staff.

Sickness was monitored to identify relationships between additional hours worked and absence. See sickness rates provided by the trust below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental</td>
<td>1.29%</td>
<td>1.68%</td>
<td>0.00%</td>
<td>1.24%</td>
<td>1.12%</td>
<td>2.28%</td>
<td>4.95%</td>
<td>4.84%</td>
<td>3.47%</td>
<td>2.63%</td>
<td>1.29%</td>
<td>0.98%</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>3.90%</td>
<td>3.05%</td>
<td>3.85%</td>
<td>4.71%</td>
<td>2.61%</td>
<td>3.67%</td>
<td>4.37%</td>
<td>3.28%</td>
<td>7.34%</td>
<td>5.86%</td>
<td>4.94%</td>
<td>3.35%</td>
</tr>
</tbody>
</table>

Risk assessments against BAPM guidelines took place regularly. Safety briefs regarding staffing and other safety issues took place three times daily with the band six nurses in charge. We were told and saw evidence on the duty rota that the service aimed for two band six qualified in speciality staff. Where needed the band seven nurse also worked a part shift.

One band 7 clinical manager and two Advanced Neonatal Nurse Practitioners provided support on the neonatal unit. The neonatal nurse practitioners support the neonatal workforce from a medical and nursing perspective.

The enhanced nurse practitioner course had been completed by four band six and the band seven nurse on the neonatal unit. Staff told us that completion of this course was a ‘stepping stone’ to becoming an advanced nurse practitioner.

The trust has reported their staffing numbers below for the period March 2017 and October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE establishment, Mar-17</th>
<th>WTE staff in post, Oct-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>92.30</td>
<td>95.48</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 3.5% children’s services for qualified nursing staff, which is lower than the trust vacancy rate of 6.4% The site level breakdown was:
Calderdale Royal Hospital 3%

(Source: Routine Provider Information Request (RPIR))

Turnover rates
From November 2016 to October 2017, the trust reported a turnover rate of 8.5% in children’s services which is lower than the trust’s rate of 12.4%
The site level breakdown was:
- Calderdale Royal Hospital 8.5%

(Source: Routine Provider Information Request (RPIR))

Sickness rates
From November 2016 to October 2017, the trust reported a sickness rate of 3.7% in children’s services. This was lower than the trust’s target of 4.0%
The site level breakdown was:
- Calderdale royal hospital: 3.7%

(Source: Routine Provider Information Request (RPIR))

Bank and agency staff usage
From November 2016 to October 2017, the trust reported a bank and agency shift total of 277 in children’s services (75 bank and 74 agency) for qualified nursing staff. There were 71 shifts not filled by bank or agency staff.

A breakdown of bank and agency usage at both Calderdale Royal Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Average per month</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Bank</td>
<td>74</td>
<td>6.16</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>74</td>
<td>6.16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>71</td>
<td>5.91</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Medical staffing
The children’s service confirmed that they were not compliant against the ‘Facing the Future’ standards because of a lack of permanent consultant cover between 5pm – 10pm. Senior medical staff said consultant staff often stayed onsite rather than go home in the evenings so they could respond quickly to situations.

Paediatric and Neonatal services were supported by a ‘Consultant of the Week’ and on-call consultants available on a 24/7 basis. In hours (8.30-5pm), this support was a physical on-site
presence on the CRH site. During the hours of 9am to 6pm, two consultants were on call for the neonatal unit and paediatric ward. On call, hours were Monday to Friday 5pm -8.30 am. The weekend on call, consultant worked from Friday lunchtime through to Monday morning.

The service has employed 12.5 whole time equivalent (wte.) consultants within the acute children’s service. Two consultants had now retired and three new consultants were recruited into post. One of these consultants had since started at the trust.

A designated paediatric surgeon was responsible for children’s surgical services throughout the trust.

We reviewed the doctors rota dated 1 March 2018 – 6 April 2018 and saw that the information identified who was covering specific areas, for example, paediatric ward, special care baby unit, ward 18 at Huddersfield Royal infirmary. The rota was available in all areas for staff to access.

We were told that the middle grade rota was produced for a six-month period, which was the preferred option by staff, as this allowed them to plan their holiday. This rota is live on line and updated as necessary.

An 11-person tier two rota and 10-person tier one rota covering general paediatrics and neonates supported the Consultant rota. There is a separate overnight and weekend rota for neonates and general paediatrics.

On the Calderdale Royal Hospital (CRH) site (Ward 3 & Neonatal intensive care unit (NICU), a paediatric and NICU resident registrar was present from 8.30am -5pm. A resident paediatric and NICU registrar were on a twilight shift from 3pm to midnight (CRH). A resident foundation doctor worked 8.30am -5pm Monday to Friday (CRH).

From 9pm -8.30 am one night resident registrar cross-covered the NICU & paediatric ward (CRH) which were co-located.

At any one time, there were 1-3 Tier 1 trainees (made up of FY2, GP trainees Specialist Paediatric Trainees) who worked a range of shift patterns on the CRH site.

Neonatal nurse practitioners worked within NICU to support the neonatal workforce from a medical and nursing perspective.

Staff told us that there was a good medical presence and support throughout the service. Consultant staff who staff described as supportive provided support to the service out of hours. Junior medical and nursing staff told us they had been able to access consultant or registrar level doctors when needed.

Where there have been staff shortfalls the service had used bank staff or short-term locum staff to support the service.

Daily consultant led ward rounds took place on paediatrics and neonates seven days a week.

We observed a medical hand over session on the neonatal unit. The handover was concise and information was reviewed systematically. We observed medical staff update the electronic handover sheet and baby’s medical notes.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE establishment, Mar-17</th>
<th>WTE staff in post, Oct-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>45.82</td>
<td>42.41</td>
</tr>
</tbody>
</table>
Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate surplus of -4.8% children’s services for medical staff, which indicates that there was a possible over-establishment for medical staff in this core service.

Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 0% for medical staff in children’s services which is lower than the trust’s rate of 12.4%

Sickness rates

From November 2016 to October 2017, the trust reported a sickness rate of 1.8% in children’s services. This was lower than the trust’s target of 4.0%.

Bank and locum staff usage

From November 2016 to October 2017, the trust reported a bank and agency shift total of 56 in children’s services (43 bank and 3 agency). There were zero unfilled shifts by bank or agency staff for medical staff.

A breakdown of bank and agency usage at both Calderdale Royal Hospital by staff type is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/agency</th>
<th>Locum doctors</th>
<th>Average per month</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Bank</td>
<td>43</td>
<td>3.58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>3</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 41 whole time equivalent staff working in children’s services at Calderdale and Huddersfield NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This</th>
<th>England</th>
</tr>
</thead>
</table>

(Source: Routine Provider Information Request (RPIR))
Records

The Trust had introduced an electronic patient record (EPR) in May 2017, which supported ongoing overview and history of a child and young person across all areas within the organisation.

We reviewed seven children’s records and noted no gaps present. Treatment reviews by name and grade of the doctor or nurse were documented. Risk assessments and care plans, which showed the involvement of the multi-disciplinary team, were documented.

The notes trolley in the neonatal unit in nursery three was locked. One trolley was seen to be unlocked located outside the high dependency and intensive care nursery. Staff told us their practice was to have the notes trolley unlocked on the neonatal unit. The trolley was located around the corner from the nurses station, which meant it was not supervised at all times.

Staff told us and we saw that a computer on wheels accompanied ward rounds to ensure that children and young people’s (C&YP’s) records were updated.

Risks were identified for children and young people with mental health needs through their care plan documentation. A specific care plan ‘Young person under 16 years with mental health needs’ was specific to patients in this group.

In line with trust processes, paediatric clinical managers audited five sets of clinical records monthly using the ward assurance framework. Audit findings generated action plans. The electronic records audit is shown below and an action plan was developed following this audit. The action plan identified three areas, which either were on track or have achieved compliance.

(Source: NHS Digital Workforce Statistics)
Medicines

Medicines management was mainly in line with trust policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys. We reviewed seven children’s drug charts and noted that children’s weights were recorded, all prescriptions were signed and dated and no gaps existed within the records.

Two dedicated pharmacists visit the neonatal and children’s services Monday to Friday. Two pharmacists dispense at the weekend and there is an on-call pharmacist overnight. Medications are accessed from the out of hour’s cupboard.

The pharmacist said there had been occasional duplication of prescriptions on the electronic patient record. Should this happen doctors are either asked to remove the duplicated drug or the pharmacist will remove it themselves.

Storage of medicines to take home packs were located in the drug cupboard. This has reduced the need to go to pharmacy for the prescription.

The stores team check and topped up medicine cupboards weekly.

Nursing and medical staff received medicines training at induction.

Non-medical prescriber practice review and yearly affirmation of competency to prescribe documentation (August 2017) were completed by prescribers.

Staff told us that matrons completed ‘Flo audits’ which is where medicines and crash trolleys are checked as part of this audit process.
The clinical areas followed a controlled drug checking procedure. We reviewed two months of controlled drugs checks and saw twice daily checks took place.

One staff member told us how a medication error had resulted in the redesign of the drug chart and since this incident; there had been no other incidents of this nature. We saw a copy of the neonatal gentamicin drug chart, which provided clear direction around the administration and dose regime to follow.

We undertook random checks with the nurse and found four out of date ampoules of Valoid. The nurse disposed of these ampoules immediately on finding them.

Daily monitoring of drug fridge temperatures had taken place. Drug fridge temperatures were documented and within the accepted temperature range.

**Incidents**

Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incidents and significant events were discussed at ward meetings, governance and paediatric improvement group (P.I.G.) meetings in association with the risk register.

The 6 February 2018 paediatric forum meeting minutes identified monthly learning from incidents were shared on the children’s virtual notice board.

Red and orange incident reports and action plans were presented at the February 2018 paediatric forum.

There were two serious incidents within children’s services during the past 12 months. One incident related to care delivered within the emergency department and the children’s inpatient ward at Calderdale Royal Hospital (Ward 3). We reviewed the serious incident and noted a full investigation, action plan and recommendations had resulted. The trust had updated progress against the action plan, which showed four of the six recommendations were fully completed. Work was still ongoing on the sepsis trigger tool on the electronic patient record. There was no indication to show that the investigation report was shared with all those involved. This incident was not followed up with staff; however, one action was to feedback the investigation outcome to those staff involved.

The compassionate care board on ward three identified the last serious incident as October 2017.

Medical and nursing staff confirmed they knew how to report incidents and had received feedback from the incidents they reported. Staff said that incident feedback was cascaded through staff meetings, daily safety briefings, in the communication book and by email. Staff told us that safety alerts were circulated via email, the general manager and risk department; relevant alerts were discussed at the directorate governance meeting.

Advanced neonatal nurse practitioners reviewed clinical incidents and summaries to identify learning from incidents. An example was given of lessons learnt which involved the neonatal transport incubator. We saw the documentation, which supported this incident and noted an investigation had been completed. Staff we spoke with were aware of this incident and what monitoring measures were put in place following the incident.

Neonatal staff told us that incidents were discussed and debriefs took place at the ‘Big Breakfast’ every Wednesday.

The paediatric service carried out regular perinatal morbidity and mortality reviews jointly with colleagues from obstetrics. Within neonates, deaths were reviewed by presentation of cases, which included investigation findings if the death was a serious incident. Cases were discussed at
the multi-agency child death overview panel (CDOP) with anonymised learning from cases presented.

In paediatrics mortality cases were discussed bi-monthly at the paediatric clinical governance meeting and then at the child death overview panel (CDOP) when all investigations, post mortems and inquests were completed.

We reviewed the two mortality cases provided by the trust and noted actions identified, however, there was no confirmation of the date of completion of the actions. These cases took place in 2015 and 2016 respectively.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for children’s’ services.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in children’s services, which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were

- Pressure ulcer meeting SI criteria with one
- Treatment delay meeting SI criteria with one

*(Source: Strategic Executive Information System (STEIS))*

**Safety thermometer**

The trust currently used the classic safety thermometer across all areas of the trust, but would be using the specific children’s thermometer from April 2018. The safety thermometer was a local improvement tool for measuring, monitoring, and analysing patient harm, and harm free care. It provided a monthly snapshot audit of avoidable harm including falls, new pressure ulcers; catheter related and urinary tract infections (CUTI).

Monthly clinical performance data was reported within the compassionate care board, displayed on clinical areas. Staff told us they could access this information, therefore keeping them informed of performance indicator outcomes.

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.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, zero falls with harm and zero new catheter urinary tract infections from December 2016 to December 2017 for children’s services.

*(Source: NHS Digital)*
Is the service effective?

Evidence-based care and treatment

Guidance from authorities such as 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 three evidenced based guidelines and additional network guidelines. The evidenced based guidelines were in date, except for one. This was the infant feeding guideline, which was just out of date. Discussions with a staff member identified that the infant feeding guideline was under review and a meeting was booked with the doctors to discuss it.

Monitoring systems were in place to ensure that clinical guideline and policy reviews took place. The minutes of the February 2018 paediatric forum meeting confirmed the following guidelines and leaflets were approved, Children going home after an appendectomy, Croup, Looking after your child’s skin during a hospital stay, Child basic life support, Infant basic life support, Bronchiolitis – Information for parents.

Guidelines for review over the next six months were identified at the February 2018 paediatric forum meeting to ensure ongoing review took place.

Staff told us the neonatal unit was working towards implementation of the ‘Bliss Baby Charter.’ The baby charter was a practical framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles. The neonatal unit had registered for Bliss; remain, to submit the audit data. One band six nurse and a band three nurse are looking at what options are in place for parents. There are also two Bliss volunteers available to support parents.

Senior nursing staff confirmed that neonatal staffing funded establishment met the British Association of Perinatal Medicine (BAPM) Guidelines (2011). However, due to ongoing sickness this meant that BAPM was not fully met at all times.

Following the neonatal network peer review two years ago a recommendation was made that paediatricians should not provide cover for the birth centre at Huddersfield Royal Infirmary. The action taken was to implement a ‘scoop and run’ system. The trust has identified no incidents following this change in practice. Another network review took place in November 2017, which was positive.

Nutrition and hydration

A variety of food choices was available to children and young people. Special diets, for example diabetic, gluten free, renal, and textured and allergy diets were available. Specialised milk formulae were provided through pharmacy.

Basic foods were kept on the children’s wards, which could be provided outside of the main meal times.

The mothers we spoke with confirmed they could access food whilst on the neonatal unit. In addition, microwave, tea and coffee making facilities were also available.

Feed times were identified on a board in the neonatal high dependency and intensive care unit. The neonatal unit had a donor milk bank in place.
Security seals were present on individual milk trays. One person checked the seals with a scanner before the two staff checked breast milk at the cot side before giving it to baby. Staff said they were reviewing feeding guidelines so that responsive feeding regimes were adopted.

An enteral feeding framework for babies was in place on the neonatal unit. Feeding groups were identified, red, amber and green groups. For example, Red group babies – ‘consider starting tropic feeds, consider advancing feeds after 24 hours if well enough, start at 0.5ml/kg/hour and use expressed breast milk if possible. Parental nutrition will be required for many red group babies.’

Improvements following informal feedback identified through the “You said we did approach” included the introduction of the “Bring me food” service. This resulted from feedback from parents and carers who wanted access to food without leaving the child’s bedside.

Another initiative which incorporated healthy eating with a “bring me fruit” resulted in a fruit and milkshake round as a way of interacting informally with children and families to check in how families are feeling and also a method to help with the response rate for FFT cards.

**Pain relief**

The adult pain management team provided help and advice on pain management issues and were contactable by bleep. The service has recently revised its pain management guidance and one of the Anaesthetists has a clinical session for paediatric pain management.

The guidance for the ‘Management of Acute Pain in Children’ (v4) was updated in 2017. The amendments related to the updated pain score to 0-3 as used on the electronic patient record and the pain ladder was revised.

Out-of-hours an anaesthetist was on call and structured pain relief was in place for each child.

We reviewed children’s notes admitted for surgery. We reviewed a sample of children’s pain charts and saw that children’s pain scores were escalated as per trust guidance.

Babies, children and young people had access to a range of pain distraction techniques and pain medication. If babies were unsettled or appeared to be in pain, this observation was discussed with the doctor to determine whether pain relief was required.

Six of the seven children’s charts we reviewed identified the use of a pain assessment tool for that child during their admission.

**Patient outcomes**

Staff told us that the children’s service was being assessed through the ‘Comparative Health Knowledge System (CHKS)’ accreditation. The paediatric service was the first service to be involved in this accreditation system whose standards covered the core principles of healthcare delivery, including, safety, leadership, governance, quality improvement, developing staff, managing risk and effective management. Staff said the first data submission had taken place and accreditation was the second week of April 2018.

Performance and therefore babies outcomes had continued to improve according to the national neonatal audit programme (NNAP) data. The trust NNAP data made a progressive improvement against the national average from 2014 to 2017. To continue to improve and ensure a safer patient service consultation with stakeholders resulted in recommissioning the audit for a further four years whilst introducing some new national neonatal unit audit programme (NNAQ) audit measures in time for data entry in 2017. So far, the NNAP 2017, quarter 3, data summary report for Calderdale Royal Hospital showed the majority of patient outcomes continued to improve. Moving forwards one of the key areas is reducing term admissions to the neonatal unit, and
auditing the care of all term babies separated from their mother using the new national audit framework.

The national neonatal unit audit programme (NNAP) for 2015 – 2016 identified named audits against eight identified areas. Four areas were above the national average. These areas were temperature within range – 65% (national average 61%), consultation with parents – 95% (national average 90%), screening for retinopathy of prematurity – 100% (national average 94%) and clinical follow-up at two years of age – 87% (national average 61%). The remaining four areas fell below the national average a 5 to 13% shortfall. We saw a general improvement made against the audits for 2016.

Staff told us the trust had missed the window of assessment for retinopathy of prematurity (RoP) screening. Following this, a clear pathway was implemented to ensure these babies were seen within the recommended time windows for first screening. We saw RoP guidelines (v1, 23 November 2016) to guide staff when managing these babies. The 2016 NNAP audit results showed 100% compliance for the trust against a national average of 94%. The national audit programme 2017 quarter 3 data summary report for Calderdale Royal Hospital showed 95.5% (44 babies), the national average 92.5%, received RoP screening on time according to the NNAP interpretation of national guidance.

The trusts neonatal annual report – antenatal steroids (01 January 2017 – 28 February 2018) showed that babies outcomes were improved at the trust compared against nine other hospitals. The eligible patients to receive antenatal steroids at Calderdale & Huddersfield NHS Foundation Trust were 156, steroids given to 145, which gave a percentage application of 93%.

Calderdale and Huddersfield NHS Foundation Trust summary of analysis data for the national paediatric diabetes audit (NPDA) 2015/16 showed it performed worse than the England average, although, it was still within expected range. Compared to audit 2014-15 the trust HbA1c has improved more than some other trusts but is still an outlier and is an outlier in the percentage of patients with HbA1c <58mmol/mol. The NPDA is a powerful tool for measuring performance, and reports on the delivery of a high quality system of care based on standards set by the National Institute for Health and Care Excellence (NICE).

The paediatric diabetes action plan (2015/16) confirmed progress made. For example, to set up nurse led clinics. Monthly nurse led clinics commenced on the 28 March 2018 on the Calderdale Hospital site and on the 4 April 2018 on the Huddersfield Hospital site. The trust has continued to audit paediatric diabetes; its most recent audit completed October 2017.

Readmission data for patients with diabetes, asthma and epilepsy was analysed by team leads quarterly. The last readmission summary for Q3 & Q4 (July 2017-March 2018) showed the higher number of readmissions of under ones was in the respiratory category.

From August 2016 to July 2017, a higher percentage of under ones were readmitted following an emergency admission compared to the England average and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Three areas were being reviewed: For under 1’s, a re-audit of readmissions for 2017-2018 was taking place. The trust was now focusing on readmissions related to feeding and respiratory conditions. All activity through the Paediatric Assessment unit was coded as an admission (not an assessment), as per local contractual arrangements. The trust thought this arrangement may skew the data. In addition, and linked to trust process the trust offered a 24 hour recall to the Paediatric Assessment Unit following discharge. The graphs presented by the trust for both age groups have shown a decline in readmissions within two days from August 2016 to July 2017.
Staff across the trust recognised the importance of listening and responding to patient and carers views. This was championed through the representatives on the ‘Trust Patient Experience and Caring Group’. The paediatric diabetes team evaluated the impact of diabetes education sessions and responses included: I can control my diabetes and it is better if I do so.

Findings from audit activity introduced changes to ways of working. For example, staff told us they had not been good at documenting communications with parents. We were shown children’s notes were medical staff had recorded their conversations with children and their families. The name, date and time of conversation were also noted in the child’s notes.

The NHS England Quality Surveillance Visit – Neonatal Peer Review took place on the 1 November 2017. In the visit report the reviewers described their visit as ‘brilliant’ and explained that Calderdale Royal Hospital was the first unit of the 14 reviewed to date that had neither an immediate risk nor serious concern identified during the visit. Areas that particularly impressed the neonatal review team included governance arrangements with evidence of clear reporting and escalation. The nursing ‘Confirm and Challenge’ process was cited as an excellent example of team working and escalation.

There were no immediate high-level concerns raised by the peer review team who visited the trust. Verbal feedback was very positive and the report received set out a number of areas of good practice and areas for development. The children’s directorate team are developing an action plan, which will be confirmed during March 2018 and approved with its delivery overseen by the Neonatal Forum.

Children’s educational outcomes were being met as they could access ETHOS (Educating those out of school) if they had been out of school for 15 days or more. The Ofsted report dated 14th February 2017 awarded this provider an outstanding rating.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows that in the 2015/16 diabetes audit Calderdale and Huddersfield NHS Foundation Trust performed worse than the England average.

The proportion of patients receiving all key care processes annually was 41.4%, which was worse, compared to a national aggregate of 35.5%. The previous year’s score was 55.3%.

The average HbA1c value (adjusted by case-mix) at the trust was 75.1% has significantly improved, compared to the national aggregate of 68.3%. The previous year’s score was a negative outlier.

Although score is worse than the England average it is still within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 69.5, which was better than the previous year’s median of 74.0.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

There were no specialties at the trust that had six or more emergency readmissions within two days of discharge following an elective admission.
The tables below show the percentage of patients (by age group) who were readmitted within two days of discharge following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

### Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>5.7%</td>
<td>2,160</td>
</tr>
</tbody>
</table>

No other specialty at this trust had six or more readmissions.

### Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.0%</td>
<td>4,717</td>
</tr>
<tr>
<td>General Surgery</td>
<td>6.5%</td>
<td>184</td>
</tr>
</tbody>
</table>

No other specialty at this trust had six or more readmissions.

The data shows that from September 2016 to August 2017, there was a higher percentage of under ones readmitted following an emergency admission compared to the England average in the paediatrics specialty.

Both the paediatrics and general surgery specialties had a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to their respective England averages.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

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

From October 2016 to September 2017 there is no data for the trust for the percentage of patients under the age of one who had multiple readmissions for asthma and diabetes.

The trust performed worse than the England average for the percentage of patients aged under one who had multiple readmissions for epilepsy.

The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, diabetes and epilepsy.
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).
(October 2016 to September 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>24.9%</td>
<td>173</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>17.8%</td>
<td>45</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>85.7%</td>
<td>7</td>
</tr>
<tr>
<td>1 to 17</td>
<td>30.2%</td>
<td>43</td>
</tr>
</tbody>
</table>

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

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

In the 2016 National Neonatal Audit Calderdale and Huddersfield NHS Foundation Trust performance was as follows:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

- There were 56 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to the trust for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window*; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

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

- There were 391 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 95% of the eligible episodes; this was above the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

- There were 15 babies born at < 30 weeks born between July 2013 and June 2014 who were assigned to Calderdale and Huddersfield NHS Foundation Trust for two-year health
assessment based on their final neonatal discharge. None of the babies born at < 30 weeks at Calderdale and Huddersfield NHS foundation trust during this period had died as of two years post discharge, compared to 1% for the UK as a whole (average).

However (0%) had suffered severe health impairment, compared to (10%) for the UK as whole. In addition (0%) had suffered mild impairment, compared to (13%) for the UK as a whole. 13 (87%) suffered no impairment, compared to the UK average of (30%).

It should be noted that these figures have not been adjusted for case mix, and the sample size of 15 babies is quite small.

What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?

- There were 119 babies born < 32 weeks at Calderdale and Huddersfield NHS foundation trust that were eligible for inclusion in the audit for Calderdale and Huddersfield NHS foundation trust Of these 18% were identified as having significant BPD. This was better than the UK average of 31%.
- 12% were identified as having mild BPD, better than the UK average of 16%.
- 70% were identified as having no BPD, better than the UK average of 52%.

Definition of Bronchopulmonary Dysplasia:

A: Mild: respiratory support (Ventilation ,CPAP, BiPAP, HHFNC and or any oxygen) on day 28 + air at 36 weeks corrected gestation or from the time of discharge if discharged earlier
B: Significant: respiratory support on day 28 + respiratory support at 36 weeks corrected gestation or from the time of discharge if discharged earlier

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

Competent staff

Staff spoke about their induction to the service and confirmed they had training profiles, which took into account their involvement with children. Examples of the types of training attended, paediatric life support, safeguarding training and safeguarding supervision.

Staff told us they felt supported; new staff had a buddy and preceptor and a two-week supernumerary period. One student nurse said they felt well supported and could approach their mentors should they require additional support or raise concerns.

Staff said the ward sister was sourcing some mental health type training sessions.

Trust training statistics identified a shortfall in attendance at neonatal and paediatric life support training. To date 83.21% of staff (114) had completed these training sessions. Of the 23 staff who had not completed life support training 16 were identified on the electronic patient record as booked in the next three months. In addition, 22 staff had completed the advanced life support course whilst, 29 staff completed the neonatal life support course.

Discussions with recovery staff identified they attended bi-yearly paediatric intermediate support training and yearly adult life support training.

Formal processes were in place to ensure medical and nursing staff received role specific training and an annual appraisal. Nursing staff told us they received yearly appraisals and training specific to their needs.
During 2017/18, the children's and neonatal services followed the trust-wide approach to appraisal in carrying out appraisals for all staff within a four-month 'appraisal window'. This appraisal window took place between July and October. In future years, this 'appraisal window' would take place during April to July.

The trust identified appraisal compliance within the children’s service as excellent. During 2017/18, over (>96%) of staff received an appraisal (183/189) against a trust target of >95%. Six staff had not received an appraisal during 2017/18 were a combination of returned from maternity leave, long-term sickness and new starters who had recently passed their six month probation period.

We saw local records, which confirmed that 91.94% of neonatal nursing staff, with the exception of the advanced nurse practitioners had completed their appraisal process for 2017 / 18. Children’s outpatient staff said they had completed their appraisals for 2017 / 18.

Nursing staff rotated across the children’s service to ensure variety and skill acquisition and maintenance.

The neonatal unit identified that nurse leads received additional training and attended relevant meetings in areas such as bereavement, medical devises, safeguarding, infection control, developmental care and incident / simulation training. These nurses supported the nursing team through the delivery of training and information updates.

Staff told us that clinical supervision was not in place. However, where staff required support through this route it would be provided on request. Debriefing had taken place following incidents.

The trust identified a comprehensive range of development programmes for nurses, for example, the band seven-development programme; matron development programme; ward manager development programme. All supported succession planning.

Medical training was supported by senior medical staff who were recognised tutors.

New medical staff attended deanery, trust and departmental inductions. Each new doctor had an allocated mentor.

Medical staff had designated days and times for teaching and training. For example, trainee paediatricians attended specialty trainee education programme in paediatrics (STEPP) training days. Registrar grades attended a Wednesday teaching day. The five GP trainees had designated training time. Monthly mortality and perinatal training was also available for trainees to attend.

The clinical director ensured all consultant appraisals are completed in the month of their birthday. All medical appraisals and revalidations were completed and medical staff completed a competency matrix before having their appraisal.

Anaesthesia for children, whether local or general, was provided by an anaesthetist with specialist training and experience in paediatric anaesthesia.

**Appraisal rates**

From November 2016 to October 2017, 88.5% of staff within children’s services at the trust had received an appraisal compared to a trust (completion) target of 100%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who have received an appraisal (YTD)</th>
<th>Individuals required (YTD)</th>
<th>Appraisal rate (%)</th>
</tr>
</thead>
</table>

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Support to Doctors and Nursing Staff | 44 | 44 | 100.0%
Support to Scientific, Therapeutic and Technical Staff | 5 | 5 | 100.0%
NHS Infrastructure Support Staff | 3 | 3 | 100.0%
Qualified Allied Health Professionals | 1 | 1 | 100.0%
Qualified Nursing Midwifery Staff | 1 | 1 | 100.0%
Qualified Nursing and Health Visiting Staff | 106 | 110 | 96.4%
Medical & Dental staff - Hospital | 9 | 27 | 33.3%
Total | 169 | 191 | 88.5%

Calderdale Royal Hospital had a 97.8% appraisal completion rate.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who have received an appraisal (YTD)</th>
<th>Individuals required (YTD)</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>94</td>
<td>97</td>
<td>96.9%</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>137</td>
<td>97.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Multidisciplinary working

The multi-disciplinary team provided clinical assessment and treatments using a child friendly approach, which utilise play and distraction therapies.

Staff identified there were effective working relationships between children and adolescent mental health service (CAMHS) professionals and paediatricians.
Discharge planning for the baby, child or young person involved all those members of the multidisciplinary team involved in their care, for example, nurses, community teams, continuing care team, GP, social care professionals and therapists.

Staff shared information with health visitors and social work staff to update them and involve them in discharge planning processes of new mothers who had experienced mental health issues.

The trust was developing a policy for transition, which was to be ratified at the April 2018 Paediatric Forum. For young people from the age of 14 years with chronic health needs such as cystic fibrosis, epilepsy neurodisability and diabetes staff should start to prepare the young person and their carers for transitioning to adult services. The children’s service utilised the national paper work called ‘Ready Steady Go’ to assist with the young person’s transition. Monthly diabetes clinics take place Thursday evenings.

Ensuring liaison with adult services the new clinician, young person and family were fully informed and involved. The transition process aimed to complete by the young person’s 18th birthday. Transition was managed either locally within health, social care or with regional services.

Neonatal staff said they had close links with the children’s community team and community physiotherapy teams in respect of babies who required ongoing support at home.

Physiotherapist staff liaise closely with hospital nursing staff, community paediatric and physio teams when children and young people require support at home.

Four children’s records showed involvement of the multi-disciplinary team documented in their care and treatment plans.

EMBRACE transport service identified a link consultant for all of the District General Hospitals. The purpose of the link doctor was to improve communication between the trust and EMBRACE, and flag up any difficulties with transfers. The consultant attended clinical governance meetings to discuss difficult cases and to spread learning from the transport service. We saw discussions had taken place in the May 2017 paediatric governance minutes. Discussions centred on retrieval cases involving Embrace. Three cases were discussed which had a common theme around communication with team. Action: To discuss any changes no matter how minor deemed on babies scheduled for transfer.

**CQC Children and Young People’s Survey 2016 – Q36**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.46 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.

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

**Seven-day services**

The Trust had worked to implement the core standards for seven-day services. It was one of four Trusts in the North of England to meet standard two in the recent data return achieving 93% against a target of 90%.

On call pharmacy support and pharmacy access was available during specified times at the weekend.

Staff told us that CAMHS support was available throughout the week and after 5pm.

Radiology services are provided 24/7 including in-hours and overnight on call.
A children’s community team provided on-call support at weekends to the ward staff should a child be discharged home requiring community nurse support.

Twenty-four hour paediatric and neonatal consultant support was in place.

Physiotherapy provision with on-call provision is available.

Staff told us they could access anaesthetists 24/7.

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

Children’s services adhered to and followed the trust wide policy. In addition, children’s services utilise the 10 steps of confidentiality to ensure that information that was given to a patient supported their decision.

Staff demonstrated through discussion that they were informed of and understood the consent process. Staff explained the consent process was completed by surgeons for children requiring surgery and that written consent was obtained prior to this.

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.

Paediatric staff told us that verbal consent was obtained prior to procedures such as the collection of bloods and insertion of nasogastric tubes.

Neonatal staff said that the majority of time parents gave verbal consent; however, on occasion written consent would be requested. The baby’s admission document identified consent options, for example, consent for donor expressed breast milk, formula feed, cup feed, bottle and dummy.

We asked staff about their understanding regarding the Frazer guidelines and Gillick competence in relation to consent processes for children and young people. The staff we spoke with demonstrated some understanding of this guidance and how they implemented it in practice. Trust training statistics confirmed attendance at Fraser and Gillick competence training sessions. For nursing staff 127 or 89.44% had completed this training. All consultant and middle grade staff had completed this training. Junior doctor attendance was 75% which meant that 18 of 24 doctors.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that From April 2017 to November 2017, Mental Capacity Act (MCA) training had been completed by 75.2% of staff in within children’s service in which there is no trust target.

Deprivation of Liberty training data has not been provided.

*(Source: Trust Provider Information Request P14/P49)*

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed better than other trusts for zero questions, worse than other trusts for zero questions and about the same as other trusts for the remaining five questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children's Survey questions, effective domain, Calderdale and Huddersfield NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
</table>

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Did you feel that staff looking after your child knew how to care for their individual or special needs?

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comparison</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 adults</td>
<td>8.25</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
</tbody>
</table>

Did staff play with your child at all while they were in hospital?

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comparison</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7 adults</td>
<td>7.21</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

Did different staff give you conflicting information?

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comparison</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7 adults</td>
<td>7.64</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

Did the members of staff caring for your child work well together?

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comparison</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 adults</td>
<td>8.60</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

During any operations or procedures, did staff play with your child or do anything to distract them?

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comparison</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 adults</td>
<td>7.48</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

Did hospital staff play with you or do any activities with you while you were in hospital?

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comparison</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-11 CYP</td>
<td>4.45</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

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

**Is the service caring?**

**Compassionate care**

Throughout our inspection, we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers. Staff had a positive and friendly approach and explained what they were doing, for example when preparing children for theatre.

We observed two children’s anaesthetic assessments and noted that the anaesthetist knelt down so they were at face level with the child and parent when taking the child’s history.

We spoke with two young people, seven parents and two grandparents who told us they had generally been happy with the care and support they had received.

Parents from the neonatal unit told us that staff always introduced themselves, had found out their needs and what they as the parent wanted to do.

To maintain dignity the neonatal unit have invested in different height mobile screens were used when mothers breast-fed their babies.

Feedback cards and comment boxes for parents to use were available throughout the service. We saw positive feedback about their experiences given by parents on cards displayed throughout the service.

Feedback from the friends and family audit identified in February 2018 that 86% of people would recommend the children’s outpatient’s service to friends and family.

The service identified areas it was currently improving through ‘You’ve told us’. In children’s outpatients, this related to more activities for older children and looking at ways to make the waiting area friendly for all age groups. The nurse said this had been partially achieved through segregating the different age groups within the waiting area.

A ‘Happy Board’ where children and young people could leave comments was implemented on ward 3 in January 2018.
CQC Children and Young People’s Survey 2016

CQC Children and Young People’s Survey 2016 questions, compassionate care, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.34</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.84</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.89</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.68</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>6.57</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.97</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.40</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>9.13</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>

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

Emotional support

The parents and young person we spoke with said nursing staff always introduced themselves at the start of shifts. Staff were described as helpful and medical staff had spoken with them and reviewed their 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 those mothers who experienced mental health problems or learning disabilities they received additional emotional support through the multi-disciplinary team. Health visitors and social workers would be involved in their care and to ensure sufficient support was in place discharge planning for home would commence on admission to the neonatal unit.
Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for families to access.

During bereavement, staff told us that copies of the baby’s hand and foot print were taken and given to the parents as part of a bereavement package.

To make young children’s experiences as positive as possible prior to surgery they were encouraged to ride in one of the children’s cars to theatre. We tracked one child’s journey to theatre and saw they rode to theatre in the car accompanied by the play leader.

An activity cupboard was located in the neonatal units’ parents’ room where children and young people could access activities whilst they were visiting their new sibling.

The trust commenced a new program of diabetes education sessions for young patients with type 1 diabetes. Monies were donated which funded two wellbeing days at a climbing centre. The children had the opportunity to take part in activities including bouldering, top roping, team building, and caving. It gave them chance to meet up with other children with type 1 diabetes, and the opportunity to meet the team in an informal environment, and learn more about their diabetes. A psychologist was present to assist with their emotional wellbeing.

**CQC Children and Young People’s Survey 2016**

**CQC Children and Young People’s Survey 2016 questions, emotional support, Calderdale and Huddersfield NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.97</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.42</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.13</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.96</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>9.03</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

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

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

We spoke with seven parents, two grandparents and two young people about their experiences. They said they were involved in their care and decision-making and were happy with the care and treatment received.

On the neonatal unit we observed staff interactions with parents, individually and as part of ward rounds.
The neonatal unit had a grand ward round every Wednesday where the multi-disciplinary team discussed babies’ progress and ongoing needs.

The baby’s admission document identified parent craft sessions that parents could attend, for example, feeding advice, nappy change demonstration, baby bathing, and sterilisation of equipment.

Information leaflets were available for parents and carers in different languages.

Access to interpreters could be actioned to ensure that parents and carers were kept informed and able to ask questions relating to their child’s care and treatment options.

We reviewed six babies and children’s care records and saw evidence of discussion with the family documented.

Children’s Diabetes team – A newly diagnosed education session was held with children young people and families in February 2018. The focus was to recap a lot of the newly diagnosed education in relation to correction doses and bolus with snack, covered glucagon and ketone testing.

We observed two children’s anaesthetic assessments and noted that the anaesthetist explained the procedures and treatment plan to the parents, giving them the opportunity to ask any questions.

The ‘10 steps to theatre board’ was a new initiative on ward three which described the pathway children took when coming into hospital for surgery. Step 1 discussed their arrival to the ward and progressed systematically to step 10 – going home. Each step informed the child and their family of what to expect along the way.

Saturday multi-disciplinary pre-operative clinics took place and were led by nursing and play staff. Children and their parents attend these clinics three to four weeks prior to surgery so that questions could be asked and answered and children familiarised to the hospital environment.

Following feedback from families in children’s outpatients, the lay out of the chairs and toys was altered to ensure improved privacy at the reception area.

CQC Children and Young People’s Survey 2016
## CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.83</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.25</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.25</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.53</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.19</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child's care?</td>
<td>0-15 adults</td>
<td>8.75</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.53</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.41</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>9.18</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child's care?</td>
<td>0-15 adults</td>
<td>8.05</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.28</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>8.95</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>8.18</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 CYP</td>
<td>9.57</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 CYP</td>
<td>9.59</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>
Were you involved in decisions about your care and treatment? | 8-15 CYP | 5.90 | About the same as other trusts | C2
---|---|---|---|---
If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there? | 12-15 CYP | 9.19 | About the same as other trusts | C2
Before the operations or procedures, did hospital staff explain to you what would be done? | 8-15 CYP | 9.22 | About the same as other trusts | C2
Afterwards, did staff explain to you how the operations or procedures had gone? | 8-15 CYP | 8.62 | About the same as other trusts | C2
When you left hospital, did you know what was going to happen next with your care? | 8-15 CYP | 7.66 | About the same as other trusts | C2

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

Is the service responsive?

Service delivery to meet the needs of local people

A full public consultation took place in 2016 on a new clinical model of services to locate all unplanned and emergency care at Calderdale Royal Hospital and all planned care plus an urgent care centre on the Huddersfield Royal Infirmary site. The full business case setting out these proposals was approved by the board in August 2017 and was with NHS Improvement. The local joint ‘Overview and Scrutiny Committee’ (Calderdale and Kirklees) referred the proposals to the Secretary of State.

A teenage area was developed on ward three at the Calderdale Royal Hospital site following feedback from users. We visited the teenage room on the ward during our visit and noted this was a designated room for young people to use away from the younger children.

We saw facilities for parents and carers throughout the paediatric and neonatal services, for example, bedrooms, kitchen facilities, bathing facilities.

Following consultation with parents of children with learning disabilities and complex needs, a big shower room was commissioned which allowed space for the use of a hoist if required.

The neonatal service was part of the Yorkshire and Humber neonatal network.

Children’s outpatients were currently working with a local author and mother, who previously accessed the service, to promote books on cultural inclusion, differentiation and adopted the diversity angle for patients that may not be able to relate to Peppa Pig books. The authors’ books pull in all members of the community and currently “Bollywood Princess” was being used at Calderdale as a distraction technique for the children that were coming in to have their bloods taken. The books were all about dance with hidden messages of keep going, not giving up, living your dream and making magical things happen.

Staff told us that room 35 on ward 3 was ligature risk assessed for use by children and young people admitted with mental health needs. We saw a copy of the rooms risk assessment, visited the room, and noted its suitability for use with this patient group.

The trust had RAG rated itself against the ‘Standards for Children’s Surgery and Anaesthesia’ in January 2018. The ratings given were a mix of amber (partial compliance) and green ratings.
(compliant), the majority of areas were rated green. Where there was partial, compliance the trust had identified actions for most areas to support that aspect.

Plans were in progress for a promotional video about the Children’s ward. Feedback was obtained and had focused on the top five things families, children and young people said they would have liked to know at the start of the families stay. This way of working had ensured the trust focused on what families want to know rather than what health professionals think they want to know. Key things suggested were food for families at child’s bedside, provision of car parking for resident parents, location of the parents’ room and provision of baby jars of food.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for zero questions, one was worse than other trusts for one questions and about the same as other trusts for the remaining 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

The trust was worse than other trusts for the questions “did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?”.

**CQC Children and Young People’s Survey 2016 questions, responsive domain, Calderdale and Huddersfield NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.62</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.36</td>
<td>Worse than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.21</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>3.17</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.52</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>7.78</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.05</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.90</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.50</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>9.21</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>RAG</td>
<td>KLOE</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.94</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>6.50</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.53</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>7.55</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>8.51</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>3.72</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>8.80</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
</tbody>
</table>

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

**Meeting people’s individual needs**

The paediatric liaison nurse reviewed all emergency department attendances, coordinated care between hospital-based services, and those delivered in the community often by different providers.

Access to ETHOS (Educating those out of school) medical needs assessment team was in place for any child or young person who has been out of school for 15 days or more. The hospital play team assessed children admitted to the service who required schooling and made a telephone referral to either the Kirklees or Calderdale team depending upon which hospital the child is based. The hospital play team ensured support is given to a suitable environment for learning, recreation and play during the child/young person’s stay in hospital.

The local children’s and adolescent mental health service (CAMHS) was provided by South West Yorkshire Partnership NHS Trust (SWYFT). The trust worked in partnership with SWYFT and a service level agreement is in place for mental health administration and scrutiny of papers.

CAMHS services provided a 24/7 service including in-hours and overnight on call. Staff that needed to access the service out of hours could do so via the SWPYFT on call arrangements.

In July 2017, an audit of children and young people who were inpatients within CHFT identified three children / young people who required a tier four mental health support were admitted over a 12-month period.

Children’s service had a designated room on ward three (pod D) where the service managed young people with mental health issues. The room was ligature free to help reduce the risk of self-harm. The service continued to speak to young people and had acted on feedback on how the room/environment continued to meets theirs and their family’s needs.
Prior to a young person’s admission to the room/ward a risk assessment would be undertaken as per page 10 of the admission guidance with ongoing assessment of risk being performed throughout their stay on the ward. In addition a care plan has been produced which acted as a check list prior and during admission.

The learning disability matron helped to support young people and their families through the transition process.

Transitional care babies were cared for in the post-natal ward, staff awareness of these babies was ensured at staff handovers.

A bereavement link nurse was available to support parents, carers and their families should they lose a baby, child or young person. A bereavement checklist was in place.

**Access and flow**

Agreed pathways of care support the Children's Services Operational Policy and agreed local guidelines are available on the CHFT intranet, for example Embrace guidelines, surgical pathways and an on call anaesthetic support.

The paediatric unit has mental health admission guidance (September 2015) in place. Staff were advised to use this guidance in association with the trusts ‘Deliberate self-harm’ guidance. This guidance was produced in partnership with the provider of child and adolescent mental health services. Ongoing assessment, management and escalation processes are identified through this guidance.

The trust confirmed that the external target for incomplete patients still on referral to treatment (RTT) pathways within paediatrics at the end of each month was 92%. This was achieved in every quarter of the year so far and performance year to date is at 96.8%.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92.10%</td>
<td>96.04%</td>
<td>97.60%</td>
<td>99.83%</td>
</tr>
</tbody>
</table>

At the end of the January 2018, two patients waited past 18 weeks.

At Calderdale Royal Hospital inpatient and day case, paediatric surgery was managed through dedicated paediatric lists and lists that had paediatric cases were scheduled first and adults later. Guidance for staff ‘Arrangements for General Surgery in Children at CRH and HRI’ was available for elective and emergency surgery.

A band seven nurse based in the Rainbow development unit managed children’s outpatients and Rainbow development unit. Currently, band five nursing staff ran children’s clinics Monday to Friday.

Leeds satellite clinics took place at the trust. These included yearly renal and cystic fibrosis clinics and quarterly endocrine clinics. Cardiology clinics operate monthly.

Referrals to the service came through outpatients, the emergency department and direct access. February 2018 children’s clinic attendances were 497 and do not attend figures were identified as 8%.

Guidance was in place through the patient access policy advising staff of the steps to take when children do not arrive (DNA) in clinic. Pages 53 to 56 of this policy were specifically related to the management of paediatric patients. Staff told us that repeat DNA’s would result in a safeguarding referral.
Neonatal Critical Care Bed Occupancy

From December 2016 to October 2017, the trust’s neonatal critical care bed occupancy was lower than the England average in nine out of 12 months, and was 100% in zero months.

Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Learning from complaints and concerns

Clinical areas displayed a ‘Compassionate Care Board’. Information about the date of the last complaint for the area was identified. In children’s outpatients this was July 2016, the neonatal unit – May 2016 and on ward three the last complaint was March 2018.

We saw the complaints and incidents folder on ward three and saw evidence of actions taken in response to complaints and incidents. Staff told us the learning and outcomes were shared with them. Following one complaint the paediatric observation policy was developed. We saw learning had resulted from the incident, which included implementation of mock arrest scenarios and bedside handovers implemented in clinical areas.

Parents and visitors could raise concerns and complaints locally, through the Patient Advice and Liaison service (PALS) or the trust complaints department. Parents we spoke with said they felt comfortable raising concerns or complaints.

Summary of complaints

From November 2016 and November 2017, there were 17 complaints about children’s services. The trust took an average of 31.5 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 25 days.

- Other (specify in comments): five
- Access to treatment or drug: three
- Values & behaviours (staff): two
- Communications: two
- Patient Care: two
- Prescribing: one
- (blank): one
- Appointments: one

Calderdale Royal Hospital: There were 11 complaints reported.
Huddersfield Royal Infirmary: There were five complaints reported.

The most common subject was: Other (specify in comments) (five) followed by communications (two) and access to treatment and drugs (two). Seven of these complaints concerned Calderdale Royal Hospital.
Is the service well-led?

Leadership

The programme of ‘Board to Ward’ visits enabled the board to have sight of the key issues in care delivery and led in developing the appropriate culture and climate to have open discussions about trust goals. Visits included an executive and a non-executive supported by a matron or lead for each area. Some staff we spoke with confirmed these visits had taken place. Key themes were discussed at a board workshop twice a year.

Senior staff said consultant job plans were reviewed early 2017. The trust sent copies of the consultant job plans, the majority of which were not signed as agreed by the individual consultants.

All the staff we spoke with described senior managers as visible and approachable.

Band seven nurses and matrons attended weekly confirm and challenge meetings and feedback from these meetings was given to staff at ward level.

Band six staff said they could access leadership courses. There had been investment in leadership skills for staff such as general managers and matrons. All matrons had attended matron development programme funded by the Trust.

Matron’s meetings took place monthly for last 18 months and a matron’s huddle took place each Monday afternoon.

Vision and strategy

In 2017, both children’s and neonatal services produced an annual report (October 2017), which outlined the last 12 months. The one and five-year strategies formed part of the annual reports. This allowed the service to not only reflect on the past year, plan for the year ahead and further in the future.

The directorate one and five-year strategies identified ‘Our vision, our behaviours, our goals and our response’. The goals included transforming and improving patient care, keeping the base safe, a workforce for the future and financial sustainability. We asked staff about the strategy and people told us that they were either not aware of a strategy or were able to give a limited description of what the strategy involved.

Throughout 2018, all clinical managers worked with their teams to agree a pledge for the care that should be expected children young people and their families. The pledge was approved at trust board. Each clinical area had developed a local vision and strategy in line with the trust’s vision. Staff on the inpatient paediatric ward 3 told us of their involvement in the development of a ‘paediatric pledge’. The neonatal unit and paediatric diabetes service had also developed pledges specific to their services. See paediatric pledge below:
Staff told us that the advanced nurse practitioner role had developed following the last neonatal peer review.

**Culture**

Staff described good teamwork and a supportive culture between medical and nursing staff. Students described a supportive culture throughout the children’s, young people and neonatal services. Students said the nursing and medical staff worked together to provide care and decide the best options for the child.

Staff told us that ward meetings took place regularly where they were encouraged to take an active part.

**Governance**

The ‘Children’s Services Governance Structure’ showed a clear pathway from board to ward and vice versa.

Trust-wide forums were in place (paediatric and surgical forum, neonatal forum, paediatric and emergency department forum and safeguarding forums) which provided opportunity for face to face joint working and assurance that treatment and care for children and young people was appropriate. Staff told us these forums reviewed and discussed policies, NICE guidelines and audit.

The multi professional paediatric surgical forum met quarterly. It had a multi-professional membership list made up of clinicians and managers from children’s, surgical services, anaesthetics and the emergency department. The purpose of the forum was to maintain and develop high quality services, ensuring the delivery of safe, sustainable, clinically effective care for children and young people receiving elective or emergency surgery.

Monthly paediatric governance meetings took place.

The neonatal manager met with the maternity governance midwife to discuss incidents.

Staff told us following an infant death; external experts were invited to review the incident.

Staff said that a multi-disciplinary neonatal forum took place every five weeks, the minutes of which were distributed to staff.
One staff member in neonates was unable to identify what governance was.

The ‘Children’s ward virtual notice board – December 2017 communicated updates in areas such as learning from incidents, medicines management, useful links and policy updates and key messages in safeguarding.

The annual 'Safeguarding Children and Adults report' was presented to the trust board. The trust identified that a board update took place six months later which included updates from the Safeguarding Committee Meeting to the Quality Committee meeting.

Building on National Safety Standards for Invasive Procedures (NatSSIPs) the trust had been working to ensure they were compliant against these standards through ensuring Local Safety Standards for Invasive Procedures (LocSSIPs) were in place in all applicable areas across the trust. Paediatric services had participated in this work and a review undertaken of procedures deemed to require the use of a LocSSIP. The Clinical Director and Matron would lead implementation of the LocSSIP within paediatrics for the service with support from the ward nursing team.

Management of risk, issues and performance

Monthly reviews and updates of the children’s risk register had taken place at the directorate meeting. Differing levels of risk were reported at the appropriate governance meeting.

Staff said local risk registers were in place for paediatrics and neonates. Neonatal staff said that space in the neonatal unit was an identified risk. We reviewed the risk register and saw this risk had been identified.

The risk register identified seven risks to the service. Staff identified four of these risks during the inspection. Six risks had a moderate rating. We saw from the actions taken to-date progress made in reducing the risks.

A named paediatrician was the clinical audit lead and attended the safety, quality board.

The clinical audit plan for children’s and neonates was a shared programme. National, divisional and local audits were identified with details of whether they were to commence, completed, awaiting national results or in the action planning stage. Audits were identified by quarter year with a named clinical audit lead. One completed audit, the audit of epilepsy admissions was presented at the paediatric clinical governance meeting in December 2017.

A member of the governance and risk team supported staff in delivering duty of candour on a case-by-case basis. Duty of candour was covered during nursing induction in a risk management session. There is also a duty of candour /being open policy.

The multi-disciplinary children’s directorate meeting was a forum where discussions took place with the paediatric outreach team. In addition, speciality-training needs were discussed.

Staff told us that aspects of patient safety were monitored through the monthly safety thermometer and ward assurance tool. The ward assurance tool includes patient dignity, documentation and medication management audits.

Information Management

Staff said that discharge letters were given to parents and sent to the child’s GP, Health Visitor / Healthcare Professional as required.

Staff said they could access out-of-hours investigations, for example, urgent laboratory tests.
Calderdale and Huddersfield Foundation Trust (CHFT) invested in an electronic track and trigger system (Nerve centre). This is an electronic observation system, accessed through iPods and laptops across hospital sites.

The children’s neurology clinic was trialled a different way of reviewing transitional age children. An alert list of transitional age children acted as a prompt to have transition conversations and to complete paper work; transition was recorded on the clinic letters.

Young people from the age of 14 years with chronic health needs such as Cystic Fibrosis, Epilepsy Neurodisability and Diabetes are transitioning to adult services. The children’s service utilise the national paper work called ‘Ready Steady Go’ to assist with the young person’s transition.

Ensuring liaison with adult services the new clinician, young person and family were fully informed and involved. The transition process aimed to complete by the young person’s 18th birthday. Transition was managed locally within health, social care or with regional services.

**Engagement**

The Trust undertook its first census survey of all staff in 2017. The first data checking finished in mid-December and the final overall response rate for the Trust was 42.8% (2434 respondents from an eligible sample of 5692 staff). Results would be shared mid-February with the trust but embargoed until March. The trust staff survey action-planning group reviewed the initial results and developed a trust-wide action plan, which would be taken through to Executive Board and Board of Directors.

Paediatric staff told us they had six weekly staff meetings, which they found useful. Staff said they we could become involved in setting the meeting agenda. Staff said minutes were taken of these meetings, which were then circulated to staff.

The results for the CYP 2016 National Survey for the trust identified that overall children and young people’s experiences of inpatient and day case care were mostly positive. The trust scored ‘about the same’ for all questions when compared with other trusts, apart from one question “Appropriate equipment or adaptations -for parents and carers saying the ward had the appropriate equipment or adaptations their child needed”, which scored slightly worse. (Since the survey the Children’s ward has developed a dedicated teenage area and some additional resources/play equipment)

The survey results suggested there was scope for improvement in a number of areas, which include Children and young people having enough things to do whilst in hospital, involving children and young people in decision-making and being treated on age appropriate wards. The results were discussed at paediatric forum on the 5 December 2017.

Monthly family and friends surveys had taken place within neonates. Engagement with parents in this way has resulted in upgraded bathrooms, parents now attend ward rounds and parents can visit the unit at any time.

Staff across the Trust recognised the importance of listening and responding to patient and carers views. This was championed through the representatives on the ‘Trust Patient Experience and Caring Group.’ A survey of adolescent patients asked about their experiences of outpatient departments. 85% had a positive experience, 88% said staff communicated appropriately with them, 93% felt comfortable in the OPD environment. There were no reports of a negative experience comments.
Family and Friends Test (FTT) was the main feedback source. A range of methods was used to engage patients with this initiative: postcards, text messaging and web based solutions. Easy read cards are also available for learning disability patients.

Paediatric wards instigated a fruit and milkshake round as a way of interacting informally with children and families to check in how families are feeling and as a method to promote the family and friends test initiative.

**Learning, continuous improvement and innovation**

The band four role was introduced on the neonatal unit in February 2018. The band four staff member's responsibilities included collection of the ‘Badgernet’ data for the service. Badgernet forms a single record of care for all babies within the neonatal service. The ‘Badgernet’ neonatal summary system allows for the daily recording of events within a neonatal unit, including statutory data collection and reporting.

The Badgernet baby diary was introduced which was designed to provide parents and family secure, real time access to photos of their baby during their babies stay in the neonatal unit. This was an opt-in service for patients. Staff created entries with friendly comments for the diary and added photos.

Jakes room is a nursery comprising of four cots with the aim of creating a nursery similar to a home environment. The aim was to give confidence to parents caring for their baby in an environment without any clinical equipment helping to ease the transition from hospital to home. The room was named Jakes nursery in appreciation of the support of Jakes parents who raised funds of over £9000 for the neonatal unit to purchase two Vapotherm machines after their son had spent time on the unit. An additional Vapotherm was purchased by The League of Friends.

Young people fed back that whilst there was a play area there was nothing for older children. Staff gathered opinion for the teenage room from young people with a mood board, and asked young people on the unit what they would like to see. Through ward fundraising events and support from a local supermarket, the trust opened a dedicated room for young people. The room was opened by Emmerdale stars and a grandmother from the local area.

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**Acute services at Huddersfield Royal Infirmary**

**Urgent and Emergency Care**

**Facts and data about this service**

The trust provides urgent and accident and emergency services at the Huddersfield Royal Infirmary and Calderdale Royal Hospital.

The accident and emergency department at Huddersfield Royal Infirmary provides a 24 hour, seven day a week service to the local population. Between April 2017 and March 2018, there were 148,929 accident and emergency department attendances at Huddersfield Royal Infirmary and Calderdale Royal Hospital. This equates to an average of 408 patients a day across urgent and emergency care services at the trust. We were unable to split this data by site.

The accident and emergency department at Huddersfield Royal Infirmary is a designated trauma unit.
There is no separate paediatric accident and emergency department at Huddersfield Royal Infirmary but between 1 March 2017 and the 28 Feb 2018 there had been 12,967 paediatric attendances.

The accident and emergency department had four resuscitation bays, one of which was dual equipped for adults and children. There were 11 cubicles to treat patients with major injuries and illnesses, four cubicles to treat minor injuries, a six bedded area for rapid assessment, two separate triage rooms and a seven bedded clinical decisions unit split in to bays of four beds and three beds, for single sex accommodation.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. There is an out of hours GP in the department ran between the hours of 6pm and 10pm, which was managed by Local Care Direct. Where patients were triaged and deemed suitable to be streamed to the GP, they would be sent there from triage.

We inspected the whole core service and looked at all five key questions. In order to make our judgements, we spoke with 10 patients and carers and 14 staff within the department. We observed daily practice and reviewed five sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

**Details of emergency departments and other Urgent and Emergency Care services**

Huddersfield Royal Infirmary – clinical decision unit AEC DU

Huddersfield Royal Infirmary – A&E Department

*Source: Routine Provider Information Request (RPIR)*

**Activity and patient throughput**

Total number of urgent and emergency care attendances at Calderdale and Huddersfield NHS Foundation Trust compared to all acute trusts in England.

There were 151,354 attendances from April 2016 to March 2017 at Calderdale and Huddersfield NHS Foundation Trust as indicated in the chart above.

*Source: NHS England*
**Total number of urgent and emergency care attendances at Calderdale and Huddersfield NHS Foundation Trust April 2017 – March 2018**

Between 1 April 2017 and 31 March 2018 there were 148,929 attendances at both Huddersfield Royal Infirmary and Calderdale Royal Hospital. Emergency attendances across the trust dropped significantly in quarter 4 January 2018 – March 2018.

![Graph showing total attendances per quarter]

### Total Attendances Per Quarter

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Jun 17</td>
<td>38024</td>
</tr>
<tr>
<td>Jul - Sept 17</td>
<td>38057</td>
</tr>
<tr>
<td>Oct - Dec 17</td>
<td>37808</td>
</tr>
<tr>
<td>Jan - Mar 18</td>
<td>35040</td>
</tr>
<tr>
<td><strong>Total Attendances Per Annum</strong></td>
<td><strong>148929</strong></td>
</tr>
</tbody>
</table>

*(Source: NHS England A&E Attendances and Emergency Admissions 2017-18)*
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased by 0.4% from 2015/16 to 2016/17. In 2016/17, the rates were lower than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
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 trust set a target of 95% for completion of mandatory training. After the inspection the trust provided updated mandatory training figures. This division focused on five core mandatory training modules prioritised by the trust, which were: Fire safety, Safeguarding (Adult and children), Infection control, Moving and handling and Data security awareness.

<table>
<thead>
<tr>
<th>Site</th>
<th>Start Group</th>
<th>Data Security Awareness</th>
<th>Fire Safety</th>
<th>Infection Control</th>
<th>Manual Handling</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
<th>ALS</th>
<th>ILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRI</td>
<td>Additional Clinical Services</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>-</td>
<td>76.92%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical</td>
<td>100.00%</td>
<td>100.00%</td>
<td>92.86%</td>
<td>78.57%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Medical and Dental</td>
<td>77.78%</td>
<td>66.67%</td>
<td>72.22%</td>
<td>72.22%</td>
<td>61.11%</td>
<td>61.11%</td>
<td>94.11%</td>
<td>80.00%</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery Registered</td>
<td>100.00%</td>
<td>100.00%</td>
<td>91.67%</td>
<td>83.33%</td>
<td>66.67%</td>
<td>58.33%</td>
<td>61.54%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

(Source: Data Request UEC3 supporting narrative)

End of year position

<table>
<thead>
<tr>
<th>CQC Core Service</th>
<th>Data Security Awareness</th>
<th>Fire Safety</th>
<th>Infection Control</th>
<th>Manual Handling</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Urgent and emergency services</td>
<td>94.58%</td>
<td>94.09%</td>
<td>94.58%</td>
<td>95.07%</td>
<td>88.77%</td>
<td>90.91%</td>
</tr>
</tbody>
</table>

(Source: Data source CQC REQUEST ALL1 UPDATE)

The trust was had not met all mandatory training targets at the time of inspection, however had a trajectory to hit the target by the end of March 2018. After the inspection the trust submitted trust wide updated year-end figures which showed they had met one target of 95% in manual handling, and were very close to the 95% target in data security, fire safety and infection control. However they did not meet safeguarding training targets with safeguarding adults training at 88.77% and safeguarding children training at 90.91%.

The trust had a detailed action plan for the completion of mandatory training. The emergency department had actions in place to identify non-compliant staff and allocate protected time to enable these staff to complete their training before the deadline. Weekly compliance lists were issued to the ward manager for monitoring and compliance.

The trust appointed a clinical practice educator to the emergency department in 2017 and as a result of this post; the monitoring and completion of mandatory training had improved.

The trust had planned that all band 6 and band 7 staff complete intermediate life support (ILS) and paediatric intermediate life support (PILS) training. The clinical practice educator was working with the electronic staff record (ESR) team to include basic paediatric life support training onto mandatory fields for the emergency department staff. As part of the band 5 ‘new starters’ induction day, the nurse consultant provided a session on paediatric life support in the simulation suite at Huddersfield Royal Infirmary, which included basic life support.
Advanced life support training by consultants and middle grade doctors was overseen through the appraisal process and by the clinical director for emergency medicine.

For nursing staff advanced life support (ALS)/intermediate life support (ILS) was not mandatory, however the trust recognised that it is good practice and since the introduction of the clinical practice educator have trained the following percentage advanced life support (ALS) 61.54%, intermediate life support (ILS) 100%.

Mandatory training was monitored at directorate and divisional level by the senior management team.

Junior doctors were able to transfer mandatory training completed at regional inductions where evidence was provided. However, this did not include fire safety, manual handling and elements of safeguarding which needed to be completed locally. These elements were included in the trust induction and are to be completed through the electronic staff record (ESR).

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training, although some courses were not provided with a target.

**Trust-wide**

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing staff in urgent and emergency care is shown in the table below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>77</td>
<td>83</td>
<td>92.8%</td>
</tr>
<tr>
<td>Dementia Awareness (incl Privacy &amp; Dignity standards)</td>
<td></td>
<td>76</td>
<td>83</td>
<td>91.6%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td></td>
<td>76</td>
<td>83</td>
<td>91.6%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>75</td>
<td>83</td>
<td></td>
<td>90.4%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>75</td>
<td>83</td>
<td>90.4%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>74</td>
<td>82</td>
<td>90.2%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>73</td>
<td>82</td>
<td>89.0%</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td></td>
<td>67</td>
<td>79</td>
<td>84.8%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>63</td>
<td>75</td>
<td>84.0%</td>
</tr>
<tr>
<td>Preventing Pressure</td>
<td></td>
<td>63</td>
<td>78</td>
<td>80.8%</td>
</tr>
</tbody>
</table>
The trust's overall mandatory training completion rate for nursing staff in urgent and emergency care was 80%.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care is shown below.
<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Slips, Trips and Falls)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>14</td>
<td>34</td>
<td>41.2%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td></td>
<td>14</td>
<td>35</td>
<td>40.0%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>12</td>
<td>31</td>
<td>38.7%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>95%</td>
<td>13</td>
<td>35</td>
<td>37.1%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>11</td>
<td>33</td>
<td>33.3%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td></td>
<td>9</td>
<td>33</td>
<td>27.3%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>8</td>
<td>35</td>
<td>22.9%</td>
</tr>
<tr>
<td>NGT E-learning 2017</td>
<td></td>
<td>6</td>
<td>35</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical staff in urgent and emergency care was 46%.

**Huddersfield Royal Infirmary**

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing staff in urgent and emergency care at Huddersfield Royal Infirmary is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td></td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td></td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Training module name</td>
<td>Trust Target (%)</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff this year</td>
<td>% Completion (YTD)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------</td>
<td>------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td></td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td></td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td></td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td></td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>95%</td>
<td>5</td>
<td>9</td>
<td>55.6%</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td></td>
<td>3</td>
<td>9</td>
<td>33.3%</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td></td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust met their target for two of the five training modules for which there was a target. The trust’s overall mandatory training completion rate for nursing staff in urgent and emergency care at Huddersfield Royal Infirmary was 85%.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care at Huddersfield Royal Infirmary is shown below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td></td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td>14</td>
<td>18</td>
<td>77.8%</td>
</tr>
<tr>
<td>Training module name</td>
<td>Trust Target (%)</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff this year</td>
<td>% Completion (YTD)</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>95%</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td></td>
<td>12</td>
<td>18</td>
<td>66.7%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>95%</td>
<td>8</td>
<td>18</td>
<td>44.4%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td></td>
<td>7</td>
<td>16</td>
<td>43.8%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td></td>
<td>7</td>
<td>18</td>
<td>38.9%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td></td>
<td>7</td>
<td>18</td>
<td>38.9%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td></td>
<td>7</td>
<td>18</td>
<td>38.9%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td></td>
<td>7</td>
<td>18</td>
<td>38.9%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td></td>
<td>7</td>
<td>18</td>
<td>38.9%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td></td>
<td>6</td>
<td>18</td>
<td>33.3%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>95%</td>
<td>5</td>
<td>18</td>
<td>27.8%</td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>3</td>
<td>18</td>
<td>16.7%</td>
</tr>
<tr>
<td>NGT Elearning 2017</td>
<td></td>
<td>1</td>
<td>18</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical staff in urgent and emergency care at Huddersfield Royal Infirmary was 45%.

(Source: Routine Provider Information Request (RPIR))

**Safeguarding**

Staff understood and were able to explain how to raise a safeguarding concern if they thought a patient maybe at risk of harm.

Nursing and medical staff we spoke with were able to explain the process for when they were concerned a patient was at risk of harm and provided us with specific examples as to when they would do this. We saw that staff were able to access the trust safeguarding guidelines, which were readily available on the intranet.

Junior staff told us any safeguarding concerns were escalated to a senior nurse and doctor.

Staff told us they could access the trust’s internal safeguarding team for advice and guidance if they were unsure about whether an issue was a safeguarding concern.
Staff were aware of safeguarding processes for child exploitation and female genital mutilation (FGM). There was a clear focus on safeguarding and there was a bespoke safeguarding training programme for the emergency department. Staff understood ‘the hidden child’ and gave examples of when they had identified and actioned safeguarding around domestic abuse.

The trust had a paediatric liaison sister that reviewed every admission for patients 17 years old and under to provide a safety net and ensure that any child safeguarding concerns were not missed and referrals could be made where applicable.

**Safeguarding training completion rates**

The trust submitted updated safeguarding training figures post inspection, however all levels had been combined as one percentage per staff group. Staff who had not yet completed training but were eligible were being booked on to the next available courses.

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRI</td>
<td>Additional Clinical Services</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Medical and Dental</td>
<td>61.11%</td>
<td>61.11%</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery Registered</td>
<td>66.67%</td>
<td>58.33%</td>
</tr>
</tbody>
</table>

The trust set a target of 95% for completion of safeguarding training.

**Trust-wide**

A breakdown of compliance for mandatory safeguarding courses from April 2017 to November 2017 for nursing staff in urgent and emergency care is shown in the table below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>54</td>
<td>59</td>
<td>92%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td></td>
<td>53</td>
<td>58</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>53</td>
<td>58</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>20</td>
<td>23</td>
<td>87%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>95%</td>
<td>20</td>
<td>24</td>
<td>83%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td></td>
<td>19</td>
<td>24</td>
<td>79%</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the safeguarding training modules for which qualified nursing staff in urgent and emergency care were eligible.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care is shown in the table below:
The 95% target was not met for any of the safeguarding training modules for which medical staff in urgent and emergency care were eligible.

**Huddersfield Royal Infirmary**

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing staff in urgent and emergency at Huddersfield Royal Infirmary care is shown in the table below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td></td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>95%</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td></td>
<td>4</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>95%</td>
<td>3</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>95%</td>
<td>3</td>
<td>5</td>
<td>60%</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the four safeguarding training modules for which qualified nursing staff in urgent and emergency care at Huddersfield Royal Infirmary were eligible.

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in urgent and emergency care at Huddersfield Royal Infirmary is shown in the table below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff this year</th>
<th>% Completion (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding</td>
<td></td>
<td>3</td>
<td>6</td>
<td>50%</td>
</tr>
</tbody>
</table>
The 95% target was not met for any of the safeguarding training modules for which medical staff in urgent and emergency care at Huddersfield Royal Infirmary were eligible.

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

**Cleanliness, infection control and hygiene**

The accident and emergency department appeared clean and tidy; however we did find some drawers and boxes in the resuscitation area that held consumables which required a deep clean. Cleaning services were provided by domestic staff. The lead nurse told us they had a good working relationship with the domestic supervisor who did a monthly walk around the department with the infection prevention and control lead, to ensure standards were maintained.

Recent environmental audits showed that the department did not always meet targets set for 11 out of 12 key areas; however the department had met the target on the isolation of infected patients consistently.

(Source: Data Request UEC1 – FLO Audit HRI)

Staff completed core training related to their roles including: WDD waste management training, infection prevention (level 1) and WDD infection control level 2 - beyond the basics.
The accident and emergency department completed hand hygiene audits. Results showed that the department met the 100% target in three out of six months. The department achieved 100% in the latest hand hygiene audit dated February 2018.

(Source: Data Request UEC1 – FLO Audit HRI)

<table>
<thead>
<tr>
<th>Month</th>
<th>Ward / Month</th>
<th>Number of observations</th>
<th>Number Assurance Compliant</th>
<th>% Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>Nurse</td>
<td>13</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>February</td>
<td>Doctor</td>
<td>3</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>February</td>
<td>Support Staff</td>
<td>3</td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source: Data Request UEC1 – HRI Hand Hygiene)

Staff adhered to the infection control policy and used personal protective equipment when delivering personal care. We observed medical and nursing staff following the trust policy for hand washing and ‘arms bare below the elbows’ guidance in clinical areas. There were adequate hand washing facilities throughout the department. Hand hygiene points were visible and well located in the department.

Green ‘I’m clean’ labels were in use throughout the department and were dated appropriately. Patients we spoke with were happy with the cleanliness and appearance of the department.

Environment and equipment

The layout of the emergency department was constrained to the current estate. In the department, doors were unobstructed. In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to sufficient seating (32 seats). There was additional seating (24 seats) used for minors patients by the cubicle area in the majors treatment area and this was also utilised by adults and children waiting to be seen. There was no separation between the small paediatric waiting area and the adult waiting area; however there was a small play area for children to use and three chairs for parents. The doors to the majors
cubicles were unlocked and there was no clear line of sight to the second waiting area from reception so there was a risk that a patient could open a cubicle door and gain access to an area they should not be in, unseen. Staff told us the triage nurse had oversight of this area and the triage room was close to this area, however the triage nurse would not have oversight when seeing a patient in the triage room.

The reception area had separate male, female and disabled toilets. We identified potential ligature points in the toilets and this was escalated whilst on site, however when we returned these had not been removed. Each toilet had a pull cord to alert staff if help was needed.

The accident and emergency department was close to car parks and had a drop off area for ambulances.

Equipment we reviewed had been electrical safety tested and was the next test date was recorded.

There was a small waiting room utilised to assess patients with mental health needs, however, this was not an official section 136 suite and it was not suitable for patients presenting with mental ill-health. The room used at Huddersfield Royal Infirmary did not meet the RCEM guidelines for a suitable environment for dealing with mental health emergencies in the emergency department. The room used was a small waiting room with several chairs and a coffee table, which were not secured, and it was not free of ligature points. However it did have two doors but they both opened inwards and there were no viewing panels fitted. Staff told us the room was normally used for patients waiting for blood test results. There was no direct line of sight in to the room from the staff station in the centre of the department. The trust had plans to undertake some work to refurbish the room to make it suitable for use within a 6 week timescale.

We found out of date consumables in the resuscitation area in drawers and grab bags, including: a single use tablet crusher that had not been cleaned or disposed of, a free value needle which was out of date (February 2018), an air inlet with valve which was out of date (June 2015), multiple 26g microlance needles that were out of date (September 2010) kept in the same tray as needles that were in date, four 22g microlance needles with no use by dates. The drawers and boxes where consumables were kept were not clean and contained some fluff. These issues were escalated on site and the sister disposed of the out of date consumables and restocked the areas accordingly.

**Assessing and responding to patient risk**

The accident and emergency department had a clear triage and screening process. Patients attending by ambulance would be brought to the rapid assessment area where blood cultures and fluids could be commenced. Rapid assessment meant that blood tests, cannulation or an ECG could be commenced as soon as the patient arrived in the department.

We found staff were able to identify and respond appropriately to patients who were at risk of deteriorating. A national early warning score system for acutely ill patients was used. This supported the process for the early recognition of adult patients who were becoming unwell.

We checked five adults’ records and found four of the five had NEWS scores completed. Of the five records, one patient had attended with suspected sepsis and had appropriate antibiotic medication commenced within an hour, had NEWS and pain scores recorded and VTE and pressure area assessments completed.
Named nurses used the SBAR tool to facilitate effective communication in patient handovers. An SBAR can be used very effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover.

There was no separate paediatric A&E at Huddersfield Royal Infirmary, however between 1 March 2017 and the 28 Feb 2018 there had been 12,967 paediatric attendances at Huddersfield. Paediatric emergencies attending by ambulance would be routed to Calderdale Royal Hospital. If a child deteriorated rapidly at Huddersfield Royal Infirmary, the trust had a process to manage paediatric resuscitation. Some nursing staff in the emergency department were trained in paediatric life support, however not all eligible staff were trained as the table below documents. Medical staff worked cross site and 94.1% of medical staff were trained in advanced paediatric life support.

<table>
<thead>
<tr>
<th></th>
<th>HRI required to complete</th>
<th>HRI completed</th>
<th>HRI Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Paediatric Life Support</td>
<td>15</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Paediatric Intermediate Life Support</td>
<td>30</td>
<td>11</td>
<td>40.70%</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>60</td>
<td>18</td>
<td>30%</td>
</tr>
</tbody>
</table>

(Source: Data request UEC28 CQC Resus)

The department used a comprehensive emergency department safety checklist that helped to identify any changes to the patient and monitor for deterioration. The checklist was on paper and detailed steps and prompts staff should take in the 1st, 2nd, 3rd, 4th, 5th and 6th hour. There was also a section for relevant referrals and risk assessments such as: adult safeguarding, child cause for concern, mental health ReACT (to assess patients for risk of harm to themselves), mental health referral, MARAC (domestic abuse) and frailty team.

Patients presenting with mental ill-health would undergo a ReACT assessment and a referral to the psychiatric liaison team would be made. The team attended within an hour to assess the patient. The room used to accommodate and assess patients with mental ill-health was unsuitable for this purpose, however this was a known risk and work was being undertaken to have the room refurbished to meet national standards. There were not enough staff in the department to provide one to one care to patients with mental ill-health at risk of absconding and self-harm. To mitigate risks in the area used to accommodate patients, the department had invested in ligature cutters that were placed centrally for staff to access. There were also guidelines on EM Beds (Guidance for Environmental Safety of Patients at Risk of Injury to Themselves or Others).

In the Emergency Departments at CHFT) around making an area safer for high risk patients which gave steps to follow, such as considering the removal of oxygen piping/tubing in the area. The department had a missing patient’s policy and formally incident reported any absconders who left
the department after being seen, but who had not had a formal capacity assessment and had presented with mental ill-health. There was a SOP flow chart for patients who did not wait to be seen and this covered vulnerable patients, such as those presenting in crisis. The trust had a document available on EM Beds called ‘Guidance for Environmental Safety of Patients at Risk of Injury to Themselves or Others’ which provided clear guidance on making a room safer for patients presenting with mental ill-health.

The department also had a flowchart for the management of paediatric and adolescent patients presenting with mental ill-health. Patients that met these criteria were assessed using a paediatric mental health pro-forma and the department contacted CAMHS to attend and assess the patient.

The department had a comprehensive sepsis management policy and staff we spoke to were confident they could recognise and treat sepsis. At the time of our inspection the department had printed sepsis awareness prompt posters that were to be displayed across the department.

The department conducted four medical huddles each day; nursing safety huddles took place twice a day.

Emergency Department Survey 2016

The trust’s scored “About the same as” other trusts for all of the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey September 2016)

Median time from arrival to initial assessment (emergency ambulance cases only)

The target time for initial assessment is 15 minutes. The data the trust has submitted shows a decline in performance since the introduction of the EPR in May 2017. The trust stated there has been deterioration in performance against all standards including initial assessment for patients arriving by ambulance. The trust understood this was because of a data capture issue due to the current inability to accurately record the time of starting the initial assessment on the EPR system for the following reasons:
“Following the introduction of dedicated ambulance assessment areas (after the launch of EPR); there was a demonstrable improvement in ambulance turnaround times on both sites. Despite this improvement, there was no associated improvement in reported times to initial assessment (ambulances are turning around quicker than before EPR but this is not reflected in a shorter time to initial assessment). This supports the interpretation of an ongoing flaw in the ability of EPR to accurately record the time of commencement of initial assessment. The Directorate are working with EPR team to address the data capture issue.”

(Source: Data request UEC7 supporting narrative)

The below chart shows the previous six months validation data for ambulance wait and turnaround times.

![Chart showing ambulance wait and turnaround times]

### Challenges

<table>
<thead>
<tr>
<th></th>
<th>60+</th>
<th>30-60</th>
<th>15-30</th>
<th>less than 15</th>
<th>Total Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-17</td>
<td>0</td>
<td>17</td>
<td></td>
<td></td>
<td>237</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1</td>
<td>7</td>
<td></td>
<td></td>
<td>184</td>
</tr>
<tr>
<td>Nov-17</td>
<td>0</td>
<td>5</td>
<td>25</td>
<td>119</td>
<td>163</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1</td>
<td>16</td>
<td>46</td>
<td>101</td>
<td>218</td>
</tr>
<tr>
<td>Jan-18</td>
<td>4</td>
<td>26</td>
<td>44</td>
<td>91</td>
<td>213</td>
</tr>
<tr>
<td>Feb-18</td>
<td>0</td>
<td>10</td>
<td>33</td>
<td>75</td>
<td>170</td>
</tr>
</tbody>
</table>

(Source: Data request UEC8 YAS Validation Graph)

The median time from arrival to initial assessment was worse than the overall England median in seven months over the 12 month period from January 2017 to December 2017. The chart is below.

**Ambulance – Time to initial assessment from January 2017 and December 2017 at Calderdale and Huddersfield NHS Foundation Trust**
In December 2017, the median time to initial assessment was 12 minutes compared to the England average of 9 minutes.

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Huddersfield Royal Infirmary

From May 2017 to December 2017 there was only a slight downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Huddersfield Royal Infirmary.

Ambulance: Number of journeys with turnaround times over 30 minutes - Huddersfield Royal Infirmary

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Huddersfield Royal Infirmary

In December 2017, 59% of ambulance journeys had turnaround times over 30 minutes.

(Source: National Ambulance Information Group)

Number of black breaches for this trust
In past 6 months the trust had six black breaches, one at Calderdale Royal Hospital and five at Huddersfield Royal Infirmary. These breaches occurred in October 2017, December 2017 and four in January 2018.

Root Cause Analysis was completed for the October and December breaches and the main findings were:

- The triage nurses comprehensive assessment could have occurred without the ambulance service being present.
- Staff working in the rapid assessment area were expected to escalate delays to the nurse in charge.
- Communication with patients and/or next of kin regarding any anticipated delays and ensure their comfort and safety is maintained.
- On-going plan to continue to feedback performance through the safety huddles to the clinical teams so they understand the importance of timely handover to patients.
- SOP in place and reviewed following the black breaches.

(Source: UEC8 black breaches supporting narrative)

The findings were shared with the teams through the safety huddles and the changes to the SOP added to the emergency department newsletter (November 2017).

Four further black breaches in January 2018 were down to winter operational pressures, volume and exit block from the department, therefore no formal RCA’s were completed. The trust planned to conduct a deep dive into the pressures to identify any learning for next year’s winter planning. The deep dive would investigate whether there were other mitigations that could be implemented going forward when no bed capacity/discharges were predicted.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From September 2016 to October 2017 the trust reported nine “black breaches”, with a steady trend over the period.

(Source: Routine Provider Information Request (RPIR))

**Nurse staffing**

Managers acknowledged that staffing had historically been a challenge, but there were improvements and new staff had been recruited. There had been a large intake of new band 5 nurses and the trust was interviewing for band 6 sisters at the time of our inspection. No one we spoke with felt that staffing was unsafe or a risk to patient safety, however they did feel that staffing on night shifts was a challenge, particularly at weekends.

Staffing was planned on an electronic system by senior staff in the accident and emergency department. Agency and bank staff were used to fill vacant shifts where possible.

Nurse staffing was over three shifts: early, late and night shifts. We were satisfied that staffing had been planned in a safe and effective manner.

Nursing numbers were displayed in the department with the planned and actual numbers. On early shifts there was one triage nurse and on late shifts there were two triage nurses rostered on the rota.

The trust reported their registered nursing staff numbers as below as of October 2017.
<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual staff – WTE in month</th>
<th>Actual staff – whole number / headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>69.6</td>
<td>79</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>7.7</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77.3</strong></td>
<td><strong>88</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

**Vacancy rates**

As at October 2017, the trust reported a vacancy rate of 11% in urgent and emergency care. The vacancy rates by site were:

- Huddersfield Royal Infirmary – the data submitted by the trust is not usable.

(Source: Routine Provider Information Request (RPIR))

**Turnover rates**

As at October 2017, the trust name reported a turnover rate of 12% in urgent and emergency care. The turnover rates by site were:

- Huddersfield Royal Infirmary – turnover rate of 0%

(Source: Routine Provider Information Request (RPIR))

**Sickness rates**

As at October 2017, the trust name reported a sickness rate of 5% in urgent and emergency care. The sickness rates by site were:

- Huddersfield Royal Infirmary – sickness rate of 3%

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

**Bank and agency staff usage**
The trust provided data showing the previous three months agency usage at all sites. Huddersfield Royal Infirmary used a total of 1516.58 hours’ worth of agency nurses in the previous three months December 2017 to February 2018.

From November 2016 to October 2017, the trust reported that 391 shifts were filled by bank staff and 1,189 shifts by agency staff with 391 shifts unfilled. They did not provide details of all shifts available, so we were unable to provide this data as a percentage.

(Source: Routine Provider Information Request (RPIR))

**Medical staffing**

There was consultant cover in the accident and emergency department between 8am and 10pm on Monday to Friday and from 9am on Saturday and Sunday for between four to six hours. This did not meet the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. There were not enough whole time equivalent consultants to staff a full weekend rota so this was undertaken on a voluntary basis. Outside of these hours, consultants were available on call. There were two middle grade doctors available in the department overnight.

The trust was undertaking work to recruit two further consultants to work in the department.

The trust reported their medical staff numbers as below as of October 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Actual staff – WTE in month</th>
<th>Actual staff – whole number / headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>18.0</td>
<td>18</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>17.4</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>35.4</td>
<td>37</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

**Vacancy rates**

As at October 2017, the trust reported a vacancy rate of 28% in urgent and emergency care. The vacancy rates by site were

- Huddersfield Royal Infirmary – vacancy rate of 34%

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

As at October 2017, the trust name reported a turnover rate of 15% in urgent and emergency care. The turnover rates by site were:

- Huddersfield Royal Infirmary - turnover rate of 14%

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

Sickness rates

As at October 2017, the trust name reported a sickness rate of 1% in urgent and emergency care. The sickness rates by site were:

- Huddersfield Royal Infirmary - rate of 0.1%

(Source: Routine Provider Information Request (RPIR))

Bank and locum staff usage

Agency staff usage by site. Nursing and Medical.

<table>
<thead>
<tr>
<th>Hours per site Medical</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>742.25</td>
<td>706.25</td>
<td>526</td>
<td>1974.5</td>
</tr>
<tr>
<td>HRI</td>
<td>1159.5</td>
<td>994.5</td>
<td>908.5</td>
<td>3062.5</td>
</tr>
<tr>
<td>Total</td>
<td>1901.75</td>
<td>1700.75</td>
<td>1434.5</td>
<td>5037</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hours per site Qualified Nursing</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH</td>
<td>437.25</td>
<td>500.75</td>
<td>660.25</td>
<td>1598.25</td>
</tr>
<tr>
<td>HRI</td>
<td>375.5</td>
<td>576.25</td>
<td>564.83</td>
<td>1516.58</td>
</tr>
<tr>
<td>Cross Site</td>
<td>632</td>
<td>766.5</td>
<td>65</td>
<td>1463.5</td>
</tr>
<tr>
<td>Total</td>
<td>1444.75</td>
<td>1843.5</td>
<td>1290.08</td>
<td>4578.33</td>
</tr>
</tbody>
</table>

The trust provided data showing the previous three months agency usage at all sites. Huddersfield Royal Infirmary used a total of 3062.5 hours’ worth of locum medical staff in the previous three months December 2017 to February 2018.

From November 2016 to October 2017, the trust reported that 547 shifts were filled by bank staff and 1,368 shifts by locum staff with 132 shifts unfilled. They did not provide details of all shifts available, so we were unable to provide this data as a percentage.

(Source: Routine Provider Information Request (RPIR))

Staffing skill mix

As of October 2017, the proportion of consultant staff reported to be working at the trust were
similar the England average, and the proportion of junior (foundation year 1-2) staff was higher than the England average

**Staffing skill mix for the 30 whole time equivalent staff working in Urgent and Emergency Care at Calderdale and Huddersfield NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>32%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ 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)

**Records**

Patient records were held on an electronic patient record system (EPR).

We reviewed five sets of patient records. We reviewed the record keeping for information inputted by nursing and medical professionals and found that it recorded relevant information. Records were appropriately completed and had allergies completed (where applicable), were dated and the name of the clinician reviewing the patient was clear.

Discharge summaries were sent to GPs electronically, where possible, otherwise they were sent via the post or with the patient.

**Medicines**

We were not assured that medicines were always managed and stored in a safe way. We found that controlled drugs register was not locked away and that a member of staff had to go and look for it to try and locate it.

When we reviewed the controlled drugs register in resus and there were numerous gaps identified in signatures. We then identified that a ketamine injection had been added to the register as ‘missing’ at 5am on the 19 July 2017. The register was damaged over two signatures and pharmacy had signed off as correct on the 17 February 2018.

We escalated this on site and requested the serious incident investigation. We spoke to the leadership team about the incident and they told us the documentation in the controlled drug register dated 19 July 2017 had been identified as relating to an entry dated 19 September 2017, the previous date was written in error. The entry was timed at 5am when both staff that signed the CD book were on a night shift. The leadership team told us neither staff member was working the night shift on 19 July 2017. The issue identified that the ketamine stocks had not been transferred to the new controlled drugs register on the 14 September 2017, five days previously. Emergency
department staff at the time identified the error in documentation and corrected the issue by entering the stock of ketamine into the new controlled drugs register, but did not report this through the incident reporting process.

The pharmacy check on 17 February 2018 did not identify this discrepancy and therefore did not generate an incident report. Once the issue had been highlighted on our inspection, an incident form had then been completed. The clinical director for emergency medicine also discussed the incident with the clinical director for pharmacy.

The emergency department team recognised that there was a gap in checking the controlled drugs register and there is now a clear process in place to make sure that daily controlled drugs checks are being undertaken and any discrepancies dealt with immediately.

We found issues with the fridge temperatures that had recorded consistently high temperatures over 9 degrees Celsius in the previous two days. This had not been escalated by staff; however the issue was escalated whilst on site. There were drugs in the fridge that were temperature critical, however the drugs were also out of date (expiry 2017). There were also other expired drugs in the same fridge with expiry dates of February 2018 and October 2016.

We found opened bottles of medication were not always labelled with an ‘opened’ date.

After escalating these issues the trust has taken action around monitoring expired medication, this included: redesigning the top-up expiry check log, expiry checks to be undertaken every two months and items with an expiry date within six months to be documented, a standard operating procedure for stock topping up to be updated by end March 2018 and compliance to be reported quarterly to the pharmacy board from June 2018.

The department used patient group direction (PGD’s) and a list of these was available on the EM Beds system. A patient group direction (PGD) allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

**Incidents**

Staff told us they recognised significant incidents and knew how to report them; however we did find an issue whilst in inspection around ‘missing’ controlled drugs which had not been reported as an incident. As soon as this was identified it was logged as a serious incident and investigated. Incidents were discussed by senior management at their monthly quality improvement forum and learning shared with staff. Learning from incidents was also fed back at the daily cross-site safety huddle meeting. Staff could access the briefing on the shared drive and add on information to be shared on both sites.

Incidents that trigged specific levels of harm went through an orange or red panel. Orange panel incidents were reviewed at divisional level and red panel incidents were reviewed at trust wide level. Incidents could be downgraded once they had been thoroughly investigated at the panel and learning was shared with staff.

To report incidents, staff used an electronic system. Staff were encouraged to report incidents, so that trends could be flagged and learnt from.

Most of the staff we spoke with were aware of the statutory duty of candour principles, however, some staff were less familiar with the principles. The accident and emergency department had a system to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. 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.

**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 February 2017 to January 2018, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: NHS Improvement - STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from February 2017 to January 2018.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with four (31% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (15% of total incidents)
- Slips/trips/falls meeting SI criteria with two (15% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (15% of total incidents)
- Apparent/actual/suspected self-inflicted harm meeting SI criteria with one (8% of total incidents)
- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with one (8% of total incidents)
- Medication incident meeting SI criteria with one (8% of total incidents)

*(Source: Strategic Executive Information System (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 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.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, 13 falls with harm and no new catheter urinary tract infections from March 2016 to December 2017 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Calderdale and Huddersfield NHS Foundation Trust**
Is the service effective?

Evidence-based care and treatment

There were a range of pathways that complied with the National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments. These aimed to promote early treatment and improve patient outcomes. We saw evidence of the sepsis pathway in use at the time of our inspection.

The department had a website called EM Beds which was used as a repository for the standard operating processes (SOPs), patient pathways, policies and guidelines in use across both hospital sites. The website had been designed in-house by a consultant working in the emergency department. It was regularly reviewed and updated by a member of the ED team who linked with the trust communications team to ensure any changes were updated. This ensured the most up to date information was available. New staff were able to access the website prior to commencing employment, so they could familiarise themselves with the way the department worked and the key processes and policies in place. Staff told us this was useful for locum and agency staff as well as new permanent members of staff. Staff were overwhelmingly positive about the SOPs in place, they stated that they helped them work consistently and effectively across both sites and there was no ambiguity around how something was undertaken as they SOPs were clear and could be picked up by anyone in the department and followed.

We saw evidence that NICE guidelines and RCEM best practice were discussed at meetings, including the quality improvement forum, so changes to guidance could be applied to systems and processes within the accident and emergency department.
The department also took part in national audits, such as those identified by the Royal College of Emergency Medicine. The department undertook local audits to review and improve practice, including mortality, x-rays and audits of under 1yr olds (infants) senior review.

**Nutrition and hydration**

Patients could access food and drinks. Sandwiches were always available on the unit and soup was offered at mealtimes by the housekeeper. Patients on the clinical decisions unit (CDU) could order a hot meal in advance of mealtimes. Dietary and cultural requirements could be accommodated in the food choices offered.

There were vending machines in the waiting areas. These offered hot and cold drinks and a selection of snacks. At the time of our inspection, the vending machines were stocked and in use.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

*(Source: Emergency Department Survey September 2016)*

**Pain relief**

Staff used a pain score tool to assess if a patient had pain. Three different pain scoring tools were used in accident and emergency, so there were appropriate tools available for a diverse range of people, including children.

We saw evidence that pain scores had been recorded in the records we reviewed.

Pain relief was prescribed in a timely manner and recorded on the EPR, where applicable. Patients told us that they had been given pain relief when they had requested it.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

*(Source: Emergency Department Survey September 2016)*

**Patient outcomes**

We saw that the trust had participated in national audits, such as those identified by the Royal College of Emergency Medicine. The results were used to benchmark and compare with other trusts nationally. There was a clinical audit lead in place for the department and they would lead on audit completion and compliance.

The trust undertook national audits alongside local audits, such as mortality, x-ray and under 1’s senior sign off reviews. The department also took part in trauma audits; the TARN trauma audits fed into the trauma group and trauma network and were jointly reviewed through the peer review process.
There were audit action plans in place to improve future outcomes across the local and national audit programme.

The trust had introduced the rapid assessment and treatment area to aid rapid assessment and undertake tests prior to the patient being seen by a doctor, to aid prompt diagnosis and treatment. There were plans to roll out this area at Calderdale Royal Hospital as it had benefitted the emergency department at Huddersfield Royal Infirmary in a positive way.

The department had a positive quality improvement programme. Staff told us about a quality improvement project undertaken by a registrar around paediatric wrist fractures which has now been developed into a new pathway to improve care for patients who must no longer have a plaster cast fitted.

The frailty team had a presence in the emergency department every day to work with elderly and frail patients who attended the department. The team used dashboards to monitor and review their performance.

Mortality was reviewed on the department by an advanced care practitioner within 48 hours of the death and was reviewed by consultants in line with the trust policy. Mortality reviews were also shared at the quality improvement forum.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

The audit lead told us that an initial review of the RCEM asthma audit suggested significant deficiencies in recording vital signs and administration of steroids in the emergency department. First-hand experience of the emergency department senior team suggested that this was likely due to a flaw in the data collection process rather than a true picture of the outcomes.

In order to ensure appropriate actions were undertaken a brief re-audit was undertaken to provide assurance that observations were undertaken, and steroids were administered.

20 patients diagnosed asthma in the ED at CHFT in Feb 2018.

Review of notes demonstrated:

- Observations recorded on arrival: 95%
- Repeat Observations recorded within 1 hour: 40%
- Prednisolone administered within 1 hour: 55%
- Prednisolone administered within 4 hours: 75%

This gave assurance that the key outputs from the RCEM audit were due to flaws in audit data capture. The trust planned to formally develop an action plan and re-audit to measure changes in data capture.

Huddersfield Royal Infirmary

In the 2016/17 Moderate and Acute Severe Asthma report, Huddersfield Royal Infirmary met the target for one of the seven standards:

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed according to guidelines.

Huddersfield Royal Infirmary was in the upper UK quartile for three standards:

- Standard 1a: O2 should be given on arrival to maintain sats 94-98%. Hospital: 36%; UK: 19%.
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 92%; UK: 25%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed
according to guidelines. Hospital: 100%; UK: 52%.

Huddersfield Royal Infirmary was in the lower UK quartile for three standards:

- Standard 2a: As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Hospital: 0%; UK: 26%.
- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Standard 5a: within 60 minutes of arrival (acute severe). Hospital: 0%; UK: 19%.
  - Standard 5b: within 4 hours (moderate). Hospital: 0%; UK: 28%.

Huddersfield Royal Infirmary’s result for the remaining metric was between the upper and lower UK quartiles:

- Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 86%; UK: 77%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17
There was an action plan in place to improve results following the RCEM audit and plans to re-audit to measure whether actions taken had improved results.

Huddersfield Royal Infirmary
In the 2016/17 Consultant sign-off audit, Huddersfield Royal Infirmary failed to meet any of the standards.

Huddersfield Royal Infirmary’s results for all standards were between the upper and lower UK quartiles:

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 15%; UK: 11%.
- Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Hospital: 5%; UK: 8%.
- Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 10%; 12%.
- Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 5%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17
There was an action plan in place to improve results following the RCEM audit. The department had re-audited in November 2017 which showed a significant improvement in results in all standards apart from standard 5b, where the results had dropped slightly from 85% to 83%.
Huddersfield Royal Infirmary

In the 2016/17 Severe sepsis and septic shock audit, Huddersfield Royal Infirmary was in the upper UK quartile for none of the standards.

The hospital was in the lower UK quartile for two standards:

- Standard 1: Respiratory rate, oxygen saturations(SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 0%; UK: 69%.
- Standard 4: Serum lactate measured within one hour of arrival. Hospital: 31%; UK: 60%.

The hospital's results for the remaining six metrics were all between the upper and lower UK quartiles:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 65%; UK: 65%.
- Standard 3: O2 was initiated to maintain SaO2> 94% (unless there is a documented reason) within one hour of arrival. Hospital: 31%; UK: 60%.
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 56%; UK: 45%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 27%; UK: 43%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 33%; UK: 44%.

(Source: Data request UEC4 ED sepsis audit Nov 17)
• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 14%; UK: 18%.

RCEM Audit: Vital signs in children 2015/16
Huddersfield Royal Infirmary

In the 2015/16 Vital signs in children audit, Huddersfield Royal Infirmary met the target for one of the six standards.

The hospital was in the upper England quartile for one of the developmental standards:

• Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Hospital: 100%; England: 60%.

The hospital was between the upper and lower England quartiles for one fundamental standard and three developmental standards:

• Standard 1. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  o Standard 1b (developmental). Capillary refill time. Hospital: 8%; England: 23%.
• Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Hospital 6.3%; England: 4.4%.
• Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 72%; England: 70%.
• Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 69%; England: 73%.

The hospital was in the lower England quartile for one of the fundamental standards:

• Standard 1. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  o Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 22%; England: 38%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16
Huddersfield Royal Infirmary

In the 2015/16 Procedural sedation in adults audit, the hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the lower England quartile for one fundamental standard:

• Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
- Standard 7a. (fundamental): Return to baseline level of consciousness.
- Standard 7c. (fundamental): Absence of respiratory compromise.
- Standard 7d. (fundamental): Absence of significant pain and discomfort.
- Standard 7e. (developmental): Written advice on discharge for all patients.

Hospital: 0%; England: 2.6%.

The hospital was between the upper and lower England quartiles for four fundamental standards and two development standards:

- **Standard 1 (fundamental):** Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  - Standard 1a. ASA grading
  - Standard 1b. Prediction of difficulty in airway management
  - Standard 1c. Pre-procedural fasting status
  Hospital: 12%; England: 7.6%.

- **Standard 2 (developmental):** There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Hospital: 38%; England: 52%.

- **Standard 3 (fundamental):** Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 90%; England: 90%.

- **Standard 4 (fundamental):** Procedural sedation requires the presence of all of the below:
  - Standard 4a. A doctor as sedationist
  - Standard 4b. A second doctor, ENP or ANP as procedurist
  - Standard 4c. A nurse
  Hospital: 54%; England: 41%.

- **Standard 5 (fundamental):** Monitoring during procedural sedation must be documented to have included all of the below:
  - Standard 5a. Non-invasive blood pressure
  - Standard 5b. Pulse oximetry
  - Standard 5c. Capnography
  - Standard 5d. ECG
  Hospital: 38%; England: 24%.

- **Standard 6 (developmental):** Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 34%; England: 41%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16**

**Huddersfield Royal Infirmary**

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit the hospital met neither of the two audit standards

The hospital was in the lower England quartile for one standard:

- **Standard 1 (fundamental):** If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. Hospital: 89%; England: 100%.

The hospital was between the upper and lower England quartiles for one standard:
- Standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Hospital: 6%; England: 2%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From January 2017 and December 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5%, and consistently better than the England average.

In August 2017 the trust’s rate was 0%, which is almost certainly a data error. In December 2017, the trust’s performance was 7.2% compared to an England average of 7.9.

Unplanned re-attendance rate within 7 days - Calderdale and Huddersfield NHS Foundation Trust

(Source: NHS Digital - A&E quality)

Unplanned re-attendance rate within 7 days – Huddersfield Royal Infirmary

Data submitted after the inspection showed that Huddersfield Royal Infirmary had unplanned re-attendance rates of between 4.60% (November 2017) and 6.93% (May 2017) against a Trust target of 5% over the year.
Competent staff

There was a dynamic clinical education programme in the department. The accident and emergency department employed a clinical practice educator. The clinical practice educator was supernumerary to the planned staffing on the unit, so was able to allocate their weekly hours to the training, development, coaching and mentoring of staff in the department. The clinical practice educator provided an outstanding approach to training, development and retention of staff on the unit.

New staff received a planned six week trust induction which included a two week supernumerary clinical training programme that was delivered in-house. The clinical nurse educator would work with staff that required additional support to ensure they felt confident and comfortable working in the accident and emergency department; this could include in-situ simulation training, support in resus or other areas of the department.

The training programme was comprehensive and covered areas including: an introduction to ESR, oxygen competency, mental health, paediatric training, cannulation and venepuncture, caring for the dying patient, introduction to triage and minor injuries skills, paediatric life support, trauma, safeguarding, ECG training, blood transfusions, alcohol and drugs, organ donation, domestic abuse and MAJAX (major incident) and CBRN (chemical, biological, radiological and nuclear defence).

There was a bespoke emergency department safeguarding training programme run in-house. It was comprehensive, in-depth and covered all aspects of adult and children’s safeguarding.

Band 5 nursing staff were given a ‘National Curriculum and Competency Framework - Emergency Nursing (Level 1) - June 2017’ workbook to work through and band 6 nursing staff were given a ‘National Curriculum and Competency Framework - Emergency Nursing (Level 2) - June 2017’ workbook. These books provided clear guidance and a comprehensive competency framework for staff to work to and be measured on.

New staff to the department received a new starters pack that outlined key contacts in the department, alongside important information and expectations of new staff.
New staff also completed a drug administration competency assessment to provide assurance that they were capable and competent at administering medicines to patients via different routes.

Band 6 staff received development pack which covered the role, key focuses, expectations, reviewing progress, an action plan to plot further development and what to move on to next.

Staff also undertook specific ‘TaRTS - Trauma and Resuscitation Team Skills’ trauma training, as there were patients who presented with serious trauma injuries, so staff were competent and able to deal with trauma injuries.

**Appraisal rates**

At the time of our inspection the trust provided updated appraisal data and explanation around rates below the 100% target. Where the rate was below 100%, this is attributed to new staff coming out of their probationary periods, staff returning from maternity leave and sickness. Members of staff had a date booked in for their appraisals to be completed. Three medical staff appraisals had also not yet been completed, but there was a plan in place to ensure that these appraisals were completed by the end of March 2018.

The updated figures showed an improvement on appraisal rates than the figures provided when the provider submitted their RPIR.

Staff we spoke to told us they received appraisals and found them useful. There were plans to further develop staff by introducing a cascaded approach to appraisals where appraisals would start with the matron appraising the band 7 staff, the band 7 staff would appraise the band 6 staff and the band 6 staff would then appraise the band 5 staff. This would provide development opportunities for staff at all levels and allow them to utilise management and coaching skills.

**Appraisal rate for Emergency Care Directorate**

<table>
<thead>
<tr>
<th></th>
<th>Appraisal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>97.3%</td>
</tr>
</tbody>
</table>

**Huddersfield Royal Infirmary**

<table>
<thead>
<tr>
<th></th>
<th>Appraisal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>100.0%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>100.0%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>95.7%</td>
</tr>
</tbody>
</table>

**Medical staff appraisal (work cross site)**

<table>
<thead>
<tr>
<th></th>
<th>Number of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Appraisals</td>
<td>12 (75.0%)</td>
</tr>
<tr>
<td>Appraisals out of date due to sickness (rescheduled)</td>
<td>1 (6.25%)</td>
</tr>
<tr>
<td>Milestone for appraisals not yet completed – dates agreed</td>
<td>3 (18.75%)</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
</tr>
</tbody>
</table>

(Source: data request UEC5 - Appraisals - supporting narrative)
From 1 April 2017 to November 2017, 86% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 100%.

A split by staff group and location can be seen in the tables below:

**Trust wide**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who have had an appraisal</th>
<th>Staff eligible for appraisal</th>
<th>Completion rate</th>
<th>Met trust target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>65</td>
<td>67</td>
<td>97%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>3</td>
<td>17</td>
<td>18%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td><strong>121</strong></td>
<td><strong>86%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

**Huddersfield Royal Infirmary**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who have had an appraisal</th>
<th>Staff eligible for appraisal</th>
<th>Completion rate</th>
<th>Met trust target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>1</td>
<td>10</td>
<td>10.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>34</strong></td>
<td><strong>73.5%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Multidisciplinary working

The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There was a palliative care team that offered in-reach support and respiratory nurses could offer support with non-invasive ventilation (NIV) patients.

For paediatric patients that presented at the accident and emergency department there were close links with the paediatric ward and regular communication with the advanced nurse practitioners that staffed the paediatric ward at Huddersfield.

We also observed excellent multidisciplinary working within the department. The frailty team worked in the clinical decisions unit and had access to therapists to aid patient recovery. Medical staff worked across emergency departments at both sites.
There were daily cross site safety huddles that were conducted via video link so both sites could take part and share issues and learning.

There was a paediatric liaison sister working across both sites to review all attendances of patients 17 years of age and under, staff told us they had an excellent working relationship.

Staff also worked with a domestic abuse support worker employed by another organisation and described them as ‘part of the team’.

### Seven-day services

The accident and emergency department was operational 24 hours a day, seven days a week.
The x-ray department facilities were in the department and could be accessed easily from the unit, 24 hours a day, seven days a week.

There was consultant cover in the accident and emergency department between 8am and 10pm on Monday to Friday on Monday to Friday and from 9am on Saturday and Sunday for between four to six hours. However there were not enough whole time equivalent consultants to staff a full weekend rota so this was undertaken on a voluntary basis. Outside of these hours, consultants were available on call. There were two middle grade doctors available in the department overnight.

There was access to medication for discharge seven days a week, 24 hours a day. The pharmacy opening hours were between 9am – 5pm Monday to Friday at the well pharmacy on the ground floor. Weekends and bank holidays the pharmacy department at basement level could dispense between 8.45am – 5pm. Outside of these hours the emergency department could dispense medication and the trust would collect prescription costs from the patient after discharge.

There was access to a frailty team seven days per week, 9am – 5pm.

### Health promotion

The accident and emergency department did not have any specific displays to promote health to patients; however patients were given information about their treatment and condition. There were a large number of leaflets to support this which were printed from the EM Beds website to ensure patients always received the most up to date leaflet.

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

We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Some staff we spoke to understood the basic principles of the act and were able to explain how the principles worked in practice in the accident and emergency department. However not all staff we spoke to felt confident in treating patients with mental ill-health or capacity issues and we were not assured they fully understood all the principles of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards.

Staff had access to the principles of the Mental Capacity Act (MCA) 2005 on the EM Beds system which outlined the actions staff should take if they are assessing whether a patient has capacity. All staff had access to the EM Beds system.

We did not see any evidence of mental capacity assessments being completed. Two staff members stated that a doctor would carry out a capacity assessment if it was required. One member of staff stated that they would always imply consent when writing their notes for example
‘gave meds with consent’ but they would not carry out a specific capacity assessment with regards to this. We spoke to another member of staff and they said they used both implied and verbal consent, for example, when taking blood they would seek verbal consent from the patient to do so.

Staff undertook bespoke safeguarding training specific to the emergency department setting, this training covered consent in depth and assessing competence using the Fraser guidelines and Gillick competence guidance.

**Mental Capacity Act and Deprivation of Liberty training completion**

As part of a focus on the Mental Capacity Act, the trust had previously purchased MCA prompt cards and these were given to every member of staff across the trust.

The trust had introduced, as part of the essential skills framework for staff, specific Mental Capacity Act and Deprivation of Liberty training. Prior to this it was delivered as part of the mandatory adult safeguarding training and was within the trust E-Learning packages. As part of the Level 3 MCA/DoLS training, the training covered the Mental Health Act and how this is similar and different to the Mental Capacity Act.

Updated training results were submitted post inspection and showed that 71.88% of staff had undertaken Mental Capacity Act and deprivation of liberty safeguards training.

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRI</td>
<td>Additional Clinical Services</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical</td>
<td>47.06%</td>
</tr>
<tr>
<td></td>
<td>Estates and Ancillary</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Medical and Dental</td>
<td>52.94%</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery Registered</td>
<td>78.26%</td>
</tr>
<tr>
<td></td>
<td><strong>Overall</strong></td>
<td><strong>71.88%</strong></td>
</tr>
</tbody>
</table>

(Source: Data request UEC21 MCA DOLS training)

The trust reported that from April 2017 to November 2017, Mental Capacity Act (MCA) training has been completed by 72% of staff in within urgent and emergency care.

Deprivation of Liberty training has been completed by 68% of staff in within urgent and emergency care.

(Source: Routine Provider Information Request (RPIR))

**Is the service caring?**

**Compassionate care**

We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed. We observed a number of interactions between staff, patients and relatives. Staff were polite, respectful and professional in their approach. We observed staff responding compassionately to patients’ pain, discomfort and emotional distress in a timely and appropriate way.

Staff spoke about patients with mental ill-health in a respectful way and demonstrated a non-judgemental attitude.

Confidentiality was respected in staff discussions with people and those close to them. One patient told us staff were ‘great, respectful and had introduced themselves’.
Intentional rounding was undertaken by nursing staff. Intentional rounding is a formal system used to periodically check on patients in order to improve patients’ experience and ensure that care is safe and reliable.

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was generally about the same as the England average from December 2016 to November 2017. The exception was May 2017, where the trust’s performance was noticeably worse than the England average.

In November 2017, the trust’s performance was 86%, compared the England average of 87%.

**A&E Friends and Family Test Performance - Calderdale and Huddersfield NHS Foundation Trust**

(Source: NHS England Friends and Family Test)

**Emotional support**

There was a room for relatives to use if needed. There was support available for the bereaved from the chaplaincy service.

We observed staff supporting patients emotionally and providing assurance to anxious and distressed patients. Staff also supported each other emotionally during difficult shifts and distressing events.

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

Patients told us staff explained their care and treatment to them in a way they could understand. We observed staff communicating in a way that people could understand and was appropriate and respectful. Patients and relatives told us they were kept informed of what was happening and understood what tests or treatment they were waiting for.

Patients waiting for a bed or who were in the department for a longer period were nursed on a bed rather than a trolley, so they were more comfortable whilst waiting to be admitted to a ward.
The department had a dedicated viewing room for patients who passed away in the department. The room was decorated in a soft and comforting way with seating available; however there was no access to any spiritual or religious materials that families using the room may require. The staff could facilitate requests to wash and prepare the deceased in this room, where families requested this due to cultural or religious beliefs.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Is the service responsive?

Service delivery to meet the needs of local people

The A&E department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day via the psychiatric liaison team. The psychiatric liaison team operated a 24 hour service across both hospital sites. They would attend the emergency department within an hour of receiving a referral, which is the trust target. Referrals to the psychiatric liaison team were made by telephone and all referrals were seen within the agreed timeframe, unless the referral was inappropriate, for example the referral was to provide support in the community and not at the hospital.

There was a separate room utilised to assess patients with mental health needs, however, this was not an official section 136 suite and it was not suitable for patients presenting with mental ill-health. The room used at Huddersfield Royal Infirmary did not meet the RCEM guidelines for a suitable environment for dealing with mental health emergencies in the emergency department. The room used was a small waiting room with six chairs and a coffee table and it was not free of ligature points. However it did have two doors but they both opened inwards and there were no viewing panels fitted. Staff told us the room was normally used for patients waiting for blood test results. There was no direct line of sight in to the room from the staff station in the centre of the department. The trust had plans to undertake some work to refurbish the room to make it suitable for use.

The nearest section 136 suite was located on site at Calderdale Royal Hospital, however not in the emergency department and was managed by local mental health trust. A section 136 suite is a place of safety for patients detained under Section 136 of the Mental Health Act.

There was an alcohol liaison nurse that visited the emergency department daily and referrals could be made via the EPR system or on paper.

Meeting people’s individual needs

There were dedicated disabled toilets available in the department. The signage on the toilet door was also in braille.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were never used for interpreting. It is best practice not to use family members for a number of reasons, including reliability of translation and patient confidentiality and staff understood this. We asked staff on both sites what their most requested languages were for translation and both sites answered with the same languages, which showed they understood the demographic of the local population.

Staff members indicated that they did not have information in easy-read format. Patients with a learning disability often attended the emergency department with a ‘VIP passport’ which indicated how they like to communicate, their likes and dislikes. However some staff we spoke to could not give a specific example of how they engaged with a person who presented with such an item.

Staff told us they could access British sign language interpreters if necessary.
The department utilised ‘distraction boxes’ for patients with dementia and learning disabilities. The distraction boxes were grab boxes full of items that could be used to help occupy patients that would benefit from them.

The department had a viewing room for families of recently deceased patients and could facilitate requests from family members to wash and prepare the body in line with cultural, religious and spiritual beliefs.

Staff were keen to take into account patients’ individual needs and gave an example of treating transgender patients, there were no mixed sex areas in the clinical decisions unit so patients would be treated as they wished to be known.

Young people who presented under the influence of alcohol or drugs would be referred to the local adolescent substance misuse service, if appropriate.

**Emergency Department Survey 2016**

The trust scored “better than” other trusts for all three of the Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey September 2016)*

**Access and flow**

The department had a six bedded rapid assessment area where patients arriving by ambulance would be taken. This meant that tests and assessments could be undertaken rapidly to aid the flow through the emergency department.

The department had a GP out of hours service that ran between the hours of 6pm and 10pm. The out of hours service was managed by Local Care Direct. Where patients were triaged and deemed suitable to be streamed to the GP, they would be sent there from triage.

The directorate team had been working closely with colleagues in Local Care Direct to put in place a new referral criteria and a SOP for the emergency department staff to follow, to ensure that patients in the department were identified in a timely manner to ensure that all the Local Care Direct slots were utilised effectively. The new process is due to be rolled out in April 2018.

The accident and emergency department used emergency nurse practitioners (ENPs) in the minor’s area. Staff told us that this had helped identify and treat more minor injuries, resulting in better flow and greater patient satisfaction.

The trust held bed meetings three times per day. Representatives from the emergency department attended and flow through all departments was discussed. Breaches were discussed alongside bed issues to aid movement through the department.

There was a monitor in the waiting room that informed patients of how long they would be waiting to be triaged and how long it would take to see a doctor. The monitor also displayed how many...
patients had attended the department and helped to address patient expectations with regards to waiting times and time to treatment.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for seven months over the 12 month period from January 2017 to December 2017. In August 2017, the median time to treatment was 0 minutes, compared to the England average of 53 minutes. This could be a data issue.

In December 2017, the median time to treatment was 73 minutes, compared to the England average of 62 minutes.

**Ambulance – Time to treatment from January 2017 to December 2017 at Calderdale and Huddersfield NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient - Huddersfield Royal Infirmary**

Data submitted after the inspection shows that Huddersfield Royal Infirmary median time spent from arrival at A&E to treatment was under one hour for two out of 11 months and over one hour nine out of 11 months. However in August 2017 the median time to treatment was just over the 1 hour target at 1 hour and 2 minutes.

(Source: Data request UEC 6 & 7 - Copy of AE Indicators April to Feb 2018)
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

The trust met the standard three times from January 2017 to December 2017. The trust breached the standard nine times from January 2017 to December 2017. The trust’s performance has, with one exception, been better than the England average.

Four hour target performance - Calderdale and Huddersfield NHS Foundation Trust

(Source: NHS England - A&E Waiting times)

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From January 2017 to December 2017, Calderdale and Huddersfield NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average.

Performance against this metric showed a trend of improvement over the period.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Calderdale and Huddersfield NHS Foundation Trust
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from January 2017 and December 2017, there were no patients that waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting between four and 12 hours were in January 2017 (292) and February 2017 (171).

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-17</td>
<td>292</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>171</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>93</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>59</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>82</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>59</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From January 2017 to December 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was, with the exception of August 2017, worse to the England average. The figure of 0% in August 2017 could indicate a data issue.

(Source: NHS England - A&E Waiting times)
In December 2017, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 5.9%, compared to the England average which was 3.5%.

**Percentage of patient that left the trust without being seen - Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing percentage of patients leaving without being seen (Calderdale and Huddersfield NHS Foundation Trust)](source: NHS Digital - A&E quality indicators)

**Percentage of patient that left the trust without being seen - Huddersfield Royal Infirmary**

Data submitted after the inspection shows that the percentage of patients that left Huddersfield Royal Infirmary without being seen peaked at 8.57% in May 2017 and was at the lowest in April 2017 at 3.01% and January 2018 at 3.23%.

![Graph showing percentage of patients leaving without being seen (Huddersfield Royal Infirmary)](source: Data request UEC 6 & 7 - Copy of AE Indicators April to Feb 2018)

**Median total time in A&E per patient (all patients)**

From May 2017 to December 2017, the trust’s monthly median total time in A&E for all patients was, with the exception of August 2017, consistently worse than the England average. The figure...
of 0 minutes in August 2017 could indicate a data issue.

In December 2017, the trust’s monthly median total time in A&E for all patients was 176 minutes, compared to the England average of 159 minutes.

**Median total time in A&E per patient - Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing median total time in A&E per patient for Calderdale and Huddersfield NHS Foundation Trust compared to England average.](image)

(Source: NHS Digital - A&E quality indicators)

**Total time in A&E per patient - Huddersfield Royal Infirmary 95th Percentile of time from arrival to Departure**

![Graph showing total time in A&E per patient for Huddersfield Royal Infirmary with 95th percentile from arrival to Departure.](image)

(Source: Data request UEC 6 & 7 - Copy of AE Indicators April to Feb 2018)

**Total time in A&E per patient - Huddersfield Royal Infirmary 95th Percentile of time from arrival to Admission (Admitted)**

![Graph showing total time in A&E per patient for Huddersfield Royal Infirmary with 95th percentile from arrival to Admission.](image)
Learning from complaints and concerns

Staff told us that complaints made whilst patients were in the department would be handled by the nurse in charge. Where possible complaints would be dealt with in the department and staff would listen and try and diffuse the situation and resolve the issues. Staff told us that complaints were recorded on the electronic incident system, as this also helped to flag trends to managers and disseminate learning to staff. Staff who were the subject of patient complaints were encouraged to reflect on their practice and use it as a learning experience.

Complaints could be made via telephoning or emailing the trust the Patient Advocacy and Liaison Service (PALS) and staff told us that they made patients aware of this service when they wanted to raise a formal complaint. Staff told us that PALS would contact the lead nurse or matron with
concerns or complaints when these were raised. Complaints were investigated by the matron and directorate general manager.

Complaints and learning from complaints were discussed at the quality improvement forum on a regular basis. Themes were identified and learning cascaded to staff. We reviewed a report that detailed complaints from February 2018. We also reviewed a document that showed the learning from complaints and the actions taken by the trust.

**Summary of complaints**

From November 2016 to October 2017 there were 95 complaints about urgent and emergency care services. The trust took an average of 41 working days to investigate and close complaints, this is in line with their complaints policy, which states that whilst they have no additional target date, the trust is are guided by the 25 and 40 day targets.

There were 40 complaints for Huddersfield Royal Infirmary.

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

**Is the service well-led?**

**Leadership**

The emergency care directorate sat within the division of medicine, which was split in to five directorates.

The local directorate structure was as the below diagram shows:

**Emergency Care Directorate**
A triumvirate of a clinical director, a directorate general manager and a directorate matron led the directorate of integrated medicine. The emergency department had a lead nurse who provided local leadership. The directorate matron provided strategic and managerial support for the emergency department and supported the lead nurse in the management of the department. This structure provided direct nursing and medical leadership.

The nursing and medical team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. Junior staff told us that they were well supported in their roles and had a clear understanding of their responsibilities. They said leaders were visible and approachable. Staff told us that senior managers were aware of the local challenges the department faced.

The directorate managers knew about the quality issues, priorities and challenges the division faced and worked collaboratively site-wide to try and deliver solutions and pilot new ways of working. We observed that managers were proactive and their positivity and motivation was inspiring.

The directorate leadership team demonstrated a clear approach to assessing and managing patient flow and safety within the emergency department. The lead nurses led a ‘safety huddle’ every morning and they discussed cross site issues using one template filled in by staff on both sites. This ensured messages and information were relayed with consistency, including staffing, complex cases and patient flow.

There was a clear commitment and focus by leaders to predict and respond to patient demand and flow issues within the emergency department, and this was supported by the other
departments in the hospital, particularly around the management of medical and surgical outliers on the clinical decisions unit.

**Vision and strategy**

The trust had a clear vision and strategy that was quality driven and which looked to transform patient access to urgent and emergency care. There was a strong vision in place for transformation of the delivery of urgent and emergency services to the local population.

As part of the departmental vision and strategy for 2017/2018, there were plans to implement a CESR Programme to mitigate middle grade doctor gaps and allow the trust to grow their own consultants. The leadership team told us the department was receiving training from Health Education England for 10 further middle grade doctors due to the consistently excellent results from the GMC survey. There was a focus on recruitment and workforce modelling, recruiting advanced clinical practitioners (ACPs) to mitigate low middle and junior doctor numbers. The trust was carrying out focused recruitment for consultants and band 5 nurses, to attract high quality candidates to roles at the trust. Investment and recruitment of a clinical practice educator would help to ensure a competent, supported nursing workforce with on-going development opportunities. The trust were also working with the EPR team to improve reporting capabilities with the system.

The department also had an education strategy for emergency nursing with a focus on educating, developing and growing a strong and competent nursing workforce.

**Culture**

We found the culture of the accident and emergency department open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders. We asked staff about the morale of the department and they all said that morale was generally good and they worked collaboratively as a team. Staff felt there were still some pressures around staffing, but the service had much improved since the last inspection and staff were proud to work there.

Staff felt supported in their work and there were opportunities to develop their skills and competencies, which was encouraged by senior staff.

Staff we spoke with wanted to provide effective care and treatment to patients and put patients at the centre of the experience. We observed staff working well together and there were positive working relationships within the multidisciplinary teams.

**Governance**

The accident and emergency department had governance, risk management and quality measures to improve patient care, safety and outcomes. The governance system supported the strategy and provided continuing assurance up to board level, with the clear focus on patient safety.

The governance structure was effective at providing a comprehensive governance framework to the department:
We reviewed the minutes from the quality improvement forums. The comprehensive agenda items were split into CQC domains such as safe, effective, caring, responsive and well led. Items for discussion included: mortality reviews, x-ray audits, safeguarding, medicines management, infection prevention and control, training and development, sepsis, audits, NICE guidance, CQUINs, friends and family test, learning from incidents, complaints, initial assessment times, did not wait, RCEM best practice, paediatric forum and trauma network.

The department held regular meetings and we reviewed minutes from the emergency department sisters meeting (chaired by the matron), the emergency care network directorate board meeting, the cross site staff meeting and the paediatric emergency care forum.

We identified some issues around the governance of the recording, storage and management of controlled drugs, medicines and consumables in the department. Managers assured us that processes had been changed and checks would be completed on a daily basis. We saw evidence of daily checks when we returned on the well led inspection and issues that had been escalated and remedied immediately, for example missing signatures. However we identified some further issues with the recording of controlled drugs and managers accepted that there was a need to provide additional training to staff in the department.
Management of risk, issues and performance

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. The leadership team were well sighted on the departmental risks and had plans in place to help manage and mitigate risks which were detailed on the risk register.

Incidents were discussed by senior management at their monthly quality improvement forum and learning shared with staff. Learning from incidents was also fed back at the daily cross-site safety huddle meeting. Staff could access the briefing on the shared drive and add on information to be shared on both sites to ensure a consistency in messages cascaded to staff.

The service undertook local and national audits to monitor and benchmark its performance at a local and national level. There were audit action plans in place to improve future outcomes across the local and national audit programme.

The service used dashboards which covered governance, quality and safety. We reviewed the integrated performance report which was made up of a series of dashboards covering the safe, effective, caring and responsive domains and benchmarked performance in key areas against other local trusts and the England average.

Information management

Staff were able to access patient information using an electronic system, EPR. Staff we spoke to was positive and engaged with the electronic patient record system. The accident and emergency department used an electronic system to track patients from presentation to discharge.

The department had a bespoke website called EM Beds that held all of the departmental policies, standard operating processes, leaflets, guidelines and pathways. Staff were able to access EM Beds internally and externally and they were overwhelmingly positive about its use. Documents held in EM Beds were updated regularly so there was always the most recent version available.

We observed good practice in relation to information security. Staff locked their computers and did not leave records open and unattended on screen.

Engagement

The accident and emergency department participated in the friends and family test and the NHS and CQC surveys.

In the past six months, the trust had initiated a number of measures to improve its engagement with local service users.

Work undertaken to increase engagement and involve the public had included:

- The department had involved patients in their governance meetings.
- The department won a trust Celebrating Success Award in 2017 with Team Lucy (care to a specific patient that attended emergency department).
- The trust planned to appoint a public engagement nurse for 15 hours a week and provided a job description for the role.
- Each emergency department had a ‘You said, We did’ board’ displayed for patients to see.
The emergency department team had completed a number of measures to increase its Friends and Family Test response rates and looked at the responses received which has since increased the percentage of patients that would recommend the service.

Following learning from a complaint, a member of the public came to talk to new starters regarding their experience in the emergency department and how they felt in whilst they were in the emergency department. This was used as an insight for staff to understand and empathise with patients who may attend the emergency department.

**Learning, continuous improvement and innovation**

The leadership had used some innovative approaches to recruiting and retaining new and talented medical staff to the accident and emergency department, including introducing a CESR programme to grow their own consultants from substantive middle grade doctors employed by the trust.

The trust had introduced a rapid assessment area. This has been introduced in to support ambulance turnaround times. At Huddersfield Royal Infirmary the trust had invested in a new six bedded area in the old plaster room to deliver this service. Ambulance turnaround times had improved the team were working with the local ambulance service to improve turnaround times further.

The department had an education strategy for emergency nursing with a focus on educating, developing and growing a strong and competent nursing workforce.

The department had successfully recruited to key roles to support the running of a high quality service. Roles recruited to included:

- **Advanced Care Practitioners (ACPs)** – The trust was successful in recruiting ACP’s at various stages in their training and had an educational strategy to support them joining the junior and middle grade doctors rota’s once qualified.
- **Medical Training Initiative (MTI)** – The trust had worked in partnership with the Deanery and had their first MTI in post with a second candidate in the recruitment process.
- **Consultant** – The trust had successfully recruited two new consultants into the department.
- **Clinical practice educator** – The trust successfully recruited a practice educator in the department ensuring a competent, supporting nursing workforce with on-going development opportunities.

The department had introduced trauma training, TaRTS training was in place supported by the clinical practice educator.

The trust had introduced safety huddles to support communication, patient and staff safety and pass on operational pressures to all team members. Safety huddles were held four times a day by medical staff and twice daily for the nursing staff. All groups of staff utilised a shared agenda to ensure consistency.

The directorate team had been working closely with colleagues in Local Care Direct to put in place a new referral criteria and a SOP for the emergency department staff to follow, to ensure that patients in the department were identified in a timely manner to ensure that all the Local Care Direct slots were utilised effectively. The new process is due to be rolled out in April 2018.
Critical Care

Facts and data about this service

The trust has 19 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Calderdale and Huddersfield NHS Foundation Trust and England

This trust

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>31.6%</td>
</tr>
<tr>
<td>Adult</td>
<td>68.4%</td>
</tr>
</tbody>
</table>

England

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>23.9%</td>
</tr>
<tr>
<td>Adult</td>
<td>68.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Huddersfield Royal Infirmary has one critical care ward; Ward HICU.

Calderdale Royal Hospital has one critical care ward; Ward CITU.

(Source: Routine Provider Information Request (RPIR))

The Huddersfield Royal Infirmary hospital site has a combined intensive care unit (ICU) and high dependency unit (HDU). This provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care.

The unit has a total of eight bed spaces, including four single rooms. The level of care provided flexed between the two sites to provide a maximum capacity of nine level three and four level two patients. Surgical or emergency admissions were taken at this site; respiratory patients were predominantly admitted to the Calderdale intensive care unit (ICU).

The critical care service is part of the West Yorkshire Critical Care Network. Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 30 September 2017 at this site, there were 217 admissions with an average age of 62 years. Sixty two percent of admissions were non-surgical, 23% were planned surgical admissions and 15% were emergency surgical admissions. The average length of stay on the unit was two days.

A critical care outreach team provides a supportive role to the wards caring for deteriorating patients and support to patients discharged from critical care. The team is available seven days a week from 7.30am to 8pm.

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**

**Mandatory training completion rates**

The trust set a target of 95% for completion of some mandatory training courses. However, the majority of courses did not have a target given. Mandatory training data was provided for critical care services at both Huddersfield Royal Infirmary and Calderdale Royal Hospital. This data was not site specific as critical care staff work flexibly across both locations.

**Huddersfield Royal Infirmary**

A breakdown of compliance for mandatory courses from April 2017 to November 2017 for nursing staff in critical care at Huddersfield Royal Infirmary is shown below:

<table>
<thead>
<tr>
<th>Course title</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>74</td>
<td>74</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>67</td>
<td>68</td>
<td>98.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>72</td>
<td>74</td>
<td>97.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>72</td>
<td>74</td>
<td>97.3%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>70</td>
<td>72</td>
<td>97.2%</td>
<td>No target</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>71</td>
<td>74</td>
<td>95.9%</td>
<td>No target</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>70</td>
<td>74</td>
<td>94.6%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>69</td>
<td>74</td>
<td>93.2%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td>66</td>
<td>72</td>
<td>91.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>66</td>
<td>74</td>
<td>89.2%</td>
<td>95%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>62</td>
<td>74</td>
<td>83.8%</td>
<td>95%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>60</td>
<td>72</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td>55</td>
<td>66</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>59</td>
<td>72</td>
<td>81.9%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>55</td>
<td>72</td>
<td>76.4%</td>
<td>No target</td>
</tr>
<tr>
<td>CPR</td>
<td>43</td>
<td>74</td>
<td>58.1%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td>26</td>
<td>74</td>
<td>35.1%</td>
<td>No target</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>19</td>
<td>74</td>
<td>25.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>17</td>
<td>72</td>
<td>23.6%</td>
<td>No target</td>
</tr>
</tbody>
</table>
The hospital's overall nursing mandatory training completion rate was 79.2%. The target was not met for four of the 19 mandatory training modules. For the other 14 mandatory training modules no targets were provided.

Calderdale Royal Hospital

The trust set a target of 95% for completion of mandatory training. There were 12 mandatory training topics to be undertaken by all staff. Further staff training data was seen on site and requested after the inspection. Staff rotated between the units at Calderdale and Huddersfield; the training data below is for all 93 ICU and critical care outreach nursing staff as it could not be broken down by site. The training figures represent expected compliance rates by March 2018.

<table>
<thead>
<tr>
<th>Course title</th>
<th>Compliance by March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>93%</td>
</tr>
<tr>
<td>Data security awareness (Information governance)</td>
<td>96%</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>100%</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>87%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>98%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>98%</td>
</tr>
<tr>
<td>Health safety and welfare</td>
<td>98%</td>
</tr>
<tr>
<td>Infection control</td>
<td>95%</td>
</tr>
<tr>
<td>Manual handling</td>
<td>84%</td>
</tr>
<tr>
<td>Mental capacity</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding children</td>
<td>99%</td>
</tr>
</tbody>
</table>

Role specific training was also completed. This included topics such as intermediate life support training. This had a target of 50%, compliance was 54% at the time of inspection and more staff were booked on to training courses later in the year.

Training was provided on sepsis as part of other training courses such as intermediate life support and critical care competencies. For medical staff it formed part of their induction training.

The clinical educator for ICU managed training and all data was stored on the 'productive ward' database. This was available by department and was accessed via the trust intranet. We saw this during our inspection and were provided with a copy. This gave an overview of the unit’s mandatory training, clinical skills and specialist skills training.

Manual handling training was an area below the trust target. Four staff members had gained competence to provide this training. This meant they could train staff on the unit rather than then having to leave to attend training.

We requested mandatory training data for consultants working in ICU. Again this could not be provided per site as staff worked across both sites. Compliance was just below the trust target of 95% at 94% in all areas with the exception of infection control.

Safeguarding

Safeguarding training completion rates

The trust set a target of 95% for completion of the majority of the safeguarding training modules. However, no targets were given for two of the modules. Data were only provided for critical care
services at Huddersfield Royal Infirmary. The trust did not provide safeguarding training data for the medical staff for critical care throughout the trust. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

Huddersfield Royal Infirmary

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for nursing staff in critical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Course title</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>62</td>
<td>72</td>
<td>86.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>7</td>
<td>19</td>
<td>36.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>5</td>
<td>19</td>
<td>26.3%</td>
<td>No target</td>
</tr>
</tbody>
</table>

The hospital’s overall safeguarding training completion rate for nursing staff in critical care was 77.8%. The target was not met for the four courses where a target was specified.

We were provided with more recent safeguarding training data following the inspection. The data could not be broken down by site as staff rotated between the ICU at Calderdale Royal Hospital and Huddersfield Royal Infirmary.

Adults and children’s safeguarding training compliance for the 93 nursing staff exceeded the trust target of 95%.

We requested data on medical staff training compliance for adults and children’s safeguarding this was just below the trust target at 94%.

Up to date safeguarding polices and guidance were accessed on the trust intranet site. These were easy to access and locate. There was a safeguarding team who were available for advice, as well as safeguarding champions in the unit.

The staff we spoke with were aware of what may be a potential safeguarding concern and how they would escalate this.

Calderdale Royal Hospital

The trust did not provide safeguarding training data for medical or nursing staff for critical care at Calderdale Royal Hospital. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR))

Cleanliness, infection control and hygiene

 Ninety five percent of nursing staff and 88% of consultants had completed infection control training against a trust target of 95%. Seventy two percent of nursing staff had completed infection control ‘beyond the basics’ training, this training was undertaken every two years but had no target
attached. Seventy eight percent of nursing staff had also completed training on aseptic non-touch technique. This training only needed to be completed once, there was no target attached to this.

We saw information displayed on cleanliness and information control on the safety information board. The latest information was from February 2018 which showed hand hygiene was 100%, the units cleaning score was 99% and the units environment audit score was 94%. The unit had link nurses for infection prevention and control.

Intensive Care National Audit and Research Centre (ICNARC) data showed there had been no unit acquired infections in blood per 1000 patient bed days between 1 April and 30 September 2017 at Huddersfield. This was better than similar units. For the same time period there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA) or *clostridium difficile*. However there had been one case of *clostridium difficile* in January 2018.

The unit was visibly clean, tidy and free from clutter. Hand hygiene points were at the entrance to the unit as well as hand wash facilities and alcohol gel at each bed space. There was a cleaning schedule for the unit and bed space cleaning charts which we saw completed.

We observed staff providing care and found appropriate use of personal protective equipment (PPE) and hand hygiene. We observed during a ward round that mobile computers were taken from patient to patient including in to single rooms and these were not wiped down between patients. Staff were unable to tell us how often mobile workstations were cleaned.

The unit had facilities for respiratory isolation and we found appropriate waste segregation and disposal systems in place.

**Environment and equipment**

The unit was compliant with health building notice (HBN) 04-02. Access was via intercom with a security camera. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance. There were four single rooms available; in the main bay bed spaces were separated by curtains to maintain patients’ privacy and dignity.

There was a rolling programme for equipment replacement including beds and ventilators. New ventilators had recently been purchased and equipment was being standardised across the two sites. Specialist equipment was available for patients with a high body mass index (BMI) when required. We checked 12 pieces of equipment for evidence of in date electrical testing stickers. We found these to be in place and in date with the exception of one portable ventilator.

During our inspection we found one of the fire exits blocked with a large piece of equipment. Later the same day we found this still to be the case. This was escalated to the matron. When we returned to the unit on a different day we found the fire exit was clear.

Resuscitation equipment was centrally located on the unit. We inspected resuscitation equipment for three months prior to the inspection. Checks were competed with no gaps. We found the transfer bag had a contents list and all items were present and in date. There was no record of checks for this which meant staff could not be fully assured that items had not been removed following checks.
Training for new equipment introduced to the unit was provided by the manufacturer, then cascade training was utilised. Equipment training was part of role specific training and recorded on the productive ward training database. This included equipment such as ventilators and hemofiltration.

**Assessing and responding to patient risk**

The critical care outreach team (CCOT) provided cover seven days a week from 7.30am to 8pm at Huddersfield Royal Infirmary. Overnight cover was provided by the hospital out of hours programme (HOOP) team. There was a standard operating policy (SOP) in place for sharing information between the two teams. There was also a handover checklist and a designated time for handover to take place. This was an improvement since the previous inspection where some issues were identified with handovers between the two teams.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They also reviewed patients who were discharged from ICU to ward areas.

The trust used the national early warning score system (NEWS) as a tool for identifying deteriorating patients. There was a clear escalation policy in place for when patients had an elevated NEWS score.

The wards had an electronic system for recording patient observations. This allowed the CCOT to remotely monitor any patients with elevated NEWS scores. Due to a reconfiguration of services, any patients who deteriorated and required respiratory support such as non-invasive ventilation would be transferred to Calderdale. If this occurred on a ward at Huddersfield the outreach nurse would stay with the patient until the transfer took place.

At the previous inspection concerns were identified in relation to critical care patients being cared for in the theatre recovery by staff who may not have the appropriate skills and training. This had been a particular issue during the night. We found from speaking to critical care and recovery staff that this situation had significantly improved.

The updated admission and discharge policy covered this situation and the processes were embedded at this inspection. There was a decision tree chart to follow to support (or not) patients being cared for in theatre recovery.

There were still instances of patients being cared for in recovery whilst waiting for a bed on ICU. We observed this during our inspection. However these patients would always be cared for by a critical care nurse. This was confirmed by critical care and theatre recovery staff. All staff reported a much more robust system in place.

We were provided with the draft terms of reference for the deterioration, recognition, response and prevention programme group. The purpose of this group was to improve patient outcomes with regards to the various aspects of deteriorating conditions. We were told real time audit data was to be collected from February 2018 on the response and treatment for patients with an elevated NEWS score of five or more. We requested details of this audit data but the trust did not provide it.

Risk assessments and care bundles were completed in the 12 patient records we reviewed. Examples included, venous thromboembolism (VTE) and moving and handling risk assessments. Safety huddles had been introduced which took place after the ward round as a way of sharing information about any risks between staff.
The electronic patients record (EPR) included a screening tool for sepsis. This would flag automatically for a patient on the wards if they had a NEWS of five or more. Sepsis care and treatment bundles were in place and we found evidence of this in the records we reviewed.

Sepsis data was collated in the department’s quality and performance report. It was also noted in the September 2017 report that the EPR screening prompts were causing some confusion, and whilst screening was occurring, the evidence was not being captured in the correct part of the EPR. In response to this a clinical working group looked at this issue and shared the correct process at the sepsis group.

Data from quarter two in 2017 showed the division of surgery and anaesthesia, of which ICU was part, was not achieving to 90% target for timely screening and treatment of sepsis. There were also some gaps where data had not been collected, for example in August and September 2017. The division was part of the sepsis improvement group and received weekly updates on compliance to enable targeted work to be undertaken. We asked the service leads about sepsis; they stated the EPR was creating some challenges and processes were taking time to become embedded.

The unit did not accept paediatric admissions. The anaesthetist or consultants would attend in an emergency and stabilise the patient until the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Staff we spoke with knew how to access the mental health liaison team and told they responded in a timely way to any referrals.

**Nurse staffing**

Information about nursing fill rates is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

<table>
<thead>
<tr>
<th>Site/location</th>
<th>Staff group</th>
<th>Actual staff - WTE</th>
<th>Actual staff - headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>70.63</td>
<td>81.00</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Support to doctors and nursing staff</td>
<td>7.44</td>
<td>9.00</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

The following nurse staffing information at Huddersfield Royal Infirmary is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

However, whilst data has been provided for Huddersfield Royal Infirmary, the trust has not provided information on vacancies, turnover, sickness and bank/agency usage in critical care at Calderdale Royal Hospital. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From November 2016 to October 2017, the trust reported a vacancy rate in critical care at
Huddersfield Royal Infirmary of 0.4%. The trust did not provide a vacancy target percentage. More recent data provided on site gave a vacancy rate within critical care of 3.13%.

(Source: Routine Provider Information Request (RPIR))

From November 2016 to October 2017, the trust reported a turnover rate at Huddersfield Royal Infirmary in critical care of 4%. The trust did not provide a turnover target percentage.

(Source: Routine Provider Information Request (RPIR))

From November 2016 to October 2017, the trust reported a sickness rate in critical care at Huddersfield Royal Infirmary of 6.4%. This is higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR))

Data from September 2017 to February 2018 showed that a total of 90 shifts were covered by agency staff. We reviewed rotas and were assured this met the GPICS standard of units not utilising greater than 20% of registered nurses from bank or agency on any one shift, when they are not the units own staff.

From November 2016 to October 2017, the trust reported a bank and agency shift total of 351 in critical care for qualified nurses at Huddersfield Royal Infirmary. There were also 49 qualified nursing shifts not filled.

A breakdown of bank and agency staff at Huddersfield Royal Infirmary by staff type is shown in the table below:

<table>
<thead>
<tr>
<th>Bank/agency/unfilled</th>
<th>Nursing Assistant</th>
<th>Qualified Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>0</td>
<td>118</td>
<td>118</td>
</tr>
<tr>
<td>Agency</td>
<td>1</td>
<td>233</td>
<td>234</td>
</tr>
<tr>
<td>Not filled</td>
<td>7</td>
<td>49</td>
<td>56</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Nurse staffing was based on guidance and standards from D16 NHS standard contract for adult critical care and GPICS. Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients’ ratio for level two patients. We observed this during our inspection.

At this site there was a supernumerary co-ordinator Monday to Friday from 8am to 4pm. Seven nights a week there was a supernumerary co-ordinator on duty. However, if there was a critical care patient in recovery this person would be moved to provide their care.

Data from August 2017 to January 2018 showed there had been 15 occasions where there had been a critical care patient in recovery. Thirteen of these happened overnight. The supernumerary coordinator provision did not completely meet GPICS standards. However it had improved since the last inspection.

The nursing handover was led by the nurse in charge. The allocation of patients was decided the shift before to save time whilst still ensuring continuity of patient care and appropriate skill mix. Nurses then completed a one to one handover at the bedside.
Planned and actual staffing numbers were displayed. Planned staffing levels for the unit was seven nurses and one health care support worker during the day and seven nurses at night. The co-ordinator was not included in these numbers.

Nursing staff rotated across both sites. Electronic rostering was in place which incorporated the safe care staffing tool. One rota was produced which covered both sites. This was managed by one of the band seven sisters.

One key aspect of creating the staffing rota was the system for managing annual leave. This was done with a spreadsheet which all staff could access, which calculated how much annual leave could be taken each week. This meant that annual leave was spread throughout the year and stopped too many staff being on leave at once which would result in difficulty in covering shifts.

There was also a spreadsheet for managing staff sickness. Senior nurses reported good support from human resources as well as a raised awareness amongst staff about sickness management.

We viewed eight weeks of staffing rotas. When the rotas were produced there were 154 unfilled shifts. We saw that the shifts were covered by bank or agency staff or existing staff working additional hours.

A change in ICU staffing had been introduced which positively impacted nursing staff. If there were empty beds and not all staff were required, historically staff would be moved to support the wards. This had changed and nursing staff were given the option to go home rather than be moved to a ward area. This flexible approach to staffing meant at busier times staff who had chosen to do this could be brought in to work to provide additional support.

The previous inspection highlighted a high vacancy and staff turnover rate. A significant amount of work had been done to improve this. This included reviewing information from exit interviews and providing additional support for newly qualified nurses. As a result of this work the staff turnover rate had reduced from 20% in 2016 to 3% in January 2018.

The critical care outreach team (CCOT) consisted of seven staff who worked cross site. With one nurse on each site seven days a week from 7.30am to 8pm. Data provided by the trust showed that all shifts from September 2017 to February 2018 were covered.

There was an escalation plan should there be any sickness within the team. This was also identified on the divisional risk register as any sickness could significantly impact the service due to the size of the team. The situation was monitored on a daily basis with additional support available from anaesthetic staff. The hospital had a central venous access devices (CVAD) team who had recently had a staffing uplift of two whole time equivalent staff. This team supported the CCOT by undertaking tasks relating to the care and management of central lines. This helped reduce some of the workload on the CCOT.

**Medical staffing**

Critical care had a designated clinical lead. Since the last inspection consultant rotas and on call arrangements had changed which meant the unit was compliant with GPICS standards. Block working was in place which delivered continuity of care and consultants were freed from other commitments when on call.

We observed a consultant led ward round and handover which was clear with detailed plans outlined for each patient.
In the 12 patient records we reviewed we saw that daily consultant led ward rounds took place in line with GPICS standards. The consultant to patient ratio did not exceed the recommended 1:8 to 1:15.

From September 2017 to February 2018 there had been no use of medical locums in critical care.

**Records**

Since the last inspection electronic patient records (EPR) had been introduced. Within ICU there were still some nursing paper records and care plans which led to some duplication of records. This was on the divisional risk register with assurance processes in place to reduce the impact of the risk.

The ICU observation charts were also paper based. The electronic system for recording observations was not used on the unit, however once a patient was ready to transfer to a ward their most recent observations would be added to the system.

The paper records were stored securely in trolleys at the end of each bed. Information provided by the trust showed 96% of nursing staff and 94% of medical staff in the service had completed information governance training against a target of 95%.

Mobile computers were used during ward rounds to record discussions and treatment plans. The ability to review patient information remotely was a benefit for the outreach team and when looking at potential admissions to the unit.

We reviewed 12 sets of nursing and medical records in detail with the help of a member of staff to help navigate the EPR. We looked at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Medical records were completed in line with trust and professional standards. There was evidence of consultant review on admission to critical care and daily review from the multidisciplinary team.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital.

The physiotherapy team completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness) requirements during a patient’s stay in critical care.

The critical care module for the EPR had not been purchased by the trust. This was why some paper documents were still used. Some adaptions had been made to the systems in terms of where information was recorded to make it more user friendly and easy to access ICU patients’ records. Staff were generally positive about the transition to EPR. A small number (five) staff gave negative comments about the EPR stating the functionality was fully integrated for ICU. Other comments were around information being recorded in more than one place and the training for the system being given too far ahead of the implementation.

We saw there were guidelines at the bedside on how to complete particular actions on the system. Pharmacy staff also told us they were very much involved in the implementation and had access to a pharmacy EPR team for support.

**Medicines**
There were electronic and paper prescription charts in use. The ICU specific infusions and medicines were on paper prescriptions. Staff on the unit told us they were used to having two prescription charts for patients, as ICU specific drugs had always been on separate charts, so no concerns were raised about this. The risk however was identified on the divisional risk register.

We reviewed incident data from December 2017 to February 2018 and found two incidents related to medication. We asked pharmacy staff if there had been any rise in medication incidents since the implementation of EPR, they stated no audits of medication charts had taken place so they were unsure.

We reviewed six electronic prescriptions and found them to be fully completed. However when we reviewed the paper prescription charts for the same six patients we found a number of gaps and omissions. For example, the allergy status was not completed on one chart, there were two infusions with no start time recorded, three drugs with a second signature missing and there were four infusions with the drug batch number not recorded.

Prompt systems were in place on the EPR when antibiotics were prescribed to ensure course duration and review date was entered.

Regular monthly audits took place asking six questions around fridge temperature recording, controlled drugs and the storage of medicines. We were provided with data from January 2017 to February 2018. The data showed the majority of areas scoring 100%. The exception to this was bedside medicine cabinets being locked. A number of steps had been put in place to improve this. We found all bedside medicine cabinets locked during our inspection.

During our inspection we found stock medicines within the unit were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records and saw that daily balance checks had been completed in line with the trust policy. This was supported by 100% compliance in checks completed from audit data from January 2017 to February 2018.

Training was provided on medicines management and the safe use of insulin. Training compliance figures at the time of inspection were 96% and 99% respectively.

Microbiology input could be accessed however attendance at the multidisciplinary ward round was variable.

**Incidents**

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 February 2017 to January 2018, the trust reported no incidents classified as never events for critical care.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from February 2017 to January 2018.
The unit at Calderdale reported 34 incidents between December 2017 and February 2018. Twenty one of these were graded as green (no harm/near miss) the remaining 13 were graded as yellow (low harm). There were no incidents reported with moderate or severe harm. The main theme of incidents was pressure damage.

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. However only one staff member could give an example of a recent incident they had reported. Senior nursing staff felt incident reporting had improved and that staff were encouraged to report incident. However with the small number of incidents reported by the unit we lacked some assurance that all incidents and near misses were being reported.

There were various systems in place to feedback learning from incidents. Face to face feedback, either on an individual basis or at team meetings was given. Information was also sent via email.

We saw the ‘bitesize’ learning board which contained brief summaries on a number of different topics and what learning or action was taken. For example an incorrect dose of a sedative was prescribed and a focus on nasogastric tubes following a safety alert.

We also observed information displayed in staff areas on learning from specific incidents. This was information on a page about the incident trigger, conclusions, root cause and lessons learnt. The staff we spoke with were aware of the one displayed during our inspection which related to pressure damage. We were not provided with any other examples of incidents or learning from staff on the unit.

The electronic incident reporting system included a prompt on the duty of candour. This 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. We saw information displayed in general areas on the duty of candour. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

We reviewed the learning from deaths policy this outlined the mortality review process. This included a standard operating policy (SOP) which detailed the specialty specific initial mortality initial screening review process, which included critical care. The policy stated all reviews must take place within four weeks and any that scores one or two would be subject to a structured judgement review.

There was a four tiered process to mortality reviews which included a trust wide mortality surveillance group, divisional, team and individual levels.

At divisional level, any deaths that were incident reported were reviewed at the divisional orange panels and divisional patient safety and quality board (PSQB).

Medical staff told us mortality and morbidity was sometimes discussed at monthly audit sessions, however this would not always be just ICU patients. We reviewed several meeting agendas and minutes and saw that mortality and morbidity was not always discussed and that is was not specific to critical care. This was not in line with GPICS standards.

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.

Data from the Patient Safety Thermometer showed that the trust reported 11 new pressure ulcers, no falls with harm and no new catheter urinary tract infections from March 2016 to December 2017.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Calderdale and Huddersfield NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers</th>
<th>(11)</th>
</tr>
</thead>
</table>

(Source: NHS Digital)

We did not see safety thermometer data displayed on the unit. Staff reported this data was not being collected. We saw that data had been collected for February 2018 showing 100% harm free care. There was no other recent data to review for this site.

Safety information was displayed on the ward information board. The information showed the last avoidable fall had been in November 2017 and the last pressure ulcer had been in July 2017. However incident data showed there had been two pressure ulcers in February 2018.

**Is the service effective?**

**Evidence-based care and treatment**

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

At the previous inspection a number of out of date paper copies of guidelines were found on the unit. We did not find this during this inspection. We reviewed ten polices and found them to be in date with an author and version control. Polices and guidance were accessed on the trust intranet which was easy to navigate.

The trust was part of the West Yorkshire Critical Care Operational Delivery Network (WYCCODN). This group met six times a year to representatives from each trust in the network. They shared and reviewed critical care specific guidance from their units. This included areas such as pain, sedation, delirium, prone positioning and nutrition.

Each area was marked against a standard framework and given a score. The unit with the highest score shared their guidance with the rest of the group. If it was identified that there was a particular area or topic for which there was not guidance available, the group would develop some.

Within the WYCCODN group it was identified that the trust was not fully compliant with the ventilator associated pneumonia (VAP) care bundle as sub-glottic suction
endotracheal/tracheostomy tubes were not routinely used. There were plans in place to trial some tubes and it was expected the unit would be compliant by May 2018.

We saw evidence of screening for delirium in the 12 records we reviewed in line with NICE guidance. This was also included on the ICU chart as a daily reminder for staff.

The previous inspection identified challenges in meeting NICE CG83 rehabilitation after critical illness. We found the physiotherapy team were able to deliver 45 minutes of daily therapy in line with guidance.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in the 12 patient records we reviewed.

We found that nutritional care plans were duplicated, as there were paper copies and records within the EPR. However we found these to be both completed and updated.

The unit had an emergency protocol for enteral feeding in place. This included a flow chart for staff to use to instigate feeding for patients who were unable to eat if a dietitian was not available, for example outside of regular working hours. This meant there were no delays to patient care.

Ninety two percent of staff had completed training in nasogastric tube competency and 55% of staff had gained competency to insert nasogastric tubes.

The dietitian provided cover from Monday to Friday and would attend the ward round. Cover was not provided at a weekend.

During our inspection we saw that water was available for those patients able to drink and fluid balance charts were fully completed in each of the records we reviewed.

**Pain relief**

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was reviewed as part of the ward round.

From the notes we reviewed we found evidence of pain scores being done and appropriate action taken in response to any indicating a patient was experiencing pain. We observed a pain assessment poster explaining to visitors how pain can be assessed even if their relative is under sedation. It also showed pictorial pain scales which were another way of assessing pain levels.

We were provided with a pilot ward assurance tool which had been implemented since the launch of EPR. There were five questions in this related to pain management, such as had pain scoring being completed and are there care plan in place. Data collection had started in September 2017. Results had improved to 100% in all areas in January and February 2018.

**Patient outcomes**

The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. More recent quarterly data may be available online. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

For the Intensive Care Unit at Huddersfield Royal Infirmary, the risk adjusted hospital mortality ratio was within expected limits in 2016/17.
We reviewed data from the 1 April 2017 to 30 September 2017 quarterly quality report, this showed the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was within expected limits for 2016/17.

We spoke with the critical care outreach team about data they collected. Staffing within the team meant that whilst the clinical responsibilities could be covered there was no allocated time for additional tasks such as audit. We requested data on the national critical care outreach activity outcome data set. This included 19 areas of data collection, such as the number of cardiac arrest calls and the number of individual patients referred to the CCORT. Some data was being collected, for example by the site coordination team and the resuscitation team. Other data was contained within the electronic patient observation record. However this information was not being collated to provide an overview of the activity and performance of the team.

The physiotherapy team completed a national rehabilitation outcome measure called the ‘Chelsea Critical Care Physical Assessment Tool’, a scoring system to measure physical morbidity in critical care patients.

**Competent staff**

**Appraisal rates**

From April 2017 to November 2017, 96.3% of staff within critical care at the Huddersfield Royal Infirmary had received an appraisal, compared to a trust target of 100%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Number of staff members who have received an appraisal (YTD)</th>
<th>Number of staff required to receive an appraisal (YTD)</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing Staff</td>
<td>69</td>
<td>72</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

We requested appraisal data for medical staff. This showed that 84% had undergone a recent appraisal. However we did find that 33% of those had taken place more than 12 months since their last appraisal.
Information provided by the trust showed that 61% of nurses in the service had a post registration award in critical care nursing. This was a significant improvement from the last inspection where it had been 39%. This met the GPICS minimum recommendation of 50%. At the previous inspection concerns were identified over the skills mix within the team within over half the staff having less than 18 months experience. This was no longer the case and no concerns were raised by any staff with regards to this.

The clinical educator had oversight of all training providing cross site cover. Training information was captured in a database. All staff completed a trust wide and local induction programme. Nursing staff were allocated mentors and completed a preceptorship programme. The clinical educator would also work with staff to provide support and training.

Staff on the unit were working to complete the national competency framework for adult critical care nurses. Information on progress with this was captured in the productive ward database. Also included in this was compliance in areas such as transfer training, specialist tracheostomy and airways training, and supporting learning in practice (SLIP) training. The unit had introduced development days for staff to attend each year where this additional training would be provided.

The majority of staff felt well supported and were happy with the training provided for their role. There was a small number of staff who felt training was lacking and not well organised and gave examples where rooms hadn’t been booked for training or they were booked on training they had already completed.

We spoke with the senior team who recognised the importance of training and development for all staff. An education and training strategy had been put in place in 2017. This captured all elements of training within the department. It included induction for new starters, continuing professional development and succession planning.

The CCOT felt their educational needs had not been an area of focus. At the previous inspection they were involved in delivering training for ICU and ward staff this was no longer the case. The team were also concerned that competency assessments for the team were not in place.

The team were keen to address this although current capacity within the team meant there was no allocated time for this. The team had completed a gap analysis against National Outreach Forum (NOF) and WYCCODN competencies and standards. We were provided with a copy of this following the inspection. This identified 23 standards of partial compliance and 10 standards of none compliance. These were all focused around education, training and development within the team. This information was due to be presented to the senior management team.

**Multidisciplinary working**

We observed good multidisciplinary team working. We saw evidence of this in the 12 patient records we reviewed. There was access to speech and language therapy, a specialist nurse in organ donation and other nurse specialists when required.

There were clear internal referral pathways to therapy and psychiatric services.

Multidisciplinary staffing was generally in line with GPICS standards. From our observations and reviewing patient records, there was not always full attendance during ward round. Whilst there was pharmacy and physiotherapy input each day. They did not always attend the wards rounds.

Microbiology input was available as needed, but this may have been by telephone rather than in person. This was also seen in the patient records we reviewed.
We reviewed the units’ admission and discharge policy. This had recently been updated and clearly outlined the criteria for admission to the unit. We observed handovers taking place and the completion of transfer documents for patients going to ward areas. This was in line with NICE CG50 acutely ill adults in hospital.

**Seven-day services**

A pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients’ medicines. There was access to pharmacy provision on call at other times.

Physiotherapists provided treatment seven days a week with an on-call service was available overnight.

X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

Daily consultant led ward rounds were observed and evidenced in the patient records we reviewed. Twenty four hour a day seven day a week consultant cover was available in line with GPICS standards.

**Health promotion**

There were guidelines in place to support patients withdrawing from drugs or alcohol and to support smoking cessation. Additional support was provided by the pharmacy team.

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

The unit had developed partnership working with improving access to psychological therapies (IAPT), as part of critical care follow up clinic.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

**Huddersfield Royal Infirmary**

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for nursing staff in critical care at the hospital is shown below:

<table>
<thead>
<tr>
<th>Course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>47</td>
<td>53</td>
<td>88.7%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD MCA &amp; DoLS Level 3</td>
<td>5</td>
<td>19</td>
<td>26.3%</td>
<td>No target</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>52</strong></td>
<td><strong>72</strong></td>
<td><strong>72.2%</strong></td>
<td><strong>No target</strong></td>
</tr>
</tbody>
</table>

MCA training had been completed by 88.7% of nursing staff in within critical care and DoLS training by 26.3% of staff. The trust had not set targets for either of these courses.

Further data was received following the inspection which showed training compliance on mental capacity for nursing staff across both sites was 90%.

Eighty eight percent of medical staff were compliant with training in mental capacity.
Staff we spoke with demonstrated a good understanding of consent, where possible staff would always seek consent from patients. It was recognised that gaining consent within the unit could be difficult due to the patients they cared for.

In the records we reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. This is used to measure the agitation, sedation or delirium levels of a patient. We saw that where appropriate these had been completed and appropriate actions taken.

Staff understood mental capacity and the need to assess and document this when any form of restraint was used. They tried to avoid using chemical restraint on patients, if safety gloves or bridles were required staff completed a capacity assessment prior to using them and reviewed patient’s capacity regularly. There were care plans to support the use of these.

Is the service caring?

Compassionate care

We observed all members of staff providing care for patients’ in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious and unconscious.

We observed patients’ privacy and dignity being maintained when care and treatment was being delivered. We also observed staff responding in a kind way to patients who were anxious or required reassurance.

Without exception all the patients and relatives gave positive feedback saying staff were extremely caring. We observed staff taking a patient from the unit to visit his new born daughter.

We saw numerous thank you cards displayed on the main corridor and positive patient comments on the ward information board. These stated there had been good communication from the consultant and staff had been observed being polite with each other as well as patients.

Friends and family test data was displayed from January 2018 indicating 100% of respondents would recommend the service.

Emotional support

Bereavement and multi faith chaplaincy services were available on site and staff could access these for patients. Relatives told us they had visited their relatives when requested.

The critical care outreach team said part of their role when reviewing patients on the ward following discharge from the unit was providing psychological support.

Staff we spoke with felt able to provide support to relatives as well as to patients and felt this was an important part their role.

Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. There was a honeycomb plaque to remember patients who had donated and the unit had held a remembrance service.

Patient records showed assessment of emotional and spiritual needs with consideration given to this in care planning. Patient diaries were being completed for some patients. Evidence has shown these can provide comfort for patients following a stay on an ICU as they can fill in gaps and help patients understand what they have experienced. The involvement of families can also have a positive influence. Patient diaries were shared at the follow up clinic.
Understanding and involvement of patients and those close to them

Staff we spoke with told us how they involved carers and relatives to aid communication and get to know the patients they were caring for. Relatives reported they had a good rapport with the nursing staff and felt able to ask questions.

The patients and relatives that we were able to speak with said they felt staff were knowledgeable and involved them in discussions about care and treatment. Relatives said they were able to speak to doctors who took time to explain things in a way which they could understand.

We saw evidence in the records we reviewed where patients and their relatives had been involved in making decisions about their care and treatment.

Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff always had access to a specialist nurse for organ donation when needed. We saw data displayed which showed during 2016 and 2017 ten families had been approached about organ donation. The specialist nurse had been involved with each of them with no missed referrals.

Is the service responsive?

Service delivery to meet the needs of local people

Since the last inspection, a follow up clinic for patients had been established which was in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standards. This was nurse led with a consultant sometimes in attendance and was held each month. The clinic had been shortlisted as a finalist in the trusts celebrating success awards. This

The critical care outreach team reviewed all patients on the wards who were discharged from intensive care. Patients received a minimum of two visits from the team.

The service did not have a critical care patient and relative support group. The unit had previously been involved with a network coffee morning which patients who had used critical care services had been invited to. There were plans to look at holding another locally but no timeframes had been set for this.

The unit was part of the West Yorkshire Critical Care Operational Delivery Network (WYCCODN) and best practice and learning was shared across the network though face to face meetings.

There was a coffee room for relatives where they could access hot drinks and have some time away from the unit. There was also accommodation for relatives to stay overnight.

Critical care provision on the unit flexed to meet the differing needs of level two and level three patients. As critical care nurse staffing was cross site there was the ability to also flex staffing if the unit became busier.

Meeting people’s individual needs

Staff we spoke with knew how to access translation services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Staff gave an example of where this had been used recently. Staff told us it was positive as they could get information directly from the patient.

There were specialist nurses for areas such as learning disabilities. VIP passports were in place and the butterfly scheme for patients living with dementia. We saw in patient records that care
plans included assessment and interventions for patients with dementia, learning disabilities and delirium.

Staff recognised the importance of involving relatives and carers. We observed this during our inspection. The patient records that we reviewed reflect that individual needs were assessed and care planning was informed by this.

Feedback from patients identified that often they made have several appointments following discharge from hospital. To help reduce the burden of this, patients were offered a telephone follow-up as an alternative to attending the clinic.

Relatives were positive about the separate areas on the unit to allow them some space and quiet time as well as the option to stay overnight.

**Access and flow**

During the period from December 2016 to November 2017, Calderdale and Huddersfield NHS Foundation Trust has seen adult bed occupancy fall. From January 2017 to November 2017, the trust’s performance was better than the English average.

**Adult critical care Bed occupancy rates, Calderdale and Huddersfield NHS Foundation Trust**

![Graph showing bed occupancy rates](image)

Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

**Delayed discharges**

We were provided with the most recent ICNARC quarterly quality report. This showed that between 1 April 2017 and 30 September 2017 the bed days of care post eight hour delay rate was 2.3% this was much better than similar units which had an average of 5.2%. This was an improvement from the previous inspection.

The unit had implemented a system to manage discharges in a more proactive way. Times for escalating were clearly documented to try and ensure the standard was met. If delays were encountered consideration was given to mix sex breaches to ensure this did not occur.

For the Intensive Care Unit at Huddersfield Royal Infirmary, there were 2,920 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was similar to the national average.
For the Intensive Care Unit at Huddersfield Royal Infirmary, there were 448 admissions in 2016/17. Compared with other units this unit was within expected limits.

ICNARC data from 1 April 2017 to 30 September 2017 showed that the number of non-clinical transfers was 1.8%. This was higher than similar unit’s rates which were 0.3%. However the year to data total was from 226 admissions was in line with that of other units.

For the Intensive Care Unit Huddersfield Royal Infirmary, the proportion of admissions that were non-delayed, out-of-hour’s discharges to the ward was within expected limits in 2016/17, based on 325 admissions. These are discharges which took place between 10:00pm and 6:59am.

The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. The patient records we reviewed showed each patient had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.

At the previous inspection there were concerns about the number of critical care patients being cared for in theatre recovery. In a three month period this had occurred on 15 occasions, with nine patients requiring an overnight stay. We reviewed the admission and discharge policy which had been recently updated. This contained clear processes and lines of accountability for when this situation arose. We reviewed data from August 2017 to January 2018 on the number of critical care patients who had been cared for in recovery. There had been a total of 15; ten of these had been an overnight stay.

The previous report also highlighted that there had been some cancellations of surgical procedures due to critical care beds not being available. Recent ICNARC data showed that in a 12 month period this had occurred on five occasions. This was a significant reduction compared to the numbers at the time of the last report (12 cancellations in previous six month period).

**Learning from complaints and concerns**

Information was available to patients and relatives on how to make a complaint. Leaflets on the patient advice and liaison service were in the relatives coffee room.

Staff told us they would try and resolve any concerns at the time they arose. The nurse in charge would be informed and they may support more junior staff. However staff were aware of the more formal process of managing complaints and the policy to support this.

There had been no recent complaints about the service. We saw responses to more informal comments on the ‘you said’ ‘we did’ board.

**Is the service well-led?**

**Leadership**

Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. There was a lead consultant and a lead nurse for critical care.
Management responsibilities across the two critical care units were shared between four band seven nurses. There was a supernumerary coordinator on site Monday to Friday from 8am to 4pm and each night. This was an improvement from the last inspection.

Additional support had been provided to the CCOT during the winter period. This support was provided by an identified anaesthetist on a separate rota. The critical care outreach team did not have a band seven lead practitioner. Management oversight was provided by the band seven on the critical care unit. The team felt this was having an impact on the development of their service. They had lost links with the network and felt the professional development of team members had also been affected. Positive action had been taken by the team with the submission of a gap analysis for the service.

From discussions with the leadership team it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. There were plans in place to address gaps and areas of non-compliance with GPICS standards. There had been a focus on access and flow at this site to reduce the number of delayed discharges from the unit.

There was a focus on developing and training for staff at all levels to ensure effective leadership. There were plans in place for succession planning. This included band six development posts and there were plans to look at implementing band seven development posts although no time frames had been set for this. The service was developing staff by looking outside of unit to gain a wider experience, this included areas such as working with the site coordination team. The focus on training and development of staff was captured in the new education and training strategy.

Staff reported feeling very supported by their teams and managers and able to escalate any concerns. A small number of staff reported senior staff not being visible and that they often worked from their offices rather than coming on to the unit. This was not the view of all the staff we spoke with however.

Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

Vision and strategy

The trust vision was “Together we will deliver outstanding compassionate care to the community we serve”. This was reflected in the care we observed and staff were clearly patient focused. We saw a mission statement and vision on the main corridor in the unit which was to ‘be a dynamic critical care unit across two sites’.

The trust identified four pillars of behaviour “we put the patients first” “we go see” “we work together to get results” and “we do the must do’s”.

The vision for the unit was ultimately dependent on the long term reconfiguration of critical care services and the plans to move to a single site service by 2021. This process was ongoing with final plans still undecided. Staff were generally positive about moving to a single site unit.

We spoke about the strategy for the service with the senior management team and were provided with the critical care objectives for 2017/2018. The goals were focused around four areas. These were transforming and informing patient care, keeping the base safe, a workforce for the future and financial sustainability.

The objectives were focused around developing and embedding existing processes and working towards compliance in all areas of the GPICS standards. However there were also objectives focused on transforming care by using new initiatives and focusing on patient experience and learning from feedback.
The service had recently had a network review and from this had produced a detailed action plan Against the GPICS standards with designated leads and identified time frames.

Culture

At the previous inspection some concerns were identified over low morale within the nursing team. Morale was felt to have improved in most areas. The exception was within the CCOT this was felt to be due to a lack of leadership within the team.

We also found that health care support workers had been excluded from the flexible working agreement within the unit. Where staff nurses had the option to go home rather than be moved to a ward this was not the case for health care staff. This had led to some dissatisfaction within this group of staff. Some nursing staff also expressed dissatisfaction over rotation between the two sites which had recently been reintroduced. However staff did understand why this was in place. The reconfiguration of some services meant different patients were cared for at each site. It was recognised as important for staff to be experienced and skilled in caring for different patient groups.

Staff told us they felt proud of their work and the care they provided to patients and their relatives.

We observed a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other’s opinions.

Staff of all we spoke with told us they felt able to raise concerns and were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care. However we lacked assurance about incident reporting within the team so could not be fully assured that staff would always recognise when this happened.

Governance

The service was in the division of surgery and anaesthesia. Governance processes had strengthened since the last inspection. Monthly, surgery and anaesthetic patient safety and quality board meetings took place, with an update provided for each service.

Monthly cross site critical care management meetings took place with had a business element and clinical governance element. We reviewed meeting minutes which had standing agenda items related to risk, incidents, complaints and network updates.

The information was disseminated to staff via team meetings, however it was identified that attendance at these meeting had been poor. Senior staff were looking at how meeting could be arranged to try and improve the number of staff attending. Safety huddles too place following ward rounds and staff felt they were a good way of sharing information.

Management of risk, issues and performance

There was a divisional risk register which contained 63 risks; ten of these were specific to critical care. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Each of the risks had evidence of recent review and had a description of existing controls, any gaps and further actions required. The risks related to the electronic patient record (EPR) system, staffing and capacity within teams and specific items of equipment.

From our discussions with the leadership team they were clear about any risks to the service and mitigating actions and the risk register reflected this.
There had been a recent network review of the service which showed overall compliance against GPICS standards had improved. Specific to this site had been a focus on access and flow. This had reduced the number of elective admissions cancelled on the day and reduced the number of delayed discharges.

There was a task and finish group in place which was developing a ward assurance tool. This audited various aspects of clinical care and showed compliance rates for each area. This was still in a pilot phase and ongoing development was in place to ensure the accuracy of the data collected.

**Information management**

The admission, discharge and transfer documentation had recently been updated and was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients’ bedside.

Staff could access information relating to polices and guidance electronically, and the system was easy to navigate.

**Engagement**

Friends and family test data as for all critical care units was a challenge to collect however recent data from January 2018 showed 100% of respondents would recommend the service.

One of the critical care objectives was to ‘ensure learning from patient experience is shared across the team’. We saw information displayed on patient feedback, however we saw limited examples of how patient feedback had helped inform or influence the service.

The senior team recognised that further work was needed in this area and there were plans to hold an afternoon tea session for patients who had used the service later in the year with a hope that further feedback would be gained.

In the minutes from the surgery and anaesthetics patient safety and quality board, patient stories were a standing agenda item. The minutes we reviewed showed at some meetings the patients presented this information which prompted discussion and reflection among the team.

The staff we spoke with felt involved and informed about what was happening in the trust. We reviewed meeting minutes which evidenced discussions around incidents, training and staffing with senior staff. However more local departmental meetings had poor attendance so information sharing at this level was not as effective. We did see a number of notice boards however that were used to share information on a wide range of topics.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network.

It was recognised further work was required with regards to the critical care outreach team.

A significant amount of work had been done to improve the retention of staff. This included reviewing information from exit interviews and implementing changes such as band six development roles.
Significant work with the universities had meant the number of staff who had completed the post registration award in critical care exceed the 50% outlined in the GPICS standards. This made the trust the best performer in the WYCCODN.

The establishment of monthly follow up clinic services ensured patients received a high standard of rehabilitation following their stay on intensive care. This included developing partnership working with improving access to psychological therapies (IAPT), as part of the clinic.

There had been a focus on training and education; this was supported by a new strategy document.

There were strong links with the organ donation specialist team with family involvement in each referral.
Maternity

Facts and data about this service

The trust has 61 maternity beds across five wards at two locations. Of these beds, 55 are located within three wards and a birth centre (CBC) at Calderdale Royal Hospital (CRH). The three wards are consultant led and CBC is midwife-led.

The remaining six beds are located in one midwife-led birth centre (HBC) at Huddersfield Royal Infirmary (HRI) for women considered low risk. No medical cover was provided at the Huddersfield birth centre. Antenatal clinics were provided in the women’s health unit; which contained an antenatal day unit, phlebotomy and ultrasound rooms, a colposcopy suite, and consultation rooms.

From October 2016 to September 2017, there were 5,066 deliveries at the trust.

A chart showing the number of births at the trust compared to other trusts in England over the 12 month period is presented below.

Number of babies delivered at Calderdale and Huddersfield NHS Foundation Trust – Comparison with other trusts in England
A profile of all deliveries from October 2016 to September 2017 is shown below.

### Table 1: Profile of all deliveries (October 2016 to September 2017)

<table>
<thead>
<tr>
<th></th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,003</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>63</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>178</td>
<td>3.5%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,959</td>
<td>78.1%</td>
</tr>
<tr>
<td>35-39</td>
<td>760</td>
<td>15.0%</td>
</tr>
<tr>
<td>40+</td>
<td>169</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,066</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The gestation period of babies born at the trust from October 2016 to September 2017 is shown in the table below.

### Table 2: Gestation periods (October 2016 to September 2017)

<table>
<thead>
<tr>
<th></th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>333</td>
<td>6.6%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>4,673</td>
<td>93.3%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,009</td>
<td></td>
</tr>
</tbody>
</table>

Notes: For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with ‘*’.

The gestation period of babies born at term (between 37 and 42 weeks) was 93.3%, which was above the England average (91.8%).

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)
Delivery numbers by quarter for the period October 2015 to September 2017 are shown in the graph below.

**Number of deliveries at Calderdale and Huddersfield NHS Foundation Trust by quarter**

![Graph showing delivery numbers by quarter](image)

*Source: HES - Deliveries (October 2015 - September 2017)*

The number of deliveries at the trust showed little variation from October 2015 to September 2017. There was a notable decrease in deliveries in Q4 2016/17, and since then the number of deliveries had increased slightly over time.

Recent data provided by the trust showed that from March 2017 to February 2018 5248 women delivered at the trust, birthing 5,303 babies.

From March 2017 to February 2018, 388 women were admitted to HBC and 264 (68%) birthed and were discharged from centre; and 124 women (32%) were transferred to the Calderdale site.

There was a downward trend in the number of women who birthed and were discharged from HBC from March 2016 to February 2018; 273 did so from March 2016 to February 2017 and 264 did so from March 2017 to February 2018.

During the inspection, we visited the birth centre and women’s health unit. We spoke with seven members of maternity services staff, and nine patients and their companions.

On the dates of our visit, HBC had closed to maternity patients because of trust-wide winter pressures; as such, we did not review any patient medical records or prescription charts at the site. A senior member of staff and a midwife was available at HBC during our visit.

We observed staff delivering care at the women’s health centre, and we reviewed trust policies and performance information from, and about, the trust.

**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 trust set a target of 95% for completion of mandatory training. No data was provided for the medical staff group.

A breakdown of compliance for mandatory training courses from April 2017 to November 2017 is shown in the tables below for qualified nursing, health visiting, and midwifery staff groups.

**Trust wide**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>209</td>
<td>210</td>
<td>99.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>207</td>
<td>210</td>
<td>98.6%</td>
<td>No target</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>206</td>
<td>210</td>
<td>98.1%</td>
<td>No target</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>171</td>
<td>175</td>
<td>97.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>205</td>
<td>210</td>
<td>97.6%</td>
<td>No target</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>155</td>
<td>164</td>
<td>94.5%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>194</td>
<td>210</td>
<td>92.4%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>97</td>
<td>108</td>
<td>89.8%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>188</td>
<td>210</td>
<td>89.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>187</td>
<td>210</td>
<td>89.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>139</td>
<td>160</td>
<td>86.9%</td>
<td></td>
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<tr>
<td>Information Governance</td>
<td>182</td>
<td>210</td>
<td>86.7%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>141</td>
<td>164</td>
<td>86.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>71</td>
<td>83</td>
<td>85.5%</td>
<td>No target</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>175</td>
<td>210</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>Preventing Pressure Ulcers</td>
<td>35</td>
<td>43</td>
<td>81.4%</td>
<td>No target</td>
</tr>
<tr>
<td>Maternity Obstetric Emergency Training (PROMPT) - 1 Year</td>
<td>39</td>
<td>51</td>
<td>76.5%</td>
<td>No target</td>
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<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td>138</td>
<td>181</td>
<td>76.2%</td>
<td>No target</td>
</tr>
<tr>
<td>CPR</td>
<td>145</td>
<td>210</td>
<td>69.0%</td>
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<tr>
<td>SABINE - Externally supported (Perinatal Institute) on line training</td>
<td>20</td>
<td>30</td>
<td>66.7%</td>
<td>No target</td>
</tr>
<tr>
<td>Training module</td>
<td>Trained staff (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate (YTD)</td>
<td>Trust Target</td>
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<tr>
<td>-----------------------------------------------------</td>
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<td>-----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>95</td>
<td>171</td>
<td>55.6%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td>108</td>
<td>210</td>
<td>51.4%</td>
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<tr>
<td>Manual Handling - People</td>
<td>86</td>
<td>210</td>
<td>41.0%</td>
<td>95%</td>
</tr>
<tr>
<td>CO Monitoring (Community Midwives)</td>
<td>11</td>
<td>27</td>
<td>40.7%</td>
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<tr>
<td>Smoking Cessation (Community Midwives)</td>
<td>11</td>
<td>27</td>
<td>40.7%</td>
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<tr>
<td>WDD - BFI Infant Feeding for Hospital and Community Maternity staff</td>
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<td>47</td>
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<tr>
<td>Antenatal Newborn Screening - 1 year</td>
<td>4</td>
<td>30</td>
<td>13.3%</td>
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<tr>
<td>Perinatal Mental Health (Midwives) - 1 Year</td>
<td>1</td>
<td>51</td>
<td>2.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Fetal Monitoring Programme</td>
<td>0</td>
<td>29</td>
<td>0.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14)

Huddersfield Royal Infirmary

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Oxygen Knowledge Assessment</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>17</td>
<td>19</td>
<td>89.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>No</td>
</tr>
</tbody>
</table>
Huddersfield Royal Infirmary had an overall 75% mandatory training completion rate. Data provided by the trust showed a completion rate of 100% for 10 mandatory training modules, and compliance for infection prevention control (level 1) training fell very slightly short of target (by 0.3%). The manual handling – people module had a completion rate of only 15.8%.

Midwifery staff at the trust were required to maintain a record of their mandatory training for appraisals, and it was the responsibility of line managers to undertake regular staff performance review and appraisals, including discussion of mandatory training.

Staff we spoke with told us that it was the responsibility of the trainer to update training completion records on the electronic staff record (ESR) system, and this was not always timely. We saw evidence of completed mandatory training that had not been captured on ESR.

We saw that there was additional mandatory training for midwifery staff which complied with the Maternity Specific Mandatory Training Policy, which was last updated January 2018.

We reviewed information we received from the trust about rates of completion for maternity specific mandatory training for staff across Calderdale and Huddersfield sites, and in the community. As of 7 March 2018, data we received showed that:

The rate of completion for 2017-2018 growth assessment protocol (GAP) e-Learning was 100% among midwifery staff. The learning forms part of the NHS England Saving babies lives in the north of England programme and the Perinatal Institute stillbirth reduction care bundle.

To date, 75% of available staff had completed third and fourth degree tears training, as per the Royal College of Gynaecologists (RCOG) and Royal College of Midwives (RCM) obstetric anal sphincter injuries (OASI) care bundle quality improvement programme. The Maternity Specific Mandatory Training Policy noted that the first year of the pilot programme should conclude at the end of April 2018; and set a compliance target of 95% of maternity staff working on the labour ward and ward 9 (CRH), birth centres (CRH and HRI), and within the community. There were plans for the remaining staff to attend training.

Data showed that 91% of applicable nursing and medical staff had completed all four components of the monitoring fetal wellbeing training programme as per the standard operating policy and the

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>No target</td>
</tr>
<tr>
<td>CPR</td>
<td>15</td>
<td>19</td>
<td>78.9%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>7</td>
<td>9</td>
<td>77.8%</td>
<td>No target</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>7</td>
<td>9</td>
<td>77.8%</td>
<td>No target</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>14</td>
<td>19</td>
<td>73.7%</td>
<td>No target</td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td>10</td>
<td>19</td>
<td>52.6%</td>
<td>No target</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>3</td>
<td>19</td>
<td>15.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
</tr>
</tbody>
</table>
Mandatory Fetal Wellbeing Policy. The training lead we spoke with discussed plans to transfer the data and monitoring system to the ESR system later in the year.

The Maternity Specific Mandatory Training Policy (January 2018) and associated training programme, detailed that feedback from colleagues had informed the development of a new three-day midwifery training programme for 2018-2019. It stated that roster managers will work with the lead midwife for patient safety and quality to block three days in one calendar week for midwives to complete maternity specific mandatory training. Community midwives and birth centre midwives will also complete an additional half-day birth centre skills and drills training.

During our inspection, we observed a drills information poster at HBC that showed the dates and content of bi-monthly safety drills for the upcoming (2018/19) year. Staff told us the topics for skills drills were based on current training needs identified through audits, clinical incidents, or complaints. Staff we spoke with at HBC said that they had recently undertaken emergency birth pool evacuation and postpartum haemorrhage (PPH) drills. Staff showed us a file of HBC staff who had attended the training.

**Safeguarding**

The service had two early intervention midwives in order to identify and put plans in for those women who had vulnerability factors identified at booking their pregnancy. This included those women on the perinatal mental health pathway and teenage pregnancies. In addition, there was a substance misuse midwife, a domestic abuse specialist midwife, and a named midwife for safeguarding in post. There was a named safeguarding midwife who held multidisciplinary team meetings with a focus on vulnerable women and babies. Other safeguarding concerns, such as abuse, were reported to the trust safeguarding team; and the local authority and police where thresholds were met. This practice was in line with the national reporting system requirements.

The trust set a target of 95% for completion of safeguarding training. No data was provided for the medical staff group.

A breakdown of compliance for safeguarding training courses from April 2017 to November 2017 is shown in the tables below for qualified nursing and health visiting and qualified nursing midwifery staff groups.

### Trust wide

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>174</td>
<td>200</td>
<td>87.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>151</td>
<td>178</td>
<td>84.8%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>156</td>
<td>187</td>
<td>83.4%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>156</td>
<td>189</td>
<td>82.5%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>No</td>
</tr>
</tbody>
</table>
Huddersfield Royal Infirmary

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>No target</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>8</td>
<td>13</td>
<td>61.5%</td>
<td>No target</td>
</tr>
</tbody>
</table>

Trust wide, qualified nursing and health visiting and qualified nursing midwifery staff groups only met one safeguarding training mode target; Safeguarding Children (Level 2).

Huddersfield Royal Infirmary had an overall 78% safeguarding training completion rate. Qualified midwifery and nursing staff were required to complete level three safeguarding children training, and nearly all staff had done so. Safeguarding adults training completion rates ranged from 67% to 73%.

The named midwife for safeguarding was responsible for the safeguarding supervision of midwifery and midwifery support staff; every three months for community staff and annually for acute staff. Additional midwives had undertaken supervision training and were competent to assist in the supervision programme.

Information provided by the trust showed that a new safeguarding supervision strategy had been implemented, and evidence of compliance was in the process of being entered on the ESR system. The trust commenced a new way of recording attendance at safeguarding supervision in November 2017. As a result, staff who required annual supervision were recorded as non-compliant in November 2017, and the compliance year reset to run from November 2017 to November 2018.

Data provided by the trust indicated that maternity services were currently ahead of the training trajectory target for safeguarding supervision. Four months into the 12 month period, 52% of staff were recorded as having received their supervision on ESR. The trust reported that supervision uptake is monitored monthly through the ‘confirm and challenge’ process and at directorate and ward manager performance reviews.

Safeguarding supervision data provided by the trust as of 22 March 2018 is presented below.

<table>
<thead>
<tr>
<th>Specialism</th>
<th>Compliant</th>
<th>Required</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRH IVF / ACON Unit</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>71%</td>
</tr>
<tr>
<td>Calderdale Community Midwives</td>
<td>16</td>
<td>7</td>
<td>23</td>
<td>70%</td>
</tr>
<tr>
<td>Service</td>
<td>CPC</td>
<td>TPC</td>
<td>OPC</td>
<td>Compliance</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>------------</td>
</tr>
<tr>
<td>Huddersfield Community Midwives</td>
<td>22</td>
<td>10</td>
<td>32</td>
<td>69%</td>
</tr>
<tr>
<td>Ward 1D ANPN CRH</td>
<td>9</td>
<td>6</td>
<td>15</td>
<td>60%</td>
</tr>
<tr>
<td>Ward 9 Ante/Postnatal CRH</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>60%</td>
</tr>
<tr>
<td>CRH Birth Centre</td>
<td>20</td>
<td>14</td>
<td>34</td>
<td>59%</td>
</tr>
<tr>
<td>HRI Women's Management</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>55%</td>
</tr>
<tr>
<td>Specialist Midwives</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>55%</td>
</tr>
<tr>
<td>CRH Maternity Unit</td>
<td>39</td>
<td>52</td>
<td>91</td>
<td>43%</td>
</tr>
<tr>
<td>HRI Ante Natal Clinic</td>
<td>7</td>
<td>11</td>
<td>18</td>
<td>39%</td>
</tr>
<tr>
<td>Calderdale Sexual Health Services</td>
<td>1</td>
<td>11</td>
<td>12</td>
<td>8%</td>
</tr>
<tr>
<td>Breast Feeding Initiative</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Acute Midwives</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>137</td>
<td>129</td>
<td>266</td>
<td>52%</td>
</tr>
</tbody>
</table>

1 Compliance as of 22 March 2018 noted as 83%.

Staff we spoke with at the women’s health unit and birth centre clearly articulated safeguarding reporting procedures using the Athena system, and felt confident escalating difficult or complex cases to managers for support, or the safeguarding team. Staff noted that safeguarding policy and procedures were easily accessible on the trust intranet. Some staff at the women’s health unit mentioned liaising closely with community colleagues and colleagues at neighbouring maternity units, to build a better picture of safeguarding concerns around individual women.

Staff we spoke with were aware of indications that highlighted vulnerable women and those considered high risk on the Athena and paper-based systems.

Similarly, a recent review of HBC, led by a trainee consultant midwife and the regional maternity lead for NHS England, detailed that staff were aware of the significance of icons indicating safeguarding concerns and domestic violence and how to access this information.

Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health and Social Care detailing the number of patients who have experienced female genital mutilation (FGM), or who have a family history of FGM. At the trust, the safeguarding midwife collated this information. Data we reviewed showed that from March 2017 to February 2018, 47 known cases of FGM were reported across the trust. Of these, 31 (two-thirds) were identified at HRI; representing 1% of all births and bookings at the site over the last twelve months.

Antenatal staff we spoke with at the women’s health unit explained safeguarding procedures to be followed for women who had experienced FGM. One member of staff we spoke with described recent contact with a woman who had experienced FGM. They explained that they had spoken with the woman about her experiences, and had sought her permission to escalate a referral through the clinic and to her health visitor and GP (who were already aware). The member of staff described that the woman had been happy with the approach she and the unit had taken.

**Cleanliness, infection control and hygiene**

The results of recent hand hygiene and cleanliness audits were displayed in the women’s health unit and HBC. The audit results showed recent hand hygiene compliance rates were 100% across both areas inspected.

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks with hand washing technique signs. Hand gels were located at entrances with signs encouraging their use, and throughout clinical areas.
We saw staff washing their hands and using hand gel between patients, as appropriate. All staff we met adhered to arms bare below elbows guidance.

HBC and (to a lesser extent) the women’s health unit were visually clean and we saw ward cleanliness scores displayed in public corridors; compliance audit rates ranged from 99% (HBC) to 92% (women’s health unit).

In the 2017 CQC maternity survey, the trust scored 9 out of a possible 10 for the cleanliness of rooms and ward; this was similar to the England average.

We reviewed a cleaning checklist for HBC and found detailed weekly checklists fully completed from October 2017 to the date of our visit. We also reviewed a file of cleaning schedules and procedures; these included rag-rating birth room cleanliness upon discharge, birth pool cleaning, staff decontamination, and the cleaning of mattress and bed frames.

Recent infection prevention and control information was visible in the areas we visited, and information included monthly cases of hospital acquired clostridi um difficile (C.diff) infection and methicillin resistant staphylococcus aureus (MRSA). Single rooms were available for the isolation of patients, if needed.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services in the last 12 months.

Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

**Environment and equipment**

Six birth rooms were available at the birth centre, all en-suite. The birth rooms we viewed were large and airy, and had a homely feel. Staff we spoke with commented that women birthing in the centre often remarked that it had a ‘hotel like’ feel, and were impressed by environment. We reviewed a ‘guest book’ at the reception desk. We saw a recent entry, in which the birth centre was described as a “perfect place”, and the patient wrote that they were “privileged to have given birth to three of my four children at this fantastic facility”.

Two of the rooms in the birth centre contained birth pools, and staff told us they had received training to evacuate women in an emergency, using perforated slide sheets. We saw a pool evacuation procedure was available in the rooms. Staff informed us the procedure had recently been updated and showed us a new version. Staff we spoke with said they had recently taken part in a pool evacuation drill (as part of a skills drill) to implement and embed the new practice.

There was adequate equipment in the birth centre to meet patients’ needs. This included a variety of equipment for women to use in labour; for example, birthing balls, birthing stools, and TENS machines.

The women’s health unit comprised an antenatal day unit, two phlebotomy rooms, two ultrasound rooms, a colposcopy suite, five consultation rooms, and a large waiting area situated off the main corridor. Some patients we spoke with described the environment, especially the main corridor and waiting area as “grubby and dated”. Many of the side rooms (for example, consultation rooms and the antenatal day unit) had undergone recent refurbishment, but the main public areas had not yet been redecorated.

A senior member of staff told us that the environment and patient flow were areas of concern in the women’s health unit, and refurbishment work was ongoing. The concern of senior staff was reflected in a risk register entry made in September 2017. Staff informed us that work was being undertaken to physically redirect the flow of patients through the unit, which included rerouting...
access to the main corridor. During our visit, we observed notices displayed at entrances informing visitors of this work.

The results of recent environment audits were displayed in the women’s health unit and birth centre; compliance rates ranged from 96% (HBC) to 87% (women’s health unit).

As a small (standalone) birth centre designated to care for women considered low risk, there was no bereavement suite available at HBC. However, we did observe posters displayed in the main corridor and some birth rooms that informed patients and visitors about the hope centre, which was located in the building and offered a multi-faith chaplaincy service.

In both HBC and women’s health unit, staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation. The utility and stock room areas we inspected were clean and well organised.

Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use. Labels were available and used appropriately. We reviewed eight pieces of clinical equipment across the two areas and noted these to be clean and labelled.

We checked 10 pieces of clinical equipment and found all items to have in date electrical testing labels.

We reviewed two emergency resuscitation trolleys (one in the birth centre and one in the antenatal day unit) and found both sealed with a numbered tag, which corresponded to the last entry in the logbook. Daily (top and bottom drawer), and monthly and ‘after use’ (comprehensive) checklists had been fully completed for the 3-month period reviewed (01 December to the date of our visit). Trolleys were orderly, the equipment reviewed was in date, and there was evidence of stock checking and rotation. We found emergency drug boxes and hypo boxes in date; a hypo box is a one-stop care kit that provides a range of glucose products for use in cases of hypoglycaemia in diabetic patients.

We checked a resuscitator in HBC and found detailed daily and weekly checklists fully completed for the period reviewed (01 January to the date of our visit). We also found the emergency trolley box, sepsis box, post-partum haemorrhage (PPH) eclampsia and cord prolapse emergency trolley, and emergency transfer bag all appropriately tagged and dated, the contents reviewed were within date, and associated daily and weekly checklists were fully completed for at least the year to date.

There was a video call entry system in use for entry HBC, and we saw that the automated exit button had been disabled. A notice was displayed at the entrance that informed visitors of the video call entry system, and prepared them to look at the camera and identify themselves. Staff were able to enter and exit the centre with the use of swipe cards and key fobs. On the dates of our inspection, the birth centre was closed to maternity patients; so we could not observe if maternity staff appropriately challenged visitors on entry and exit. Midwifery staff we spoke with at the birth centre did not raise any concerns about security arrangements.

Assessing and responding to patient risk

A maternity services risk management strategy was in place. The document set out the division’s arrangements for risk management in maternity services.

Meetings and forums with responsibility for risk management within maternity services included the maternity service weekly governance meeting, FSS orange panel validation meeting, stillbirth reduction forum, clinical performance and improvement, patient experience and improvement, directorate governance board, divisional patient safety quality board, and divisional board.

A named risk management midwife was in post at the trust.
There was a policy for the Early Recognition and Management of Sepsis within Adult Acute Hospital Settings in place at the trust. The policy detailed the signs of inflammatory response syndrome (SIRS) and criteria and assessment frameworks for sepsis.

The trust had an ‘Early Recognition of the Severely Ill Pregnant Woman’ (ERSIPW) clinical guideline in place. The guideline provided a framework of key responsibilities of various staff groups involved in the recognition and care of ill pregnant women, what to do in the event of deterioration, and escalation pathways to follow.

The trust also had a guideline for the Management of Neonates at Risk of Early-Onset Neonatal Infection in place.

Staff we spoke with in the antenatal clinic felt confident using the Athena system to document assessments. An audit of 10 electronic patient records of women admitted to HBC between October 2016 and August 2017 showed that women received the appropriate frequency and number of antenatal appointments and that an appropriate risk assessment was undertaken in all cases.

Following our inspection in 2016, the trust invited the Royal College of Obstetricians & Gynaecologists (RCOG) to review maternity services, and they did so in July 2016. The RCOG review concluded that HBC had high transfer rates; and cited audit data that showed the transfer rate of women in labour stood at 17.5% in 2010, and had increased to 27.5% in April 2016.

The RCOG recommended that the trust should review criteria for access to the birth centre, including risk assessment processes for exceptions to admittance criteria, and that “requests by [higher-risk] women to have their baby at Huddersfield also need to be reviewed by the head of midwifery and divisional director”.

Staff we spoke with at the women’s health unit told us that women considered higher risk were encouraged to birth at CRH, and staff explained they would talk through the rationale for this with women.

Data provided by the trust showed that from January 2017 to December 2017 seven women who were considered higher risk (outside of criteria) were admitted to HBC.

The trust provided information that described (typically fortnightly) review processes of higher-risk women by the consultant midwife and head of midwifery. The trust told us a working document (spreadsheet) was maintained and was used for tracking and audit purposes, but they did not provide us with this data.

We did, however, see evidence of three cases escalated for review to the medical director/ chief nurse/ divisional director that concerned women outside of criteria who wanted to birth at HBC.

We reviewed the HBC protocol, which detailed birth centre admittance criteria, criteria for care on birth centres during birth, medical conditions indicating increased risk suggesting planned birth at an obstetric unit, other factors indicating increased risk suggesting planning birth at an obstetric unit, and medical conditions indicating individual assessment when planning place of birth.

In response to RCOG recommendations, and in line with NICE Intrapartum Care Quality Standard (published December 2015, updated February 2017), the trust had produced a patient information leaflet to ensure that differences between the service delivery options were made explicit.

We reviewed the trust leaflet, ‘Where would you like your baby to be born – home, birth centre or labour ward?’ which was available on the trust website. The leaflet clearly outlined differences between the services offered at Huddersfield and Calderdale birth centres. The leaflet explicitly stated that HBC is a freestanding birth centre and that no doctors were available on the same site.
(HRI) for either mothers or their babies. The leaflet also set out typical transfer rates for women in their first pregnancy (40%) and for women in a subsequent pregnancy (5%), and average transfer times (for example, 35 minutes overall, where the transfer time was critical).

The HBC protocol included information about indications for intrapartum transfer, protocols for antenatal, intrapartum and postnatal transfers, and maternal and fetal conditions that may require transfer.

A review of HBC, led by a trainee consultant midwife and the regional maternity lead for NHS England, was conducted in August 2017. The review identified that the HBC protocol did not reflect NICE guidance in terms of indications for transfer following initial risk assessment (with respect to reduced fetal movements in the past 24 hours and the management of significant proteinuria in the presence of moderate hypertension). In addition, that the HBC guideline did not clearly reflect national guidance around the circumstances in which prolonged rupture of membranes and non-significant meconium may be an indication for transfer. The review recommended that the guideline needed to be revised to reflect these omissions, or that the reader should be referred to the relevant trust guideline where this is made clear. We reviewed HBC protocol and could not see that these changes had been made.

The HBC protocol detailed pathways for transfer, which included pathway for the transfer of collapsed baby from HBC, pathway for the unwell baby, management of obstetric emergencies in the birth centre, imminent breech, management of unexpected intrauterine or neonatal death, and what to do when a woman declines treatment or refuses to transfer.

The trust provided us with the escalation protocol for emergencies at HBC. The protocol provided practical information and guidance for midwifery and the multi-disciplinary team about clinical decision making and required actions in the event of emergencies.

We also reviewed HBCs standard operating procedure for neonatal emergency transfer, which was designed to support midwives in providing robust care to the neonate requiring ongoing resuscitation throughout transfer from HBC to CRH.

In the birth unit, we reviewed midwifery emergency information posters and flowcharts, which were displayed behind the reception desk. These detailed guiding actions in the event of different emergencies, and the pathways to be followed. The guidelines displayed mirrored information found in HBC protocol and escalation guidelines.

Information provided by the trust detailed that the rate of completion for 2017-2018 new born resuscitation (NLS) training was 96.6% among midwives across the trust; and 17 birth centre and community midwives were new born infant physical examination (NIPE) trained. During our inspection, we reviewed a record of recent NIPE checks at HBC, and found these appropriately completed.

An independent audit of 10 (purposefully chosen) case notes of women admitted to HBC between October 2016 and August 2017 found appropriate management of neonatal resuscitation, shoulder dystocia and postpartum haemorrhage in line with PROMPT training.

A maternity risk register record (dated March 2017) described that the protocol for a collapsed baby at HBC had changed and a “scoop and run approach” had been implemented. The ambulance provider (Yorkshire Ambulance Service) was involved with the training; and a transfer drill had been carried out with the provider. Staff we spoke with at the birth centre confirmed that they had carried out a joint exercise drill with the ambulance provider.

In July 2016, the transfer time of ‘priority one’ cases was identified as a quality and safety risk and placed on the maternity risk register. It was recognised that “there is a risk that care of women and
babies at HBC may be compromised due to YAS having insufficient capacity at times to respond to priority one transfer requests leading potentially to poorer outcomes for women and babies”. The risk was initially categorised as moderate and subsequently downgraded to presenting a low risk.

Data provided by the trust noted that the senior clinical manager and consultant midwife met with YAS during 2016 to clarify response times, and escalation routes for concerns. YAS advised that their target response time for priority one (life-threatening) calls was within eight minutes to reach HBC.

The trust informed us that ambulance transfer times were reviewed monthly and reported quarterly to the Clinical Performance and Improvement Group by the clinical audit midwife.

Data provided by the trust showed that from January 2017 to December 2017, there were 137 transfers from HBC to Calderdale, and 126 of these women (92%) were transferred by ambulance. Within these figures, 10 babies were transferred along with their mothers.

The report noted that all transfers were reported as incidents, and all were subsequently graded as yellow or green with the exception of one; which related to a woman who had an antenatal stillbirth. The report detailed that no harm had resulted from any transfer.

Of the 126 women transferred by ambulance, 116 were transferred as a priority one call (obstetric emergency requiring immediate intervention) and 10 women were transferred as a priority two call (obstetric complication not requiring immediate intervention).

Data provided by the trust about the 116 priority one calls showed that:

- The average time for YAS to respond to a call and reach HBC was 13 minutes (range 6 to 30 minutes).
- 14 (12%) of the 116 priority one calls met the eight minute target for attendance at HBC, and 102 (88%) calls did not.
- 41 (35%) of the priority one calls took 15 minutes or more to arrive at HBC.
- The average transfer time between HBC and the Calderdale site (arrival at the labour ward) was 37 minutes (range 16 to 80 minutes).
- The average time for a call being made to arrival at the Calderdale site (labour ward) was 50 minutes (median 47 minutes) (range 23 to 95 minutes).

The median transfer time for a call being made from the birth centre to arrival at the obstetric unit was the same as that identified in the birthplace national prospective cohort study for transfers for potentially urgent reasons from free-standing midwifery units located within 20 km of the nearest obstetric unit (Rowe et al, 2013), a median of 47 minutes.

We saw that a risk register entry dated January 2018 noted that, to date, no poor outcomes associated with delayed attendance of ambulances on site at HBC had been reported, and weekly case review and monthly audit continued.

### Midwifery and nurse staffing

The trust has reported their staffing numbers below as of 31 October 2017.

<table>
<thead>
<tr>
<th>Site/location</th>
<th>Staff group</th>
<th>Actual staff - WTE</th>
<th>Actual staff - headcount</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Hospital</th>
<th>Service Description</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>NHS infrastructure support</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Qualified nursing &amp; health visiting staff</td>
<td>7.2</td>
<td>8.0</td>
</tr>
<tr>
<td></td>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Qualified nursing midwifery staff</td>
<td>118.6</td>
<td>138.0</td>
</tr>
<tr>
<td></td>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calderdale Royal Hospital</td>
<td>Support to doctors and nursing staff</td>
<td>40.8</td>
<td>50.0</td>
</tr>
<tr>
<td>Cross-Site</td>
<td>Qualified nursing &amp; health visiting staff</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-Site</td>
<td>Qualified nursing midwifery staff</td>
<td>61.4</td>
<td>70.0</td>
</tr>
<tr>
<td></td>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-Site</td>
<td>Support to doctors and nursing staff</td>
<td>8.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Qualified nursing &amp; health visiting staff</td>
<td>7.0</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Qualified nursing midwifery staff</td>
<td>9.5</td>
<td>12.0</td>
</tr>
<tr>
<td></td>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>Support to doctors and nursing staff</td>
<td>12.0</td>
<td>15.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>265.8</td>
<td>311.0</td>
</tr>
</tbody>
</table>

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of -1.2% in maternity:

- Calderdale Hospital: -4.6%
- Huddersfield Royal Infirmary: -26%
- Cross site staff: 8%

The negative percentages mean that the trust currently has more WTE in position than they had originally budgeted for.

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 7.7% in maternity:

- Calderdale Royal Hospital: 7.6%
- Huddersfield Royal Infirmary: 0%
- Cross site staff: 9.7%

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 4% in maternity:

- Calderdale Royal Hospital: 3.7%
- Huddersfield Royal Infirmary: 1.2%
- Cross site staff: 5.4%

**Bank and agency staff usage**

From November 2016 to October 2017, the trust reported that 260 shifts were filled by bank staff and two shifts by agency staff with 361 shifts unfilled. They did not provide details of all shifts.
available, so we were unable to provide this data as a percentage.

**Midwife to birth ratio**

RGOG guidance, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, recommends a ratio of one midwife to 28 births (1:28).

From October 2016 to September 2017, the trust had a ratio of one midwife to every 26.96 births. This was similar to the national average (26.82), and a slight improvement on the previous reporting year (27.33).

The trust informed us that they used their escalation policy to move staff flexibly across the service to meet women’s needs, and as such, they were not able report midwife to birth ratio by site.

The maternity dashboard provided by the trust showed that from March 2017 to February 2018 there were 5248 deliveries at the trust, and 5303 babies were delivered. Of the 5248 women who delivered at the trust, data showed that 5135 (97.8%) received one-to-one care in labour.

Senior staff we spoke with at HBC described regular contact between Huddersfield and Calderdale birth centres about activity and staffing levels.

Senior staff explained midwifery colleagues used the Birthrate Plus tool in conjunction with the intrapartum scorecard (NPSA). The NSPA scorecard is a tool for monitoring and improving patient safety in maternity units. Data collected using the scorecard can be used to demonstrate maternity staffing and activity levels, which can then be used to inform planning of staffing and activity and/or escalation procedures. Senior staff described that the tool was used every two hours in the birth centre to monitor staffing levels and understand the range of issues in escalation. They explained that activity was discussed on a day-to-day basis and data analysed quarterly to examine skill mix provision.

Currently, two midwives and a midwifery support worker staff HBC 24 hours a day. A consultant midwife is based at HBC and runs clinics at HRI.

A maternity escalation policy was available on the trust intranet. The policy provided practical guidance for maternity and trust staff about clinical decision making and required actions in the event of a situation where capacity, volume and complexity of workload presented challenges in the delivery of a safe maternity service for women and their babies.

On the dates of our visit, HBC had closed to maternity patients and housed surgical outlier patients. Staff we spoke with told us that maternity patients due to deliver at HBC were informed in advance of the closure and redirected to CRH birth centre. One member of midwifery staff was redeployed to CRH birth centre and one remained at HBC, to manage and redirect any unannounced maternity patients.

This practice was in line with escalation procedures; which allowed for assessment of workload, and if no women were in labour, to move one member of midwifery staff where needed.

Operational flow charts detailed that if one woman was labouring at HBC, two midwives were required; if two women were labouring at HBC, two midwives and a midwife support worker were required; and if three women were labouring at HBC, two midwives, an on-call midwife, and a midwife support worker were required.

Staff we spoke with explained that if a midwife needed to transfer a woman to CRH, the on-call community midwife would be contacted to take their place at HBC.
A focus group undertaken in August 2017, described that staff explained that it was sometimes difficult to reach the on-call midwife as telephone numbers had not been updated, or the on-call midwife would be delayed as travelling a long distance. When deciding who to call, staff would typically phone the midwife who lived close to the birth centre or was likely to be working nearby.

Red Flag maternity staffing guidance was published by NICE in February 2015, and highlights signs that may indicate there are not enough midwives available; for example, a delay of two hours or more between a woman coming in for induction of labour and the process being started. Data provided by the trust showed that from March 2017 to February 2018 there were 117 maternity staffing related incidents across the trust, and 80 of these were recorded as ‘red flag’ incidents.

Data provided by the trust showed that five staffing incidents were recorded at HBC from January 2017 to December 2017, three of the incidents related to missed or delayed care (suturing). One of these was documented as having occurred due to staffing workload.

In two cases, staffing incidents concerned less than the required number of staff for women in labour. An incident in May 2017 occurred when three women were in labour, but only two midwives were present and the on-call midwife could not be reached. A doctor from HRI Accident and Emergency department attended at the request of the night matron. An incident also occurred in September 2017 when a woman birthed at HBC with only one midwife on site, as less than two registered midwives were present during the shift. Both of the incidents were recorded as (NICE) ‘red flag’ incidents.

### Medical staffing

Information provided by the trust confirmed that no consultant cover was provided to the midwife-led birth centre at Huddersfield; but that a consultant anaesthetist was available to consult in emergencies.

### Records

In June 2015, CHFT maternity services went live with the K2 Athena & Guardian electronic patient record systems across all areas. In summer 2017, the trust launched Cerner Millennium EPR.

K2 Athena software was used to record women’s medical, obstetric, family and social histories. The software prompted staff to complete fields not entered and was used to record risk assessments. The system prompted staff to complete additional (for example, mental health) assessments, dependant on women’s initial responses. Staff also used the system to complete and record women’s birth plans at their 36 weeks appointment. The K2 Guardian software was used to monitor fetal heart rate. Cerner EPR is a separate system, used to facilitate admissions and discharges, and electronic prescribing.

A maternity electronic patient record lead was in place at the trust, and a business continuity plan was available that showed what to do in case of a system failure or an individual’s inability to access the system. This included the use of concurrent paper-based documentation.

The trust provided us with information about how monthly records audits were conducted, which outlined their standardised approach to carrying out CRAS (Clinical Record Audit Standards) reviews. We saw evidence that themes and evidence of learning from audits was captured on a regular basis; for example, audit themes for November and December 2017 included antenatal
steroid administration, management plans and risk assessments within Guardian and Athena systems, and maternal post-delivery documentation.

Staff we spoke with at HRI described that they were familiar with the electronic record systems, had received adequate training, and found them easy to access and use. Staff explained that nearly all patient records were held electronically within maternity services, but that paper records were still in use, and contained documents such as blood results, scans, and fetal growth charts. Staff also described that they were able to generate pdf documents from the electronic systems, and would offer a copy to women to keep in their hand-held notes (for example, their birth plan).

We reviewed an EPR training file at HBC that demonstrated staff had received training and support for using the system.

As part of a review of the birth centre, an in-depth audit of 10 patient case notes of women who had planned to deliver at HBC between October 2016 and August 2017 had been undertaken. The record review found that use of K2 Athena and Guardian was well-embedded and data entry appeared comprehensive and included appropriate narrative entries. There was demonstration of comprehensive documenting of risk assessment throughout pathways, decision-making and referral, triage telephone conversations, and there was a clear audit trail.

Records showed that for all 10 case notes, fetal heart recording every 15 minutes in the first stage of labour was achieved. However, in 5 of cases fetal heart rate did not appear to have been documented after every contraction or at least every 5 minutes in the second stage of labour. The review recommended that the need to monitor and document the fetal heart rate after every contraction or at least every five minutes in the second stage of labour needed to be embedded.

**Medicines**

At HBC and the women’s health unit we found that medicines were stored securely and access restricted to authorised staff. We examined the controlled drugs checklist in the women’s health unit (antenatal day unit) and found balance checks carried out in accordance with the trust policy.

We checked the storage and monitoring of medicines requiring refrigeration and found this was carried out in accordance with trust policy and national guidance. We found daily temperature monitoring checklists completed for the year to date, which included documentation of minimum and maximum ranges.

Medical gas cylinders at HBC were appropriately stored in secure brackets/trolleys/chains according to trust policy.

Patient group directives (PGDs) were in use in maternity. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We reviewed a file of four PDGs at HBC and found these appropriately signed and dated by individual staff with authority to administer the medicine.

A medicines management self-assessment audit was carried out at HBC February 2018. The audit found that all applicable criteria were met with respect to the safe storage and monitoring of medicines requiring refrigeration, key medicine safety and security criteria, patient group directives, handover of care (medicine related issues), handling of pharmaceutical waste, medicines at transfer/discharge, and staff knowledge. Most criteria for the safe storage of medicines and controlled drugs, and the preparation and administration of medicines were also met.
An improvement plan was attached to the assessment, which included prioritised recommendations, named individuals with responsibility for implementation, and action dates. However, we could only see recommendations dated to March 2015 and March 2017.

**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 February 2017 to January 2018, the trust reported zero incidents which were classified as never events for maternity.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from February 2017 to January 2018.

Of these, the most common type of incident reported was Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant) with three (75% of total incidents). The other serious incident reported was screening issues meeting SI criteria (25% of total incidents).

The trust informed us that all stillbirths and neonatal deaths received a first level review using the NSA intrapartum stillbirth proforma, as per their standard operating procedure. All cases were then discussed at the weekly maternity governance meeting and weekly orange panel meeting. Cases where there may have been failures in care proceed to a level two review; an ‘orange investigation’ or a serious incident investigation.

The trust reported 17 neonatal deaths between January and December 2017. Information provided by the trust showed that all cases of neonatal death were presented at the child death overview panel. The most common causes of death were congenital abnormality (seven cases) and prematurity (seven cases).

Level two (orange) investigations had been commissioned for two of 15 stillbirths that had occurred at the trust between January 2017 and December 2017. The trust reported there had been one serious incident investigation related to stillbirths and neonatal deaths.

Three serious incident’s had been reported for maternity services between March 2017 and March 2018. At the time of our inspection, one of these had been completed, one was due for review at the divisional orange panel and trust serious incident panel, and another was currently under investigation.

We reviewed the completed serious incident investigation report provided, which identified areas of good practice and areas of concern, contributory factors and recommendations.

We found that one of the serious incidents reported in maternity services had originated at HRI; this was currently under investigation. Information provided by the trust described the incident involved a woman who was transferred from HBC to the Calderdale site.
There was an Incident Reporting Management Policy (incorporating the serious incident process) in place at the trust. Incidents were reviewed and discussed at the weekly orange panel meeting and weekly maternity governance meeting.

Incidents were reported on an electronic system (DATIX). All staff we spoke with were aware of how to report incidents and gave examples of what types of things they would report.

Data provided by the trust showed that 98 incidents in maternity services where harm was caused were recorded at the trust from March 2017 to February 2018.

We reviewed a selection of weekly maternity governance meetings from 2017 to 2018 and found these appropriately attended by the head of maternity / deputy head, matrons, consultants, and audit, risk, and patient safety and quality managers / leads. The group were responsible for ensuring all incidents are appropriately reported and graded via DATIX. We saw evidence of the review of clinical outcomes and incidents of concern, recommendations made about further examination of cases, and lessons learned.

We also reviewed perinatal mortality and morbidity meeting minutes for the last 12 months, which showed appropriate sharing of information about incidents, and lessons learned.

Policy stated that learning from audits, incidents, complaints and claims was disseminated via monthly audit meetings, a maternity newsletter, displayed on appropriate notice boards, and by trust email. In addition, that all clinical members of the maternity team were encouraged to engage with and attend a variety of communication or learning forums. Staff we spoke with at HRI described that they primarily learned about incidents through audit and team meetings, training and skill drills, email and newsletter alerts, and informal talks with colleagues.

The trust provided information that showed feedback from staff indicated that they preferred face to face discussion rather than email, and preferred learning to be distributed from the weekly governance meeting in a newsletter rather than email. As a result of this feedback, the service had recently begun issuing weekly learning lessons newsletters from the weekly governance meeting, the trust reported that this has been well received.

We observed examples of the weekly ‘safer maternity care’ newsletter, which demonstrated dissemination of learning from incidents. For example, one newsletter focused on instances of retained placenta and guideline recommendations.

Staff we spoke with told us that there was a good incident reporting culture, and they were encouraged and supported to report incidents, and received appropriate feedback. They also described they could request a debrief after a clinical incident had occurred.

Staff gave us examples of the types of incidents they had reported, and explained that learning from incidents was reflected in skills drills; for example, a postpartum haemorrhage drill had recently taken place. Staff described that management had responded to concerns raised by staff by purchasing new equipment and implementing a new pool evacuation protocol, and had they had held a skill drill to embed the new practice.

The duty of candour is a regulatory duty that relates to openness and transparency. It 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.

Duty of candour was evidenced in the completed serious incident investigations, incident reports, and meeting minutes we reviewed. Staff we spoke with said they were open and honest with women if things went wrong.

**Safety thermometer**
The maternity safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm-free care. This was in use and data was collected each month on perineal and abdominal trauma, post-partum haemorrhage, and infection. We saw information displayed in wards and departments, and was discussed at maternity clinical governance meetings.

Is the service effective?

Evidence-based care and treatment

The care and treatment provided to women was based on guidance from the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence based practice.

Staff at Huddersfield told us that policies and guidance could be accessed on the trust intranet, which they found easy to navigate. We reviewed manually held clinical guidelines and policies at HBC with respect to perineal trauma, prevention and management of postpartum haemorrhage, and shoulder dystocia; and found all were within date.

Maternity policies and clinical guidelines provided electronically by the trust were seen to be within date with version control.

Nutrition and hydration

Refreshment facilities were available in antenatal clinic waiting area. Women and their families had access to kitchenette facilities at HBC to make snacks (for example, jam and toast) and hot and cold drinks; these facilities were available 24 hours per day, seven days a week. Kitchenettes were equipped with microwaves to warm food brought in externally.

Data provided by the trust from March 2017 to February 2018 showed an average breastfeeding initiation rate of 76%; this is lower than the England average of 81%.

Breastfeeding information leaflets and posters were displayed in patient areas we visited, and showed contact details for support groups in the local community.

Pain relief

Pain relief options for labour at the birth centre included Entonox (nitrous oxide and oxygen) and pharmacological methods, such as meptid and pethidine.

No consultant cover was provided to HBC, but we were told a consultant anaesthetist was available to consult in the event of emergencies.

We reviewed HBC pain management data, collected from monthly audits undertaken between September 2017 and January 2018. Data showed a monthly overall compliance rate of 100% over the period.

Patient outcomes

The trust provided us with monthly data about instrumental (assisted) delivery rates from March 2017 to February 2018.
Data showed that 11% of births (585) were instrumental deliveries; of these instrumental births, 432 (74%) were forceps deliveries and 153 (26%) were ventouse (vacuum) deliveries. This is a slight improvement on the previous year; of the 5508 women who delivered at the trust between March 2016 and February 2017, 677 (12%) had an assisted delivery.

**Maternity active outlier alerts**

As of January 2018 there were no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)**

The MBRRACE UK report (published October 2017) showed the trust’s stabilised and risk-adjusted extended perinatal mortality rate (per 1000 births) for January 2015 to December 2015 was 5.5, almost 6% higher than the comparator group average (5.2); and slightly worse than the perinatal mortality rate from January to December 2014 (5.4).

Senior staff we spoke with told us that CHFT was a pilot site for the new MBRRACE Perinatal Review Tool, and will be using this from April 2018.

Recent data showed the trust had made significant improvements in its stillbirth rate since our last inspection. Data we reviewed showed that the unadjusted (total) stillbirth rate had fallen from 0.36% (20 of 5595 births) for the period March 2016 to February 2017 to 0.26% (14 of 5303 births) for the period March 2017 to February 2018.

A risk of more women who birth at the trust having a measured postpartum blood loss of over 1500mls, experiencing a third and fourth degree tear, or undergoing delay in manual removal of placenta was entered on the maternity risk register in March 2016, the risk was initially categorized as moderate and was graded as low at the time of our visit.

Data provided by the trust showed that from March 2017 to February 2018 there were 5248 deliveries at the trust, and 5303 babies were delivered.

The trust reported that of the 5248 women who delivered at the trust from March 2017 to February 2018, 97 (1.8%) experienced a third or fourth degree tear. This is an improvement on the previous year; of the 5508 women who delivered at the trust between March 2016 and February 2017, 164 (3.0%) experienced a third or fourth degree tear.

The trust reported 197 women (3.8%) who birthed at the trust between March 2017 to February 2018 had postpartum blood loss of more than 1500mls. This was about the same as the previous year; of the 5508 women who delivered at the trust between March 2016 and February 2017, 203 (3.7%) had postpartum blood loss of more than 1500mls. An entry on the maternity risk register described that the trust’s method of measuring blood loss was more accurate than other service providers, and so rates appeared comparatively higher.

Data provided by the trust showed manual removal of placenta in 129 (2.5%) of 5248 women who delivered at the trust between March 2017 and February 2018. We saw entry space for delay in manual removal of placenta (over one hour post-diagnosis to transfer) in the maternity dashboard, but could not see that any data had been entered for this period.

Transfer data for March 2017 to February 2018 showed 388 women were admitted to HBC and 264 (68%) birthed and were discharged from the centre; and 124 women (32%) were transferred
to the Calderdale site. This transfer rate is higher than that identified in the birthplace national prospective cohort study for freestanding birth centres (Rowe et al., 2013) (22%).


Data was provided for 115 women and babies transferred from March 2017 to February 2018 (data for nine cases in September 2017 was missing) that showed 87 women (76% of those transferred) were transferred during labour or within 24 hours after giving birth.

Of the 115 transfers, 19 women (17%) were transferred antenatally, 61 women (53%) were transferred during labour (41 of these (36%) were transferred during the first stage of labour, 16 (14%) women were transferred during the second stage of labour, and four (3%) were transferred during the third stage of labour), 26 women (23%) were moved postnatally, and nine babies (8%) were transferred.

Compared to birthplace national prospective cohort study data for freestanding birth centres (Rowe et al., 2013), it appears that a disproportionate number of women were transferred antenatally.

Birth centre data provided by the trust showed that from April 2017 to February 2018 the transfer rate for 173 women labouring for the first time (nulliparous) over the period was 49% (85), and for 190 multiparous women 16% (31); with an overall transfer rate of 32% (116 of 363). These figures are higher than those identified in the birthplace national prospective cohort study (Rowe et al, 2013); which was 35% for nulliparous women and 9% for multiparous women labouring in a stand-alone birth centre.

Information provided by the trust showed that from January 2017 to December 2017 seven women who were considered higher risk (outside of criteria) were admitted to HBC.

Data indicated that two of these women were booked to deliver elsewhere (CRH and at home), but decided to deliver at HBC shortly before labour or during labour; both were recorded as having normal births at HBC.

An additional two women were booked to birth at HBC and had normal deliveries.

Of the three remaining women, one was transferred to CRH in labour, and two were transferred postnatally for 3rd and 4th degree tears.

An entry in the maternity risk register described that all transfers were reviewed through the weekly maternity governance meeting process. We reviewed the weekly maternity governance meeting minutes for October 2017 to March 2018 and found transfers and outcomes appropriately reviewed. The trust told us that themes and trends of transfers and outcomes were independently analysed by the clinical audit midwife on a monthly basis with a quarterly report presented to the Maternity Clinical Performance and Improvement Group (CPAIG). We saw evidence of this having occurred in July 2017, October 2017 and January 2018.

The trust told us no orange or red incidents relating to transfers from HBC to CRH had taken place during the 12 months prior to our visit.
Competent staff

Appraisal rates

From April 2017 to November 2017, 96.2% of staff within maternity at the trust had received an appraisal compared to a trust target of 100%.

The split by staff group can be seen in the table below:

Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff who have received an appraisal</th>
<th>Staff who require an appraisal</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>179</td>
<td>186</td>
<td>96.2%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>61</td>
<td>64</td>
<td>95.3%</td>
</tr>
</tbody>
</table>

Huddersfield Royal Infirmary

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff who have received an appraisal</th>
<th>Staff who require an appraisal</th>
<th>Appraisal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

A preceptorship package was available for newly registered midwives at the trust. New starters were given an induction period incorporating mandatory training; this was initially for one month, but could be adjusted to suit individual staff needs.

A maternity specific training policy was in place at the trust. Midwifery staff were required to maintain a record of training for the purposes of appraisal. It was the responsibility of line managers to undertake regular staff performance review and appraisals, including discussion of mandatory training.

From April 2017 to November 2017, 100% of maternity staff at Huddersfield had received an appraisal under the new A-EQUIP (advocating for education and quality improvement) model of midwifery supervision.

Midwifery staff we spoke with at Huddersfield described the A-EQUIP model as “effective”, explained they received regular appraisals, and felt there was “still a good governance process in place for supervision”, despite changes brought about by the new model.

We reviewed information we received from the trust about rates of completion for maternity specific training for staff across sites. As of 7 March 2018, data we received showed that:

Of the 308 nursing and medical staff available for maternity obstetric emergency (PROMPT) training, 284 had attended during 2017-2018. The training included topics on shoulder dystocia,
vaginal breech, cord prolapse, massive obstetric haemorrhage, eclampsia, and recognition of severely ill pregnant women, and modified early warning scores (MEWS). Rates of completion for 2017 to 2018 were 92.2%, and surpassed the NHS resolution completion requirement rate (90%). Data showed that 24 members of staff had not been PROMPT trained. However, this group included junior doctors forecasted to complete training by the end of March 2018. Removing this group from the data gave 95% attendance achieved of total staff available.

The rate of completion for 2017-2018 new born life support (NLS) training was 96.6% among midwives across the trust; which exceeded the 95% compliance target set by the trust.

This was supported by senior staff at HBC who told us that midwives working at the birth centre were newborn life support (NLS) and newborn infant physical examination (NIPE) trained; and a member of midwifery staff we spoke to at the centre confirmed they had received training.

The trust provided information that showed 44 midwives at the trust were NIPE trained, and this accounted for 20% of the midwifery workforce. The trust informed us that 27 of NIPE trained midwives worked on wards and the maternity assessment centre at CRH. The remaining 17 worked in birth centres (including at Huddersfield) and in the community. The trust noted they supported five to eight midwives a year to undertake NIPE training at the University of Huddersfield.

The trust provided us with information about bereavement training rates in maternity, and told us that all midwives now participate in bereavement training as part of the service induction programme. The trust reported 26% of applicable maternity staff (57 of 219) were currently trained. Four band 6/7 nurses were trained to obtain consent for post-mortem. The trust informed us that in 2018, they will begin to deliver a second mandatory training day, and bereavement training will be included in this and led by the newly appointed bereavement lead.

**Multidisciplinary working**

Terms of reference showed good multidisciplinary membership of committees, meetings and forums with responsibility for risk management within maternity services at the trust. Groups and forums included the maternity service weekly governance meeting, FSS orange panel validation meeting, stillbirth reduction forum, clinical performance and improvement, patient experience and improvement, directorate governance board, divisional patient safety quality board, and divisional board.

Good multi-disciplinary working was evident in clinical areas. HBC staff described good working relationships with community midwifery staff, and there were close links with community staff on the women’s health unit regarding safeguarding concerns and complex cases.

Staff we spoke with described they could access advice and guidance from specialist nurses/midwives, as well as other health professionals.

Multidisciplinary training was positively encouraged within maternity services (for example, through PROMPT training); to enhance skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.

Live skill drills were facilitated in the immediate management of obstetric and neonatal emergencies in clinical practice. These drills encouraged multi professional working with obstetricians, neonatal paediatricians, obstetric anaesthetists, midwives and support workers.
HBC staff we spoke with during our visit described they had attended multidisciplinary skills drills, and we saw evidence of their attendance at PPH, cord prolapse and eclampsia, and emergency transfer drills. Staff in the women’s health unit described attending multidisciplinary meetings, such as the quarterly screening meeting.

**Seven-day services**

HBC was open twenty four hours a day, Monday to Sunday.

Services located at the women’s health unit, such as the antenatal day unit, provided a five day (Monday to Friday) service.

Emergency maternity and diagnostic services were available at the Calderdale site, twenty four hours a day, seven days per week.

**Health promotion**

We saw information displayed in the women’s health unit on topics such as, ‘physical activity for pregnant women’; this gave advice on areas such as keeping active, cutting down on alcohol, and healthy eating. We also saw information on baby movements, reducing the risk of infections, safer sleeping for babies, reducing the risk of cot death, coping with crying, and information about the positive birth movement.

In HBC we saw additional patient leaflets and displays that informed patients about access to psychological therapies, the availability of breastfeeding support, and the importance of baby vaccinations.

Information about free antenatal classes and free support groups (such as, ‘nurturing and feeding your new born’) were displayed on the main public corridor of the women’s health unit.

There was smoking cessation and substance abuse midwives in post; and we saw informative posters about smoking cessation displayed.

The trust did not provide baby milk to try to encourage breast feeding. This also meant that those who chose to bottle feed could be observed making up formula. Facilities for the making formula and storage of pre-made milk were available.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2017 to November 2017, Mental Capacity Act (MCA) and Deprivation of Liberty training had been completed by 82.9% of staff in within maternity.

<table>
<thead>
<tr>
<th>Course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>206</td>
<td>244</td>
<td>84.4%</td>
</tr>
<tr>
<td>CHFT MCA &amp; DoLS Level 1 2017</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>WDD MCA &amp; DoLS Level 3</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))
During our visit, staff we spoke with at HBC and the women’s health unit clearly articulated the use of Gillick competency for consent of patients under the age of 16 years.

The trust informed us that six band 6 and 7 midwives were trained to obtain consent for post mortem; and four of these were trained during 2017.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

**Friends and family test performance (antenatal), Calderdale and Huddersfield NHS Foundation Trust**

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

In October 2017, performance for antenatal was 97% compared to the England average of 96%.

**Friends and family test performance (birth), Calderdale and Huddersfield NHS Foundation Trust**

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

In October 2017, performance for birth was 100% compared to an England average of 96%.

**Friends and family test performance (postnatal ward), Calderdale and Huddersfield NHS Foundation Trust**
From October 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

In October 2017, performance for postnatal wards was 98% compared to the England average of 94%.

**Friends and family test performance (postnatal community), Calderdale and Huddersfield NHS Foundation Trust**

From October 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

In October 2017 performance for postnatal community provision was 99% compared to the England average of 98%.

(Source: NHS England Friends and Family Test)

January 2018 FFT test performance data for maternity services at the trust was publically displayed in HBC. Information showed the proportion of patients who would recommend antenatal care (98.1%), care during labour and birth (100%), postnatal ward care (100%), and postnatal community care (96.6%).

In the women’s health unit, February 2018 FFT test performance data for antenatal services at the trust was publically displayed. This showed that 93% of patients would recommend the antenatal care provided and 5% of patients would not.

**CQC Survey of women’s experiences of maternity services 2017**

The trust performed similar to other trusts for all of the 15 questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were</td>
<td>About the same</td>
<td>8.82</td>
</tr>
</tbody>
</table>
### Birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same 8.07</td>
</tr>
<tr>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same 9.41</td>
</tr>
<tr>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same 9.23</td>
</tr>
<tr>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same 8.07</td>
</tr>
</tbody>
</table>

### Staff during labour and birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same 9.28</td>
</tr>
<tr>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same 7.31</td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same 7.74</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same 9.54</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same 8.41</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same 9.24</td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same 8.43</td>
</tr>
</tbody>
</table>

### Care in hospital after the birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same 7.84</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same 8.12</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same 9.01</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same 8.81</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

During our inspection, we observed women’s health unit staff speaking to patients and their families with respect and understanding.

The patients and relatives we spoke with were all positive about the care they had received. Several women we spoke with described the care they had received as “excellent” or “very good”, and described the staff as “lovely”.

A guestbook we viewed at HBC contained overwhelmingly positive messages. A recent entry stated, “big thanks to [name of midwife] and all the members of staff who provided me with second to none care”.

### Emotional support

There was a bereavement policy in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death. As well as clinical pathways, the policy outlined approaches for creating memories and the involvement of children/siblings, and options for registration of death, investigations, coroner involvement, funeral arrangements, and religious considerations.
The trust reported that in 2017, 16 band 5 midwives undertook bereavement training and 35 midwives / student midwives attended a RCM local bereavement study day. The trust informed us that in 2018 they will begin to deliver a second mandatory training day, and bereavement training will be included in this. The trust told us that bereavement training will be developed and led by their newly appointed bereavement lead.

As a stand-alone birth centre designated to care for women considered low risk, there was no bereavement suite available at HBC. However, we did observe posters displayed in the main corridor and some birth rooms that informed patients and visitors about the hope centre, which was located in the building and offered a multi-faith chaplaincy service. We also saw patient information leaflets that informed patients about the pastoral, spiritual and religious care available; and others that informed patients about access to psychological therapies.

A number of women we spoke with in the women’s health unit described that they felt “supported”.

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

Following our inspection in 2016, the service recognised that obtaining and acting on feedback from women was a challenge. Following the inspection, the trust approached Healthwatch Kirklees and Healthwatch Calderdale to lead an engagement project to look at how the trust could improve the opportunities for parents and expectant parents to give feedback on their experiences. During our recent inspection, we saw that the trust had acted on many of the recommendations made.

At our recent inspection, there was a maternity patient experience group in place at the trust. The responsibilities of the group included reviewing all patient feedback (for example, from the national maternity patient survey, FFT, complaints, incidents, and local patient surveys), and identifying a minimum of three key themes/trends per quarter to action over the following quarter, and monitoring these. The group also had responsibility for developing, implementing and monitoring an annual patient experience improvement work plan.

The women we spoke with during our visit felt they had been involved in decision making and had been able to ask questions and express preferences. One woman we spoke with described she felt “able to ask questions”, that information had been explained “in a way they understood”, she had “confidence” in the care given, and she had been “involved in decisions”.

We saw a wide variety of information leaflets for women on topics, such as fetal movements (which was available in seven different languages), preeclampsia, baby breaches, ‘waters broken but not in labour’, and latent phase of labour.

We observed that HBC had an ‘always ask’ information board, a campaign to empower pregnant women to overcome fears about speaking to professionals about health concerns. The campaign is aimed at challenges the fears that prevent women from seeking information on how to recognise potential problems and gives them tips on how to manage the appointment, get listened to and taken seriously by healthcare professionals. The notice board featured the pictures and designations of midwifery staff, and a signed charter.

Information about the friends and family test was available in a range of languages; and we saw FFT comment cards and a comment box available at HBC. We also saw a ‘guest book’ displayed on reception desks for patients and visitors to write comments in.

The trust also informed us that they have refreshed their maternity voice partnership group; which meets six times per year. The group have recently launched a new social media page called ‘let’s talk maternity’, which will primarily be used so that women and families can share their views and
ideas regarding local maternity services, and the trust can provide updates and information that women and families might find useful.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Bed Occupancy**

From April 2016 to September 2017 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Data provided by the trust for the period March 2017 to February 2018 showed monthly figures for the number of maternity beds available, the number occupied at midnight, and the proportion occupied. Data showed a 56% average occupancy rate across maternity services at the trust over the period.

Data showed there was a 13% average occupancy rate at HBC over the period.

The bed occupancy rates presented above are calculated using midnight occupancy data. Senior staff we spoke with at HBC described women were admitted at the centre approximately 65% of the time, and no patients were in attendance approximately 35% of the time.

**Meeting people’s individual needs**
Commissioners are required to commission maternity services to ensure that four birth settings are available in the local or a neighbouring area. A woman at low risk of complications may choose to have her baby at home, in a freestanding midwifery unit, in an alongside midwifery unit, or in an obstetric unit (Intrapartum care for healthy women and babies; NICE guideline CG190, recommendation 1.1.2).

NICE guideline, Intrapartum care for high risk women (GID-CGWAVE0613), is in development and not expected to be published until March 2019.

Women cared for by the trust had the option to deliver at home, at the freestanding birth at Huddersfield, the (alongside) birth centre at CRH or the labour ward at CRH; and the trust had produced a patient information leaflet to ensure that differences between delivery options were made explicit.

The rooms at HBC were large and had en-suite facilities; and a birthing pool was available in two of the delivery rooms. Equipment for women to use in labour (e.g. birthing balls, birthing stools, TENS machines) was available.

We reviewed the trust’s interpretation and translation policy at HBC. The policy detailed booking procedures for provision of face-to-face and telephone interpretation services, and for written translation services; and additional information and useful guidelines for communicating with people whose first language is not spoken English. The trust had appointed a British Sign Language provider in June 2016.

We saw that FFT information was available in a wide range of languages, and FFT comment cards and boxes were available in the areas visited. We also observed that some patient information posters (for example, ‘baby movements’) were displayed in a variety of languages. Information on the trust maternity website about antenatal workshops could be downloaded in a wide variety of languages.

Maternity services had a number of specialist midwives who had received extra training to provide advice to patients and staff on topics including substance misuse, safeguarding, bereavement, domestic abuse and learning disabilities.

We saw ‘guest books’ available on reception desks for patients to write comments in about the care they had received.

The areas we visited had “you said we did boards” with comments and feedback displayed about the standard of care. These highlighted actions taken as a result of feedback. For example, women had said that they would like their birthing partner to have somewhere to sleep, and the trust purchased fold out beds for partners to use (and this had been implemented at HBC). In another example, women had complained about delayed discharge due to waiting for neonatal examinations. The service had supported more midwives to undertake a neonatal examination course and employed more midwives who already held the qualification. Other changes included the introduction of kitchenettes across sites.

**Access and flow**

The trust provided us with data for maternity closures, which identified that four closures had taken place over the past twelve months; three of these were closures of HBC.

The three closures of HBC had taken place in the 12 months prior to our visit, these had occurred in January (nine days), February (five days), and March (closed 5 March with operational plans to reopen 16 April) 2018.
The trust reported that each closure of HBC was due to insufficient medical and surgical capacity across both sites. The decision to close the HBC was made by the chief operating officer / chief nurse, and taken using a risk based approach as part of a trust wide silver level escalation.

During the closures, one midwife remained on duty at HBC and a fully resourced room was maintained in case a woman arrived unannounced. The trust noted that there had been no examples of this happening during periods of closure to date (as of 7 March 2018)

In 2018, a total of 16 women were diverted from HBC to Calderdale birth centre (CBC) during the closures as of 7 March 2018. The trust informed us that if a woman was diverted, the Matron contacted her to apologise on behalf of the trust, and an incident report was completed.

The RCOG review that took place in July 2016 identified that HBC had low birth rates and high transfer rates, with staffing implications that question cost effectiveness and practicality; as the service utilised two band six midwives 24 hours a day.

In response, the trust had opted to implement a model of improved flexible working. The trust told us that they plan to introduce a system of integrated care within HBC; opening it as needed, and thereby freeing up midwifery staff to work in the community and support other units. An update to the trust’s RCOG action plan in January 2018 detailed that new staffing arrangements and a communication strategy were in place, and awaiting trust board approval.

During our visit, senior staff we spoke with explained that the new working model had temporarily been placed on hold, to accommodate winter pressures; but that the model would be implemented in the near future.

An entry on the maternity risk register (opened July 2017), described there was a risk that current antenatal clinic capacity exceeded demand leading to overbooking of clinics. It was noted that this risk had been exacerbated by gaps in medical workforce during 2017-2018, and the risk has been escalated via an incident report. Possible impacts of the risk included poor experience for women (including long waiting times due to overfull and overrunning clinics), and poor experience for staff arising from frustration caused by excessive workload. Actions taken to mitigate the risk included capacity and demand mapping, increased room capacity at CRH and HRI sites (by one room each) for diabetes clinics, which had the largest throughput of patients. Review of pathways for women attending antenatal clinics, and exploration of alternative options for contact and frequency were marked as ongoing. The risk was initially categorised as high and had been downgraded to moderate.

The trust shared information with us that showed from February 2017 to January 2018, 91.33% of 12 week antenatal bookings were undertaken within the specified timeframe (less than 13 weeks) across the trust. Information shared by the trust described that all maternity cases not booked by 12+6 weeks were reviewed by the community matron to determine reasons for late booking. The most common reasons identified for late bookings were that the woman was outside of the United Kingdom, was undecided with regards to termination of pregnancy, or had transferred from another area but had un-booked in the other area.

Learning from complaints and concerns

Summary of complaints

From November 2016 to October 2017 there were 43 complaints about maternity. A breakdown of complaints is shown in the table below. Over two-thirds of the complaints related to clinical treatment.

<p>| Clinical Treatment | 29 |</p>
<table>
<thead>
<tr>
<th>Values &amp; behaviours (staff)</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>5</td>
</tr>
<tr>
<td>Patient Care</td>
<td>3</td>
</tr>
</tbody>
</table>

The trust took an average of 38 days to investigate and close complaints; this was not in line with their complaints policy, which stated complaints should be completed within 25 working days.

(Source: Provider Information Request P55)

There was a trust complaints policy and procedure in place, which staff we spoke with were aware of; and we saw patient advice and liaison service (PALS) information leaflets on display in the areas we visited. Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform the ward or birth centre manager or co-coordinator.

Staff at the antenatal clinic told us that the complaints they verbally received typically concerned the environment and patient flow (clinic waiting times); and work was ongoing at the time of inspection to improve this.

There was a raising concerns policy in place at the trust. Staff we spoke with told us that there was a good incident reporting culture, and they were encouraged and supported to report incidents and concerns – and received appropriate feedback. Staff explained that learning from concerns and incidents was reflected in skills drills; for example, pool evacuation and postpartum haemorrhage drills.

As a result of feedback from staff, maternity services had recently (January 2018) begun issuing a weekly safer maternity care newsletter based on agenda items from the weekly governance meeting, and the trust reported that this has been received well.

We saw evidence of learning from incidents and complaints. Completed serious incident reports we reviewed captured lessons learned. We also saw signs that concerns were appropriately addressed; for example, as a result of learning from feedback, the trust told us that they now aim to contact all women due to birth at Huddersfield Birth Centre during a closure and offer an ambulance to Calderdale.

Is the service well-led?

Leadership

Inpatient, outpatient, and community midwifery services at the trust were part of the families and specialist services division, women’s services directorate. The management structure in place had clear lines of responsibility and accountability. A triumvirate of divisional clinical directors, a general manager and a head of midwifery led the division.

The head of midwifery and associate director of nursing sat on the trust board, and a deputy head of midwifery was in post. The service had three matrons, who had divided responsibility for community midwifery, birth centres and specialist midwives; labour wards, inpatient wards and neonatal intensive care unit (NICU); and antenatal clinics, gynaecology and sexual health.

There was a general manager and departmental clinical midwifery managers for different areas and services across the two sites.
Maternity services at the HRI site were midwifery-led. The birth centre manager divided her time between Huddersfield and Calderdale birth centres, and a consultant midwife based at HBC ran clinics at the Huddersfield site. There was also a cross-site matron for community midwifery and birth centres.

During our visit, the head of midwifery explained that she took a proactive role in monitoring the quality of care delivered, and routinely undertook ‘go see’ inspections. These included monitoring the HRI women’s health unit with the improvement manager, and sitting and talking to patients there about their experiences. Staff we spoke with at the site reported good visibility of the senior management team.

Information provided by the trust described that daily ‘rounding’ by matrons and clinical managers had been implemented; these provided a visible presence for women and staff, and women and staff were encouraged to talk about their experiences and concerns. Matrons completed a daily ‘situation report’ which the trust told us was shared with other matrons, the director of operations, head of midwifery, and general manager. We saw a situation report completed in March 2018 which covered incidents and safeguarding concerns, patient experience and promoting compassionate care, EPR related incidents, discharge delays, bed allocation, high dependency patients, VTE assessments, staffing and capacity, and actions undertaken.

At ward level, staff in the women’s health unit at HRI reported they felt supported by senior management, and there was a good leadership structure in place.

When asked about clinical leadership in HBC, the staff felt they could ask for advice and support when needed and explained the birth centre manager or consultant midwife could be called for support.

All midwifery staff we spoke with at the HRI site said that managers were supportive and approachable and they would feel confident escalating any concerns.

During our visit, we reviewed the results of a teamwork and staff climate survey at HBC, dated June 2017. The results showed 100% compliance for team collaboration, and encouragement to report concerns.

**Vision and strategy**

The head of maternity services sat on the trust board and had direct access to the board when maternity was under consideration.

The head of midwifery was the professional and management lead for midwives, and responsible for developing the strategic direction of the service. The deputy head of midwifery worked collaboratively with the head of midwifery to develop the strategic direction and implementation of midwifery strategies.

A five year strategic plan for the trust was in place. The trust’s stated vision and values included ensuring that the work it carried out always “puts the patient first”, and the plan identified a vision that “together we will deliver outstanding compassionate care to the communities we serve”.

The maternity service had a clear vision for the future, “driving patient experience and safety though a holistic family approach”. Key priorities included delivering maternity care integrated with specialist services and providing choice for mothers. This included extended ante-natal, intra partum and post-natal care (provided in the community, where possible) and increased choice for women where to deliver, with midwifery led maternity available on both hospital sites.
Senior staff we spoke with during our visit had a clear direction for maternity services at HRI, and key areas of development and focus had been identified.

In response to the RCOG review, the trust planned to implement a new model of flexible (responsive) working at HBC; opening it as needed, and thereby freeing up midwifery staff to work in the community and support other units.

The capacity of the diabetic clinic, which experienced the greatest amount of footfall on the women’s health unit, had been increased. Ongoing work planned at the women’s health unit included reviewing pathways for women attending antenatal clinics and exploring alternative options for contact and frequency.

**Culture**

The trust provided us with information that demonstrated different methods they had developed to better understand and improve the culture within maternity services to enable teams to deliver compassionate care. These included a team working and safety culture survey, a validated tool recommended by the Improvement Academy (IA). The IA analysed data collected and provided verbal and visual feedback to teams, and each team developed a local action plan based on their own survey results. The clinical managers of each area manage the action plans, and we saw evidence of updated reports and action plans dated to March 2018.

The trust reported that the survey will be repeated in April-May 2018, as part of the trust’s wave two maternal and neonatal safety collaborative work.

During our visit, we reviewed the results of a teamwork and staff climate survey at HBC, dated June 2017. The results showed 100% compliance for important issues discussed at handover, briefing of personnel at the start of shifts, the quality of team collaboration, and encouragement to report concerns.

The trust had also commissioned a ‘work together to get results breakthrough workshop’, facilitated by the chief executive (July 2017). Workshop attendees were invited because they had on occasion witnessed (or heard about) questionable behaviour between colleagues which may be based on issues linked to race, gender or status or other forms of diversity. Four key areas for action were identified: excellence reporting (like incident reporting), verbal positive comments (good mouthing), challenging inappropriate behaviour, and cultural mandatory training.

Other work undertaken with maternity services included team working and human factors masterclasses, which 64 members of staff attended during 2017 and most recently in January 2018.

Maternity services had also recently devised an anonymous, online survey (launched January 2018) so that they could learn more about staff experiences and their recommendations. As a result of feedback, the service had implemented a weekly learning lessons newsletter from the weekly governance meeting, and reported that this had been well received.

Staff we spoke with during our visit reported good teamwork at HRI maternity services; and despite pressures, staff were motivated and positive about the work they did and passionate about the support they provided to women.

Staff told us that they felt supported by their managers and were encouraged to develop their skills.

Similarly, the results of recent focus group data (August 2017) provided by the trust described that midwifery staff expressed they are encouraged to attend the monthly team meeting at least twice a year and everyone felt able to suggest agenda items. Staff explained they had been able to make
suggestions to improve the HBC; such as developing and practising a new pool evacuation procedure, and introducing a ‘birth box’, which streamlined the consumables stored in the room. Staff also felt supported to attend study days to improve services for women (for example, hypnobirthing), the expectation being they would share learning with the wider team.

**Governance**

There were effective structures, processes and systems of accountability in place to support the delivery of good quality and sustainable services. The head of maternity services was professionally accountable for providing direct communication to the director of nursing on all matters relating to maternity services and escalating any significant operational risks.

There was a women’s directorate governance board, and maternity governance meetings and orange panel reviews took place each week. Divisional quality and safety group and mortality meetings took place each month.

We reviewed a selection of weekly maternity governance meetings from 2017 to 2018 and found these appropriately attended by the head of maternity / deputy head, matrons, consultants, and audit, risk, and patient safety and quality managers / leads. The group were responsible for ensuring all incidents are appropriately reported and graded via the incident reporting system. We saw evidence of the review of clinical outcomes and incidents of concern, recommendations made about further examination of cases, and lessons learned.

The women’s directorate had a clinical director and a clinical governance midwife in post to ensure effective clinical governance.

**Management of risk, issues and performance**

We reviewed the maternity dashboard which was red, amber, green (RAG) rated and provided information on a number of key indicators; and included regional indicators for comparison. With the exception of transfer data, data was not specific to the Huddersfield site.

We reviewed the maternity risk register, dated to 07 March 2017. At the time of viewing, 15 indicators were listed; nine of these were categorised as presenting a moderate risk, and six were identified as presenting a low risk. Risks primarily related to safety and quality.

The transfer time of priority one cases from HBC to CRH was identified as a quality and safety risk in July 2016 and placed on the maternity risk register. The risk was initially categorised as moderate and was subsequently graded as a low risk.

There was evidence of monitoring of actions taken and ongoing review for all risk register entries.

There was a maternity services risk management strategy in place. Groups and forums with responsibility for risk management within maternity services included the maternity service weekly governance meeting, orange panel validation meeting, stillbirth reduction forum, clinical performance and improvement, patient experience and improvement, directorate governance board, divisional patient safety quality board, and divisional board. The strategy outlined the processes for managing and escalating risks, as well as individual responsibilities.

The head of maternity was responsible for the co-ordination of clinical risk and for ensuring expert advice was available for risk management within maternity services. The deputy head of maternity was responsible for supporting and embedding the implementation of the risk management process within maternity services and ensuring the recommendations from incidents, complaints and claims were implemented. A risk management midwife was in post.
Staff we spoke with at HRI told us that there was a good incident reporting culture, and they were encouraged and supported to report incidents – and received appropriate feedback.

Arrangements were in place in case of suspension of maternity services, and we saw evidence of robust planning in the maternity escalation policy and business continuity plan for maternity services.

**Information management**

In June 2015, CHFT maternity services went live with the K2 Athena & Guardian electronic patient record systems across all areas. K2 Athena software was used to record women’s medical, obstetric, family and social histories, generate risk assessments, and record birth plans. The K2 Guardian software was used to monitor fetal heart rate. In summer 2017, the trust launched Cerner Millennium EPR; a system used to facilitate admissions and discharges, and electronic prescribing.

A maternity electronic patient record lead was in place at the trust, and a business continuity plan was available that showed staff what to do in case of a system failure or an individual’s inability to access the system; this included the use of concurrent paper-based documentation.

Staff we spoke with at HRI described that they were familiar with the electronic record systems, had received adequate training, and found the systems easy to access and use. We reviewed an EPR training file at HBC that demonstrated staff had received training and support for using the system.

The trust had a confidentiality policy and an information governance policy in place. Staff received training on information governance and were aware of the importance of managing confidential patient information.

Staff we spoke with told us that they could access information relating to policies and guidance electronically, and the system was easy to navigate.

The policies and guidelines we reviewed were all found to be within date with version control.

We saw a range of patient information leaflets available at HRI, and observed that (where stated) nearly all were in date. In HBC we noted that the patient information leaflet, ‘what happens if my heart stops’ was due for renewal in late 2017. However, a member of staff had recorded actions taken to rectify this in the resuscitation trolley log book; which included informing the team responsible and requesting updated information.

**Engagement**

The national NHS staff survey (2017) showed the trust scored 3.75 (out of five) overall in the staff engagement indicator. This was similar to the previous year (3.80).

We noted good examples of actively engaging staff so that their views were reflected in the planning and delivery of services and in shaping the culture, within maternity services.

The maternity specific mandatory training policy and maternity specific training programme (2018) showed that feedback from colleagues had informed the development of a new three-day midwifery training programme for 2018-2019.

The trust also provided us with information that demonstrated different methods they had developed to better understand the culture within maternity services since our last inspection, and ways of improving the culture to enable teams to deliver compassionate care. Much of this work had been undertaken in 2017-18, and was ongoing at the time of inspection. Methods included a team working and safety culture survey, a ‘work together to get results breakthrough workshop’
facilitated by the chief executive, team working and human factors masterclasses, and an anonymous online staff survey.

Staff we spoke with at HRI told us that they felt supported by their managers and were encouraged to develop their skills, and make suggestions to improve services.

Considerable work had been undertaken since our last inspection to ensure that the views and experiences of people who used maternity services were gathered and acted on to shape and improve the service and culture.

The trust had commissioned Healthwatch Kirklees and Healthwatch Calderdale to lead an engagement project to look at how the trust could improve the opportunities for parents and expectant parents to give feedback on their experiences. During our recent inspection, we saw FFT comment cards and boxes and FFT results, ‘always ask’ information boards (a campaign to empower pregnant women to overcome fears about speaking to professionals about health concerns), ‘you said we did’ boards, and ‘guest books’ for patients and visitors to write comments in were prominently displayed in the areas visited.

The trust had also established a maternity patient experience group, with a remit to provide assurance to the maternity forum that maternity patients are receiving a positive patient experience, where this feedback/data is not positive to develop remedial plans/innovative solutions to address this, and to celebrate the positive patient experience across the directorate.

The trust told us that they had also refreshed their maternity voice partnership group, which meets six times per year. The group recently launched a new social media page called ‘let’s talk maternity’; which will primarily be used for surveys, so that women and families can share their views and ideas regarding local maternity services.

Daily ‘rounding’ by matrons and clinical managers had also been implemented. These provided a visible presence for women and staff; and women and staff were encouraged to talk about their experiences and concerns.

Learning, continuous improvement and innovation

Since our last inspection, we saw evidence of the different ways in which leaders and staff within maternity services had strived for continuous learning, improvement and innovation.

We observed that maternity services at the trust were participating in research projects; and was one of two NHS trusts taking part in a study, ‘VIP: Voices in partnership, video-informed practice’, hosted by the University of York and funded by the National Institute of Health Research. The study aims to video or audio-record women in labour to capture conversations between women and care providers, to inform interactional practices of decision making during childbirth in maternity units.

The trust also used standardised improvement tools and methods, and participated in the MBRRACE UK audit. Senior staff we spoke with told us that CHFT was a pilot site for the new MBRRACE Perinatal Review Tool, and will implement this from April 2018.

A stillbirth reduction forum was in place at the trust, and the trust had made significant improvements in its stillbirth rate since our last inspection. The trust’s stillbirth rate was the lowest in the region during quarter one of 2017 to 2018 (2.4 per 1000), this was a considerable achievement considering that five years ago the trust’s stillbirth rate was above the national average.

We saw participation in and learning from external reviews; for example, those undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) and local Healthwatch groups.
The trust had also commissioned a review of Huddersfield birth centre led by a trainee consultant midwife and the regional maternity lead for NHS England. The review made a number of recommendations, however, we did not see any evidence that these had been acted upon at the time of our inspection.

Additional information received from the trust outlined upcoming maternity services initiatives. These included an event planned for May 2018 to review and co-design a new pathway for women with diabetes in pregnancy; to be undertaken in conjunction with the trust patient experience team.

Shortly after our inspection, the trust informed us that they were advised by NHS Digital that they had been awarded funding to implement an electronic patient health record (ePHR) for maternity services. The award means that from the end of April 2018 women receiving care at CHFT will be able to access their maternity notes and pregnancy information via their personal smart phones, tablets and computers.
Services for children and young people

Facts and data about this service

Calderdale and Huddersfield NHS Foundation Trust (CHFT) provides hospital services in West Yorkshire that provides hospital services at Calderdale Royal Hospital (CRH) and at Huddersfield Royal Infirmary (HRI). The distance between the two hospitals is approximately five miles.

On the Huddersfield site, acute surgery for children and initial triage and assessment for medical patients presenting to the emergency department was available. A dedicated paediatric day case surgery day took place weekly on Fridays at the Huddersfield site. (Three lists am and pm). These lists support ear, nose and throat surgery, dental, maxillofacial, ophthalmology, general surgery, urology, orthopaedic paediatric patients.

EMBRACE provided regional transfers to appropriate centres for children and neonates who required specialist and/or intensive care. Inter-hospital transfers between Huddersfield Royal Infirmary and Calderdale Royal Hospital were made by local ambulances with parent, nurse or medical escort as required based on the patient’s clinical condition.

During our inspection of children’s services at Huddersfield, we visited the children’s outpatients department and ward 18 the children’s ward.

We spoke with three medical staff, nine nursing staff, five members of the multi-disciplinary team and five parents. We reviewed three children’s records.

The trust has 64 inpatient paediatric beds across two sites:

- Calderdale Royal Hospital - 56 beds are located within two wards
- Huddersfield Royal Infirmary - eight beds are located within one ward

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 7,391 admissions otherwise known as spells from October 2016 to September 2017.

Emergency spells accounted for 94% (6,972 spells), 4% (327 spells) were day case spells, and the remaining 1% (92 spells) were elective.

**Percentage of spells in children’s services by type of appointment and site, from October 2016 to September 2017, Calderdale and Huddersfield NHS Foundation Trust**
Total number of children’s spells by Site, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale Royal Hospital</td>
<td>7,111</td>
</tr>
<tr>
<td>Huddersfield Royal Infirmary</td>
<td>272</td>
</tr>
<tr>
<td>This trust</td>
<td>7,391</td>
</tr>
<tr>
<td>England total</td>
<td>1,102,315</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

**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 trust was committed to ensuring all staff completes required mandatory training and has set a 95% target for 2017/18. Executive board and the workforce (Well Led) committee monitored compliance. There were 10 mandatory training subjects. For 2017/2018, the trust had decided that due to the implementation of the electronic patient record (EPR) staff would concentrate on five mandatory training subjects and this would be monitored and measured for compliance. These sessions were fire safety, infection prevention and control, information governance, manual handling and safeguarding (Adults and Children).

The trust had RAG (Red, amber and green) rated compliance against its mandatory training records. The statistics submitted identified a target of 95% by the end of March 2018.

From 142 nursing staff all but one nurse had completed mandatory training.

Updated mandatory training figures for consultants (16 in total) showed all but one consultant who started in the trust in February 2018 had completed mandatory training.

Middle grade doctors (four doctors) had nearly achieved 100% mandatory training compliance with the exception of one consultant. Junior doctors commenced placements in February 2018 and of the 24 doctors’ compliance ranged between 16.67% for the completion of safeguarding adults to 100% for completion of the female genital mutilation training.

We saw evidence of staff attendance at mandatory training on electronic documents. The records showed that the majority of staff had completed their mandatory training for 2017 / 2018. Reason’s for non-completion was due to staff sickness or maternity leave.

We spoke with members of staff of all grades throughout the service, who confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, manual handling, infection control, and safeguarding.

**Mandatory training completion rates**

The trust set a target of 95% for completion of some mandatory training. However, the majority of courses did not have a target given.

**Trust-wide**
A breakdown of compliance for mandatory courses from April to November 2017 for nursing staff in children’s services care is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>115</td>
<td>119</td>
<td>96.6%</td>
<td>No target given</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>115</td>
<td>119</td>
<td>96.6%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>109</td>
<td>115</td>
<td>94.8%</td>
<td>No target given</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>112</td>
<td>119</td>
<td>94.1%</td>
<td>No target given</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>112</td>
<td>119</td>
<td>94.1%</td>
<td>No target given</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>107</td>
<td>117</td>
<td>91.5%</td>
<td>No target given</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>97</td>
<td>109</td>
<td>89.0%</td>
<td>No target given</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>104</td>
<td>117</td>
<td>88.9%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>95</td>
<td>109</td>
<td>87.2%</td>
<td>No target given</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>98</td>
<td>119</td>
<td>82.4%</td>
<td>No target given</td>
</tr>
<tr>
<td>Information Governance</td>
<td>96</td>
<td>119</td>
<td>80.7%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>96</td>
<td>119</td>
<td>80.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>96</td>
<td>119</td>
<td>80.7%</td>
<td>95%</td>
</tr>
<tr>
<td>CPR</td>
<td>90</td>
<td>115</td>
<td>78.3%</td>
<td>No target given</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>82</td>
<td>109</td>
<td>75.2%</td>
<td>No target given</td>
</tr>
<tr>
<td>Clinical Pathways for Sick Children</td>
<td>42</td>
<td>61</td>
<td>68.9%</td>
<td>No target given</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>66</td>
<td>110</td>
<td>60.0%</td>
<td>No target given</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>59</td>
<td>106</td>
<td>55.7%</td>
<td>No target given</td>
</tr>
<tr>
<td>Blood Transfusion 05: Anti-D (Clinical)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>No target given</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,691</strong></td>
<td><strong>2,021</strong></td>
<td><strong>83.7%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for nursing staff in children’s services was 83.7%. The target was not met for the four modules for which it was specified. The remaining 15 modules had no target set.
A breakdown of compliance for mandatory courses from April 2017 to November 2017 for medical staff in children’s services care is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>38</td>
<td>43</td>
<td>88.4%</td>
<td>No target set</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>28</td>
<td>40</td>
<td>70.0%</td>
<td>No target set</td>
</tr>
<tr>
<td>Information Governance</td>
<td>28</td>
<td>43</td>
<td>65.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>24</td>
<td>42</td>
<td>57.1%</td>
<td>No target set</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>24</td>
<td>43</td>
<td>55.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>21</td>
<td>43</td>
<td>48.8%</td>
<td>No target set</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>7</td>
<td>15</td>
<td>46.7%</td>
<td>No target set</td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>20</td>
<td>43</td>
<td>46.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>20</td>
<td>43</td>
<td>46.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>20</td>
<td>43</td>
<td>46.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>17</td>
<td>40</td>
<td>42.5%</td>
<td>No target set</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>16</td>
<td>43</td>
<td>37.2%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>14</td>
<td>40</td>
<td>35.0%</td>
<td>No target set</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>15</td>
<td>43</td>
<td>34.9%</td>
<td>95%</td>
</tr>
<tr>
<td>CPR</td>
<td>13</td>
<td>43</td>
<td>30.2%</td>
<td>No target set</td>
</tr>
<tr>
<td>NGT Elearning 2017</td>
<td>4</td>
<td>43</td>
<td>9.3%</td>
<td>No target set</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>309</strong></td>
<td><strong>650</strong></td>
<td><strong>47.5%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

The trust’s overall mandatory training completion rate for medical staff in children’s services was 47.5%. The target was not met for the five modules for which it was specified. The remaining 11 modules had no target set.

**Huddersfield Royal Infirmary**

There is no Huddersfield specific data as the data submitted covered all staff working in Childrens’ services, reflecting the rotational nature of roles within the service.
Safeguarding

The executive lead for safeguarding children and adults was the chief nurse who was responsible for ensuring robust and effective arrangements for safeguarding adults and children within Calderdale and Huddersfield Foundation Trust (CHFT). There was safeguarding reporting arrangements in place to ensure safeguarding processes were monitored trust wide.

The trust fulfilled its statutory requirements by having a named doctor for safeguarding children and named nurses for safeguarding children and adults. The head of safeguarding represented the trust at local safeguarding adults and children’s boards.

The head of safeguarding was responsible for key safeguarding staff within the trust and reported directly to the deputy chief nurse. The head of safeguarding provided strategic support and direction to the governance and safeguarding arrangements for CHFT.

CHFT hosted two designated doctors for safeguarding children, two designated doctors for ‘looked after children’ and a designated and named nurse for ‘looked after children’ in the Calderdale area. The designated nurse for Kirklees was employed by another provider. These roles are directly commissioned through the clinical commissioning group (CCG). A consultant paediatrician is the SUDIC lead.

Named and designated safeguarding nurses in post-attend the sub-groups of the local ‘Safeguarding Children and Adults Boards’ and contribute to multi-agency collaboration and partnership working. The safeguarding team linked closely with other key departments such as risk and governance, human resources, and also patient safety and quality boards within the divisions.

The safeguarding committee had two sub-groups, learning and audit, and training and policy. Staff also told us that a serious case review group was also in place. Safeguarding subgroups provided a forum to bring together key senior professional and operational managers across all divisions. The individual groups reported directly to the safeguarding committee and supported the chief nurse in discharging their responsibilities in relation to safeguarding and strengthening accountability.

The safeguarding committee reported directly to the ‘Quality Committee’ and provided twice-yearly updates for the meeting. This raised the profile of safeguarding within the trust and ensured lines of accountability were aligned directly with the trust board.

The electronic patient record system had flags to alert staff of children and young people who were under child protection plans or were looked after children. The trust incident reporting system alerted senior management and safeguarding team of any incidents or near misses involving a child.

Policies and procedures within the trust included references to multi-agency policies and procedures. CHFT had a safeguarding children’s policy, a domestic abuse policy, a female genital mutilation (FGM) guideline and a mental capacity act and deprivation of liberty policy. Non-adherence to policy was reported through the trust incident reporting system.

Safeguarding procedures were communicated to staff through training attendance, safeguarding supervision, safeguarding newsletters, monthly virtual notice board trust wide and safeguarding champions.
Staff demonstrated knowledge of the safeguarding guidance to follow. They knew what to do and who to contact should a concern be raised. Staff confirmed that feedback was received and lessons learnt from individual safeguarding incidents.

The female genital mutilation (FGM) guideline referenced mandatory reporting. CHFT have developed and implemented the collection and collation of data of known cases of FGM. This data was captured by staff using a data collection form within the FGM guideline and reported monthly at the safeguarding committee meeting. In addition, quarterly FGM data is submitted to the Department of Health.

Female Genital Mutilation (FGM) was flagged on the new-born/child’s electronic record (Cerner) as a “risk of FGM” if a mother or female relative had been identified as a survivor of FGM. Health records of any female babies that were born to survivors of FGM was documented in the child’s red book and information was shared with health visitors and GP through the discharge summary.

Systems were in place to support the teenagers. Meetings took place between the named nurse for children’s safeguarding and the named midwife for safeguarding. The safeguarding team liaised with the specialist midwifery team when a pregnant young woman were admitted to the antenatal maternity service.

All staff were required to complete safeguarding adults and children training every three years at the required level of training as per the draft intercollegiate document for ‘Safeguarding Adults’ and the intercollegiate document for ‘Safeguarding Children’. Staff attended child safeguarding training, initially at trust induction and then during annual mandatory training. The trust confirmed that the level three safeguarding module included information on sexual exploitation and a bespoke workshop was available for staff to access. Female genital mutilation (FGM) was discussed within all levels of safeguarding training for both adults and children. FGM training was also an essential skill for specific members and groups of staff that may meet survivors of FGM as a once only e-learning package introduced in January 2017. Paediatric staff confirmed they had undertaken this training. FGM was included in the safeguarding training for both adults and children. Ad-hoc training was delivered on request.

Training statistics provided by the trust confirmed that 89.44% of nursing staff had completed safeguarding children training and 97.18% had completed safeguarding adults training. Level two children’s safeguarding training was completed by 100% of nursing staff, whilst 87.5% had completed level three training sessions. Fourteen nursing staff remained to complete safeguarding level three training. Thirteen places were booked before the end of March 2018 and one staff member was due to attend the level three safeguarding training in quarter one of 2018/19.

Training statistics for medical staff confirmed 100% completion of safeguarding adults and children’s training. Consultant and middle grade staff had completed level three safeguarding training. Medical staff identified three paediatricians were to complete level four child safeguarding training. Gaps in attendance existed for junior doctors at both training sessions, 16.67% (four junior doctors) had completed safeguarding adults and 75% had completed safeguarding children training. Eight or 66.67% of junior doctors had also completed children’s level two training.

Staff completed annual safeguarding supervision. The safeguarding supervision policy (v4) identified that a minimum of one session in a 12-month period.

**Safeguarding training completion rates**

**Trust-wide**
The trust set a target of 95% for completion of safeguarding training.
A breakdown of compliance for safeguarding courses from April 2016 to November 2017 for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>19</td>
<td>26</td>
<td>73.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>21</td>
<td>29</td>
<td>72.4%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>5</td>
<td>11</td>
<td>45.5%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>15</td>
<td>40</td>
<td>37.5%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>15</td>
<td>40</td>
<td>37.5%</td>
<td>No target given</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>75</strong></td>
<td><strong>146</strong></td>
<td><strong>51.4%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

At trust-wide level, the 95% target was not met for three of the five safeguarding modules for which medical staff was eligible from November 2016 to November 2017 also two of the five modules had no targets given. Trust-wide completion rate for medical staff was 51.4%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>97</td>
<td>109</td>
<td>89.0%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Safeguarding Children &amp; Adults Level 2 2017</td>
<td>97</td>
<td>109</td>
<td>89.0%</td>
<td>No target given</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>93</td>
<td>108</td>
<td>86.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>32</td>
<td>44</td>
<td>72.7%</td>
<td>No target given</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>325</strong></td>
<td><strong>376</strong></td>
<td><strong>86.4%</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

At trust-wide level, the 95% target was met for one of the five safeguarding modules. It was not met for two of the five safeguarding modules for which qualified nursing staff was eligible from November 2016 to November 2017. Two of the safeguarding modules did not have any targets given, and trust-wide completion for qualified nursing staff was 86.4%.

**Cleanliness, infection control and hygiene**

Clinical areas were visibly clean.

Hand gel pumps and washbasins were located throughout the clinical environment including entry and exit points to clinical areas.

Staff throughout the children’s service observed good infection control practices. These practices included handwashing, bare below the elbow and the use of hand gel between patient contacts.

Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available.
Cleaning schedules were in place, which identified the tasks and frequency of cleaning in each area. Cleaning schedules had signatures and dates to confirm respective tasks completed. 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.

Staff received infection prevention and control training as part of their induction and as part of the annual mandatory training. Staff confirmed completion of yearly online infection control training. The children’s service training statistics confirmed 95.77% of nursing and midwifery staff, 93.75% of consultant staff, 100% of middle grade doctors and 41.67% of junior doctors have attended this training to-date.

The children’s outpatient department confirmed that weekly infection prevention and control checks had taken place. Audit scores confirmed 100% compliance in hand hygiene and cleaning scores were 96%.

The play specialist or nursing staff cleaned children’s toys. We saw a toys cleaning log completed in the children’s outpatient department.

The trust did not regularly complete surgical site infection surveillance in children and young people.

We reviewed infection control audits from February 2018 on ward 18 and children’s outpatient clinic. The infection control audit generally showed compliance against areas measured. Breeches found were identified. However, we were unable to ascertain whether the changes identified had been actioned, as the document did not identify this.

The Infection Prevention Quality Improvement Audit on ward 18 (1 February 2018) scored cleaning – 99%, overall infection control score – 97%, estates – 88% and matrons total 93%. The overall score was 94% a green rating awarded. Green compliance ratings were awarded when the score was between 91-94%.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.94 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)

**Environment and equipment**

Ward 18 had eight bed spaces plus one assessment/treatment area to deliver care for children and young people requiring short-term medical observation or inpatient paediatric surgical/orthopaedic care. At times of high activity, additional bed spaces could be utilised as per the escalation policy.

Children’s outpatients had a designated children’s waiting area.

Adolescent facilities were upgraded following feedback from ‘You said, we did’ exercises. The service had looked at the age relevance of some of the activities in Acre Mills children’s outpatient clinics; following this a football table was introduced at the Acre Mill children’s outpatients’ clinic.

Clinical areas were secure. Entry to clinical areas was either by swipe card or by pressing a bell to alert staff to open the door. Swipe cards were required to exit clinical areas.

Equipment suitable for babies, children and young people was seen in all clinical areas.
We observed resuscitation trolleys were sealed. Random checks of resuscitation equipment showed all equipment to be in date.

Throughout our inspection, we undertook random checks on clinical equipment and noted they were generally serviced and this was denoted by the presence of a sticker. We found the calibration on a set of scales (no. 82032199) out of date; however, other checks on the appliance had taken place. This was escalated to the nurse to action.

The recent children’s outpatients’ environmental audit scored 100%.

**Assessing and responding to patient risk**

The service had identified guidelines and protocols to assess and monitor patient risk and react to changes in risk level.

Calderdale and Huddersfield Foundation Trust (CHFT) had invested in an electronic track and trigger system (Nerve centre). This is an electronic observation system, accessed through iPods and laptops across hospital sites.

The paediatric advanced warning score (PAWS) was used to monitor children at risk of deterioration by grading the severity of their condition and prompted nursing staff to get a medical review at specific trigger points. If the child’s observations scored, above three, this showed deterioration in condition and relevant staff were alerted so appropriate actions were taken. We reviewed three children’s records and saw that the PAWS triggers were acted upon. The hospital out of hour’s team at Calderdale and Huddersfield Foundation Trust (CHFT) has ensured prompt management of patients with an elevated paediatric advanced warning score (PAWS) score.

PAWS audit data from April 2017 to February 2018 ‘Ward 18 Observations on Time’ showed compliance from 69 to 78%. In response, the children’s service matron and ward managers had undertaken monthly audits of five records to identify PAWS compliance as part of the trust’s ward assurance framework. This would continue until an improvement was maintained. The Paediatric PAWS action plan dated 1 March 2018 identified one set of actions, which included undertaking PAWS audits, staff education and the allocation of a band 6 sister to work on the ‘EPR Going Forward’ incentive.

Retrieval services provided by EMBRACE whose role was to transfer sick babies and children to the paediatric units based in Leeds and other centres.

A lead nurse for sepsis had led education and training on the implementation of sepsis bundles. The trust has adhered to the National Institute Clinical Excellence (NICE) guidelines for management of sepsis in children. Staff told us that an alert is generated through the EPR system when sepsis is detected. The inspector witnessed this alert during the inspection.

The trust confirmed daily surgical safety check audit data was provided to the operating services manager. Discussions of this data took place monthly at directorate team meetings, the surgical patient safety and quality board (PSQB) and Calderdale and Huddersfield Foundation Trust (CHFT) integrated performance report. Performance had been static across all operating services over the last 12 months at 99% average across all theatre teams.

Incomplete compliance was tracked back to the theatre team involved by the operating services manager, which included feedback to the relevant speciality team. Analysis of findings identified the third part of the World Health Organisation (WHO) checklist could be problematic due to the timing of the process and activity in theatre at this time. Work was ongoing to ensure that this part of the process was always led by the surgeon to drive a sustained change across all areas to
100% compliance. As part of ongoing quality assurance processes theatre, team managers performed regular observation of practice and WHO compliance audits.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.61 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 9.69 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, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.94</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.61</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>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)?</td>
<td>0-15 adults</td>
<td>9.69</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

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

### Nurse staffing

The nursing service delivered a seasonal workforce model, which reflected the seasonal variation in activity. This resulted in reduced beds during the summer period and some weekends to reflect service need and safe staffing. Escalation took place by the nurse in charge to the General Manager/Matron.

Three workforce models managed staffing throughout the service. These models were referred to as base, summer and winter. The base model ran from March to July and September to November; the summer model was from July to August and the winter model ran from November to February. The workforce model was reviewed annually and signed off at trust level to ensure safe staffing.

We reviewed the staffing for the winter model with senior staff and saw that staffing levels from funded level to actual levels were achieved against most grades. All trained nursing staff were in post and a new band three (22.5 hours / week) was due to start on the 19 March 2018.

Rosters covering the periods of November 2017 and February 2018 for Wards 3 and 18 were reviewed. Staffing for both wards was built on one roster. The roster system used (Allocate) allowed reports to be run to filter advanced paediatric life support (APLS) trained nurse cover only. The APLS rota showed full APLS cover with one exception: Night shifts 6th Feb and 2nd March had only one APLS trained nurse due to late notice sickness; these were reported through the trust incident reporting system.

Senior staff told us they felt they had achieved the RCN (2013) staffing standards within their current staffing establishment. They said that during the day the band six-community nurse when
present could help out on the ward and provide management support for band five staff when required.

The paediatric service had two band seven nurses (1.92 whole time equivalent hours) who worked across both hospital sites. The band seven nurses worked 50% clinical: 50% management.

Nursing staff said there were occasions when band five nurses would be in charge of ward 18 when the advanced paediatric nurse practitioner was called to the emergency department.

Nurses generally worked 12.5-hour shifts on ward 18. Staff told us that they did not have a band six nurse working every shift. A band five nurse who had the advanced paediatric life support (APLS) course often led shifts. Band six staff rotated across the service and stayed on ward 18 for six-months before returning to the Calderdale Hospital site to maintain skills.

The site coordinator provided cover if one nurse was left on the ward, because the advanced paediatric nurse practitioner was in the emergency department.

If there was insufficient, staffing staff told us they would report this through the trust incident reporting system. Staff told us that no staffing level incidents had occurred.

One staffing incident for ward 18 occurred during the past 12 months. The incident related to one nurse sent to assist paediatrics at Calderdale Royal Hospital. This left one nurse and one patient on ward 18 at Huddersfield Royal Infirmary. The advanced paediatric nurse practitioner (APNP) was also on duty, although they may attend the emergency department (ED) throughout the shift. The steps taken in relation to this situation were in line with the departmental escalation policy. The incident was closed with a satisfactory outcome. Closure comments within the incident were as follows: The site co-ordinator was aware that a member of staff would need to be sourced from elsewhere in the hospital to go to ward 18 should the APNP need to go to ED. Staff were aware of the escalation procedure should this not have been done.

We saw two copies of the safer staffing levels information associated with the ward. The dates seen were the 14 August 2017 and 5 February 2018. The information confirmed staff numbers and the numbers of children on the ward. The information did not raise any concerns about safe staffing levels.

At Huddersfield Royal Infirmary, a 24/7 paediatric advanced nurse practitioner (APNP) rota supported the inpatient ward (Ward 18) and the emergency department. An on call consultant paediatrician supported the APNP. The trust had employed seven APNPs who worked a range of shift patterns.

Nurses also worked within the service with specialist interests, for example, epilepsy and respiratory conditions.

During the past six months, the following bank and agency staff had worked within children’s services: Bank – 71 individuals used (predominantly Trust employees with bank contracts - 74% of total uncontracted workforce) and agency – 25 individuals used (26% of total uncontracted workforce).

Medical and nursing staff within the children’s service were asked to take up a bank contract. To ensure safe practice roster managers reviewed rosters, which identified any individuals who had worked or were about to work in excess of the European Working Time directive.

Sickness was monitored to identify relationships between additional hours worked and absence. See sickness rates provided by the trust below:
The trust has reported their staffing numbers below for the period March 2017 and October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE establishment, Mar-17</th>
<th>WTE staff in post, Oct-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>92.30</td>
<td>95.48</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 3.5% children’s services for qualified nursing staff, which is lower than the trust vacancy rate of 6.4%.

The site level breakdown was:

- Huddersfield Royal Infirmary 0%

(Source: Routine Provider Information Request (RPIR))

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 8.5% in children’s services which is lower than the trust’s rate of 12.4%.

The site level breakdown was:

- Huddersfield Royal Infirmary 0%

(Source: Routine Provider Information Request (RPIR))

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 3.7% in children’s services. This was lower than the trust’s target of 4.0%.

The site level breakdown was:

- Huddersfield royal Infirmary: 0%

(Source: Routine Provider Information Request (RPIR))

**Bank and agency staff usage**

From November 2016 to October 2017, the trust reported a bank and agency shift total of 277 in children’s services (75 bank and 74 agency) for qualified nursing staff. There were 71 shifts not filled by bank or agency staff.

(Source: Routine Provider Information Request (RPIR))

**Medical staffing**

The children’s service confirmed that they were not compliant against the ‘Facing the Future’ standards because of a lack of permanent consultant cover between 5pm – 10pm.
Consultant paediatric support to the Huddersfield site was in place 24 hours per day seven days per week via the paediatric on-call rota. Paediatric services were supported by a 'Consultant of the Week'.

At night, the on call, consultant at Calderdale Royal Hospital provided cover at Huddersfield Royal Infirmary. Discussions with the paediatric consultant identified that over a 12-month period he had been called in to see a sick child in the emergency department at the weekend on three occasions and twice overnight. We were told that the children were stabilised and had good outcomes from their treatment.

A paediatric consultant was available on ward 18 from 9am to 1pm. From 1pm until 5pm, a different paediatric consultant covered safeguarding every day on the Huddersfield Royal Infirmary site. After 5pm, an advanced paediatric nurse practitioner was available due to paediatric consultants not based on site until the next day.

The weekend on call, consultant worked from Friday lunchtime through to Monday morning. Two consultant staff for paediatrics and neonates were based on the Calderdale Royal Hospital site at weekends. Senior medical staff said consultant staff often stayed onsite rather than go home in the evenings so they could respond quickly to situations. There was full 24/7 consultant on call support to the HRI site through General Surgery, Urology, Orthopaedic and Anaesthetic on call rotas.

An 11-person tier two rota and 10-person tier one rota supported the consultant rota. The service employed 12 consultants within the acute children’s service.

A designated paediatric surgeon was responsible for children's surgical services across the trust.

There was 24/7 anaesthetist cover to support the deteriorating child.

Paediatricians provided input as necessary should a child have an unexpected difficult surgery requiring intravenous fluids.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE establishment, Mar-17</th>
<th>WTE staff in post, Oct-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>45.82</td>
<td>42.41</td>
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</table>

(Source: Routine Provider Information Request (RPIR))

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate surplus of -4.8% children’s services for medical staff, which indicates that there was a possible over-establishment for medical staff in this core service.

(Source: Routine Provider Information Request (RPIR))

Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 0% for medical staff in children’s services which is lower than the trust’s rate of 12.4%

(Source: Routine Provider Information Request (RPIR))
Sickness rates
From November 2016 to October 2017, the trust reported a sickness rate of 1.8% in children’s services. This was lower than the trust’s target of 4.0%.

(Source: Routine Provider Information Request (RPIR))

Bank and locum staff usage
From November 2016 to October 2017, the trust reported a bank and agency shift total of 56 in children’s services (43 bank and 3 agency). There were zero unfilled shifts by bank or agency staff for medical staff.

(Source: Routine Provider Information Request (RPIR))

Staffing skill mix
In October 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 41 whole time equivalent staff working in children’s services at Calderdale and Huddersfield NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>49%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (SIR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records
The Trust introduced the electronic patient record (EPR) in May 2017. EPR supports ongoing overview and history of a child and young person across all areas of the organisation.

We reviewed three children’s record and noted no gaps present. The name and grade of the doctor or nurse were documented against completed treatment reviews. We saw risk assessments, care plans and involvement of the multi-disciplinary team documented.
We saw risks could be identified for children and young people with mental health needs through care plan documentation. A specific care plan ‘Young person under 16 years with mental health needs’ was specific to patients in this group.

In line with trust processes, paediatric clinical managers audited five sets of clinical records monthly using the ward assurance framework. Audit findings generated action plans. The electronic records audit is shown below and an action plan was developed following this audit. The action plan identified three areas, which were either on track or have achieved compliance.

**Medicines**

Medicines management was in line with trust policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys.

We reviewed three children’s drug charts and noted that children’s weights were recorded all prescriptions were signed, dated and no gaps existed within the records.

Three nurse prescribers worked on ward 18. Patient group directives were in place for specific medication, for example, Ibuprofen and Paracetamol. We saw the guidance on nurse prescribing. Non-medical prescriber practice review and yearly affirmation of competency to prescribe documentation (August 2017) was completed by prescribers.

We checked the medication storage with a nurse present and found all drugs to be in date. The ward also had drug stock provided for out of hour’s use, which were in date.
The clinical areas followed a controlled drug checking procedure. We reviewed two months of controlled drugs checks and saw twice daily checks took place.

The drug fridge was locked and we saw written records confirming daily temperature checks of the fridge had taken place.

Staff said that the paediatric pharmacist ensured sufficient drug supplies were available for ward use.

The pharmacist said there had been occasional duplication of prescriptions on the electronic patient record. Should this happen doctors are either asked to remove the duplicated drug or the pharmacist will remove it themselves.

Nursing and medical staff received medicines training at induction.

**Incidents**

Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incidents and significant events were discussed at ward meetings, governance and paediatric improvement group (P.I.G.) meetings in association with the risk register.

Medical and nursing staff confirmed they knew how to report incidents and had received feedback from the incidents they reported. Staff said that incident feedback was cascaded through staff meetings, daily safety briefings, in the communication book and by email. Staff told us that safety alerts were circulated via email, the general manager and risk department; relevant alerts were discussed at the directorate governance meeting.

The paediatric service carried out regular perinatal morbidity and mortality reviews jointly with colleagues from obstetrics. In paediatrics mortality, cases were discussed bimonthly at paediatric clinical governance meetings followed by discussions at the child death overview panel (CDOP).

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for children’s’ services.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in children’s services, which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were

- Pressure ulcer meeting SI criteria with one
- Treatment delay meeting SI criteria with one

*(Source: Strategic Executive Information System (STEIS))*

**Safety thermometer**
The trust used the classic safety thermometer across all areas of the trust, but will be using a specific children’s thermometer from April 2018. The safety thermometer used a local improvement tool for measuring, monitoring, and analysing patient harm, and harm free care. It provided a monthly snapshot audit of avoidable harm including falls, new pressure ulcers; catheter related and urinary tract infections (CUTI).

Monthly clinical performance data was reported within the compassionate care board, displayed on clinical areas. Staff told us they could access this information, therefore keeping them informed of performance indicator outcomes.

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.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, zero falls with harm and zero new catheter urinary tract infections from December 2016 to December 2017 for children’s services.

(Source: NHS Digital)

Major Incident awareness and training

Staff told us that the trust major incident plan would be followed.

The trust confirmed that on 24 January 2018, children’s services undertook a facilitated table top exercise (TTE) relating to business continuity management and service managers. The aims of the TTE was to test the business continuity plan, raise awareness, review the plan and criticise the requirements for any changes regarding service disruptions and delivering business group part of critical infrastructure.

During the exercises, emergency preparedness, resilience and response (EPRR) tools were identified to use, apply and implement responses strategies to initial operational recovery. The additional purposes were to embed integrated emergency responses. Feedback was that “The Group were really positive staff, engaging, skilled and loyal to delivery of patients safety was very obvious”

The paediatric directorate have business continuity plans in place for the three core elements of the service: neonatal intensive care unit / special care baby unit, Paediatric wards and Child Health.

Is the service effective?

Evidence-based care and treatment

Guidance from authorities such as 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 three evidenced based guidelines. The evidenced based guidelines were in date, except for one. This was the infant feeding guideline, which was just out of date. Discussions with a staff member identified that the infant feeding guideline was under review and a meeting had been booked with the doctors to discuss it.
Monitoring systems were in place to ensure that clinical guideline and policy reviews took place. The minutes of the February 2018 paediatric forum meeting confirmed the following guidelines and leaflets were approved, Children going home after an appendectomy, Croup, Looking after your child’s skin during a hospital stay, Child basic life support, Infant basic life support, Bronchiolitis – Information for parents.

Guidelines for review over the next six months were identified at the February 2018 paediatric forum meeting to ensure ongoing review took place.

**Nutrition and hydration**

A variety of food choices were available to children and young people. Special diets, for example diabetic, gluten free, renal, and textured and allergy diets were available. Specialised milk formulae were provided through pharmacy.

Basic foods were kept on the children’s wards, which could be provided outside of the main meal times.

Tea and coffee making facilities were available for parents.

Improvements following informal feedback identified through the “You said we did approach” included the introduction of the “Bring me food” service. This resulted from feedback from parents and carers who wanted access to food without leaving the child’s bedside.

Another initiative which incorporated healthy eating with a “bring me fruit” resulted in a fruit and milkshake round as a way of interacting informally with children and families to check in how families were feeling and also a method to help with the response rate for family and friends test cards.

**Pain relief**

As there were no resident children on ward 18 the day we visited, we reviewed three retrospective children’s records. The children’s records identified the use of a pain assessment tool for that child during their admission which had been used as per guidance.

The ‘Guidance for the Management of Acute Pain in Children’ (v4, 2017) had amendments made following review. The amendments related to the updated pain score to 0-3 as used on the electronic patient record and the pain ladder. The pain assessment guideline was reviewed with multi-disciplinary team involvement. The next date for review is 2020. The pain assessment guideline was on the electronic patient record and an automatic referral was made to the pain team or anaesthetist as appropriate if the child’s pain score was three or above.

The adult pain management team provided help and advice on pain management issues and were contactable by bleep. The service had recently revised its pain management guidance and one anaesthetist had a clinical session for paediatric pain management.

During out-of-hours, an anaesthetist was on call and structured pain relief was in place for each child.

**Patient outcomes**

Staff told us that they were now part of the Comparative Health Knowledge System (CHKS) accreditation. The paediatric service was the first service to be involved in this accreditation system whose standards covered the core principles of healthcare delivery, including, safety, leadership, governance, quality improvement, developing staff, managing risk and effective management. Staff said the first data submission had taken place and accreditation was the second week of April 2018.
Staff across the trust recognised the importance of listening and responding to patient and carers views. This was championed through the representatives on the ‘Trust Patient Experience and Caring Group’. The paediatric diabetes team evaluated the impact of diabetes education sessions and responses included: I can control my diabetes and it is better if I do so.

Children’s educational outcomes were being met as they could access ETHOS (Educating those out of school) if they had been out of school for 15 days or more. The Ofsted report dated 14th February 2017 awarded this provider an outstanding rating.

Calderdale and Huddersfield NHS Foundation Trust summary of analysis data for the national paediatric diabetes audit (NPDA) 2015/16 showed it performed worse than the England average, although, it was still within expected range. Compared to audit 2014-15 the trust HbA1c has improved more than some other trusts but is still an outlier and is an outlier in the percentage of patients with HbA1c <58mmol/mol. The NPDA is a powerful tool for measuring performance, and reports on the delivery of a high quality system of care based on standards set by the National Institute for Health and Care Excellence (NICE).

The paediatric diabetes action plan (2015/16) identified areas to improve which had been completed. For example, to set up nurse led clinics. Monthly nurse led clinics commenced on the 4 April 2018 on the Huddersfield Hospital site. The trust has continued to audit paediatric diabetes; its most recent audit completed October 2017.

Readmission data for patients with diabetes, asthma and epilepsy was analysed by team leads quarterly. The last readmission summary for Q3 & Q4 (July 2017-March 2018) showed that the higher number of readmissions of under ones was in the respiratory category.

From August 2016 to July 2017, a higher percentage of under ones were readmitted following an emergency admission compared to the England average and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Three areas were being reviewed: For under 1’s, a re-audit of readmissions for 2017-2018 was taking place. The trust was now focusing on readmissions, which related to feeding and respiratory conditions. All activity through the paediatric assessment unit was coded as an admission (not an assessment), as per local contractual arrangements. The trust thought this arrangement may skew the data. In addition, and linked to trust process the trust offered a 24 hour recall to the paediatric assessment unit following discharge. The graphs presented by the trust for both age groups have shown a decline in readmissions within two days from August 2016 to July 2017.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows that in the 2015/16 diabetes audit Calderdale and Huddersfield NHS Foundation Trust performed worse than the England average.

The proportion of patients receiving all key care processes annually was 41.4%, which was worse, compared to a national aggregate of 35.5%. The previous year’s score was 55.3%.

The average HbA1c value (adjusted by case-mix) at the trust was 75.1% has significantly improved, compared to the national aggregate of 68.3%. The previous year’s score was a
negative outlier. Although score is worse than the England average it is still within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 69.5, which was better than the previous year’s median of 74.0.

(Source: National Paediatric Diabetes Audit 2015/16)

Emergency readmission rates within two days of discharge

There were no specialties at the trust that had six or more emergency readmissions within two days of discharge following an elective admission.

The tables below show the percentage of patients (by age group) who were readmitted within two days of discharge following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>5.7%</td>
<td>2,160</td>
</tr>
</tbody>
</table>

No other specialty at this trust had six or more readmissions.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.0%</td>
<td>4,717</td>
</tr>
<tr>
<td>General Surgery</td>
<td>6.5%</td>
<td>184</td>
</tr>
</tbody>
</table>

No other specialty at this trust had six or more readmissions.

The data shows that from September 2016 to August 2017, there was a higher percentage of under ones readmitted following an emergency admission compared to the England average in the paediatrics specialty.

Both the paediatrics and general surgery specialties had a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to their respective England averages.
Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From October 2016 to September 2017 there is no data for the trust for the percentage of patients under the age of one who had multiple readmissions for asthma and diabetes.

The trust performed worse than the England average for the percentage of patients aged under one who had multiple readmissions for epilepsy.

The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, diabetes and epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Calderdale and Huddersfield NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>24.9%</td>
<td>173</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>17.8%</td>
<td>45</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>85.7%</td>
<td>7</td>
</tr>
<tr>
<td>1 to 17</td>
<td>30.2%</td>
<td>43</td>
</tr>
</tbody>
</table>

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

Competent staff

Staff training profiles took into account their involvement with children. Examples of the types of training attended, paediatric life support, safeguarding training and safeguarding supervision. Staff said they had an afternoon of training monthly which followed on from their team meeting.

Trust training statistics identified a shortfall in attendance at neonatal and paediatric life support training. To date 83.21% of staff (114) had completed these training sessions. Of the 23 staff who had not completed life support training 16 were identified on the electronic patient record as
booked in the next three months. In addition, 22 staff had completed the advanced life support course whilst, 29 staff completed the neonatal life support course.

During 2017/18, children’s services followed the trust-wide approach to appraisal in carrying out appraisals for all staff within a four-month ‘appraisal window’. This appraisal window took place between July and October. In future years, this ‘appraisal window’ will take place during April to July. Formal processes ensured medical and nursing staff received role specific training and annual appraisal. Nursing staff told us they received yearly appraisals and training specific to their needs.

The trust identified appraisal compliance within the children’s service as excellent. During 2017/18, over (>96%) of staff received an appraisal (183/189) against a trust target of >95%. Six staff had not received an appraisal during 2017/18 were a combination of returned from maternity leave, long-term sickness and new starters who had recently passed their six month probation period.

Nursing staff rotated across the children’s service to ensure variety and skill acquisition and maintenance.

Staff told us that clinical supervision was not in place. However, where staff required support it was provided on request. Debriefing took place following incidents.

There is a comprehensive range of development programmes for nurses, for example, the band seven development programme; matron development programme; ward manager development programme. All of these support succession planning.

Medical training was supported by senior medical staff who were recognised tutors.

New medical staffs attend deanery, trust and departmental inductions. Each new doctor has an allocated mentor.

Medical staff had designated days and times for teaching and training. For example, trainee paediatricians attended STEPP (specialist trainee education programme) training days. Registrar grades attend a Wednesday teaching day. The five GP trainees have designated training time. Monthly mortality and perinatal training was also available for trainees to attend.

The clinical director ensured all consultant appraisals are completed in the month of their birthday. All medical appraisals and revalidations were completed and medical staff completed a competency matrix before having their appraisal.

Anaesthesia for children, whether local or general, was provided by an anaesthetist with specialist training and experience in paediatric anaesthesia.

**Appraisal rates**

From November 2016 to October 2017, 88.5% of staff within children’s services at the trust had received an appraisal compared to a trust (completion) target of 100%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who have received an appraisal (YTD)</th>
<th>Individuals required (YTD)</th>
<th>Appraisal rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>44</td>
<td>44</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>--------</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>106</td>
<td>110</td>
<td>96.4%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>9</td>
<td>27</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>169</td>
<td>191</td>
<td><strong>88.5%</strong></td>
</tr>
</tbody>
</table>

There was no appraisal rate data provided for Huddersfield Royal Infirmary.

(Source: Routine Provider Information Request (RPIR))

**Multidisciplinary working**

The multi-disciplinary team provided clinical assessment and treatments using a child friendly approach, which utilised play and distraction therapies.

Staff identified effective working relationships between the children’s and adolescent mental health service (CAMHS) professionals and paediatricians.

Discharge planning for the child or young person involved all members of the multidisciplinary team involved in their care, for example, nurses, community teams, continuing care team, GP, social care professionals and therapists.

The trust was developing a policy for transition, which was to be ratified at the April Paediatric Forum. Young people from the age of 14 years with chronic health needs such as Cystic Fibrosis, Epilepsy Neurodisability and Diabetes were transitioning to adult services. The children’s service utilised the national paper work called ‘Ready Steady Go’ to assist with the young person’s transition. Monthly diabetes clinics take place Thursday evenings.

To ensure liaison with adult services the new clinician, young person and family were fully informed and involved. The transition process aimed to complete by the young person’s 18th birthday. Transition was managed either locally within health, social care or with regional services.

Physiotherapist staff liaised closely with hospital nursing staff, community paediatric and physio teams when children and young people required support at home.
Staff told us that they liaised with another trust regarding patients with metabolic disorders. Staff said links existed with education services to ensure children’s educational needs were met. Play therapy staff provided a five day service at for Acre Mills children’s outpatient department and ward 18.

Three children’s records showed involvement of the multi-disciplinary team documented in their care and treatment plans.

EMBRACE transport service identified a link consultant for all of the District General Hospitals. The purpose of the link doctor was to improve communication between the trust and EMBRACE, and flag up difficulties with transfers. The consultant attended clinical governance meetings to discuss difficult cases and to spread learning from the transport service. Discussions had taken place in the May 2017, which were documented in the paediatric governance minutes. Discussions centred on retrieval cases involving Embrace. Three cases were discussed which had a common theme around communication with the team. Action: To discuss any changes no matter how minor deemed on babies scheduled for transfer. We did not see any evidence to confirm this had taken place.

**CQC Children and Young People’s Survey 2016 – Q36**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.46 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.

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

**Seven-day services**

The Trust had worked to implement the core standards for seven-day services. It was one of four Trusts in the North of England to meet standard two in the recent data return achieving 93% against a target of 90%.

Staff told us that CAMHS support was available throughout the week and after 5pm.

On call pharmacy support and pharmacy access was available during specified times at the weekend.

Radiology services are provided 24/7 including in-hours and overnight on call.

A children’s community team provided on-call support at weekends to the ward staff should a child be discharged home requiring community nurse support.

Twenty-four hour paediatric and neonatal consultant support was in place.

Physiotherapy provision with on-call provision was available. Staff told us that when a child admitted with a fractured femur over the weekend, physiotherapy staff came to the ward to see them.

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

Children’s services adhere and follow the trust wide policy. In addition, children’s services utilise the 10 steps of confidentiality to ensure that information that is given to a patient supports their decision.

Staff demonstrated through discussion that they were informed of and understood the consent process. Staff said the first question they asked when the child was admitted was ‘Has consent been obtained’.
Staff said surgeons obtained written consent for children requiring surgery.

We reviewed two children’s notes for evidence of consent processes and saw completed consent forms for specific investigations, for example, prior to surgery.

Paediatric staff told us that verbal consent was obtained prior to procedures such as the collection of bloods, insertion of long lines and nasogastric tubes.

Children who attended for blood transfusion received a booklet, which also covered the consent process.

We asked staff about their understanding regarding the Frazer guidelines and Gillick competence in relation to consent processes for children and young people. The staff we spoke with demonstrated some understanding. Trust training statistics confirmed attendance at Fraser and Gillick competence training sessions. For nursing staff 127 or 89.44% had completed this training. All consultant and middle grade staff had completed this training. Junior doctor attendance was 75% which meant that 18 of 24 doctors.

One staff member said Mental Capacity Act training was not available to access.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that From April 2017 to November 2017, Mental Capacity Act (MCA) training had been completed by 75.2% of staff in the children’s service in which there is no trust target. Deprivation of Liberty training data has not been provided.

*(Source: Trust Provider Information Request P14/P49)*

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed better than other trusts for zero questions, worse than other trusts for zero questions and about the same as other trusts for the remaining five questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children’s Survey questions, effective domain, Calderdale and Huddersfield NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.25</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.21</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.64</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.60</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>7.48</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>
Did hospital staff play with you or do any activities with you while you were in hospital?

<table>
<thead>
<tr>
<th>Age group</th>
<th>Score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP</td>
<td>4.45</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

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

Is the service caring?

Compassionate care

Throughout our inspection, we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers. Staff had a positive and friendly approach and explained what they were doing, for example when undertaking blood tests.

We spoke with five parents about their experiences. They said they were happy with the care and treatment their children received.

Feedback cards and comment boxes for parents to use were available throughout the service. We saw positive feedback about their experiences given by parents on cards displayed throughout the service.

CQC Children and Young People’s Survey 2016

CQC Children and Young People’s Survey 2016 questions, compassionate care, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.34</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.84</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.89</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.68</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>6.57</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.97</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>
Do you feel that the people looking after you were friendly?

8-15 CYP

9.40 About the same as other trusts C1

Overall, how well do you think you were looked after in hospital?

8-15 CYP

9.13 About the same as other trusts C1

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

Emotional support

Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for families to access. One parent said they had not been offered spiritual support, although, knew how to access the chaplaincy service if required.

Staff said that children who regularly attended the service received ‘Bravery cards’ following their blood test or cannulation. On collection of five bravery cards, the child received a present. Staff said they raised funds for this by selling cakes, galas and parent donations had contributed.

We saw children provided with emotional support using distraction therapies, for example, reading a book and playing with a tablet whilst undertaking blood tests. Both children were reassured throughout the process, which relieved any anxieties they had. Following the blood test, both children were asked to choose a sticker to reward their good behaviour.

CQC Children and Young People’s Survey 2016

CQC Children and Young People’s Survey 2016 questions, emotional support, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.97</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.42</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.13</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.96</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>9.03</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

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

Understanding and involvement of patients and those close to them

We spoke with five parents about their experiences who said they had been involved in decisions made about their children’s care.

We reviewed four children’s care records and saw evidence of discussion with the family documented.

Information leaflets were available for parents and carers in different languages.
The trust commenced a new program of diabetes education sessions for young patients with type 1 diabetes.

When required interpreters were employed to keep parents and carers informed and able to ask questions relating to their child’s care and treatment options.

We observed a patient and his mother’s attendance at clinic. The doctor was friendly and made both the mother and young person welcome. Questions related to the medication the young person took and advice was given to the mother about the importance of controlling the young person’s weight. The doctor answered questions in a friendly manner; the next appointment was agreed with the mother.

The ‘10 steps to theatre board’ was a new initiative, which described the pathway children took when coming into hospital for surgery. Step 1 discussed their arrival to the ward and progressed systematically to step 10 – going home. Each step informed the child and their family of what to expect along the way.

CQC Children and Young People’s Survey 2016

**CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Calderdale and Huddersfield NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.83</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Question</td>
<td>0-15 adults</td>
<td>8-15 CYP</td>
<td>12-15 CYP</td>
<td>16+CYP</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>9.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>8.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>8.53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>8.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>8.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>9.53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>9.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>9.18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>8.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>8.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8.95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8.18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td>9.57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td>9.59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you involved in decisions about your care and treatment?</td>
<td>5.90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>9.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>9.22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8.62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>7.66</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service responsive?

Service delivery to meet the needs of local people

A full public consultation took place in 2016 on a new clinical model of services to locate all unplanned and emergency care at Calderdale Royal Hospital and all planned care plus an urgent care centre on the Huddersfield Royal Infirmary site. The full business case setting out these proposals approved by the trust board in August 2017 and is with NHS Improvement. Local joint ‘Overview and Scrutiny Committee’ (Calderdale and Kirklees) had referred the proposals to the Secretary of State.

Facilities were available for parents and carers, for example, kitchen and toilet / bathroom facilities.

The trust had RAG rated itself against the ‘Standards for Children’s Surgery and Anaesthesia’ in January 2018. The ratings given were a mix of amber (partial compliance) and green ratings (compliant), the majority of areas were rated green. Where there was partial, compliance the trust had identified actions for most areas to support that aspect.

Plans were in progress for a promotional video about the children’s ward. Feedback has been obtained and has focused on the top five things families, children and young people said they would have liked to know at the start of the families stay. This way of working has ensured the trust focused on what families want to know rather than what health professionals think they want to know. Key things suggested were food for families at child’s bedside, provision of car parking for resident parents, location of the parents’ room and provision of baby jars of food.

CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for zero questions, one was worse than other trusts for one questions and about the same as other trusts for the remaining 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

The trust was worse than other trusts for the questions “did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?”.

CQC Children and Young People’s Survey 2016 questions, responsive domain, Calderdale and Huddersfield NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.62</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.36</td>
<td>Worse than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.21</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>3.17</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>RAG</td>
<td>KLOE</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.52</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>7.78</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.05</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.90</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.50</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>9.21</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.94</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>6.50</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.53</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>7.55</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>8.51</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>3.72</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>8.80</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
</tbody>
</table>

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

**Meeting people’s individual needs**

The paediatric liaison nurse reviewed all emergency department attendances, coordinated care between hospital-based services, and those delivered in the community often by different providers.

Access to ETHOS (Educating those out of school) medical needs assessment team is in place for any child or young person who has been out of school for 15 days or more. The hospital play team assess children admitted of school age and make a telephone referral to either the Kirklees or Calderdale team dependent upon which hospital the child is based. The hospital play team provide support through a suitable environment for learning, recreation and play during the child/young person’s stay in hospital.

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The local children’s and adolescent mental health service (CAMHS) was provided by South West Yorkshire Partnership NHS Trust (SWYFT). The trust worked in partnership with SWYFT and had a service level agreement for mental health administration and scrutiny of papers. Staff told us that children and young people who required support through the CAMHS service were admitted to Calderdale Hospital if they required an inpatient stay for medical reasons.

CAMHS services provide a 24/7 service including in-hours and overnight on call. Staffs that needed to access the service out of hours did so via the SWPYFT on call arrangements. As staff rotated across the service staff said that staff would be present on the Huddersfield Hospital site to advice on this patients group needs.

The learning disability matron supported young people and their families through the transition process.

**Access and flow**

Agreed pathways of care where identified for staff to access. The children's service operational policy and agreed local guidelines were available on the trust intranet, for example, Embrace transfer guidelines, surgical pathways and an on call anaesthetic support.

Guidance for staff ‘Arrangements for General Surgery in Children at CRH and HRI’ was available for elective and emergency surgery.

Ward 18 takes children and young people from birth to 16 years of age.

Staff told us that part of the criteria for admission of a child to ward 18 from the emergency department was that the child had a paediatric advanced warning score (PAWS) of less than three. The scales were based on clinical observations intended to predict deterioration.

The trust confirmed that the external target for incomplete patients still on referral to treatment (RTT) pathways within paediatrics at the end of each month was 92%. This was achieved in every quarter of the year so far and performance year to date is at 96.8%.

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>92.10%</td>
<td>96.04%</td>
<td>97.60%</td>
<td>99.83%</td>
</tr>
</tbody>
</table>

At the end of the January 2018 there were only two patients waiting past 18 weeks.

Weekly dedicated paediatric day case surgery took place on Fridays on the Huddersfield site. (Three lists am and pm). This provided support for ear, nose and throat, dental, maxillofacial, ophthalmology, general surgery, urology, orthopaedic paediatric patients.

Ward 18 takes emergency admissions from GPs, admitted through a consultant pathway.

Medical patients from the emergency department (ED) were seen in ED first and a decision made whether they were to be sent to Calderdale Royal Hospital or admitted to ward 18 at Huddersfield for two to three hours observation.

Children attended phlebotomy clinics on the ward or outpatient areas, which ensured that children and young people’s blood samples were taken in a timely manner. Staff said they performed this role on both hospital sites. Staff said this meant that children would not have to attend the hospital pathology laboratory for these tests.

Late evening transition diabetes clinics took place.
Guidance was in place through the patient access policy advising staff of the steps to take when children do not arrive (DNA) in clinic. Pages 53 to 56 of this policy were specifically related to the management of paediatric patients. Staff told us that repeat DNA’s would result in a safeguarding referral.

**Learning from complaints and concerns**

The trust had a complaints policy and procedure in place.

Clinical areas displayed a ‘Compassionate Care Board’. Information about the date of the last complaint in children’s outpatients was July 2016.

Staff said if they had any concerns they would raise them with senior staff and they had received feedback from managers following complaints investigations.

Parents and visitors could raise concerns and complaints locally and through the trust complaints department. Parents we spoke with said they felt comfortable raising concerns or complaints.

**Summary of complaints**

From November 2016 and November 2017, there were 17 complaints about children’s services. The trust took an average of 31.5 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 30 days.

Other (specify in comments): five
- Access to treatment or drug: three
- Values & behaviours (staff): two
- Communications: two
- Patient Care: two
- Prescribing: one
- (blank): one
- Appointments: one

Huddersfield Royal Infirmary: There were five complaints reported.

The most common subject was: Other (specify in comments) (five) followed by communications (two) and access to treatment and drugs (two). Seven of these complaints concerned Calderdale Royal Hospital.

(Source: Routine Provider Information Request (RPIR))

**Is the service well-led?**

**Leadership**

The programme of ‘Board to Ward’ visits enabled the board to have sight of the key issues in care delivery and lead in developing the appropriate culture and climate to have open discussions about trust goals. Visits included an executive and a non-executive supported by a matron or lead for each area. Some of the staff we spoke with confirmed they heard the executive team had walked around clinical areas.
Key themes were collated and discussed at a board workshop twice a year. Board members used the information and experience gained through their visits to triangulate information presented to the trust board.

All the staff we spoke with described senior managers as visible and approachable.

Band seven nurses and matrons attended weekly confirm and challenge meetings and feedback was given to staff at ward level. Staff told us that these meetings had taken place with the assistant director of nursing.

There had been investment in leadership skills for staff such as general managers and matrons. All matrons had attended matron development programme funded by the trust.

Band five and six staff said they could access leadership courses. We later spoke with a band five nurse who said they had just started a leadership-training course.

Matron’s meetings had taken place monthly for last 18 months.

The matron’s huddle had taken place each Monday afternoon.

Senior staff said consultant job plans were reviewed early 2017. The trust sent copies of the consultant job plans, the majority of which had not been signed off as agreed by the individual consultants.

**Vision and strategy**

In 2017, children services produced an annual report (October 2017), which outlined the last 12 months. The one and five-year strategy formed part of the annual reports. This allowed the service to reflect on the past year, plan for the year ahead and further into the future. However, not all staff when asked was aware of this strategy.

The directorate one and five-year strategies identified ‘Our vision, our behaviours, our goals and our response’. The goals included transforming and improving patient care, keeping the base safe, a workforce for the future and financial sustainability. We asked staff about the strategy and people told us that they were either not aware of a strategy or were able to give a limited description of what the strategy involved.

Each paediatric clinical area had developed a local vision, pledge and strategy in line with the Trust’s vision. In 2018, all clinical managers worked with their teams to agree a pledge for the care that should be expected children young people and their families. The paediatric pledge shown below was approved and signed off at trust board. When visiting ward 18 we saw the pledge displayed on the wall.
Culture

Staff described good teamwork and a supportive culture between medical and nursing staff. Students described a supportive culture throughout the children’s, young people and neonatal services. Students said the nursing and medical staff worked together to provide care and decide the best options for the child.

Staff told us that ward meetings took place regularly where they were encouraged to take an active part.

Governance

The ‘Children’s Services Governance Structure’ showed a clear pathway from board to ward and vice versa.

Trust-wide forums (e.g. Paediatric and Surgical Forum, Paediatric and Emergency Department Forum and Safeguarding Forums) provided the opportunity for face to face joint working and assurance that treatment and care for children and young people was appropriate. Staff told us these forums took place monthly and the discussions included policies, ‘National Institute of Clinical Excellence’ guidelines and audit. We saw minutes of the meetings held in October 2017 and February 2018, which showed discussions, had taken place about open incidents, medical devise training and infection control incidents. Discussions relating to clinical guidelines and information leaflets for approval and any due for review in the next six months had also taken place.

The trust had a multi professional paediatric surgical forum, which was held quarterly with a multi-professional membership list made up of clinicians and managers from children’s, surgical services, anaesthetics and the emergency department. The purpose of the forum was to maintain and develop high quality services, ensuring the delivery of safe, sustainable, clinically effective care for children and young people receiving elective or emergency surgery.

Monthly paediatric governance meetings took place.

The annual ‘Safeguarding Children and Adults report’ was presented to the trust board. The trust identified that a board update took place six months later including updates from the Safeguarding Committee Meeting to the Quality Committee meeting.
The ‘Children’s ward virtual notice board – December 2017 communicated updates in areas such as learning from incidents, medicines management, useful links and policy updates and key messages in safeguarding.

Building on ‘National Safety Standards for Invasive Procedures’ (NatSSIPs) the trust had been working to ensure they are compliant against these standards through ensuring ‘Local Safety Standards for Invasive Procedures’ (LocSSIPs) were in place in all applicable areas across the trust. Paediatric services had participated in this work and a review undertaken of procedures deemed to require the use of a LocSSIP. Implementation of the LocSSIP within paediatrics will be led by the Clinical Director and Matron for the service with support from the ward nursing team.

**Management of risk, issues and performance**

The children’s directorate had a live risk register. Monthly reviews of the risk register had taken place with the differing levels of risk reported at the appropriate governance meeting. Monthly monitoring of the risk register also took place at the directorate meeting.

The risk register identified seven risks to the service. We noted staff identified two of the seven risks pertinent to this hospital site during the inspection. The risks identified related to medical cover. The actions taken to-date against each risk showed progress made in reducing the risk.

The clinical audit plan for children’s and neonates is a shared programme. National, divisional and local audits were identified with details of whether they were to commence, completed, awaiting national results or in the action planning stage. Each audit was identified by quarter year with a named clinical audit lead. The audit of epilepsy admissions was presented at the paediatric clinical governance meeting in December 2017.

A member of the governance and risk team supports staff in delivering duty of candour on a case-by-case basis. Duty of candour is included in the nursing induction within a risk management session. There is also a duty of candour /being open policy.

The multi-disciplinary children’s directorate meeting was a forum where discussions took place with the paediatric outreach team. In addition, speciality-training needs are discussed.

Staff told us that patient safety was monitored through the monthly safety thermometer and ward assurance tool. The ward assurance tool includes patient dignity, documentation and medication management audits.

**Information Management**

Staff said that discharge letters were given to parents and sent to the child’s GP, health visitor and/ or healthcare professional as required.

Staff said they could access out-of-hours investigations, for example, urgent laboratory tests.

Calderdale and Huddersfield Foundation Trust (CHFT) invested in an electronic track and trigger system (Nerve centre). This is an electronic observation system, accessed through iPods and laptops across hospital sites.

Young people from the age of 14 years with chronic health needs such as Cystic Fibrosis, Epilepsy Neurodisability and Diabetes were transitioning to adult services. The children’s service utilised the national paper work called ‘Ready Steady Go’ to assist with the young person’s transition.

Ensuring liaison with adult services the new clinician, young person and family were fully informed and involved. The transition process aimed to complete by the young person’s 18th birthday. Transition was managed locally within health, social care or with regional services.
Engagement

The Trust undertook its first census survey of all staff in 2017. The first data checking finished in mid-December and the final overall response rate for the Trust was 42.8% (2434 respondents from an eligible sample of 5692 staff). Results shared mid-February with the trust, were embargoed until March. The trust staff survey action-planning group reviewed the initial results and will develop a trust-wide action plan. This action plan was taken to executive board and board of directors.

Staff told us that they had been involved in discussions relating to the future of the service. They had looked at a number of options as part of this process; however, felt that the current way of working was the safest for children.

Staff said they were kept informed and had an opportunity to input into changes at monthly team meetings.

The results for the children’s and young people’s ‘2016 National Survey’ for the trust identified that overall children and young people’s experiences of inpatient and day case care were mostly positive. The trust scored ‘about the same’ for all questions when compared with other trusts, apart from one question “Appropriate equipment or adaptations - for parents and carers saying the ward had the appropriate equipment or adaptations their child needed”, which we scored slightly worse. (Since the survey a dedicated teenage area and some additional resources/play equipment)

The survey results suggested scope for improvement in a number of areas, which included children and young people having enough things to do whilst in hospital, involving children and young people in decision-making and treated on age appropriate wards. The results were discussed at Paediatric Forum on the 5 December 2017.

Staff across the Trust recognised the importance of listening and responding to patient and carers views. This was championed through the representatives on the trust ‘Patient Experience and Caring Group.’ A survey of adolescent patients asked about their experiences of outpatient departments. Eighty-five percent had a positive experience, 88% said staff communicated appropriately with them, 93% felt comfortable in the outpatients environment. No reports of a negative experience comments requested additional activities and to continue the excellent relationship with teenage patients.

Family and Friends Test is the main feedback source. Methods used to engage patients with this initiative include, postcards, text messaging and web based solutions. Easy read cards are also available for learning disability patients.

Learning, continuous improvement and innovation

The children’s neurology clinic trialled a different way of reviewing transitional age children. An alert list of age suitable children acted as a prompt to have transition conversations and to complete paper work; transition was recorded on the clinic letters.
Community Services

Community health inpatient services

Facts and data about this service

Community Place is a community inpatient service provided by Calderdale and Huddersfield NHS Foundation Trust (CHFT). It is a joint venture between CHFT Community Division and Calderdale Council which opened as a pilot in January 2017. The Community Place is located within Calderdale Royal Hospital, in Halifax. Community Place provides a step-down intermediate care inpatient service for patients who require social or reablement support to return home independently or with support from social services or reablement team.

From March 2017 to February 2018, 320 patients had stayed at Community Place, with an average length of stay of 11 days.

Community Place has 12 beds, with a mix of single en-suite rooms and same sex accommodation bays with shared washing and toilet facilities. The unit has its own dining room, with a kitchen and lounge area.

Community Place has not previously been inspected as it is a new service from January 2017.

We made two visits to Community Place. We inspected the service on 20-22 March 2018. We also visited the service during our well-led inspection on 3-5 April 2018. Our inspection visits were unannounced (staff did not know we were coming) to enable us to observe routine activity. All five key questions were inspected. During this inspection, we spoke with 13 members of staff, 11 patients, and five relatives. We observed care and treatment and looked at six care records. We observed three multidisciplinary (MDT) meetings, two safety huddles and an initial assessment.

Our overall rating of this service was requires improvement. We rated safe as inadequate. We rated effective, responsive and well-led as requires improvement and caring was rated as good.

Following our first inspection visit, we raised a number of concerns about patient safety with managers and senior managers at the trust. The trust responded immediately by taking action to suspend admissions to the unit while immediate action was taken to address patient safety concerns. The trust also developed an action plan to further address identified issues.

During our second visit, we found the actions taken had not had a sustained impact and some patient safety concerns were still in evidence. We discussed our findings with senior managers at the trust.

At the end of our inspection the trust took the decision to bring forward the planned pilot end date. Patients were transferred to appropriate acute care and Community Place closed on 6 April 2018.
Is the service safe?

Mandatory training

Mandatory Training completion

The unit had two members of qualified nursing staff and 14 non-registered care staff including 7 band four senior reablement support workers and seven band 2 reablement assistants and one ward clerk.

The table below shows mandatory training compliance by staff group, for each of the mandatory training modules against the trust target, at the time of inspection.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Data Security Awareness</th>
<th>Fire Safety</th>
<th>Infection Control</th>
<th>Manual Handling</th>
<th>Safeguarding Adults</th>
<th>Safeguarding Children</th>
<th>MCA/DOLS</th>
<th>Resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>92.86%</td>
<td>92.86%</td>
<td>85.71%</td>
<td>64.29%</td>
<td>78.57%</td>
<td>78.57%</td>
<td>75.00%</td>
<td>38.46%</td>
</tr>
<tr>
<td>Administrative and Clinical</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>50.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>50.00%</td>
<td>-</td>
<td>56.00%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>88.24%</td>
<td>94.17%</td>
<td>88.84%</td>
<td>76.59%</td>
<td>76.47%</td>
<td>76.59%</td>
<td>75.00%</td>
<td>46.00%</td>
</tr>
</tbody>
</table>

At the time of inspection, the overall mandatory training compliance rate was 75% which was below the trust target of 95%. This was lower than for other services in the community division, which were above 80% in February 2018.

Although the trust target of 95% was not met for any of the eight modules, nursing staff had a 69% completion rate for eight mandatory training modules. Non-registered care staff (band 4 and band 2 reablement workers had a 76% completion rate (shown as ‘additional clinical services’ above).

The lowest scoring module was resuscitation with 40% compliance. However information from the trust indicated that staff that were non-compliant were booked to complete mandatory basic life support training within April and May 2018. We saw evidence that 13 staff were trained to provide basic life support when Community Place first opened (January 2017).

Manual handling scored 71% compliance. Information from the trust indicated manual handling training had been cancelled twice previously. Two staff told us they had not completed any manual handling training since they started working for the trust. Following our first visit, managers told us further manual handling and equipment training had been established for all staff.

Staff we spoke with told us they felt up to date with mandatory training and that it was useful to be able to use a mobile phone app to check which training was due.

Safeguarding

Safeguarding Training completion

Training data showed nursing staff had a 100% completion rate for safeguarding adults training and 50% had also completed training in safeguarding children (although there were no child patients on Community Place).

Non-registered care staff (reablement support workers and assistants) staff had a 79% completion rate for both safeguarding adults training and safeguarding children training.

The data indicates that although the trust target of 95% was not met, the compliance rate for safeguarding training for Community Place staff was 88%.

Managers told us level 3 safeguarding training had been put in place for all staff on the unit following an incident in November 2017. At that time, managers were not assured that staff had a full understanding of the safeguarding process. The investigation also highlighted that escalation
processes were unclear between the trust and the local authority and managers told us this had since been clarified.

The revised operating procedures for Community Place (December 2017) displayed on the unit noted that safeguarding issues would be reported to the local authority safeguarding team and logged on the trust incident system. It specified the escalation processes for staff to use.

Although there was no agreed safeguarding lead on the unit, staff we spoke with explained they would notify the unit manager or person leading the shift, in the first instance, if they had concerns about a patient. We observed managers recognise a potential safeguarding incident relating to abuse in the patient’s home area, during inspection.

Staff were aware of the new process for escalation via the trust site co-ordinator and knew how to access this support for any problems on the unit.

**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.

Community Inpatients health services made three adults safeguarding referrals last 12 months.

Following the inspection, we requested more up to date data from the trust. This showed the unit made four adults safeguarding referrals between October 2017 and April 2018. These related to the serious incident investigations in November 2017 and February 2018.

**Cleanliness, infection control and hygiene**

Information displayed on the ward showed the unit had recorded no cases of Clostridium difficile (C.diff), methicillin resistant Staphylococcus aureus (MRSA), and methicillin sensitive Staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.

However, manager assurance reports indicated the unit had previously identified cases where a patient was a C.diff or MRSA carrier and that a pathway for IPC issues was in development with the community public health team. This indicated the reporting and management of infection prevention and control (IPC) issues was unclear.

We saw that monthly ‘bare below the elbows’ audits, had been completed by the unit manager until December 2017 and showed 100% compliance. Managers told us a registered nurse was responsible for IPC issues (from January 2018) and monthly audits of hand hygiene and the ward environment were scheduled (frontline ownership or FLO audits). Minutes indicated IPC issues were discussed at team meetings and hand hygiene audits were carried out.

Following inspection, we requested the most recent FLO audits which covered a range of IPC issues. We were provided with an example FLO audit completed in June 2017 and two FLO audits completed in April 2018, following our inspection.

Managers explained two FLO audits were completed on the same date for the infection control team to externally validate the approach taken by the Community Place team. Managers
acknowledged that there was variation in the findings of the two audits, with overall compliance scored at 58% by the infection control team and a number of issues identified in relation to hand hygiene, patient areas/equipment, waste disposal and leadership. Managers told us unit staff responded to the findings of the ICT team on the same day.

Following the inspection, we requested IPC training data. Infection prevention and control was part of mandatory staff training. The data indicates that although the trust target of 95% was not met for IPC training, the compliance rate for Community Place staff was 76%.

We saw that team meeting minutes noted band 2 and 4 staff could approach the IPC lead for training in non-touch aseptic technique (ANTT) and we saw evidence that the IPC lead had completed ANTT training as required.

Following inspection, the trust told us bespoke sepsis awareness training was in progress and 35% of non-registered care staff (reablement support workers and assistants) had so far received this training. Incident data indicated there had been one incident where a patient on the unit had been diagnosed with sepsis, in February 2018.

During inspection, we observed staff using appropriate personal protective equipment when completing clinical tasks. They complied with hands bare below the elbows national best practice, correct handwashing technique and use of sanitising hand gels was observed.

We saw completed cleaning checklists in place and that infection prevention and control was discussed at team meetings. However some patient equipment did not have ‘I am clean labels’ e.g. walking frames.

The unit was visibly clean and hand-washing facilities were available. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available.

There was no sluice or dirty linen storage on the unit, staff used the facility on the adjoining ward.

**Environment and equipment**

We noted that there was limited moving and handling equipment on the unit e.g. no hoist to assist patients if they fell. Falls monitoring and pressure relieving equipment were not routinely in use, although the unit kept a stock of non-slip slippers and socks. We saw that one piece of equipment used to assist patients after a fall, had no evidence of up to date servicing. We raised these issues as immediate concerns and managers responded by taking a number of actions. Following our visit, additional falls monitoring equipment, weighing scales, and pressure relieving equipment and access to moving and handling equipment was arranged.

On our second visit, staff told us they could borrow equipment from another ward or contact the site co-ordinator for assistance. Work was ongoing to identify and obtain appropriate equipment as required by patients.

Staff had access to bring emergency resuscitation equipment from an adjoining ward. The responsibility for checking this equipment was with the adjoining ward. We looked at the checking records, found that these were up to date, and had been completed daily.

We saw that substances that could be harmful to health were stored in a locked cupboard in line with best practice.

We looked at a random selection of sterile single use items of equipment and found that all items were in date except for some throat swabs. This was raised with staff during the inspection.

The unit was clutter free and tidy on our visits.

**Assessing and responding to patient risk**
Managers told us action had been taken following an incident investigation in November 2017. At that time, the unit was unable to provide assurance that risks to clients on the unit were assessed and their safety monitored, for example falls, nutritional and pressure area assessments. There were examples of poor care because staff had not effectively recognised or acted when a patient showed deterioration. Since then, an action plan including training had been put in place for staff, nursing support had been increased, a safety huddle introduced and the escalation process improved.

**Risk assessments**

On admission, staff were expected to complete a series of checks on admission to assess the level of risks for each patient, for example moving and handling, falls, skin and nutrition (and mental capacity, if appropriate). Managers told us a holistic care plan was developed based on these assessments.

During inspection, we looked at records for patients on the unit and we observed the daily patient safety huddle meeting and handover. We found that risks to patients were verbally highlighted and flagged using a visual system for reference. Staff spoke positively about the handover being the key source of information about each patient.

Overall, we reviewed the records for 10 patients. We completed six comprehensive reviews and checked key assessments for a further four patients. We found that record keeping relating to risk was of a poor standard, risk assessments and care plans were not routinely in place and properly completed.

We found that documentation such as risk assessments and care plans were not routinely and fully completed for all patients, for example falls, pressure areas, and nutrition and hydration assessments. This indicated the actions taken following the incident in November, had not been fully effective.

For example:

- We found that not all patients identified as at high risk of falling had comprehensive falls assessment and care plans in place such as to identify appropriate equipment or support needed on the unit to mitigate this. Some staff told us this was because this was a community setting and patients would not have this level of support at home. There was an expectation that patients were medically fit. However, senior managers told us the unit had a duty of care to all patients and agreed that risk assessments should be completed to ensure appropriate care was given.

- We found that risk assessments for patients at high risk of pressure area damage were not properly completed to enable a care plan to be put in place e.g. they did not document how often checks were needed, or what equipment was required to mitigate the risk.

- We noted that one patient with a urinary tract infection (UTI) and one with a suspected UTI did not have fluid balance charts in place. These charts enable staff to monitor how much a person is drinking and prevent deterioration. Over our two visits, we also heard from two families who were concerned that patients’ nutrition or hydration needs were not being monitored or recorded appropriately. We found that one of these patients also did not have a MUST assessment or core care plan or holistic assessment in the notes.

- We found that important information about patient observations were not recorded clearly in patient records e.g. one patient with urinary infection did not have observations recorded on two days and records stated only ‘observations ok’ following a fall. One patient had no baseline observations recorded. Another was highlighted as needing ‘extra observations’ at
the safety huddle, but nothing was documented in the notes. Incident data showed a similar example had been identified in November.

- We found that risk assessments and care plans were not routinely reviewed as a patient’s situation changed. For example one patient at high risk of falling was not re-assessed after a fall. Another risk assessment was not up to date and did not reflect the person’s current ability, which had changed over time. We saw this had been identified as an action following previous incidents.

These issues meant care staff did not have all the information they needed to care for patients, to mitigate risks or monitor changes. This meant there was a risk that a deteriorating patient may not be recognised, staff may not know when to escalate potential problems and care may not meet people’s changing needs.

We raised these issues as immediate concerns.

Managers responded immediately by taking a number of actions:

- Admissions to the unit were temporarily suspended whilst remedial actions were undertaken.
- All guests received an immediate review of their falls risk assessment status by the divisional lead for falls. As a consequence of this review, one guest, who was identified as high risk of falls, was moved from a side room to a main bay with a member of staff allocated to provide constant supervision.
- An immediate assessment of all guests’ nursing and care needs was undertaken by the Deputy Director of Nursing, and senior nursing staff from Community Teams, which included a comprehensive assessment and review of care plans.
- One guest identified as high risk for potential pressure area deterioration. A documented pressure area assessment had been undertaken in the notes identifying the need for pressure relieving equipment. Appropriate pressure relieving equipment was secured and is in place.
- One guest showed signs of an unexpected deterioration during the nursing assessment and was taken by a nurse to the Emergency Department for assessment, reviewed and returned to the unit later that evening.
- A unit-wide GP review was expedited who reviewed guests identified through the nursing review.

We discussed the immediate actions with managers who told us a daily nursing review of all patients was now in place.

We reviewed data from the trust, which indicated similar issues had been identified following an incident and service review in November 2017 and the action plan which managers had developed.

On our second visit, we reviewed records for three patients who had been newly admitted to Community Place. We found that risk assessments were not routinely in place or had not been properly completed, as before. We raised these issues as immediate concerns.

**Clinical oversight and escalation**

We discussed the escalation process with managers. Accountability for clinical oversight of patients was not clear. Band 4 care staff (unregistered), were expected to lead the unit. The role of the nursing staff in relation to clinical accountability was unclear.
We spoke with care staff who demonstrated a clear awareness of the new escalation procedure in the event of an emergency. Care staff escalated concerns to the registered nurse or unit manager or called for a GP visit as required. Out of hours, care staff told us they would contact the hospital site co-ordinator or night matron in the first instance. Staff accompanied patients from Community Place if they were transferred to the hospital emergency department.

Prior to the November review, incident data showed care staff had contacted 999 or 111 in order to access medical care out of hours. Following the November review, a new escalation process was agreed, via the hospital site co-ordinator. However, incident data indicated the new escalation procedure was not always effective in accessing support from the trust out of hours. On one occasion (Feb 2018), care staff again contacted 999 as they were unable to get the medical support needed using the agreed route via the hospital.

The service did not use systems such as intentional rounding or an early warning score (EWS). An EWS is an assessment and clinical observation tool to facilitate the early detection of deterioration in patients.

**Safety alerts**

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. Managers told us no relevant alerts had been received in the last 12 months. Managers were able to describe their actions and responsibilities should they receive an NPSA.

**Staffing**

**Safer Staffing levels**

The minimum safe staffing level for Community Place was defined as:

- 1 x band 4 senior reablement workers (senior HCAs) 24 hours, 7 days per week
- 2 x band 2 reablement workers (HCAs) 24 hours, 7 days per week.

Senior (band 4) reablement workers (care staff) led each shift.

In addition, the following staff worked on the unit during office hours Monday – Friday:

- Unit Manager
- Registered Nurse
- Social worker
- Occupational Therapist
- Ward Clerk

We discussed staffing with managers who told us priority was given to filling the late and night shifts as these are the shifts that are not covered by a registered nurse and less support is available from the wider team. A registered nurse would work to fulfil the duties of the reablement support workers where shifts were unfilled during the day.

Where there was unavailability of band 4 senior reablement support workers a request was made to the trust flexible workforce team for a Band 5 registered nurse. Previously some band 4 shifts had been covered by band 3 workers, which managers recognised was not appropriate.

In the event that this was not covered support was given by the Clinical Commander/ Night Matron/ Ward 4C to ensure patients are safe.
Managers explained that to mitigate current vacancies, three Band 2 staff were interviewed and promoted into band 4 positions temporarily which left four vacancies at band 2. This was intentional as band 2 was the easiest position to backfill with Flexible Workforce and there were bank band 2 staff who work on the unit regularly and took up additional shifts.

Additional registered nurse support had been put in place from December 2017 in response to the investigation in November 2017.

During inspection, we had some concerns about the minimum safe staffing levels and the skill mix for the unit:

The new band 4 staff were being inducted into their new roles at the time of inspection and were due to commence in April 2018. However, during inspection (on 20 and 22 March), there were two occasions where new Band 4 staff were already leading shifts and on one of these, there was no registered nurse on shift to support.

Information received following inspection shows the newly promoted staff members were not due to have completed their Band 4 competencies until the middle of April 2018.

We had some concerns about the staffing skill mix during inspection. On two occasions during inspection (22 March and 4 April 2018), only one of the three care staff was experienced on working on the unit and had access to the electronic patient record system for Community Place.

We raised staffing as a concern and managers responded. Following our inspection visit, a forward review of staff rosters was undertaken to provide assurance of full workforce cover on every shift. The workforce model was revised to ensure a band 6 Registered Nurse was available 7 days per week (daytime only), to support with clinical issues, in addition to care staff.

Following inspection, we looked at eight weeks of staffing rotas from 5 February to 1 April 2018:

We had some concerns about senior staffing cover at night and weekends.

Of those shifts which did not meet the minimum planned staffing levels in February and March 2018, we found that 65% had no identifiable senior cover and 50% were on weekends.

We saw that on five occasions the late shift was below the planned staffing levels, although there was a band 4 staff member or registered nurse on shift (5, 22, 23, 31 March and 1 April 2018). We saw that on nine occasions the night shift was below the planned staffing levels (5, 8, 9, 12, 28 February and 3, 11, 17, 30 March).

We found there were six occasions where there was no senior cover on the late shift and seven occasions where there was no senior cover at night (such as band 4 support worker or registered nurse, excluding the new band 4 staff). This indicated band 2 staff were responsible for the unit overnight. On one occasion (11 March 2018), there were only two band 2 bank staff on shift. Managers told us the night matron would be aware of any staffing shortfalls. On one occasion (28 February 2018), there was no senior cover for either the late shift or and night shift and no registered nurse was available during the day.

Information indicated that at the time of the serious incident reported in November 2017, there was one band 2 and one bank staff and no senior staff on duty at the weekend. The incident investigation from November 2017 had identified as a risk that band 2’s were regularly in charge of the shift.

We also had concerns about new band 4 staff leading shifts during their induction period.

We found positive examples of mentoring, such as when a registered nurse was available to support a newly promoted Band 4 support worker on 13 and 14 March 2018. However we also
found examples when an experienced senior or registered nurse was not available; such as the late shifts on the weekend of 2-4 and 29-30 March 2018, the late shift 12 March 2018 and the night shift on 28 February 2018. In effect, managers were allowing newly-uplifted Band 4 staff to act as the senior for the shift, before their competencies had been signed off.

Following inspection we also reviewed data from the trust on fill rates from December 2018 to March:

**Unfilled bank agency shifts:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Band 2</th>
<th>Band 2/4/5</th>
<th>Band 4</th>
<th>Early Shifts</th>
<th>Night Shifts</th>
<th>Late Shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-17</td>
<td>20</td>
<td>4</td>
<td></td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Jan-18</td>
<td>6</td>
<td>2</td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Feb-18</td>
<td>4</td>
<td>5</td>
<td></td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mar-18</td>
<td>16</td>
<td>4</td>
<td></td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

There were a total of 24 unfilled shifts in December 2017, 6 in January, 9 in February and 20 in March. No data was given for November 2017:

Managers told us that late and night shifts were prioritised.

From February to March 2018, we saw that 88% of band 4 (senior) night shifts were filled, 93% of late shifts were filled and 100% band 4 early shifts were filled.

From February to March 2018, we saw that 96% of band 2 night shifts were filled, 82% of late shifts were filled and 86% early shifts were filled.

There were 46/56 or 82% night shifts and 45/56 or 80% late shifts which met the planned minimum staffing levels of 1 band 4 and 2 band 2 staff from 5 February to 1 April 2018.

There were 10 days with no registered nurse cover from 5 February to 1 April (8, 10, 11, 21, 23, 28 February and 12, 22, 29, 30 March 2018), a fill rate of 82%.

Therapy staff worked four days per week, with a fill rate of 100%

**Vacancies**

We discussed staffing and vacancies with managers who told us that there were no vacancies for qualified staff and there would be four vacancies for unqualified staff at Band 2 and one at Band 4, once the new Band 4s started their new roles.

Following inspection, we requested information on use of bank and agency staff:

**Bank Agency Shifts:**

<table>
<thead>
<tr>
<th>Shift Type</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP</td>
<td>75</td>
<td>134.5</td>
<td>116</td>
<td>123.5</td>
</tr>
<tr>
<td>Band 2 Healthcare Assistant</td>
<td>321.5</td>
<td>328</td>
<td>318</td>
<td>673.5</td>
</tr>
<tr>
<td>Band 4 Healthcare Assistant</td>
<td>10</td>
<td>8.25</td>
<td>87.5</td>
<td>172.5</td>
</tr>
<tr>
<td>Band 5 Registered Nurse</td>
<td>20</td>
<td>0</td>
<td>33.5</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Managers explained vacancies and bank/agency usage had increased as there was an uncertainty regarding the future of the unit with only short term contracts offered. Where staff had left, recruitment was not possible due to short term contracts. In response three band 2 care staff
were interviewed and promoted into band 4 positions temporarily which left four full time equivalent vacancies at band 2. This was intentional as band 2 is the easiest position to backfill with flexible workforce and there are bank band 2 staff who work on the unit regularly and take up additional shifts. The new band 4 staff were being inducted into the new role at the time of inspection.

The November 2017 review had identified a number of gaps in staffing including access to social work staff, physiotherapy and occupational health support. The review acknowledged there had been delays in discharge related to the unit manager covering gaps in social worker role for a period of several months in addition to their own role.

Managers told us the occupational therapy post provided by the local authority was currently vacant and being filled by trust staff who were already part of CHFT Support and Independence Team. They provide cover four days per week on Community Place to ensure the service is maintained.

**Turnover**

From November 2016 to October 2017, the trust reported an overall staff turnover rate of 21.5%. The qualified nursing and health visiting staff turnover rate from November 2016 to October 2017 was 0%.

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

We requested further information and discussed staff turnover during our visit. Staff turnover rate for Community Place for the last 12 months is 26.64% which is above the overall trust staff turnover rate.

Managers told us retention of Band 4 support workers had been a challenge due to the short-term nature of contracts available for the unit as a pilot. Following our inspection, managers told us staff contracts had been extended to promote continuity.

**Staff Turnover**

<table>
<thead>
<tr>
<th>Job Role</th>
<th>Avg Headcount</th>
<th>Avg FTE</th>
<th>Starters Headcount</th>
<th>Starters FTE</th>
<th>Leavers Headcount</th>
<th>Leavers FTE</th>
<th>LTR Headcount %</th>
<th>LTR FTE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clerical Worker</td>
<td>1.00</td>
<td>0.80</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Health Care Support Worker</td>
<td>1.00</td>
<td>1.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Healthcare Assistant</td>
<td>8.67</td>
<td>8.17</td>
<td>4</td>
<td>4.00</td>
<td>3</td>
<td>2.27</td>
<td>34.62%</td>
<td>27.76%</td>
</tr>
<tr>
<td>Helper/Assistant</td>
<td>8.25</td>
<td>7.93</td>
<td>2</td>
<td>2.00</td>
<td>2</td>
<td>1.80</td>
<td>24.24%</td>
<td>22.71%</td>
</tr>
<tr>
<td>Sister/Charge Nurse</td>
<td>1.42</td>
<td>1.33</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

**Sickness**

From November 2016 to October 2017, the trust reported an overall staff sickness rate of 4.1%, which was slightly higher than the trust target of 4%. The qualified nursing and health visiting staff sickness rate from November 2016 to October 2017 was 0%, which was lower than the trust target of 4%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*
Managers told us sickness was high on the unit and there had been periods of long-term sick leave.

We discussed how staffing was covered in the event of sickness. Managers advised that part time staff could be contacted to work extra hours, if necessary. Flexible workforce staff were also used. There was a process to escalate staffing concerns.

During our inspection there was staff annual leave, on one occasion we noted this was not mitigated appropriately to maintain minimum safe staffing levels.

**Suspensions and supervisions**

During the reporting period, this core services reported that there were no cases where staff have been either suspended or placed under supervision.

*(Source: Routine Provider Information Request (RPIR) – Suspensions and Supervisions tab)*

**Quality of records**

Overall, we reviewed the records for 10 patients. We completed six comprehensive reviews and checked key assessments for a further four patients. We found that record keeping relating to risk was of a poor standard, risk assessments and care plans were not routinely in place and properly completed. We found records were not completed in line with staff's registering bodies.

**Systems and access**

Staff used both paper and electronic systems for record keeping. This was confusing as information was held in both areas and there were some gaps and inconsistencies between paper and electronic records. For example, some paper notes said ‘refer to electronic record’. One patient’s paper notes did not record a fall. Managers told us all staff could access the electronic records, however bank staff and some substantive and MDT staff were unable to access the electronic records. On one occasion during inspection, only one of the care staff on shift were able to access the system.

The trust used a separate electronic patient record (EPR) which recorded patients’ care in the hospital prior to admission to Community Place. Care staff at community place were not able to access this system, although it was accessible to the registered nurse and therapy staff working on the unit.

Managers recognised there was an inherent risk in using two systems and we saw a single paper system was implemented during our second visit. At this time, we saw risk assessments were being added as needed, where they had not previously been completed, which included information transcribed from the electronic system and which were accessible to all staff working on the unit.

**Risk assessments**

We noted that risk assessments were not routinely and fully completed for all patients. We found that care plans were not routinely and fully completed for all patients, for example falls, pressure damage and nutrition and hydration assessments. We noted that risk assessments and care plans were not routinely reviewed as a patient's situation changed, for example after a fall.

We noted that important information about patient observations were not clearly recorded, for example for a patient, following a fall.

We noted that where patients had been highlighted as needing to increase their intake of fluid to reduce risk of developing infection, nutrition and hydration charts were not routinely in place to enable staff to monitor this.
This meant staff did not have all the information they needed to care for patients, to mitigate risks or monitor changes.

We raised these issues as immediate concerns. Managers took immediate action to review all patients to identify nursing needs and review falls risk and equipment needs.

The November review identified that staff do not have all the information they need to deliver safe care – particularly in relation to acceptance of missing discharge summaries on admission from another ward.

Audit and action

Following inspection, we reviewed two documentation audits completed in January and February 2018. There were two areas of non-compliance in each audit; ‘consent recorded at every visit’ and ‘allergies/ reactions are recorded’ with actions. We saw feedback on the issue of allergy recording and patient demographics was given at a team meeting (Feb 2018), although we did not see the issues of consent discussed.

However, the documentation audit did not comment on the presence discharge summaries or the quality of clinical risk assessments, although it did check whether appropriate care plans were in place. This meant managers were unable to effectively monitor whether staff had all the information they needed to provide safe care.

Following our first visit, managers told us a process for weekly assurance review of all patients’ documentation by a registered nurse, had been put in place.

During our second visit, we reviewed four further sets of notes for patients who had been admitted since our last visit. We found limited evidence that documentation including risk assessments were properly completed to enable staff to deliver safe and person-centred care:

- None had a falls risk assessment tool completed for falls, which was accessible to all staff on the unit.
- One patient had a risk assessment tool completed for malnutrition (MUST), although this was incorrectly scored as a medium instead of a high risk.
- Three sets of notes contained food charts which were not fully completed.
- Four sets of notes contained fluid balance charts, although completion was poor.
- For two patients, a core care plan was not completed (including mobility, transfers, personal care, nutrition and hydration, medication, social activities and skin checks and stoma care).
- All patients had a risk assessment tool for pressure area damage, a care plan and evidence of repositioning, however the frequency of skin checks was not specified from the risk assessment.
- We also saw that a discharge summary for one patient sent to their usual GP indicated the patient was discharged to their usual place of residence, rather than to community place.

Medicines

Patients admitted to Community Place were discharged from acute hospital care and were required to bring 2 weeks supply of their ‘to take home’ (TTO) medicines with them. Information from the trust indicated there had been 3 incidents reported where patients had arrived without their medicines and action had been taken to rectify this.
Patients kept their own medications in locked cabinets at the bedside. Patients were encouraged to self-medicate to promote independence and we saw staff supporting patients with their medications.

The community pharmacist provided support for the unit, including weekly checks or medicines administration records (MAR charts), a monthly medicines audit and medicines education. We saw the community pharmacist supporting new band 4 staff to gain their medicines competency during inspection. Managers told us an audit of TTO supply was planned in April 2018.

Community Place had its own specific medicines management policy which was tailored to its aims and we saw there was appropriate storage and documentation for controlled drugs and medicines which required refrigeration. Staff assessed patients’ level of support and independence in taking medicines and provided support. If an injection was required out of hours, e.g. insulin for a diabetic patient, there was an arrangement that a nurse from the adjoining ward would be requested to assist.

We reviewed a weekly and monthly medicines management audit (Feb 2018) and saw actions identified for similar areas of non-compliance e.g. missed signatures, staff not verbally checking for allergies before giving medication. Minutes showed the results were discussed with individual members of staff and at team meetings.

During inspection, we also saw that some medications charts were not always signed when medicines had been administered.

We observed some staff applying dressings before they had received a prescription from the GP. Managers told us this was not acceptable and instead they would implement a new system of dressings which could be applied without prescription, if required.

We saw some prescription creams and ointments were left out by patients’ beds and not locked away. Managers told us this was assessed on an individual basis according to the level of support and type of medicine.

Managers responded and a full review of all patients’ medications was undertaken by the lead pharmacist, following our inspection.

**Safety performance**

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ during their working day such as at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient’s own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

Managers told us the Safety Thermometer audit commenced on Community Place in February 2018 and information was inputted onto the National Data Base. In March, there were 12 patients admitted, 91.7% harm free care and one pressure ulcer.

**Incident reporting, learning and improvement**

**Serious Incidents - STEIS**

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 did not report any serious incidents between November 2016 and October 2017.

(Source: NHS Improvement - STEIS)

We discussed incidents with service managers during inspection who told us there had been two serious incidents reported on the unit since October 2017. However, we also noted that the date of the last serious incident displayed on the patient safety board on the ward, was given as December 2017. Following inspection, we saw that a fall resulting in a fractured neck of femur had also been discussed at the December team meeting, however this did not appear to have been reported as a serious incident and it was unclear whether it had been investigated.

Of the two reported serious incidents, one was a safeguarding incident, which had occurred in October 2017 and was reported in November. The other was an incident where a patient had sustained a fractured neck of femur injury following a fall on the unit in February and the investigation was ongoing at the time of inspection.

We saw that both incidents had been investigated. We requested these reports and reviewed the initial 72 hour report for the November incident. Neither final report was available at the time of our inspection. The November 2017 incident had prompted a wide-ranging service review and we saw an action plan had been developed in response. Information from the trust indicated a delay in investigating the serious incident from November 2017, although work on the action plan in response to the service review began in the meantime.

The November incident prompted a service review and managers shared the resulting action plan with us. This highlighted that while staff were aware of incidents and the majority were able to access the reporting system, incident reporting was not routine. Incidents had not been reported as required and opportunities for learning had been missed.

During inspection, we found that staff were aware of how to report an incident and there was some evidence to suggest incident reporting was improving. For example recent governance meeting minutes also noted that an increase in the number of falls reported in the community division could be due to Community Place now reporting falls more routinely due to greater staff awareness and understanding of the incident reporting process, following the November review.

Following inspection, we requested further incident data from the trust.

From May 2017 to March 2018, there were 70 incidents. The table below shows the most common theme was slips trips and falls (32 incidents), followed by incidents relating to administration of medicines (12 incidents).

From September 2017 to March 2018, there were 54 incidents. Of these, 37 caused no harm and 17 caused harm. Of the 15, 2 were classed as serious harm, 5 as moderate harm (2 x pressure injuries and three falls), and 10 as low harm.

We saw that themes and learning from medicines incidents and audits were discussed at team meetings. We saw that safeguarding incident reporting processes were discussed at a team meeting following the serious incident in November.

However, there was limited evidence of improvement following lessons learned, for example in relation to falls and risk assessments.

For example, there were 10 falls incidents in the last 12 months each of which had identified a need for all patients to have a falls risk assessment in place on admission, including one incident
where no risk assessment was in place. The November review had identified a lack of assurance that risks to patients were being assessed and monitored effectively. We saw that falls prevention was also noted in team minutes and assurance reports since November 2017 as a learning need review. During inspection, we saw specialist falls leads were brought to the ward to address issues identified, however we did not see evidence that falls prevention training had been completed or that effective falls risk assessments were in place. This indicated the unit had not maximised the opportunities for learning and improvement in this area.

**CIP Type of Incidents by Further Detail**

- Slips, trips, falls and collisions
- Administration or supply of a medicine from a clinical area
- Preparation of medicines / dispensing in pharmacy

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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 were understood the principles of being open in relation to the duty of candour. Managers had a clear understanding of the duty of candour and we saw evidence that this had been applied following reported serious incidents in November and February. However, it was unclear whether the duty of candour had been applied following a fall with harm, in December 2017.
Is the service effective?

Evidence-based care and treatment

Staff followed the standard operating procedure (SOP) for community place to deliver the service. The SOP was dated December 2017 and had been updated following the November review and approved via the divisional governance meeting.

The SOP outlined escalation procedures including how to obtain medical support out of hours, and how operational issues should be reported to the trust and local authority e.g. escalation procedures, reporting of safeguarding issues, incidents and complaints. The SOP also contained practical information for all staff to follow e.g. acceptance and exclusion criteria, staffing model, roles and responsibilities, record keeping and medicines, operating hours, how to access support with catering and facilities issues. The SOP outlined the steps staff should take to prevent and respond to pressure damage. Although information steps were set out for staff to use risk assessments and report falls, the SOP did not outline a set process staff should follow, after a fall.

Therapy staff worked to national NICE guidelines and completed home assessment visits with patients at risk of falling, in accordance with best practice guidelines from the College of Occupational Therapists.

Staff had access to trust policies via the intranet, although not all MDT staff were able to access these. We saw paper print-outs of trust policies were kept at the nursing station, although managers were aware that this presented a risk that staff referred to policies were out of date.

There were local policies in place for medicines management, which reflected the nature of the service and supported its aims to promote independence and self-care as far as possible.

Following inspection, we saw the SOP and medicines policy did not reflect recent NICE guidance on medicines as it referred to three levels of support which may be given to patients. NICE guidance now states; “The term 'medicines support' is defined as any support that enables a person to manage their medicines. This varies for different people depending on their specific needs”. There were clear training requirements and a competency assessment for staff supporting people with medicines which stated training must be completed prior to the care worker administering medication unsupervised. However, this should include dealing with medicines or supporting a person with their medicines in any way, not just administering.

There was an audit plan and following inspection, managers provided examples of monthly audits completed since November 2017, including audits of hand hygiene, patient documentation, medication and the ward environment (FLO). The safety thermometer audit had been introduced from February 2018.

We saw that actions identified from documentation and medicines audits were discussed at team meetings and with individual members of staff. Managers told us the FLO audit had also been verified, following inspection, to address a lack of assurance about the initial approach.

Nutrition and hydration

Patients told us the meals available on the ward were good, there was a choice of food and they could make themselves a hot drink when they wished.

Staff told us they had recently introduced different colour water jugs for different times of day, to help staff to identify how much water people were drinking during the day.
During inspection, two family members raised concerns that staff were not monitoring their relative’s nutrition or hydration needs effectively, to prevent them becoming unwell and that food and drinks taken, had been incorrectly recorded.

One patient told us they had concerns that their specific needs were not being met as staff did not understand his needs following a stroke e.g. having a weakness on one side and reaching for drinks.

The MUST tool is a malnutrition universal screening tool (MUST), a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We reviewed patient records and saw that the MUST tool was not routinely used to identify and monitor people’s needs.

We noted that where patients had been highlighted as needing to increase their intake of fluid to reduce risk of developing infection, nutrition and hydration charts were not routinely in place to enable staff to monitor this. Where they were in place, we saw they were not well completed.

We also saw that the unit did not have weighing scales and patients’ weights were not routinely recorded and monitored.

This meant staff did not have all the information they needed to meet and respond to people’s needs.

We raised these issues as immediate concerns and managers responded. This is considered in detail in the assessing and responding to risk section, above.

**Pain relief**

Patients we spoke with told us they could access pain relief as required.

**Patient outcomes**

**Audits – changes to working practices**

The trust has participated in no clinical audits in relation to this core service as part of their Clinical Audit Programme.

*(Source: Routine Provider Information Request (RPIR) – Audits – Changes to working practices tab)*

We discussed audits with managers who confirmed that as a pilot service, community place had not participated in any national outcome audits. The community division did not take part in the National Audit of Intermediate Care, although managers told us they were considering whether it would be appropriate.

Patients’ needs were assessed prior to admission to the unit by a registered nurse, social worker or occupational therapist e.g. for medication, personal care, hot drink preparation, mobility. Managers told us this information was used to develop a full holistic care plans within 24 hours.

The occupational therapist set goals with patients although they did not use a therapy outcome measures assessment tool. Therapy support was available 4 days per week and therapy time was not logged or monitored.

Patients gave examples of the improvements they had made in terms of confidence, physical ability and memory while on the unit, although in one set of patient notes we reviewed, no intended patient outcomes were documented.

Staff described examples of patients whose initial assessment of support needs had been significantly reduced during the time they spent on the unit.
Managers acknowledged that a lack of meaningful performance data meant the service was unable to properly measure the effectiveness and responsiveness of the service.

For example, the service did not routinely collect information relating to referral, admission, assessment and discharge dates or times and planned discharge dates were not always recorded on arrival.

Information provided by the trust in relation to length of stay, delayed discharges and readmissions to acute care, are considered in the ‘responsive’ section of this report.

**Competent staff**

**Induction**

Information from the trust indicated managers did not have assurance that the induction programme had been completed for all staff.

We reviewed three examples of the induction checklist for the first three months of employment which also detailed the mandatory training to be completed in the first two weeks. For one new starter the checklist was not completed after five weeks (Band 2); one was signed off by the manager as completed after two months (Band 2); one was signed off after seven months, although the mandatory training section of the form was blank (Band 3).

**Appraisals and supervision**

Information from the trust indicated that 100% of staff had received an appraisal within the last 12 months, at the time of inspection.

Clinical staff told us they had one to ones with the unit manager and supervision within their profession.

Following inspection, managers identified a need for all staff to have clinical supervision minimum six-weekly.

**Training and competencies**

The November review identified a significant gap in the workforce having the right skills and knowledge to meet the needs of the patient group, no clear articulation of the learning needs of the workforce and a variable skillset across Band 4s in ability to understand patient observations. Further training and support was put in place at that time to support staff to develop skills to care for patients appropriately.

Managers explained that ‘following an incident on the unit in November 2017 a decision was made to implement the National Care Certificate for band 2 care staff. Band 4 care staff would undertake a suite of competencies that reflect the needs of the unit. The current workforce were enrolled onto these programmes at the time and all new starters were routinely registered to complete the programme. The unit manager was responsible for ensuring completion of the care certificate and had access to the database to monitor compliance.

The suite of competencies submitted are planned to be completed by the band 4 staff and will be signed off by the end June 2018. When employed originally band 2 and band 4 staff commenced the CHFT core competencies for health assistants: Infection control, personal cares, physiological measurements, sampling, catheter cares. In addition, bespoke training sessions have been delivered on the unit including Sepsis awareness and medications management. All staff will receive sepsis training through a rolling programme. Currently x3 band 4s and x2 band 2s [36%] have received training.’
During inspection, we discussed training records with managers who noted there was poor compliance and progress against the care certificate target dates for completion on two records reviewed.

Following inspection, we reviewed the community place training matrix for band 4 and band 2 staff and the suite of competencies for band 4 staff. We noted that use of the nutritional risk score (MUST) and Waterlow score (pressure risk assessment) were included. We saw falls prevention training was not included, although a need for this training had been identified as a need during team meetings. Data from the trust indicated the two registered nursing staff had completed falls prevention training (updated every three years). We reviewed training records for two members of care staff who had also completed preventing falls training.

We also saw that no specific competency in relation to reablement skills for care staff had been developed.

We discussed competencies with managers and following our first visit, manager told us that a formal competency review of each staff member was put in place for the following week. At the same time, an additional programme of training in fundamental aspects of care provision, including nutrition and hydration, tissue viability management and frailty, would be put in place.

**Appraisal rates**

From November 2016 to October 2017, 100% of permanent non-medical staff within the community inpatients services core service had received an appraisal.

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

**Multidisciplinary working and coordinated care pathways**

We observed that a daily safety huddle took place involving nursing, care, therapies and social work staff where patient needs were shared with the multidisciplinary team.

GPs chaired MDT meetings with patients and families twice a week. We observed three MDT meetings with good communication between professionals. We saw a community nurse invited to join the MDT meeting, to share information and support the family of patient they had known a long time.

Managers and healthcare professionals worked collaboratively with partner organisations and other agencies to arrange onward care for patients in their own homes e.g. carrying out home visits to assess individual needs. However, managers identified some challenges in relation to developing a cohesive management structure due to the partnership approach of the pilot and also in securing timely support for patients from social care partners which could impact on length of stay for patients. The November service review identified

Staff spoke positively about working as part of a multidisciplinary team.

Admission assessments could be completed by nursing, social work or occupational therapy staff, depending on the predominant need of the patient. However managers told us this could lead to inconsistency in completion.

Arrangements for clinical oversight of patients within the team was unclear. For example, it was unclear who was responsible for specific tasks e.g. risk assessments and developing the care plan. Staff told us patients did not have a named care worker or nurse with overall responsibility for their clinical care. We saw that care staff carried out day to day care of patients, but were not involved in MDT meetings.
Health promotion

People were encouraged in self-care and independence by the model of care. The Community Place is designed to support people to maintain their independence for as many functional activities as possible.

Staff supported patients to undertake their own activities of daily living to meet their own personal goals, including eating, getting dressed and making cups of tea.

Support was given to help patients to move toward managing their own medication.

We saw some activities were led by care staff e.g. game sessions and some weekly sessions were provided by a charity e.g. cooking, arts and crafts.

We saw some health information leaflets available for patients and families e.g. pressure ulcer care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards

From April to November 2017 the one member of qualified nursing staff had not completed Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) training.

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

Following the inspection, we requested more up to date training data as the staffing model had changed (as per mandatory training section, above).

This showed non-registered care staff (band 4 and band 2 reablement workers had a 75% completion rate for MCA or DoLS training. Information about nursing staff completion rate was not provided.

Staff informed people of the purpose of the unit and obtained their consent prior to transfer to Community Place, although patient feedback data showed 50% people did not feel informed about how long they would be likely to stay on the unit, before they arrived.

Patients who did not have capacity to consent to come to Community Place were not accepted. Staff told us the unit manager carried out mental capacity assessments before patients came to the ward or if a patient became confused on the ward, although staff told us a formal capacity assessment was not always documented.

Staff recognised that capacity could fluctuate although how this was managed was not documented. Patient records did not evidence whether a patient with a learning disability had had a capacity assessment during care planning. It was not clearly recorded whether the unit had accessed support from the learning disability matron to develop and review care plans for a patient with a learning disability.

A serious incident was being investigated at the time of inspection. Managers told us the patient was sent to Community Place at 2am from the emergency department, which was against admission criteria. The patient did not have capacity due to dementia and arrived with no medications and no past medical history. This was not reported as an incident in itself, but as part of a falls incident which occurred later.

Following inspection, we reviewed two documentation audits completed in January and February 2018. Consent was identified as an area of non-compliance in each audit. Actions included; ‘Need to ensure consent is obtained during each visit and recorded on assessment. Need to also obtain consent when undergoing any assessment.’ We saw feedback on another issue from the audit of
was discussed at a team meeting (Feb 2018), although we did not see the issues of consent discussed.
Is the service caring?

Compassionate care

The majority of patients and families we spoke with gave positive feedback about the service.

One family member told us the unit had been invaluable because staff had; 'built mum up to what she was before'. Another patient told us; 'I’m doing more for myself, slowly but surely. I’m getting back to normal'.

Staff interactions with patients were generally observed to be positive and supportive. We saw privacy and dignity was maintained during care. Staff answered call bells in a timely way and assisted patients appropriately e.g. during mealtimes. Staff kept a stock of toiletries on the unit, ready for patients who arrived without.

Following inspection, we reviewed patient questionnaire results. We saw 124 of 320 patients (approximately. 40%) had given their views from March 2017 to February 2018. This showed 60% patients would be likely or extremely likely to recommend Community Place to friends and family if they needed similar support after a stay in hospital. 100% patients reported they felt treated with respect and dignity by the staff in the Community Place and 100% rated the support they received from staff as excellent or very good.

One patient commented; 'The service is needed because they could not get the care for me before I left hospital but I was not unwell so better to have a service like Community Place where I can go to recuperate rather than going home and not being able to manage but also not taking up a hospital bed.

The friends and family test was introduced on the unit in December 2017. During inspection, we saw data displayed which said 100% of patients would recommend Community Place to friends and family.

Emotional support

Staff referred to people staying on the unit as ‘guests’ rather than patients, to distinguish it from a hospital acute ward and promote a culture of self-care and independence.

Patient questionnaire data showed 87% patients said staff encouraged them to do tasks for themselves and 75% patients felt they were listened to by members of the Community Place Team. However one patient we spoke with felt; ‘doctors don’t listen to you. They talk over you.’

We saw positive feedback in the comments book and that staff had helped patients to leave comments.

One patient wrote; ‘It was my 94th birthday and I received a beautiful card signed by the management and staff and also a birthday cake to celebrate, and would like to thank everyone concerned. Unexpected but appreciated enormously’.

Patients were encouraged to go out with family members as appropriate e.g. to a hair appointment. One patient told us staff were going to arrange support to help them attend a family event at the weekend.

On the day of discharge, a staff member was allocated to ensure guests were supported on the day of discharge and to make a courtesy call to the person the following day, to check the person’s package of care had started. We saw staff offered emotional support to one guest who was upset to be leaving the unit and moving on and the need for this was appropriately shared with other members of the team at handover.
One comment in the patient questionnaire suggested the unit could be improved by having access to a telephone to contact family.

We noted there was no specific private area for conversations or meetings with patients and families on the unit. On one occasion a patient was asked to leave the day room, so a meeting could take place. On another occasion, a bay on an empty ward next door was used, where equipment had been left.

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

We saw patients and families were invited to join multidisciplinary (MDT) meetings which took place twice a week.

Family members and carers we spoke with told us they felt listened to during MDT meetings and that it was helpful to have access to all the professionals in one place. A community nurse was invited to attend one meeting and the patient’s carer said it was very reassuring to have someone else there who had known the patient for a long time, when making decisions. Another family member said it was helpful to have medical terms explained and be able to ask questions.

Although no formal carer’s assessment was used, we saw staff signpost one carer to other sources of support and information e.g. the Alzheimer’s Society, during the MDT.

We saw staff discussed plans for discharge and people were kept informed if there was a change to the plan. Patient discharge questionnaire data showed 75% patients felt they had the right amount of information from about their care and treatment and got answers to their questions from Community Place staff. It also showed 75% of patients felt involved in decisions about their care, 13% felt involved to some extent.

However, it also showed 50% of patients did not feel informed about the Community Place and how long they would stay on the unit before they arrived. 37% said they were informed and 13% said they didn’t know. One patient commented ‘I was particularly shocked to find out I was going to an old people’s home and a more than a little disheartened by it. I was told I was going into rehab to get me back home. I do think this needs addressing and explaining better.’

On discharge, 72% patients said they knew who to contact if they were worried about their condition or treatment once they left Community Place, 14% said no, 14% didn’t know.

We saw staff had helped patients to record their feedback in the Community Place comments book and thank you cards from patients were displayed on the ward.

Some patients made suggestions for improvement including having more activities and a larger day room, access to a telephone to contact family, a clock that was easier to read, and an environment more suited to their needs e.g. towel dispensers located too high. It was not clear how patient suggestions were responded to.
Is the service responsive?

Planning and delivering services which meet people’s needs

The service had been developed in partnership with the local authority, as a pilot service, to meet the identified needs of the local population.

Community place was designed to provide support and reablement to people who were medically stable and ready for discharge, but who require additional support that prevented them being discharged home. The unit was a step down service which meant people transferred to Community Place following a period of acute care in one of the trust’s acute hospitals. One member of staff described the service as a bridge between the hospital and home.

Patients were medically fit for discharge and the unit was designed on a social care model which promoted independence. However many had ongoing nursing needs which would be managed by the community nursing team after their discharge home. The hospital trust retained a duty of care toward people while staying on the unit.

All patients were assessed prior to admission to ensure they were medically fit and care staff in the community setting could meet their needs, including nursing, therapy and social care support. This multi-disciplinary team then worked together to achieve an appropriate discharge for patients, taking account their needs and wishes.

However, we found limited evidence in patient records that the service planned effectively to meet the nursing needs of patients.

Although the service was located on the hospital site, it had initially operated separately. This model was confusing and had meant staff were unable to easily access the support and infrastructure they needed to ensure high quality care for patients e.g. medical care out of hours (discussed in the assessing and responding to risks, section, above.

The service ethos was to encourage patients to be as independent as possible while on the unit.

People were encouraged to dress daily and be involved in activities of daily living. People could get up when they wanted to, were not part of a hospital routine. Family and friends were encouraged to visit whenever they wished; there were no specific visiting times.

People were assessed and supported to self-medicate as appropriate and locked storage for medicines was available at each bedside.

Facilities included two four-bedded bays and four single side rooms with en-suite facilities. The facilities were flexible to ensure single sex accommodation was maintained. There was a communal dining and lounge area, to support people in their recovery.

The day room had a TV and a radio and a variety of board games, books and puzzles were available. Volunteers came once a week to offer a session of cooking, art or music.

Therapy staff could arrange home visits for patients, to assess their needs in their own environment. Alternatively, they could take patients to the main therapy bathroom / kitchen within the main hospital, for assessment. Although there was no physiotherapist on the unit, occupational therapists were also able to assess for walking aids and access equipment for patients.
Meeting the needs of people in vulnerable circumstances

The integrated workforce model, including input from social workers, GP, nursing, therapy and care staff based on the unit, was designed to respond to people with complex needs. Staff spoke positively about working collaboratively to co-ordinate appropriate health and social care for people to return home safely.

We found that care plans were not always fully completed with an individualised assessment of their care needs, with an appropriate care plan and goals to meet their needs. Staff told us patients were not allocated a named staff member, who was responsible for ensuring patients had a personal care plan.

Patients’ specific needs such as dementia, hearing loss, sight problems or learning disability were verbally highlighted in the safety huddle and visually on the patient safety board using symbols, to prompt staff to make reasonable adjustments in caring for patients. The electronic system included a symbol to identify patients with a learning disability although we also noted one patient with a learning disability was wrongly identified on the patient safety board as having dementia.

One patient who had had a stroke told us they had concerns that their specific needs were not being met as staff did not understand his needs and care was not adapted to meet them. The SOP indicated people in this situation would usually be excluded from admission to the service as it was not designed to meet their rehabilitation needs.

We saw staff interacting appropriately with a patient with a learning disability and managers told us the learning disability specialist nurse had been involved on admission; however we did not see evidence of this in the patient record. No learning disability passport or ‘I am me’ booklet or similar was use to readily identify a person’s needs and wishes. This can be useful to readily support new or bank staff working on the unit, to care for people with a learning disability or people living with dementia.

Information leaflets were available on the ward and a statement offering information in different languages was included on the community place patient information leaflet. We did not observe any information in easy-read or other formats.

Managers told us it could be arranged although there were no formal arrangements in place for interpreting or translation support or accessing information in different formats. However staff gave a positive example where an interpreter had been requested and the extent of the person’s confusion and mental health needs only became apparent once the interpreter was involved.

Staff supported several patients living with early stage dementia or suspected dementia on the unit and patients were able to access the service unless their dementia would prevent them from engaging with the self-care and reablement approach. The environment was not specifically adapted to support people living with dementia e.g. high contrast or easy ready signage. Staff had not completed any specific dementia training, although more than half of the people on the unit during inspection were living with early stage or suspected dementia.

We saw the hospital chaplain came to the unit to support one family and staff told us they accompanied patients to the multi-faith room as required.

We saw signposting was offered to carers for information and support during MDT meetings, although we did not see evidence of carer’s assessments being used.

We saw staff could make referrals to the memory clinic for people experiencing memory problems, or to the mental health team, to support patients experiencing low mood. We saw staff acknowledge the needs of a person with anxiety on the day of discharge.
We saw staff sensitively discussing the needs of a patient possibly approaching the end of life, with a family member, including a discussion about the person’s needs and wishes with regard to resuscitation and readmission to further care.

Staff told us the unit did not routinely care for patients nearing the end of life, but that occasionally a patient would deteriorate and staff gave examples of being able to access palliative care to support patients and families. During inspection, there was one patient on the unit whose primary need was identified as being for end of life, although patients were usually unable to come to Community Place if this was the primary need.

**Access to the right care at the right time**

We discussed referrals, admission and length of stay with unit managers who described the aim for the unit was for people to stay up to 7 days at Community Place.

**Referral and admission**

A clear referral process and criteria were in place which had been improved following the November review. This had also highlighted some patients were accepted onto the unit without discharge summaries.

Referrals were now received via a central email inbox and triaged against the defined admission and exclusion criteria. Reasons for refusal were recorded. Managers told us they could be screened within a couple of hours.

Prior to acceptance to the unit, a nurse, occupational therapist or social worker assessed a patient for suitability, against the criteria, to ensure they were appropriate.

We saw that the majority of patients on the unit during inspection were admitted within 24 hours of assessment. We saw that admission to the unit could be postponed for a few days, if people still had acute medical needs.

Performance information was not routinely collected relating to referral, assessment and admission criteria or times. Managers told us admissions were accepted until 8pm although there was an ongoing serious incident investigation relating to the admission of a patient out of hours, outside of the admission criteria. Data on inappropriate admissions was not audited, although managers felt incident data did not indicate any issues.

Information provided by the trust indicated bed occupancy was high and staff told us there was rarely a waiting list.

**Delayed discharges**

Between January 2017 and October 2017 there were four delayed discharges within this core service. This amounts to 3.2% of the total discharges (126). Three of which were in January 2017 and the remaining one was in May 2017.

<table>
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<th>Total Discharges</th>
<th>Total Delayed Discharged</th>
<th>% Delayed Discharges</th>
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<tr>
<td>126</td>
<td>4</td>
<td>3.2%</td>
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Following inspection, we requested further up to date information from the trust on delayed discharges and length of stay.

Managers explained that as people admitted to Community Place were in effect an extended length of stay following an acute episode, they were already considered to be a delayed discharge from hospital on admission to the unit and this is usually the reason for admission to the unit. This had created difficulty in calculating delays specific to Community Place. However, weekly data
was collated identify how many guests on the unit, average length of stay and the reason the guests are waiting to be discharged home.

Managers told us this would allow the service to monitor where problems are arising with social care provision and capacity.

**Length of stay**

We reviewed data from the trust in relation to discharge and length of stay. From March 2017 to February 2018, 320 patients stayed at Community Place, with an average length of stay of 11 days.

Overall, 46% of people stayed on Community Place for seven days or less and 54% of people stayed for more than seven days. The greatest length of stay was 67 days. Data showed 12% of people stayed for more than 21 days.

Managers acknowledged estimated discharge dates were not always recorded on arrival, which limited the ability to identify patients staying longer than their estimated discharge date.

The patient information leaflet stated; ‘A provisional date to go home will be discussed within 24 hours of moving to the Community Place’. However, patient discharge questionnaire data showed only 37% of patients felt informed about how long they would stay on the unit before they arrived. 50% said they were not informed and 13% said they didn’t know.

During our inspection, there were 12 patients at Community Place at the time of our first visit. Four people had been on the unit for more than 6 weeks, including one patient with a learning disability, who had been on the unit for 12 weeks. We raised this as an immediate concern and managers took action to address this.

On our second visit, these patients had either been discharged or were discharged that week. Managers acknowledged that sufficient timely action had not been taken to escalate or prioritise action to address long stays.

**Transfer and readmission**

Information was not routinely collected relating to patients who had been transferred back to the acute hospital, although managers told us data had been reviewed in February 2018 and provided this information:

<table>
<thead>
<tr>
<th>No. of patients readmitted whilst on community place</th>
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<tbody>
<tr>
<td>Jan-17</td>
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<td>1</td>
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The above table indicates approximately two patients per month were readmitted to acute care at the hospital, from community place over the past 12 months.

Six patients were readmitted in October and 7 in November 2018, three as a result of the service review following an incident.

**Learning from complaints and concerns**

**Complaints**

Community Inpatient services did not receive any complaints from January 2017 to October 2017.

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

Information about how to make a comment about the service was included in the Community Place patient information leaflet. We saw trust leaflets on the unit with information about how to raise a concern with the trust patient advice and liaison service although no posters.
Complaints or compliments were directed to the team manager in the first instance who would decide whether to progress them through the trust or local authority procedures, depending on the nature of the complaint. All complaints were to be logged on the trust incident reporting system. Mangers confirmed no complaints had been logged.

Two families raised informal concerns with the inspection team, which were directed to the unit manager to respond.

The November 2017 review noted one informal complaint about staff attitude and behaviour. One informal complaint regarding potential poor care with regards to supporting a patient with dressing was discussed at a team meeting. One other example was given where an apology was given to a family following an informal complaint about person being discharged in their night clothes, which had been the patient’s choice.

**Compliments**

Community Inpatient services did not receive any compliments from November 2016 to October 2017.

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

Staff displayed thank you cards from patients and families on the ward. We saw positive comments about the service and staff in the comments book held at reception.
Is the service well-led?

Leadership

Community Place was based at the hospital and led by a social care manager, who reported to a senior nurse leader in the community division of the hospital trust. Shifts were led by band 4 care staff employed by the trust, with support from a registered nurse. Medical leadership was provided by a local GP practice.

The unit had experienced some initial management changes since opening in January 2017. The unit manager at the time of inspection was appointed in April 2017 and the senior nurse leader assumed responsibility for Community Place in July 2017.

Following an incident in November 2017, a service review identified that leadership of the unit was not clear within the shared care model and that governance and management arrangements did not function or interact effectively. It identified a need to strengthen operational management meetings with local authority and to put in place regular one to ones between managers and nursing staff.

During inspection, we found that the escalation process had been improved but the leadership model was confusing and accountability for clinical oversight was not clear. Managers told us the social care manager was responsible for all aspects of health and social care provided on the unit, an integrated model. Senior nursing staff told us the unit was run by care staff, not nurses. We found roles and responsibilities were not clearly implemented, for example in relation to developing care plans and accountability for ongoing patient care.

The November service review identified a number of previously unrecognised risks to the service, including that the management structure that was not working cohesively and there was clear route of escalation, for example, when the workforce model was not maintained.

We saw these risks were included on the community divisional risk register and an action plan was developed. This indicated that lines of accountability, links to the trust, systems for reporting and monitoring, joint working and routes for escalation had not been effectively established or embedded at the outset.

During inspection, staff gave positive examples of how they felt current managers had improved this and supported them e.g. to progress into band 4 roles, to access occupational health support and by introducing the e-rostering system in December 2017. Staff told us staffing had previously been poorly-managed. Staff told us uncertainty regarding the future of the unit as a pilot service had also impacted on retention of band 4 staff shift leaders.

On inspection, Managers shared the action plan developed following the November review. Nursing support had been increased. Staff told us escalation processes were now in place and they felt confident to use them. However, we found improvements had not been monitored or tested and some actions were not properly embedded or completed.

Following our inspection, the trust reviewed and changed the management model, to strengthen clinical leadership. A senior nurse was made responsible for leading the unit. The social work manager became responsible for discharge, patient flow and length of stay. Managers ensured a registered nurse was available daily, to support care staff. Staff contracts were extended.
Vision and strategy

Senior managers described the vision for Community Place as an innovative partnership model, designed to maximise people’s independence and reduce continuing dependency on care and support services.

The aim of the service was to prevent prolonged hospital stays and premature admissions to long term residential care, which supported the strategic goals shared by the trust and the local authority.

Managers had developed an action plan for Community Place following concerns highlighted from a serious incident in 2017. Managers explained the priorities identified within the plan formed the basis for the service strategy and current quality improvement work. The service had introduced a number of changes to improve integration with the trust, including; a revised workforce model; improved referral process and escalation routes. Work was ongoing and progress against delivering the action plan was monitored via the trust PSQB.

Staff we spoke with, were aware of the vision and ethos of Community Place as different from a hospital acute ward, with one describing it as ‘a bridge between hospital and home’.

However, we did not see information on the trust vision or service aims displayed on the unit. Some staff felt engaged with the vision but unsure of what was expected in terms of the level of support for patients and current service priorities.

Culture

Some staff spoke positively about working as part of an MDT team and gave examples of how they were supported e.g. by the manager to access occupational health support and by the community pharmacist to develop medicines management skills.

Some staff did not feel valued and felt the short-term nature of the service as a pilot was having a negative impact on staff morale, retention and continuity of care. Senior managers had a good understanding of these issues affecting staff morale.

Team meeting minutes indicated staff concerns, conflicts and team working were openly discussed and expectations of behaviour were articulated. We saw that staff were encouraged to take responsibility for their own development and training needs.

The majority of staff told us they felt able to raise any concerns with a manager. We saw that staff had been supported to report racial harassment from a patient.

Governance

Managers and senior nurses described the governance structure which linked Community Place to the trust. Although systems were in place, we were not assured they were fully effective or that action was taken to monitor and audit identified issues.

The unit manager held monthly meetings with care and nursing staff to discuss operational issues, including findings from audits, safeguarding and incidents. The community pharmacist, senior nurse and occupational therapists also contributed to team meetings. GPs were not involved in team meetings.

We reviewed three sets of minutes from team meetings. We found some incidents reported were not discussed and some incidents discussed were not reported. It was unclear how actions arising from the action plan developed following the incident in November 2017 were communicated with
unit staff. Managers told us team meetings had not always taken place regularly due to the unit manager covering a vacant position, in addition to their own.

The unit manager met with the senior nurse monthly and provided monthly assurance reports which included topics such as: risks, incidents, complex cases, staffing issues. The senior nurse prepared a dashboard report and attended the divisional patient safety and quality board (PSQB) and that in turn fed into the corporate governance committee and to the trust board. We saw that the board was notified of the work done to address risks identified following the November incident.

We reviewed three available manager assurance reports (September, October and January) and two dashboard reports and a board report. We found that some issues relating to patient outcomes or service delivery were not highlighted effectively to senior managers. The risks and concerns sections and the managing difficult cases sections were not completed in any of the three assurance reports. Neither the dashboard or the assurance reports identified when there were patients staying more than the intended seven days on the unit. Assurance reports were not completed in November or December, following the serious incident.

We reviewed minutes from three PSBQ meetings and noted that progress to address issues following the serious incident were reported here. We saw that a recent rise in the number of falls reported in the community division had been noted and senior managers attributed this to improved incident reporting on Community Place. However, during inspection, managers acknowledged that this also indicated that the service had previously missed opportunities for reporting and learning from incidents and that it was unclear whether this indicated more falls or better reporting.

The November review identified that processes for escalation were not always clear between the trust and the local authority. Processes had been strengthened and clarified following the November incident.

We reviewed examples of completed audits and the local audit plan for the unit and we found that some local audit processes were not fully effective. For example, the documentation audit did not check whether clinical risk assessments were in place for patients. Completion of clinical risk assessments was identified as a concern during our inspection and had previously been identified as an area of risk in the November review and as a factor in other incidents. Following inspection, information from the trust also indicated environmental audits were not completed to the required standard, so there was limited assurance that IPC issues had always been effectively monitored.

Processes were in place for risks and incidents to be escalated to the senior team and issues had been added to the divisional risk register as appropriate. A weekly 'orange panel' meeting was held to review any serious incidents that were reported.

Information from the trust indicated managers did not have sufficient oversight of overall staff progress against mandatory training requirements following the November review and had highlighted limited assurance about induction training. Training compliance levels at Community Place were not flagged as an area of limited assurance, at divisional governance meetings.

**Management of risk, issues and performance**

**Management of risk**

The trust community division held one risk register for all services. Service managers and senior nurses monitored the risks for their own areas and escalated risks for inclusion on the risk register, as appropriate. Senior managers reviewed risks every month at the divisional PSQB meeting.
We reviewed the divisional risk register. There was one specific risk for Community Place. This related to a lack of assurance that patients were in receipt of high quality care that was responsive to their needs and included issues around escalation, staff competencies and management structures. This had been identified following an incident in November 2017 and senior managers had added to the risk register in December 2017, following the incident investigation and service review in November.

Managers told us they were satisfied the service had made appropriate progress against the action plan, to address the identified risk, for example, escalation processes were now in place. Although senior managers had reduced the overall risk score, they explained the risk would remain on the register until they were assured changes in practice were embedded.

During inspection, we identified a number of risks which were similar to those identified following the incident investigation in November, for example; clinical risk assessments and care plans not being routinely completed for patients at risk of falls; staff not having sufficient skills and experience to respond to the needs of the patient group. These had not been identified within the providers monitoring or audit systems.

This indicated implementation had not been sufficiently effective or monitored and changes had not been sustained, to mitigate risks.

**Management of performance**

The November review had identified there was no clear measure of quality within the service and that the dashboard did not provide meaningful data.

During inspection, we found a similar position. Although the service aimed for a length of stay of seven days and a full holistic assessment to be completed with 24 hours of arrival, there were no specific targets were set for Community Place. Performance information was not routinely collected relating to referral, assessment and admission criteria or times.

Although a range of performance data was collected monthly, including patient experience data, as part of a monthly dashboard report for the service, it did not identify potential issues which could affect patient outcomes or service delivery. For example, although average length of stay and reasons for delayed discharges were recorded, long stays were not reported. This meant potential negative impacts on patients from long stays were not flagged and addressed.

Managers recognised further work was needed to use the performance data collected to demonstrate whether the service was delivering against its vision.

**Management of escalation and emergencies**

During inspection, we saw fire evacuation information was displayed. Mandatory training data showed 94% of staff had completed fire safety training.

Following inspection, we requested the fire evacuation plan for Community Place. We saw that the fire evacuation plan and evacuation strategy templates for this service area were blank. This indicated evacuation arrangements were not in place when the unit opened.

Following inspection, we requested the business continuity plan for Community Place.

We looked at the community division business continuity policy and saw that this recognised the trust and the division’s essential activities. The appendix relating to community place was dated March 2018. This indicated it had not been fully operational since the unit opened.

**Information management**

Mandatory training data showed 88% of staff had completed data security awareness training.
Records were stored securely in line with data protection procedures; preventing the risk of unauthorised access to patient information.

Community place used an electronic record system, in line with the rest of the community division and the trust’s digital strategy; however, paper records were also in use.

**Systems and access**

Staff used both paper and electronic systems for record keeping. This was confusing as information was held in both areas and there were some gaps and inconsistencies between paper and electronic records. For example, some paper notes said ‘refer to electronic record’. One patient’s paper notes did not record a fall. Managers told us all staff could access the electronic records, however bank staff and some substantive and MDT staff were unable to access the electronic records. On one occasion during inspection, only one of the care staff on shift were able to access the system.

The trust used a separate electronic patient record (EPR) which recorded patients’ care in the hospital prior to admission to Community Place. Care staff at community place were not able to access this system, although it was accessible to the registered nurse and therapy staff working on the unit.

Managers recognised there was an inherent risk in using two systems and we saw a single paper system was implemented during our second visit. At this time, we saw risk assessments were being added as needed, where they had not previously been completed, which included information transcribed from the electronic system and which were accessible to all staff working on the unit.

**Engagement**

We saw there was a comments book at the nursing station and patients and families were invited to MDT meetings. People were also invited to give their views and suggestions on the service using a patient feedback form, on the day of discharge. We saw some informal complaints were shared in team meetings, however there was limited evidence that patient feedback and suggestions were used to shape the service.

We saw structured monthly staff meetings were minuted. Agenda items included safeguarding and incidents, medicines management and record keeping. Meetings had not always taken place regularly, but we saw that agendas were standardised and minutes were shared with the team by email.

**Learning, continuous improvement and innovation**

Community Place was an innovative partnership model, designed to maximise people’s independence and reduce continuing dependency on care and support services.

Staff referred to people staying on the unit as ‘guests’ rather than patients, to distinguish it from a hospital acute ward and promote a culture of self-care and independence.

The service was developed as pilot, with funding identified until June 2018. Following the inspection the service was voluntarily closed by the trust and the three remaining patients were transferred to other wards within the trust.
Calderdale and Huddersfield NHS Foundation Trust is an integrated trust, which provides acute and community health services. The trust serves two populations; Greater Huddersfield which has a population of 248,000 people and Calderdale with a population of 205,300 people.

Calderdale Integrated Sexual Health service was established following a successful tender bid that the trust won in 2015. The service provides a fully integrated level three sexual health service to the population of Calderdale.

The service is based at Broad Street Plaza in Halifax. There are two satellite clinics based in Todmorden and Brighouse.

All services provide a ‘one stop shop’ for testing and treatment for genital infections and all methods of contraception.

The service at Broad Street Plaza also offers medically led human immunodeficiency virus (HIV) care. Additionally the trust works with both local pharmacies and GP practices to ensure contraceptive treatment is easily accessible and available seven days per week.

The service works with many partners, both voluntary and statutory, to provide a confidential treatment and educational service which aims to improve the sexual health of the local population regardless of gender or sexuality.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity and we inspected all key questions.

During the inspection, we visited all three locations. We spoke with 19 members of staff, including all grades of nursing, medical, administration staff and the senior leadership team. We also spoke with eight patients and their relatives. We observed care and treatment being provided. We reviewed 13 care records (including medical notes and nursing documentation) and we observed care being provided when patients gave consent.
Is the service safe?

Mandatory training

The trust set a target of 95% completion for selected modules of mandatory training. The overall training compliance rate for community sexual health was 85%.

A breakdown of compliance for mandatory courses from for medical/dental and nursing/health visiting staff groups are shown below:

Medical and dental staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTT Assessment</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Information Governance</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>CPR</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>NGT Elearning 2017</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95%</td>
</tr>
</tbody>
</table>

The two eligible medical and dental staff members achieved 100% completion for 14 out of 16 mandatory training modules. The NGT E-learning 2017 and moving and handling modules both had a 50% completion rate.

During the inspection, the trust provided us with more up to date training data.

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Data Security Awareness (IG)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>95%</td>
</tr>
</tbody>
</table>
The data indicates that the trust target was met for all but one of the modules, although it should be noted that for said module, only one member of staff had failed to complete the training.

Nursing and health visiting staff

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Use of Insulin v2.0</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>WDD Waste Management Training (Clinismart)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>CHFT Fire Safety 2017</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>ANTT Assessment</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>WDD - PREVENT Training</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>CPR</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>95%</td>
</tr>
<tr>
<td>YH Medicines Management Essentials</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td></td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td></td>
</tr>
<tr>
<td>Information Governance</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>95%</td>
</tr>
<tr>
<td>WDD Infection Control Level 2 - Beyond the Basics</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>CHFT Falls Prevention 2017</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>0</td>
<td>8</td>
<td>0.0%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Nursing and health visiting staff achieved a 100% completion rate for 10 mandatory training modules. The lowest scoring module was manual handling – people, with 0%.

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

During the inspection, the trust provided us with more up to date training data.

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Data Security Awareness (IG)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>95%</td>
</tr>
</tbody>
</table>

The data indicates that the trust target was met for all but one of the modules, although it should be noted that for said module, only one member of staff had failed to complete the training.
Nursing, medical and support staff we spoke with told us they felt up to date with mandatory training and that they were supported to attend training.

Staff told us that they received an email from the trust three months before training was next due to enable them to book on to upcoming training courses.

**Safeguarding**

**Safeguarding training**

The trust set a target of 95% completion for selected safeguarding training modules. The overall training compliance rate for community sexual health was 78%.

A breakdown of compliance for safeguarding courses from for medical/dental and nursing/health visiting staff is shown below:

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding in Athena CHFT</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

The two eligible medical and dental staff members both had 100% completion across the four safeguarding modules.

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

During the inspection, the trust provided us with more up to date safeguarding training data.

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGM</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children – Level 3</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults – Level 3</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Nursing and health visiting staff**

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>95%</td>
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</tbody>
</table>

Nursing and health visiting staff achieved 100% completion rate for three safeguarding modules; safeguarding level 2 failed to meet the trust’s 95% target by scoring 71.4%.
During the inspection, the trust provided us with more up to date safeguarding training data.

<table>
<thead>
<tr>
<th>Module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGM</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Adults – Level 3</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>95%</td>
</tr>
<tr>
<td>Safeguarding Children – Level 3</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>95%</td>
</tr>
</tbody>
</table>

All staff were required to meet the competencies as set out in the safeguarding children and young people: roles and competences for health care staff intercollegiate document (2014) and the adult safeguarding levels and competencies for healthcare professionals inter collegiate document (2014).

All staff we spoke with were able to describe their responsibilities in relation to safeguarding both adults and children, and were aware of the intercollegiate guidelines. It was evident this was an important part of their role. All staff were required to complete level 3 adults and children’s safeguarding training.

Staff were also provided with training to recognise and appropriately manage female genital mutilation (FGM) and child sexual exploitation (CSE). The trust had an identified FGM lead consultant who was available to support staff.

The table above indicates one member of nursing staff was out of date for safeguarding children level 3 training however, this had been completed in the past and we were provided with assurance of the individual’s competency and also saw evidence that this training was booked for this member of staff.

Two of the medical staff were out of date for Safeguarding Adults – Level 3 training, again we had no concerns about the competency of these staff members, who we met and spoke with, during the inspection. Again, this training was booked.

The service had robust safeguarding processes in place. All staff we spoke with were aware of and could detail the processes they would follow. A proforma was completed for all patients under 18 years old, who attended the service. This enabled staff to identify any safeguarding concerns for children and young people attending the clinics. We saw that these were fully completed in the care records we looked at for young people under 18 who had attended the clinic.

All vulnerable patients were added to a Calderdale matrix that was reviewed each week at a multi-disciplinary meeting. This was attended by relevant safeguarding personnel as well as representatives from the police, the youth offender’s team and a child exploitation social worker. The service manager, medical and nursing staff from the service also attended these meetings.

Attendance at these meetings formed part of the staff members safeguarding supervision and this was logged centrally to provide evidence of the number of hours each member of staff had completed in line with the intercollegiate standards. The service manager told us most staff achieved in excess of 40 hours documented supervision each year.

Vulnerable adults and children were also flagged on the electronic record keeping system used by the service.
The service also identified one or two named nurses for vulnerable adults and children so these people could liaise with a named person.

The trust had policies available to support staff and staff were able to access these on the trust intranet. The service had a safeguarding shared drive that all staff could access. Staff also told us they could access the trusts safeguarding team for support. A monthly meeting was held with the trusts safeguarding team.

**Cleanliness, infection control and hygiene**

All of the clinics we visited were visibly clean. Hand-washing facilities were available in all the clinics we visited. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available.

We observed staff using appropriate personal protective equipment when completing clinical tasks. They complied with hands bare below the elbows national best practice, correct handwashing technique and use of sanitising hand gels was observed.

We observed staff providing care and treatment and noted that staff used a non-touch aseptic technique when completing a procedure that required a sterile approach.

We looked at waste receptacles for sharps, for example those used for needles and those for other products, for example when intra uterine devices were removed and found these were used appropriately, they were signed in line with best practice and temporary closures were in place.

We saw a medicines fridge located in the dirty utility room at Broad Street Plaza clinic. We discussed this with the service manager who immediately arranged for the fridge to be relocated in an appropriate clean environment.

Frontline ownership (FLO) audits were completed each week by the service manager. We looked at the results of these from January to March 2018 and found that compliance was consistently above 95%. The non-compliance related to an area of flooring at the Broad Street Clinic that needed replacing.

**Environment and equipment**

The clinics we visited were clutter free and well maintained. Staff had access to the equipment needed to safely care for the patients attending the clinics.

We saw that most electrical equipment was safety tested and had been serviced or calibrated in line with manufacturers’ guidelines. Some electronic blood pressure machines had no evidence of servicing.

Equipment for the service was delivered to the main clinic at Broad Street Plaza clinic. Staff restocked the satellite clinics at Todmorden and Brighouse with the equipment they needed from the main clinic.

Each clinic had emergency resuscitation equipment. We looked at the checking records, found these were up to date, and had been completed daily.

On the first day of our visit, we noticed the doors to the clean and dirty utility were left open at the Broad Street Plaza clinic. These cupboards both contained items that should not be accessible to the public. We raised this as a concern and it was immediately rectified and communicated to staff.

We saw that substances that could be harmful to health were stored in a locked cupboard in line with best practice.
We looked at a random selection of 15 sterile single use items of equipment for example blood sample bottles, needles and syringes and found all items were in date.

Assessing and responding to patient risk

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. The service nurse manager was able to describe how NPSA’s were disseminated to the service and what their actions and responsibilities were following receipt of an NPSA.

Staff we spoke with were able to describe the procedures they would follow if a patient deteriorated. We were told in the event of an emergency staff would call emergency services; they had access to emergency equipment and were trained to provide basic life support. All medical and nursing staff were 100% compliant with cardiopulmonary resuscitation.

The service did not use a safety checklist prior to performing invasive procedures however; electronic guidelines were based on the world health organisation’s (WHO) five steps to safer surgery.

Staff used the Faculty of Sexual and Reproductive Healthcare (FSRH) UK Medical Eligibility Criteria for Contraceptive Use (UK MEC) guidance. The UK MEC helps clinicians decide what contraceptives they can safely recommend based on the medical conditions of patients in their care. This key guidance is informed by robust and up-to-date evidence on when contraceptives can and cannot be safely used.

Staffing

Total numbers – Planned vs Actual

As of 31 March 2017, the trust told us they had 6.79 WTE qualified nurses (nine whole number staff members) in post against a budget of 8.39 WTE qualified nurses.

(Source: Routine Provider Information Request (RPIR) Universal P16 – Total Staffing)

Vacancies

Medical staffing

From November 2016 to October 2017, the trust reported an overall vacancy rate of 1.6% for medical and dental staff in community sexual health services. The trust did not provide a vacancy rate target.

There were no medical vacancies within the service at the time of our inspection.

Nurse Staffing

From November 2016 to October 2017, the trust reported an overall vacancy rate of 25.5% for nursing and midwifery staff in community sexual health services. The trust did not provide a vacancy rate target.

(Source: Routine Provider Information Request (RPIR) Universal P17 – Vacancy)

We discussed staffing and vacancies with the service manager who told us there were no vacancies at the time of our inspection. One newly recruited member of staff was awaiting recruitment checks and a start date.
We had no concerns about the planned staffing levels for the clinics. Staff worked flexibly across all three clinics to meet the needs of the service.

Where possible staff worked in the clinics closest to where they lived. This helped to maintain services in the event of adverse weather.

**Turnover**

**Nurse Staffing**

From November 2016 to October 2017, the trust reported an overall turnover rate of 19.9% for nursing and health visiting staff in community sexual health. The trust did not provide a turnover rate target.

**Medical staffing**

From November 2016 to October 2017, the trust reported an overall turnover rate of 0% for medical and dental staff in community sexual health. The trust did not provide a turnover rate target.

*(Source: Routine Provider Information Request (RPIR) Universal P18 – Turnover)*

**Sickness**

**Nursing staffing**

From November 2016 to October 2017, the trust reported an overall sickness rate of 0.8% for nursing and health visiting staff in community sexual health, which was lower than the trust target of 4%.

**Medical staffing**

From November 2016 to October 2017, the trust reported an overall sickness rate of 0.3% for medical/dental staff in community sexual health, which was lower than the trust target of 4%.

*(Source: Routine Provider Information Request (RPIR) Universal P19 – Sickness)*

We discussed how clinics were covered in the event of sickness. The service manager advised that part time staff could be contacted to work extra hours, if necessary or they would cancel their management time. During our inspection there was staff sickness, we noted that the service was unaffected.

**Quality of records**

The service had recently moved from a paper based to an electronic record keeping system (IMS). The team had developed a service specific proforma. All staff were able to use the system and access was available at the main hub and the two satellite clinics.

We looked at 13 sets of electronic medical and nursing records and saw that the proforma was fully completed and included comprehensive record of the patients care. We observed that care was clearly and sensitively explained and followed a logical order. We noted that appropriate risk assessments were completed and where necessary patients were provided with advice and support to manage their condition.

Overall, we reviewed the records for 10 patients. We completed six comprehensive reviews and checked key assessments for a further four patients. We found that record keeping relating to risk was of a poor standard, risk assessments and care plans were not routinely in place and properly
completed. We found records were not completed in line with the Nursing and Midwifery Council (NMC) code of practice which requires nurses to: ‘Keep clear and accurate records relevant to your practice’ and; ‘Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.

The trust used a separate electronic paper record (EPR) which was also accessible to staff working in the sexual health service.

**Medicines**

The service maintained a supply of the most frequently used medicines for sexual health and contraception, based on national best practice guidance. This included anti-viral medication, contraceptive pills, pain relief and antibiotics.

These were able to be dispensed by nursing staff using patient group directions (PGD's). We looked at the PGD's for the service, found that these were appropriate, in date, and signed by the relevant practitioners. Staff had completed competency checks to allow them to supply and administer under the PGD's.

We checked that medicines were stored safely and securely and found no concerns in any of the clinics we visited. We also checked the medicine fridges and saw daily minimum and maximum temperature checks were completed.

**Safety performance**

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).

The service had not reported any never events from March 2017 to March 2018.

**Incident reporting, learning and improvement**

**Serious Incidents – STEIS – Community Children Services**

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents between November 2016 and October 2017.

Staff we spoke with were aware of the system and could tell us when they would report an incident. Some junior staff told us they would report an incident to the nurse in charge.

The service manager explained that they reviewed all reported incidents. The most commonly reported incidents were patients feeling unwell following a procedure such as insertion of an intra-uterine device.

The manager was able to provide details of the most recent moderate incident and outcomes following this. These included changes to practice that had been clearly communicated to the staff involved and to the rest of the team. We saw evidence of this in team meeting minutes, via an email sent to all staff and by implementing changes to the electronic paper records template for that procedure.

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 were able to describe their responsibilities in relation to the duty of candour. The service manager had a clear understanding of the duty of candour and this was evidenced in the moderate incident that had occurred.
**Is the service effective?**

**Evidence-based care and treatment**

Staff followed the British Association of Sexual Health and HIV (BASHH), the Faculty of Sexual and Reproductive Health (FSRH) and the British HIV Association (BHIVA) guidelines.

The services electronic record system provided staff with links to the nationally recognised best practice guidelines on the relevant website. For example guidance was available to support staff with which contraceptive pill would be recommended for each individual.

All staff we spoke with were aware of and could detail the guidelines they followed. A review of updated guidelines was a standard part of the agenda for team meetings.

Patient group directions (PGD’s) used within the service were in line with National Institute for Health and Care Excellence (NICE) medicines practice guideline [MPG2].

**Nutrition and hydration**

Staff in all clinics provided water for patients attending the service. There were no other facilities for patients to obtain food, snacks or drinks at the Broad Street Plaza clinic, however the clinic was based in Halifax town centre. We spoke with the service manager who provided a clear rationale for not providing these facilities in vending machines.

At the Brighouse clinic staff told us they provided tea and coffee for patients.

Complimentary tea and coffee was available in the waiting room at Todmorden Health Centre.

**Pain relief**

Staff were able to provide pain relief via PGD’s. Patients we spoke with told us that pain relief had been provided when they needed it.

**Patient outcomes**

**Audits – changes to working practices**

The trust has not provided any information on any audits they have undertaken as part of their clinical audit programme which relate to community sexual health services.

(Source: Routine Provider Information Request (RPIR) Universal P37 – Audits Clinical)

The service manager was able to demonstrate some of the local audits that were completed for the service. This included frontline ownership (FLO) infection control audits and record keeping audits that included a detailed review of safeguarding referrals.

The service submitted data to the sexual and reproductive health activity data set (SRHAD). The requirement to submit data came into effect on 1 April 2010. It consists of anonymised patient-level data submitted on an annual basis and was designed to provide a source of contraceptive and sexual health data for a range of uses from commissioning to national reporting.

The service also submitted data for the genitourinary medicine clinic activity data set (GUMCAD) The GUMCAD is the national surveillance of STIs and is an internationally unique dataset used to inform sexual health policy decisions and evaluate interventions.

The service was also submitting data to NHS England to support the work that was looking at the role that Pre Exposure Prophylaxis (PrEP) could play in preventing HIV in those at the highest risk. PrEP is a new way of using anti-retroviral drugs (ARVs), usually used for treating people with diagnosed HIV, to stop those at very highest risk from contracting the virus. Recent evidence had
shown that this approach can be highly effective in preventing HIV as long as the drugs are taken regularly. Evidence of effectiveness is strongest for men who have condomless sex with multiple male partners.

The service also submitted data to the office for national statistics to be used in the statistical bulletins for sexual health.

The service commissioners monitored key performance indicators and met with the service leads on a three monthly basis to review performance.

**Competent staff**

The trust met the FSRH standard which states all sexual and reproductive health services at Level 3, as specified in the National Strategy for Sexual Health and HIV1 for England and equivalent services in the rest of the UK, should be consultant-led and have one full-time consultant with current accreditation (including Membership of the Faculty of Sexual and Reproductive Healthcare (MFSRH)) per population of 125,000 to ensure adequate quality of service provision, training, clinical governance and risk management across all three levels of service provision.

All medical staff employed within the service were dual qualified in sexual and reproductive health. In addition, three of the medical staff were qualified to provide HIV care in line with NHS England guidelines.

**Appraisals**

From November 2016 to October 2017, all staff within community sexual health received an appraisal.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff required</th>
<th>Staff completed</th>
<th>Completion %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Universal P43 - Appraisals)

All nursing, medical and support staff we spoke with told us they had an up to date appraisal. Most staff told us they had received an induction programme when they joined the trust however some more recently recruited staff said they had not yet attended or completed an induction programme.

Nursing and medical staff met the minimum national requirement for working in sexual health services, as set out in the Faculty of Sexual and Reproductive Healthcare (FSRH) Standards 2016. Medical and Nursing staff were members of the FSRH and were able to access the most up to date guidelines via the FSRH website.

All of the medical staff and four nursing staff had completed the FSRH diploma. This equated to 100% of medical staff and 50% of the nursing staff. The FSRH diploma demonstrates that staff are qualified and competent to provide safe and effective sexual and reproductive health care in community, primary and secondary care settings.
Staff within the service completed the sexually transmitted infection foundation (STIF) education programme. This course provides multidisciplinary training in the knowledge, skills and attitudes, skills, required for the diagnosis, management and prevention of STIs. In addition, they also completed contraception and sexual health (CASH) training.

Newly recruited staff were required to complete a full range of competencies in line with the recommendations set out by the FSRH. This included the FSRH electronic knowledge assessment (EKA’s), completion of an e-portfolio, the ‘course of five’ that includes theoretical and practical competency assessment of key skills such as contraceptive implants, contraceptive pill dispensing and intra uterine device fitting etc., prior to completing the FSRH diploma.

The service employed a HIV specialist nurse and three of the medical staff were qualified to provide care to patients with HIV.

Health care assistants completed role specific competencies such as venepuncture and microscopy.

The service employed staff on apprentice roles. Staff we spoke with who were employed in this role told us they were supported by staff within the service and their assessors. They said they had received a local induction and information about the scope of their role.

**Multidisciplinary working and coordinated care pathways**

The service worked closely with a large number of external agencies to provide an integrated multidisciplinary level three sexual health service.

The service had close links with a Sexual Assault Referral Centre (SARC). These centres provide services to victims/survivors of rape or sexual assault.

The service worked closely with a local charitable organisation which worked to improve sexual health, reduce HIV transmission and provide support and advocacy for people living with HIV across Kirklees and Calderdale.

**Health promotion**

We saw from patient records that staff prioritised health promotion when seeing and treating patients.

Each clinic had information boards containing sexual health promotion information for patients. This included information about forced marriage support, child sexual exploitation, an emergency health clinic that was available on a Saturday morning, HIV testing and contraceptive advice.

The service also gave details of specialist services that were held in conjunction with the sexual health service for example details were displayed about a smoking cessation group.

We saw that the service was displaying information about ‘safetx’. This is a randomised controlled trial of an intervention delivered by mobile phone messaging to reduce sexually transmitted infections (STI) by increasing sexual health precaution behaviours in young people.

The service also displayed information about a substance recovery group, and drug and alcohol support groups that were available to support local people.

We saw information about chlamydia testing kits was displayed in all clinics. This included a text system for requesting a testing kit.

The service had a dedicated health promotion lead. This member of staff told us they offered a service to all local secondary schools. This included education of promoting healthy sexual
relationships. In addition, bespoke education was provided on an ad hoc basis. We were given an example of this being based on consent following an incident within a school.

In addition to the work within schools, the health promotion team also told us about the chlamydia screening service that was available. They also participated in a condom distribution scheme targeting men who have sex with men (MSM) and also going out with ‘street angels’. Street Angels provide care for those who may need support as a result of homelessness, intoxication, drug abuse, assault or any other issue which could cause personal distress or has the potential for physical harm.

The health promotion lead also told us about work that had targeted other groups, for example, sex workers, the over 40’s who might be embarking on a new relationships, women’s centres, children involved in sexual exploitation and women who had experienced domestic violence.

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

**Mental Capacity Act and Deprivation of Liberty training**

Between November 2016 and October 2016 both medical and dental staff and nursing and health visiting staff achieved 100% completion for MCA & DoLS level 3 training.

**WDD MCA & DoLS Level 3**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Medical and dental staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing and health visiting staff</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Staff were able to describe how they would assess a young person’s competence in line with national guidance, such as Fraser guidelines and Gillick competence. Gillick competence is used by healthcare professionals to determine whether a child aged under 16 years old can consent to medical care or treatment. Fraser guidelines are specifically used to determine whether a child should be given contraceptive or sexual health advice or treatment, without informing their parents.

We saw staff obtaining consent before providing any care or treatments.

**Is the service caring?**

**Compassionate care**

We received consistently positive feedback from everyone we spoke with. One patient told us they would give the service a score of 10 out of 10.
We spoke with another patient who told us they had used the service on at least three occasions and had always found the staff to be ‘lovely’. They described the staff as very friendly and always felt able to talk to them even when a difficult situation arose.

Patients told us they would recommend the service to their friends and family.

We saw that patient’s privacy was maintained with privacy screen within waiting rooms and also information slips, which allowed patients to identify their needs to staff by completing the advice slip, rather than having to verbally inform staff within the reception area.

We saw staff providing care and treatment in a non-judgmental and relaxed but professional, caring, calm and confident manner whilst ensuring that patient’s dignity was maintained and they were given the opportunity to ask questions.

**Emotional support**

Patients using the clinics told us staff respected their privacy and dignity and they felt their confidentiality was maintained.

Chaperones were routinely available for all patients.

Patients and their relatives told us staff supported them emotionally. All patients we spoke with told us they felt safe and well looked after.

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

We saw staff providing full detailed explanations about the care they were providing. We saw that support and explanations were also given to people accompanying patients where appropriate.

Patients told us staff explained everything to them and they were involved in discussions about their care. Relatives also said they were involved.

We saw ‘you said we did’ information displayed in the Broad Street Plaza clinic.

We were told that evaluation was requested following sexual health education sessions within schools. This data was used to shape the education provided based on the young people’s feedback.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The three main sexual health clinics were located across the local area to ensure local people had access to a clinic close to their home.

The service offered booked appointments as well as drop in clinics at all three sites. Appointments had been introduced following feedback from patients that waiting times were too long at drop in clinics.

We spoke with senior staff who told us the service was commissioned based on a national template. The service provided a fully integrated level three sexual health service. This included genito-urinary medicine, family planning (contraceptive) and HIV service. The service held a HIV support surgery each month.

Staff were able to provide a range of services at all sites including contraception and sexual health treatments, for example removal of genital warts. Blood specimens and other samples could be taken in these clinics and were transported to the acute trust laboratories via a courier service.
The service website offered and ‘ask the expert’ service. This was available through a secure NHS email system. One member of the team was designated to check and respond to any messages at least twice daily.

Free parking was available at Todmorden and Brighouse clinics. At Broad Street Plaza there was an adjacent pay and display car park. Broad Street Plaza was in the town.

We felt that the signs to the clinics at Todmorden and Brighouse could be improved. We noticed that directions to these clinics were not always clearly visible.

**Meeting the needs of people in vulnerable circumstances**

Staff told us they were able to access a rape crisis unit that was located in Dewsbury.

The trust employed a consultant who acted as the lead for female genital mutilation (FGM) concerns.

The staff within the service were knowledgeable and able to focus on the recognition and support of any women who were victims of female genital mutilation, children at risk of sexual exploitation and domestic abuse of both male and female patients.

They also participated in a condom distribution scheme targeting men who have sex with men (MSM) and also going out with ‘street angels’. Street Angels provide care for those who may need support as a result of homelessness, intoxication, drug abuse, assault or any other issue which could cause personal distress or has the potential for physical harm.

There was a specialist HIV nurse employed by the service. Where necessary this member of staff provided home visits to older people and those who could not access a clinic. They also visited patients when they were admitted to an acute hospital ward to provide advice and support to the patient and the staff on the ward.

We were told the staff constantly considered how they could reach vulnerable groups such as the travelling community, sex workers and people attending substance misuse support groups.

The service had developed a ‘clinic in a bag’ that enabled them to go out in to the community to reach many groups of people who might not routinely access sexual health care.

The service manager was able to detail their involvement, as a named key worker, in the care of a young person who was at risk of child sexual exploitation who had been supported through a multi-disciplinary approach.

We were also told how staff in the service had recognised, that a community group which was set up to support young mothers with mental health problems such as post-natal depression, was a group they could also help by attending the group meeting with the ‘clinic in a bag’.

The service had worked with substance misuse, domestic violence and probation services and held a drop in clinics for people from these groups.

The service had provided a full day clinic service for people with learning disabilities. In addition, the service had worked with commissioners to determine what else could be provided for this group of people. Staff within the service told us they would be happy to provide an outreach service to meet the needs of vulnerable people.

A nurse from the service visited a local school every other week that accommodated children who had been removed from mainstream school. This was to provide education on contraception, including condom demonstrations, safe sex and to provide signposting for drug and alcohol services for young people.
This visit also enabled young people to register for the c-card scheme. The c-card scheme is aimed at young people between 13-24 years old who can register to get a range of free condoms, femidoms, lube, dams, information and advice. The aim of the service is to promote reproductive and sexual health and help young people to access local services.

The service was working with partner agencies to provide a ‘no worries clinic’ for young people. This was being held in conjunction with a substance misuse service, an emotional wellbeing service and a young people’s mental health provider. The aim of the clinic was to provide a holistic emotional and physical wellbeing service to young people utilising expertise from within the local area to reduce the resource needed by providing an integrated service. Each service had produced assessment tools to enable all services to signpost to the most suitable service if necessary. Each clinic had access to a telephone is staff providing the services identified an immediate risk.

Microscopy was undertaken at the Broad Street Plaza clinic this meant patients could be provided with some test results immediately without these having to be sent to the acute trust laboratories.

Staff within the service were aware of the trusts translation and interpretation service. Staff we spoke with were aware that family members should not be used as interpreters.

**Access to the right care at the right time**

The service offered a walk-in and booked appointment system at all three clinics. Details about the times of clinics could be found on the trust website. Cards with clinic details were also held in the reception area of each clinic.

The walk-in service accounted for 57% of activity and booked clinics accounted for 39% of activity. The remaining 4% of activity was carried out in outreach clinics which were a combination of both appointment types. The average arrival to treatment time for booked clinics was 18 minutes during the 12 month period between April 2017 and March 2018. This was within the trust’s target wait time of 20 minutes. The average arrival to treatment time for walk-in patients was 26 minutes during this period. This was better than the FRSH recommended maximum waiting time of two hours for walk-in patients.

Patients who attended the clinic requesting a termination of pregnancy were advised they could self-refer to the acute trust. If young people under 16 years old and appointment was made on their behalf.

Referrals could be made by the patients themselves or from any other appropriate service, for example GP’s.

Appointments with consultants were available on a booked appointment basis. The service manager told us these appointments could usually be arranged within 48 hours of a request.

There were two targets in relation to initial enquiry to appointment for contraceptive treatment or implants; the British Association for Sexual Health and HIV (BASHH) requirement to see 80% of service users within 48 hours of request and the local commissioners target of seeing 85% of patients within 48 hours of request. The service reported that 99.1% of patients were offered an appointment within 48 hours of accessing the service and 97.6% were seen within 48 hours of accessing the service during the past 12 months (April 17 – March 18). This meant the service had consistently exceeded both BASHH and local commissioner standards.

The service had 8,005 new appointments and 3,345 follow up appointments during the period between April 2017 and March 2018. This equated to a new to follow up rate of approximately 0.42 follow up patients for each new patient seen by the service.
The service has an electronic recall system which was reviewed daily by a designated member of staff. This identified patients that had a treatment plan requiring a text reminder or follow up phone call as part of their treatment. This system was also used to monitor patients that did not attend (DNA) their appointments, including vulnerable patients (such as those under 16 years old). The DNA rate for patients within the community sexual health service was 4.49% during the past 12 months.

The service reported that all patients with positive infections were contacted by the Health Advisor who arranged appointment for treatment. Following treatment, all patients were given a further compliance call within 7 days to check they have complied with treatment.

The service previously routinely checked intrauterine device (IUD) / intrauterine system (IUS) patients six weeks following insertion of implant. Recent guidance from the FRSH indicated that patients should now only be rechecked if any concerns or anticipated problems were identified.

Patients that had undergone an implant procedure were risk assessed and recalled for follow up as required. This included those patients where any potential safeguarding issues were identified.

The service reported that all patients were provided with verbal and written information following IUD / IUS procedures. This included the relevant follow up information and included contact details to reschedule an appointment if required.

Learning from complaints and concerns

Complaints

Community sexual health services did not receive any complaints from November 2016 to October 2017.

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

We saw posters displayed in clinic advising patients about how to raise a concern with the trusts patient advice and liaison service.

Patients we spoke with told us they would feel comfortable raising any concerns they had about their care and treatment.

Is the service well-led?

Leadership

We felt that leadership of the service was positive. The sexual health service had a clear clinical and operational leadership team structure.

Staff told us the service manager was visible, approachable and supportive. One member of staff said the manager was ‘brilliant’ and they were supported with training needs.

During our inspection the service manager showed us a number of electronic resources they held to ensure they maintained high-level oversight. This included staffs completion of role specific training and competencies, mandatory training and safeguarding supervision.

The service manager told us they aimed to lead by example and ensure the service was not hierarchical.

Vision and strategy

Some staff we spoke to were not aware of the trust visions and values and we did not see these displayed in all areas we visited.
We saw that the service had developed a mission statement that was displayed at the Broad Street Plaza Clinic.

Staff told us the vision of the service was to provide a truly integrated level three service and to ensure they worked with partner agencies to raise awareness with vulnerable and hard to reach groups in the local community.

We looked at the documented 2016 to 2019 strategy for the service. This showed that the service aimed to provide one of the few truly integrated sexual health services in the country. The vision and strategy was based on a proven track record and extensive local knowledge. The overarching aim was to reduce the need for clinic activity by improving sexual health outcomes and reducing sexual health inequalities year on year.

**Culture**

During our inspection, we found staff were open and honest. All staff reported a positive culture in the service and they spoke about good team working.

All staff we spoke with told us they felt confident to approach their line manager if they were unhappy about something.

Staff talked about being part of a great team who all wanted to provide high quality care for patients.

Staff we spoke with were proud of the service they provided. They spoke positively about their colleagues, acknowledged the skills of their colleagues and recognised that this meant they were able to provide a truly integrated level three service for the local population.

**Governance**

We were assured there were robust governance processes within the service that included all risks and patients incidents being reported and reviewed by the service manager.

Where necessary risks and incidents were escalated to the senior team and if appropriate added to the service risk register. A weekly ‘orange’ meeting was held to review any serious incidents that were reported.

The service manager attended the divisional governance meeting that in turn fed in to the corporate governance committee.

The service manager also attended the divisional patient safety and quality board (PSQB).

**Management of risk, issues and performance**

The service manager was aware of the risks to the service. We were told the team had highlighted that their electronic record system did not communicate with the trusts pathology system therefore test results were added to the patient record manually. It was recognised there was a risk that information could be added to the wrong patient record, therefore this was escalated to the risk register and work was ongoing to establish if the systems could be linked to mitigate the risk. We saw that this was specified on the risk register for the service.

Staff we spoke with were aware of their responsibilities in the event of a potential or actual disruption to the service. Staff had recently experienced difficulties due to adverse weather conditions. When this happened staff walked to their nearest base and provided services from there. We were told in the event of a major incident staff from the service would be redeployed to the acute areas to provide support.
We looked at the business continuity plans in which the service was included and saw that this recognised the trust and the division’s essential activities. The loss of services, for example loss of ICT, staff or premises were identified, activities were risk assessed and tactical options were identified.

The service manager told us weekly confirm and challenge meetings were held to monitor risks, issues and performance. We were told this was a two way process which give the senior team oversight of the service including for example mandatory training compliance. The process also allowed the service lead to challenge the senior team if they felt the service was not being supported to improve performance for example if training was not available.

Information management

Information provided by the trust showed overall compliance for information governance training for all staff was 100%. We did not have any concerns about the security of patients’ records or confidentiality at this inspection.

If any correspondence contained confidential or patient identifiable information staff used a secure NHS email service and not the trusts email system.

Computers were available in all of the clinics; staff were able to access policies and clinical guidelines via the trusts intranet or the internet.

The trust had electronic systems in place for staff to request clinical tests for patients, for example blood screening.

Engagement

The service had engaged patients in how the service was provided. This included using a ‘you said we did’ feedback mechanism. This had resulted in more booked appointments when patient’s feedback that drop in clinic waiting times were too long.

The service had a website for service users. Details of this were displayed in the clinics we visited. We had some concerns with some of the content of the website, including the information provided. We raised this when we met with the senior team who told us they would address these concerns.

The service also used social media to promote the services provided.

We saw information about routine fire alarm tests were displayed in all of the clinics we visited.

Learning, continuous improvement and innovation

The service had developed a ‘clinic in a bag’ initiative to enable them to go out in to the community and support vulnerable, sometimes hard to reach people.

The service was constantly considering ways to reach out to vulnerable groups within the local area. Consideration had been given to an extensive range of people including young people, those at risk of and the victims of CSE, asylum seekers, immigrants, transient communities, sex workers and also the homeless. In addition, the service had forged positive working relationships with schools, substance misuse, domestic violence and other community groups.

The service had themed events that were promoted through advertising and social media, for example, they were advertising ‘Get festival ready’ and ‘spring screen’ at the time of our inspection. They had previously visited local pubs on the Friday before Christmas dressed as ‘sexual elves’ to promote the service and to distribute condoms.
The service website offered and ‘ask the expert’ service. This was available through a secure NHS email system. One member of the team was designated to check and respond to any messages at least twice daily.

We information was displayed about ‘safetxt’. This is a randomised controlled trial of an intervention delivered by mobile phone messaging to reduce sexually transmitted infections (STI) by increasing sexual health precaution behaviours in young people.

The service lead was planning to increase the audit activity to enable the service to produce measurable patient outcomes and improve services based on service user’s needs. This included auditing the treatment of patients with gonorrhoea, hepatitis B and MSM patients.

The service needed to revert to a paper based system when providing any outreach service. We were told it would improve the service if they were provided with a device to enable them to access the electronic patient record system.

One member of staff told us they felt it would be beneficial if they were able to provide a psychosexual service.