

James Paget University Hospitals NHS Foundation
Trust

James Paget Hospital

Quality Report

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Date of inspection visit: 16th and 17th August 2016
Date of publication: 20/12/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Good 

Medical care (including older people's care)

Good 

Surgery

Good 

Maternity and gynaecology

Good 

Services for children and young people

Good 

End of life care

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

The James Paget University Hospitals NHS Foundation is a university hospital providing the care to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia. The main trust site is in Gorleston and is supported by services at Lowestoft Hospital, the Newberry Clinic and other outreach clinics in the local area.

The James Paget Hospital officially opened on 21 July 1982, was established as a third wave NHS Trust in 1 April 1993 and became a Foundation Trust on 1st August 2006.

The trust has 458 inpatient beds and 26 day case beds located on the James Paget University Hospital. The trust provides critical, intensive and high dependency care, general and orthopaedic surgery and medicine, maternity, paediatrics and neonatal services.

In August 2015 James Paget University Hospitals NHS Foundation Trust was inspected under our comprehensive inspection programme and rated as good overall. However, the safe key question was rated as requires improvement because medical care, surgery, maternity and gynaecology, children and young people and end of life care were all rated as requiring improvement in this area. End of life care was also rated as requires improvement under the effective and well led key questions with surgery also being rated as requires improvement under the responsive key question.

We therefore carried out a focused inspection between 16 and 17 August 2016 to review the areas which were rated as requires improvement at our inspection in August 2015.

We found that improvements had been made in safety across children and young people, maternity services and surgery. Although medical services had improved in areas which were found to be unsafe in August 2015, during this inspection we found that areas were not being staffed with sufficient numbers of staff. This meant the services rating for safe remained as requires improvement.

We undertook a full review of end of life services and surgery services due to there being more than one area of requires improvement following our previous inspection. End of life services demonstrated improvements which meant their overall rating changed from requires improvement to good with all but the safe key question achieving a good rating. Safe had not improved enough to achieve a revised rating.

Surgery services had also demonstrated improvement enough to receive a revised rating of good. All key questions received a good rating.

Our key findings were as follows:

- There was a culture of reporting and learning from incidents. We found that staff were aware of their responsibilities in relation to reporting incidents, managers undertook incident analyses and investigations to determine any areas of improvement and staff were provided with feedback.
- All staff we spoke with regards to duty of candour correctly understood this to be the 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 were provided examples of this working in practice which included patients being contacted when there had been a serious incident in relation to the care or treatment provided to them.
- There were effective safeguarding procedures in place for both adults and children. Staff had received appropriate training, there were clear examples on interagency working and lessons were shared to ensure people were safeguarded when they used services at this hospital.

Summary of findings

- Improvements had been made to the checking of equipment. We found that relevant checks had been undertaken and documented. This meant the provider had complied with a requirement notice issued following our last inspection under regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
- Improvements had been made within children and young peoples' services to ensure that patients having a mental health crisis were appropriately assessed to ensure their needs could be met.
- A new children's outpatient department had been opened. Following concerns about infection control raised at our last inspection this department had been moved from next to the antenatal clinic meaning that pregnant women attending antenatal appointments were not exposed to children with potentially infectious conditions, such as chickenpox.
- A new end of life care strategy had been developed which outlined the five priorities of end of life care as determined by the Leadership Alliance for Care of Dying People. Each priority had trust actions, these were realistic and some had already been implemented, such as providing additional training to staff. These priorities also aligned to the trusts own visions and values.
- A non-executive director had also been appointed to oversee and provide advice on the delivery of end of life services in line with Department of Health guidance.
- Medical care services had implemented a new care pathway for older people. This pathway allowed staff to monitor the care and treatment being received by older people across the hospital.
- The trust had opened an emergency theatre in line with national guidance, which meant that emergency surgery did not impact upon surgical patient lists. There had been an improvement in referral to treatment times and the hospital was looking at increasing the services it provided as day case surgery.
- However, we had concerns with staffing levels and training completion within medical services. There were not enough nursing staff employed to meet planned shift ratios. For example, for the period May to July 2016 the nurse fill rate for day shifts on ward 16 averaged 64.75% and the short stay medical unit filled an average of 79.32%. We also found that only 77% of medical grade staff had completed their mandatory training.
- In children and young people's services only 68% of staff had completed paediatric intermediate life support training against a target of 95%. We did however note dates had been booked to provide this training to those staff which required it.
- We found that staff were shared between the neonatal unit and paediatric department in periods of high demand or short staff. However, the service could not confirm this sharing of staff to ensure safe staffing was maintained because records were not kept.
- In maternity services the birth to midwife ratio was not consistently being met however, 18 new midwives had been appointed to improve this.
- The palliative care team was also understaffed and were not commissioned to provide a seven day service. Nursing and medical staffing for palliative care did not meet national recommendations.
- Across services we found that medicine management procedures were not being appropriately monitored. We saw medicines in stock which had passed their use by dates, the signing of prescription charts was inconsistent and often illegible and fridge temperature monitoring was poor.

We saw areas of outstanding practice including:

- Staff within end of life services going above and beyond to show compassion to the patients they were caring for in the last days and weeks of life. We heard of occasions where staff had facilitated and contributed to helping people fulfil their last wishes such as seeing their pets or being supported to take trips.
- The deep sedation list for patients for whom endoscopy procedures may be traumatic such as those who have mental health issues or learning disabilities.

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

The trust should also:

Summary of findings

- Review its registered nurse staffing across the emergency and medical divisions to ensure sufficient numbers of registered nurses are on duty to ensure the delivery of safe care.
- Review medical and dental staff participation in mandatory training and increase compliance with required training.
- Ensure all staff have the appropriate up to date paediatric and or neonatal life support training.
- Consider reviewing their medicines management practice to ensure medications are appropriately stock checked so that out of date medicines are disposed of and action is taken when fridge temperatures are recorded outside of accepted ranges.
- Consider reviewing prescription recording to ensure that signatures on prescription charts are legible.
- Consider improving the recording of shared staffing across ward 10 and the neonatal unit to prove safe staffing standards are maintained.
- Consider reviewing infection control arrangements within the children and young people's service to ensure effective hand hygiene and equipment cleaning.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care (including older people's care)

Rating

Good



Why have we given this rating?

Overall the medical care service has received a rating of good. In August 2015 the effective, caring, responsive and well-led key questions were all rated as good. We returned to the hospital to undertake a focused inspection of the safe key question only as in August 2015 safety was rated as requires improvement. Our inspection findings from August 2016 demonstrated that although key improvements had been made, there were other concerns highlighted which meant the rating of requires improvement for safety remained. This was because:

Registered nurse staffing across medical wards was a concern, with one ward filling an average of 64% of its registered nurse shifts in May, June and July 2016. This was worse than the previous inspection in August 2015 when the lowest fill rate was 74% for any medical ward. We also found that only 77% of medical staff had completed their mandatory training.

During the August 2015 inspection, medication was stored appropriately however, during the current inspection, we found medication that had not been stored appropriately.

However:

Staff knew how to report safety incidents and gave examples of incidents that should be reported. Ward managers investigated safety incidents and did root cause analyses.

Staff complied with infection control practices, including using personal protective equipment and washing their hands. We checked 17 pieces of equipment and all were within their service dates.

Staff checked medication fridge temperatures daily. We saw records of daily checks and actions taken if the fridge temperatures exceeded the recommended range. This practice ensured medicines were not damaged by being stored at too high or too low a temperature. Medical and nursing staff kept detailed records and updated them regularly. Nurses assessed risks to patients and took appropriate actions to reduce or remove the risks.

The trust had implemented a frail elderly pathway and could monitor the location and progression of all frail elderly patients across the trust.

Summary of findings

Surgery

Good



We undertook a full review of surgery services which has been rated as good overall. All key questions achieved a rating of good which was an improvement from our August 2015 inspection. Both safety and responsiveness had improved from requires improvement to good. Surgery services were rated as good overall because: The environment was clean, tidy and areas of concern identified at our last inspection had been addressed. We reviewed five sets of notes and found that documentation was complete and accurate. Staff reported patient safety incidents and there were clear examples of lessons learnt. Completion of the surgical safety checklist was embedded in practice. Evidence based care and treatment was in place throughout the division and national audit data showed the trust to be similar to the national average. There was good multidisciplinary working and staff applied the Mental Capacity Act correctly. Pain relief was administered in a way best suited to patients need. The friends and family test (FFT) for the surgical wards was very positive, with high percentages of patients saying they would recommend the ward they were received care on. We observed examples of kind, compassionate and respectful care during the inspection. 'Dementia radio' was used on a ward with elderly patients, to provide familiar music and aid anxiousness. A new day surgery unit had opened in August 2015 which allowed patients to be treated without requiring them to stay in hospital. The trust had opened an emergency theatre in line with national guidance, which meant that emergency surgery did not impact upon surgical patient lists. There was good evidence of learning from complaints and concerns. However: Some patients reported frustration with internal and external communication and whilst staff said they had a good relationship with the executive team and felt listened to, they felt concerns were not always acted upon. An area identified for improvement within the August 2015 comprehensive inspection report was for a review of awareness of the risk register. Our August 2016 inspection findings showed staff's concerns were not reflective of high grade risks on the divisional risk register.

Summary of findings

Maternity and gynaecology

Good



Overall maternity and gynaecology service were rated as good. In August 2015 the effective, caring, responsive and well-led key questions were all rated as good. We returned to the hospital to undertake a focused inspection of the safe key question only as in August 2015 safety was rated as requires improvement. Our findings at this inspection demonstrated that improvement had been made and the safe key question was rated as good. This was because:

Managers had moved the paediatric clinic away from the antenatal clinic in response to concerns about infection control raised at our last inspection. This meant that pregnant women attending antenatal appointments were not exposed to children with potentially infectious conditions, such as chickenpox.

Staff consistently completed safety checks for emergency equipment in the maternity and gynaecology services and medicines were stored securely across the maternity and gynaecology services. All clinical areas and equipment we saw were visibly clean and managers had responded to midwifery staffing shortages and had recruited 18 midwives to start work from June to September 2016.

However:

We found three medications that were out of date on the maternity ward. This meant that the efficacy of these medications could not be assured if they were given to women.

The midwife to birth ratio was consistently higher than the ratio of 1:29 recommended by the Birthrate plus staffing tool. However, senior staff had recruited 18 new midwives due to start work from June to September 2016 in order to improve this.

There were no processes in place for gynaecology services to monitor safety outcomes for patients and staff signatures on prescription charts were not always legible. The provider took action to mitigate this by introducing electronic prescribing shortly after our inspection. The safety checklist for the resuscitation trolley on the maternity ward was not easy to read. This meant that there was a risk of staff not documenting safety checks accurately.

Services for children and young people

Good



Overall children and young people's services were rated as good. In August 2015 the effective, caring, responsive and well-led key questions were all rated as good. We returned to the hospital to undertake a focused

Summary of findings

inspection of the safe key question only as in August 2015 safety was rated as requires improvement. Our findings at this inspection demonstrated that improvement had been made and the safe key question was rated as good. This was because:

The trust has made significant changes to the children's outpatient service, which now has a new dedicated children and young people's outpatient clinic, no longer sharing space with the maternity service.

The trust has developed a standard operating procedure (SOP) to ensure a senior (band 6 or above) paediatric nurse was available at all times via a rota as per Royal College of Nursing best practice guidance (2013) in relation to nurse staffing levels for children's and young people's services.

Resuscitation equipment was checked and recorded daily, with full checks undertaken weekly as per trust policy. There was also a new children and young person flowchart to risk assess those with mental health crises needing a place of safety and safeguarding training had improved with all but one staff trained to level three.

However:

The paediatric immediate life support refresher training was below trust requirements but we did see evidence of booked dates to rectify this.

Ward 10 and the NNU had not produced regular data for the hand hygiene and personal protection equipment audit. Medicines were not stored appropriately on the NNU with poor management of medicine fridge temperatures and out of date medicine in drug cupboards.

End of life care

Good



We undertook a full review of end of life care which was rated good overall. The safe key question was rated as requires improvement which had not improved from our previous inspection in August 2015 but the effective and well-led key questions had improved from requires improvement to good and responsive remained as good. Caring was rated as outstanding. This was because: Staff were proud of the service they provided and patients gave high praise of the caring support they received. We saw examples of the hospital's teams going beyond their normal duties to be compassionate and supportive and Staff took into account personal preferences to provide outstanding personalised care. The mortuary and chaplaincy had well embedded procedures to go the extra step to provide person

Summary of findings

centred care and offered a 24 hour service. The hospital had access to the Louise Hamilton centre which provided support and resources to cancer and palliative patients.

There was an improvement in the percentage of patients receiving individualised care and this was above the England average. The hospital provided a fast track discharge and in 2015 73% patients wishing to die at home were discharged. There was a much more unified care plan for dying patients and this was well-referenced and accessible to staff

There was now an end of life care strategy for end of life services that reflected the trusts vision and values. The leadership structure was clear and following recommendations there was now a clinical lead and a non-executive director for end of life care and we found board level staff to have an understanding of the service and the areas of concern and risk.

However:

The palliative care team were understaffed and were not commissioned to provide a seven day nursing service.

Ward staff had difficulty accessing all palliative care records as a different computer system was used.

The service had implemented new Clinically Agreed Plans (CAPs) to replace the previously used Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. However, key areas of CAPs were not understood by front line staff and internal audits in March 2016 found that they were not always completed. Re-audit in late summer 2016 had shown improvement in the completion of the CAP.

James Paget Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people; End of life care.

Detailed findings

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Background to James Paget Hospital

The James Paget University Hospitals NHS Foundation is a university hospital providing the care to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia. The main trust site is in Gorleston and is supported by services at Lowestoft Hospital, the Newberry Clinic and other outreach clinics in the local area.

The James Paget Hospital officially opened on 21 July 1982, was established as a third wave NHS Trust in 1 April 1993 and became a Foundation Trust on 1st August 2006.

The Trust employs 3,000 staff, making it the largest local employer in the area. As a University Hospital, the Trust trains over one third of the medical students from the University of East Anglia.

The health of people in Great Yarmouth is varied compared with the England average. Deprivation is higher than average and about 24.9% (4,400) children live in poverty. Life expectancy for both men and women is lower than the England average. The health of people in Waveney is varied compared with the England average. Deprivation is lower than average, however about 21.8% (4,300) children live in poverty. Life expectancy for both men and women is similar to the England average

We inspected in August 2015 as part of our ongoing programme of comprehensive inspections to rate all services at the trust.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included one CQC Inspection Manager and six CQC Inspectors including a IR(ME)R specialist and a variety of specialist advisors including a medical doctor, a surgeon, an end of life care doctor, an end of life care nurse and a theatre nurse.

How we carried out this inspection

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

- Is it safe?

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

Detailed findings

The inspection took place between 16 and 17 August 2016.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); NHS Improvement; NHS England; Health Education England (HEE); and the local Healthwatch.

We carried out an announced inspection visit between 16 and 17 August 2016. We spoke with a range of staff in the

hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists and radiographers. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at James Paget Hospital.

Facts and data about James Paget Hospital

Beds 484

- 456 inpatient beds
- 26 day case beds

Staff: 2,508 WTE (April 2015)

- 274 Medical
- 800 Nursing
- 1,434 Other

Revenue £181,271

Activity summary 2014/15

Inpatient Admissions: 23,896

Day case admissions: 33,849

Outpatient attendances: 272,745

A&E attendances: 71,400

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	N/A	N/A	N/A	N/A	Good
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	N/A	N/A	N/A	N/A	Good
Services for children and young people	Good	N/A	N/A	N/A	N/A	Good
End of life care	Requires improvement	Good	 Outstanding	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Medical care (including older people's care)

Safe

Requires improvement



Overall

Good



Information about the service

The medical care services at James Paget Hospital covered a wide range of specialities, including acute medicine, respiratory medicine, cardiology, gastroenterology and haematology. Medical care services also included a discharge lounge.

James Paget Hospital admitted 21,585 medical admissions between January 2015 and December 2015, of which around 45% were emergency admissions, 5% were elective and 50% were day cases. There were 241 medical beds.

We spoke with six patients and 26 staff, including doctors, nurses, healthcare assistants, pharmacists and administration staff. We interviewed the medical and surgical clinical leads for endoscopy and interviewed the clinical directors for the emergency division and the deputy director of nursing.

We visited nine clinical areas during the inspection including the emergency admissions and discharge unit, oncology unit, stroke unit, the short stay medical unit, the acute cardiac unit, the coronary care unit, ward 6, ward 15 and ward 16. We reviewed 18 patient records (including nursing and medical documentation) and checked 17 pieces of medical equipment. We reviewed hospital policies and guidance, and reviewed minutes from meetings, staff rosters, incident investigations and audit data to enable us to reach a fair and accurate rating.

Summary of findings

Overall the medical care service has received a rating of good. In August 2015 the effective, caring, responsive and well-led key questions were all rated as good. We returned to the hospital to undertake a focused inspection of the safe key question only as in August 2015 safety was rated as requires improvement. Our inspection findings from August 2016 demonstrated that although key improvements had been made, there were other concerns highlighted which meant the rating of requires improvement for safety remained. This was because:

- Registered nurse staffing across medical wards was a concern, with one ward filling an average of 64% of its registered nurse shifts in May, June and July 2016. This was worse than the previous inspection in August 2015 when the lowest fill rate was 74% for any medical ward.
- Only 77% of medical staff had completed their mandatory training.
- During the August 2015 inspection, medication was stored appropriately. During the current inspection, we found medication that had not been stored appropriately.
- During the August 2015 inspection, the trust had struggled to recruit a specialist care of the elderly consultant. During the current inspection, we found the trust had continued to be unable to recruit into the role.

However:

- Mandatory training rates amongst ward nursing staff had improved compared to the previous inspection in August 2015.
- During the previous inspection in August 2015, we found intravenous fluids being stored in temperatures that exceeded 25 degrees centigrade. During this inspection, we found intravenous fluids stored in rooms with in range temperatures.

Medical care (including older people's care)

- Staff continued to report incidents and we found shared learning following incidents. This was in line with the findings of the previous inspection in August 2015.

Are medical care services safe?

Requires improvement



We rated safe as requires improvement because:

- Medical staff compliance with mandatory training was 77%, against a trust target of 95%.
- Registered nurse staffing across medical wards was a concern, with one ward filling an average of 64% of its registered nurse day shifts in May, June and July 2016. Registered nurse night shift fill rates for May, June and July 2016 were 89%, with one ward filling an average of 73% of its registered nurse night shifts.
- Senior matrons assessed staffing throughout the day; however, the divisional management team told us they were not aware of the staffing concerns, particularly on ward 16 on the day of our inspection. This showed a lack of oversight of staffing across medical wards.
- Patients told us that staff took a long time to answer nurse call buzzers, especially at night. This could result in delays for patients receiving pain relief, being able to use the toilet or accessing help in an emergency.

However:

- Staff knew how to report safety incidents and gave examples of incidents that should be reported.
- Ward managers investigated safety incidents and did root cause analyses. The deputy director of nursing further investigated unusual incidents or those causing concern.
- Staff complied with infection control practices, including using personal protective equipment and washing their hands.
- We checked 17 pieces of equipment and all were within their service dates.
- Staff checked medication fridge temperatures daily. We saw records of daily checks and actions taken if the fridge temperatures exceeded the recommended range. This practice ensured medicines were not damaged by being stored at too high or too low a temperature.
- Medical and nursing staff kept detailed records and updated them regularly. Nurses assessed risks to patients and took appropriate actions to reduce or remove the risks.

Medical care (including older people's care)

- Mandatory training compliance amongst nursing staff was good. Nine of the 10 medical wards achieved 91% or above for mandatory training compliance amongst nursing staff.
- The trust had implemented a frail elderly pathway and could monitor the location and progression of all frail elderly patients across the trust.

Incidents

- The trust reported 30 serious incidents between June 2015 and May 2016 within medical care, including older people's care. These included 20 pressure ulcer incidents, eight slips, trips and falls, one delay in treatment and one infection control incident.
- The trust reported no never events between June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff reported safety incidents on an electronic reporting system. They were aware of how to report incidents and what should be reported as an incident. We reviewed governance meeting minutes from the emergency admissions and discharge unit (November 2015 and May 2016), respiratory (March and May 2016) and stroke (March 2016). All governance meeting minutes discussed relevant serious incidents and actions to take. We were told that staff got feedback following an incident and learning points were shared at team meetings, shift handovers and through emails from ward managers.
- Ward managers did a root cause analysis following a serious incident. Ward 15 had a folder containing information on root cause analyses of safety incidents and learning points for staff to use.
- Staff held mortality and morbidity meetings monthly. They kept detailed minutes and included learning points for each case discussed. Managers shared learning with staff through individual feedback to staff involved, emails and regular newsletters.
- Senior matrons and the deputy director of nursing undertook "deep dive" investigations where an increase in incidents had been identified or additional concerns had been raised. The trust supplied information regarding a deep dive into falls from April 2015 to March 2016. The deep dive found 7% of falls occurred during

morning or evening handover times when less staff were available in ward areas. The deep dive found that 60% of these falls were categorised as "found on floor".

Senior sisters were informed at their monthly key performance indicator meetings and shared the results with ward staff. As a result, staff not involved in hand over must remain within bays to supervise patients and maintain safety. A member of staff must be able to see each bay of patients throughout the night to further reduce the risk of patients falling.

- Staff had a good understanding of duty of candour and could provide appropriate examples of when it might apply. Staff on ward 16, ward 15 and the short-stay medical unit provided examples within the last two months where duty of candour had been applied. 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.

Safety thermometer

- The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring and analysing harm-free care. Staff reported the number of falls, urinary tract infections, pressure ulcers and venous thromboembolisms each month. Ward areas displayed the results on notice boards.
- The trust reported 12 pressure ulcers between April 2015 and April 2016. From July 2015 to July 2016, the trusts pressure ulcer prevalence was around the national average.
- The trust reported 11 falls with harm between April 2015 and April 2016. The trust performed better than the national average for falls with harm between July 2012 and August 2016.
- The trust reported nine catheter-acquired urinary tract infections from April 2015 to April 2016. The trust performed worse than the national average for acute hospitals for catheter acquired urinary tract infections between July 2015 and July 2016.

Cleanliness, infection control and hygiene

- The trust reported no cases of MRSA bacteraemia in the year to July 2016. The trust reported six cases of

Medical care (including older people's care)

clostridium difficile (C. Diff.) to the Department of Health between January 2016 and July 2016. This is below the national average for acute trusts in England for the same period.

- Staff followed the trust's hand hygiene and 'bare below the elbows' policy. Staff used personal protective equipment as required. We observed staff washing their hands in line with the World Health Organisation's Five Moments of Hand Hygiene and saw staff using alcohol gel at appropriate times.
- Ward staff undertook hand hygiene audits bi-monthly on each ward. We reviewed audit data from June, July and August 2016 on ward 16, ward 15, the short-stay medical unit, stroke unit and oncology unit where each ward scored 100% in the last two audits.
- The deputy director of nursing planned to implement monthly hand hygiene audits to be undertaken by different teams to ensure a robust and consistent approach. Month one would be undertaken locally by the ward, month two by a 'buddy' ward and month three by the infection control team.
- Equipment, trolleys, surfaces and curtains were visibly clean. Commodes and sluice rooms checked on six wards were visible clean and tidy. 'I am clean' green stickers were widely used across the hospital to indicate that a piece of equipment had been cleaned. All green stickers we looked at were dated appropriately.
- Staff had a good understanding of the process for caring for a patient with a communicable disease. Patients who posed an infection risk were cared for in side rooms. The hospital had dedicated beds for patients with infectious diseases. We observed patients being isolated and staff taking appropriate precautions to prevent the spread of infection.
- We observed staff disposing of waste in line with trust policy. Housekeeping staff emptied domestic and clinical waste bins regularly and used personal protective equipment while doing so.
- Sharps bins, for the disposal of clinical equipment such as needles and scalpels, were in use and stored appropriately.
- The endoscopy unit consisted of five washers and staff were seen to keep contaminated and clean equipment separate. The endoscopy unit had a vacuum packing machine to sterilise and pack equipment to allow a timely turnaround of equipment to prevent delays for patients. The vacuum-packed equipment remained sterile for one week.

- We observed endoscopy staff using personal protective equipment and undertaking appropriate hand hygiene techniques.
- The endoscopy unit held monthly decontamination meetings attended by a variety of staff, including medical, nursing and a Joint Advisory Group approved engineer. We reviewed meeting minutes from June and August 2016, which showed discussions around all aspects of infection control. Attendees set actions with designated responsible individuals.
- The Joint Advisory Group for Gastrointestinal Endoscopy (JAG) ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.

Environment and equipment

- .
- Inspection staff were challenged when entering some clinical areas; however, staff on two wards did not challenge CQC staff.
- Emergency resuscitation equipment was available on every ward and easily accessible. Medication in resuscitation trolleys was secured with red tamper-proof tags to highlight if the drawer had been opened. Staff checked resuscitation trolleys daily and we saw signed checklists for July, August and September 2016 (up to the inspection date) on each ward inspected.
- We checked 17 pieces of equipment (such as patient monitoring equipment, defibrillators, patient hoists and computer equipment) across multiple clinical areas and found all were within their required service date and safety checked where appropriate. Equipment was stored appropriately and where required kept on charge to ensure usability.

Medicines

- The trust used an electronic prescription system to prescribe and document administration of medication. All clinical areas used this system. This allowed a doctor (or other competent person) to prescribe medication remotely without being on the ward.
- Nursing staff used laptops secured to medication trolleys during medication rounds to access patient prescriptions. We observed two medication rounds and nurses on both occasions were able to access and accurately explain the prescription system and demonstrate they could use it.

Medical care (including older people's care)

- Intravenous fluids and insulin medication were prescribed on paper medication charts. All the prescriptions we reviewed were clear and accurate, and staff could access them easily.
- Staff checked medication fridge temperatures daily in each clinical area we visited we reviewed daily records for July, August and September (up to the date of the inspection) and saw they were up to date with no gaps. However, ward 16 did not have a medication fridge at the time of inspection as it had broken and a replacement had not yet arrived. Staff were using the medication fridge of the adjacent ward. Staff told us the temporary process was working and they had no problems accessing fridge medication when required.
- Medicines were stored securely in a locked medicine room in each clinical area except on ward 17, which did not have a secure medicine room. Staff on ward 17 stored and dispensed medication in an open area behind the reception desk. This area had open access; however, staff could not see the area fully from the main ward area. Medicine cupboards were locked on ward 17 but we found two medications in an untagged open pharmacy bag and saline solution (used for preparing medication or for checking that cannulas are working properly) left unsecured and easily accessible. This posed a risk to patients, as there was no control over who had access to the medication and saline solution. There was a risk medication left out could be ingested, removed or tampered with.
- One of the medications found unsecured on ward 17 required storage in a fridge. We informed the nurse in charge, who contacted the pharmacy department to seek guidance on the use of the medication when stored outside of a fridge.
- We escalated our concerns to the nurse in charge who did not know how long the pharmacy bag had been left unattended. The nurse in charge removed the medication, stored them appropriately and contacted the pharmacy department for advice.
- Two registered nurses checked controlled drugs twice a week. We checked the controlled drug book and noted these checks were being recorded.
- We checked 18 controlled drugs across multiple clinical areas. All controlled drugs checked correlated with the controlled drugs registers held in each clinical area.
- We reviewed 19 sets of patient notes, including medical and nursing records. The notes were legible, signed, dated and completed in full. Documentation was easily found within patients' notes.
- All 19 records we reviewed contained individualised care plans for patients. Staff completed risk assessments on admission and throughout a patient's stay, including using a Malnutrition Universal Screening Tool (MUST), pressure ulcer risk assessments and falls risk assessments. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines, which can be used to develop a care plan.
- All 19 records had fully completed early warning scores (EWS) and evidence of appropriate escalation when patients were found to be deteriorating. EWS is a simple physiological score whose primary purpose is to prevent delay in intervention or transfer of critically ill patients.
- Patients' medication was prescribed electronically. We reviewed three electronic prescriptions and found all to be fully completed. Nursing staff were positive about the electronic prescription system, which had been implemented since the previous inspection in July 2015.
- Of the 19 records we reviewed, 12 had antibiotics prescribed. We found evidence of antibiotic review by a senior doctor in 11 of the 12 cases.

Safeguarding

- Patients we spoke with, and their relatives, told us they felt safe in the hospital.
- The adult safeguarding policy was updated in August 2015 and set out the responsibilities of staff across the trust for protecting patients from abuse.
- Adult safeguarding level two training formed part of staff's yearly mandatory training. Safeguarding was also included on the trust's induction programme for new staff. Information provided by the trust showed that all registered nurses on nine of the 10 medical wards had completed adult safeguarding level two training. On the emergency admission and discharge unit, 97% of registered nurses unit had complete adult safeguarding level two training.
- The trust had a named safeguarding lead nurse and a safeguarding team.
- We reviewed minutes from the safeguarding committee from November 2015, February 2016 and May 2016. The meeting minutes were detailed and discussions had

Records

Medical care (including older people's care)

around multiple areas that could affect the safeguarding of patients. Discussions included training compliance, internal and external safeguarding concerns and a review of policies and strategies.

- All staff we spoke with were aware of their responsibilities in relation to safeguarding. Staff knew how to report and escalate concerns about patients.

Mandatory training

- All staff had mandatory training on a yearly, two-yearly or three-yearly basis, depending on the topic covered.
- Information supplied by the trust showed that nine out of the 10 medical wards achieved above 91% compliance with mandatory training for registered nurses. The ambulatory unit achieved 85% compliance with mandatory training for registered nurses. The ambulatory unit achieved 67% compliance with basic life support, infection control, medicines management and fire training. The trust had a target of 95% for mandatory training compliance.
- The senior leadership team for the emergency division told us that medical staff compliance with mandatory training was currently 77%. The senior leadership team cited information governance training being paper based and changes to how mandatory training was delivered to medical staff as the reasons for the low compliance. The hospital provided data to support the statements made during the inspection and confirmed medical staff were 77% compliant with mandatory training.
- The senior leadership team told us that information governance training was now being included in the face-to-face training day to provide it to more staff. The structure of mandatory training days was being reviewed with the aim of increasing participation in training by reducing the time it took.
- Although medical staff compliance with mandatory training was low, we were confident the divisional management team had taken action to improve it.

Assessing and responding to patient risk

- The hospital used a modified early warning score (EWS) system to identify patients at risk of deterioration. Staff used the SBAR tool to escalate and inform medical staff if patients deteriorated. SBAR stickers were used in patient notes and completed in full. SBAR is an acronym

for Situation, Background, Assessment, and Recommendation, a technique to facilitate prompt and appropriate communication between healthcare professionals.

- Staff had access to senior medical support and the critical care outreach team if they needed additional advice and support. An on-call consultant was available overnight and would attend the hospital if required. Nursing staff told us they felt confident that junior and senior medical cover was available when required.
- We reviewed 19 sets of medical records and all contained risk assessments. We saw evidence of action being taken to reduce risks. Patients with high Waterlow scores showing they were at risk of pressure ulcers were seen to be using air mattresses. We found one patient on the emergency admissions and discharge unit with a high Waterlow score who was not on an air mattresses but staff were able to provide reassurance and an explanation of why this had not happened.
- The hospital had introduced enhanced observation training for staff to reduce the risk of patients falling, particularly at night. The emergency divisional senior management team told us that ward sisters and charge nurses had attended two training sessions, since June 2016, with two more training sessions planned. Ward sisters and charge nurses were responsible for passing on the training to staff nurses and healthcare assistants in their own ward areas. It was now required that a member of staff must be able to see each bay of patients overnight to reduce the risk of falls during the night.
- Data received from the trust shows that consultants reviewed 86% of patients within 14 hours of admission to the emergency admission and discharge unit. The London Quality Standards 2013 state that consultants should review all emergency admissions with 14 hours of admission to an acute setting.
- Two patients on the short-stay medical unit and three patients on ward 15 told us that staff took a long time to answer nurse call buzzers. One patient on the unit told us they had had to wait up to 15 minutes on occasions for nurses to answer the call buzzer. One patient on ward 15 told us they had had to wait up to 10 minutes sometimes for nurses to respond to their buzzer. However, we found staff responded to nurse call buzzers in timely fashion despite concerns over staffing numbers.

Medical care (including older people's care)

- The endoscopy unit ran monthly 'deep sedation lists' for patients who required additional support throughout an endoscopic procedure. The endoscopy clinical leads told us a specific anaesthetist oversaw the list and the learning disability liaison nurse assisted in the planning of the lists. The learning disability liaison nurse championed and advocated for patients with disabilities or those unable to advocate for themselves. The clinical leads told us patients with increased anxiety; those with a learning difficulty (for example autism or down syndrome) and those patients requiring additional sedation were the primary patient groups on the lists.
- The endoscopy unit had installed nitrous oxide (a pain relieving gas used to help sedate patients within a theatre environment) in all treatment rooms. The clinical leads for endoscopy told us this had reduced the number of 'full sedations' being carried out and allowed patients to recover and be discharged quicker. The use of nitrous oxide reduces the risk of complications and risk to patients during and after endoscopic procedures due to its rapid onset but short duration of effects.

Nursing staffing

- All wards we visited displayed the number of planned staff (registered nurses and healthcare assistants) and the actual number on shift. We found actual staffing on medical wards met the planned staffing during our previous inspection in August 2015. However, during this inspection we found that most wards did not have the planned number of staff on shift, for both registered nurses and healthcare assistants.
- For example, on the first day of our inspection on Tuesday 16 August 2016, the emergency admission and discharge unit had one less nurse and one less healthcare assistant than planned, the oncology unit had one less nurse and one less healthcare assistant, and ward 15 had one less nurse and one less healthcare assistant than planned..
- Ward 16 was a particular concern. We found that there were two less nurses than planned in the morning, three less nurses in the afternoon and one less nurse overnight on 17 August 2016.
- Staff on ward 16 told us they felt understaffed and pressured. They said that patient observation was not as robust as they would want due to staffing shortages.

- Staff gave the example of patients isolated due to infection being monitored by a healthcare assistant rather than a registered nurse due to the lack of nurses on duty.
- Following the identification of these staffing concerns, we raised our concerns with management and asked for further information to assess the risk to patients.
 - The trust supplied data for eight medical wards showing the percentage of planned shifts filled each month for May, June and July 2016. The average fill rate for registered nurse day shifts was 84.95%, and registered nurse night shifts was 89.33%. Ward 16, the short stay medical unit and the acute cardiac unit had the lowest average day shift fill rates for registered nurses (RN) between May 2016 and July 2016. Ward 16 filled an average of 64.75% of RN day shifts, the short stay medical unit filled an average of 79.32% of RN day shifts and the acute cardiac unit filled an average of 83.92% of RN day shifts.
 - Ward 15, ward 16 and ward 17 had the lowest average night shift fill rates for registered staff between May 2016 and July 2016. Ward 15 filled an average of 76% of RN night shifts, ward 16 filled an average of 85.14% of RN night shifts and ward 17 filled an average of 73.63% of RN night shifts. This demonstrated that there were not enough registered nurses to deliver and meet the care needs of patients.
 - The average fill rate for healthcare assistant (HCA) day shifts between May 2016 and July 2016 was 107%, and the average HCA night shift fill rate was 91.36%. The emergency admissions and discharge unit, ward 15 and ward 16 had the lowest average day shift fill rates for HCA shifts between May 2016 and July 2016. The emergency admissions and discharge unit filled an average of 91.35% of HCA day shifts, ward 15 filled an average of 93.76% of HCA day shifts and ward 16 filled an average of 93.78% of HCA day shifts.
 - The short stay medical unit, ward 2 and ward 15 had the lowest average night shift fill rates for HCA shifts between May 2016 and July 2016. The short stay medical unit filled an average of 85.91% of HCA night shifts, ward 2 filled an average of 74% of HCA night shifts and ward 15 filled an average of 71.92% of HCA night shifts.
 - This demonstrated that despite registered nurse shortages, additional HCA support was not available to support patient with toileting, eating and maintaining patient safety during the night.

Medical care (including older people's care)

- We raised concerns with the deputy director of nursing, who told us that staffing was reviewed throughout the day and that they were unaware of the extent of the problems on ward 16 on the day of the inspection, as these had not previously been highlighted. This showed that the process for reviewing staffing was not effective.
 - Two patients from the short-stay medical unit and four patients from ward 15 told us they felt staffing was limited, especially during the night.
 - From May 2014 to March 2015, agency use across medical wards varied between 0% and 4%. Ward 17 had the lowest average agency use during this time and ward 12 had the biggest agency use.
 - Across 14 medical wards, there were 37.7 whole time equivalent registered nurse vacancies. The medical divisional management team told us the trust had a plan in place to fill the vacancies by using overseas nurses.
 - Agency staff were made familiar with the area before starting to care for patients. Staff told us they try to use the same agency staff to maintain consistency. Ward 16 told us they block book agency and bank staff to ensure that shifts are covered.
 - The trust had specialist nurses in some areas, for example cardiology, respiratory and stroke. Specialist nurses were available Monday to Friday daytime hours for advice and guidance on patients.
 - We observed a morning 'board round' on the emergency admission and discharge unit (EADU). The nurse in charge of the unit, a physiotherapist and occupational therapist from the rapid intervention team, and a junior doctor attended morning board rounds. The team discussed all patients and overnight changes and concerns were highlighted to the relevant staff.
 - Nursing staff had verbal handovers between shifts in each ward area. Written handovers were also in use for nursing staff.
 - Senior matrons assessed staffing on wards throughout the day. On ward 17, we observed a safety handover of staffing and patient acuity between the nurse in charge and the senior matron responsible for the division.
- national average of 36%. However, the trust had a significantly higher proportion of junior doctors (37%) compared with the national average of 21%. The remaining 8% of doctors were middle grade, similar to the national average of 6%. The lack of registrar level doctors and slightly lower consultant level medical staff, combined with the higher than national average junior doctor rates posed a risk of lack of senior oversight of patients, particularly overnight and at weekends.
- Consultants reviewed patients on the emergency admission and discharge unit twice a day. Consultants within cardiology undertook daily ward rounds, and we found twice-daily ward rounds within the hyper-acute stroke unit.
 - The divisional management team told us that other consultants also had daily 'board rounds' to talk about patients but did not routinely see patients each day. Four patients on ward 15 and two patients on the short stay medical unit told us they did not see a doctor regularly and found it difficult to speak with a consultant.
 - We raised concerns to the divisional management team regarding the below average senior medical cover, high junior doctor rates and patient feedback regarding difficulties in speaking with a consultant. The divisional management team told us that consultants struggled to review patients in person due to an increasing workload, split time between outpatient clinics and inpatient activity and a lower proportion of consultants and registrars than the national average. The divisional management team told us the hospital had struggled to recruit consultants and sighted the geographical location of James Paget Hospital as a factor in this.
 - The divisional management team told us the hospital had struggled to recruit an older person's medical consultant. The management team believed this was partly due to the hospital's location. However, in the interim, the trust had employed a medical physician to focus on elderly care.
 - The emergency admission and discharge unit (EADU) had two consultants covering 7am to 4pm and one consultant covering 4pm to 8pm. This was in line with the Royal College of Physicians and Society for Acute Medicine recommendations that all acute admissions units should have a consultant present for a minimum

Medical staffing

- The trust employed 82 medical doctors, with 34% of these being consultants, which was slightly lower than the national average of 37%. The trust had a lower proportion of registrar level doctors (21%) than the

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of 12 hours per day to review patients. Having a consultant present for 13 hours per day helped ensure consultants reviewed more patients within 14 hours of admission, in line with London Quality Standard 2013.

- We observed a morning handover on EADU, which all grades of medical staff attended. The handover was efficient with all relevant discussions, such as patient conditions and workload discussed.
- Junior doctors told us that consultants were contactable and supportive.

Major incident awareness and training

- We found effective planning for emergencies that could have a significant impact on patient care and the resilience of the service.

- The hospital had a seasonal resilience plan in draft form at the time of the inspection. The plan detailed the hospital's response to a rise in demand for medical services during the winter months.
- Staff received fire training as part of the hospital's mandatory training program. Between 67% and 100% of nursing staff had completed fire training across medical wards at the time of the inspection.
- Fire extinguishing equipment was available on each ward and staff were aware of how to respond to a fire. The hospital undertook regular fire alarm tests to ensure the system was in good working order.

The hospital had backup power supplies and lighting in the event of a power failure.

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

Information about the service

James Paget Hospital surgical services are located within the Elective Division and provide surgical services to patients in Norfolk, Suffolk and Great Yarmouth and Waveney. The range of services on offer included; elective and emergency surgical care for trauma and orthopaedics, colorectal, upper gastrointestinal (GI), urology and general surgery. During our 2015 inspection a new purpose built day surgery unit opened. The unit is used to treat most of the common non-cancer surgery cases. The unit holds 20 patient trolleys and is able to accommodate bariatric patients. For more major operations patients are admitted as in-patients to surgical wards. The trust has 143 surgical in-patient beds, including a small eight bedded private patient suite.

There were 25,729 surgical episodes of care between January and December 2015. There were 17,886 surgical episodes of care between January and June 2016, 1,928 of these were elective, 9,736 were day case and 6,202 were non-elective.

As part of this inspection we visited the theatre suite, the day surgery unit and five surgical wards,. We spoke with patients and relatives, and staff members from a range of professions. We observed care, reviewed records and data provided as part of this inspection by the hospital, patients and stakeholders.

Summary of findings

We rated surgery services as good overall. All key questions achieved a rating of good which was an improvement from our August 2015 inspection. Both safety and responsiveness had improved from requires improvement to good.

Surgery services were rates as good overall because:

- The environment was clean, tidy and areas of concern identified at our last inspection had been addressed.
- We reviewed five sets of notes and found that documentation was complete and accurate. Staff reported patient safety incidents and there were clear examples of lessons learnt. Completion of the surgical safety checklist was embedded in practice.
- Evidence based care and treatment was in place throughout the division.
- National audit data showed the trust to be similar to the national average with some areas identified for improvement. The national bowel cancer audit showed that the trust was treating higher than the England average number of urgent or emergency cases at 36% compared to 16%.
- There was good multidisciplinary working and staff applied the mental capacity act correctly. Pain relief was administered in a way best suited to patients need.

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- The friends and family test (FFT) for the surgical wards was very positive, with high percentages of patients saying they would recommend the ward they were received care on.
- We observed examples of kind, compassionate and respectful care during the inspection. 'Dementia radio' was used on a ward with elderly patients, to provide familiar music and aid anxiousness.
- services were meeting referral to treatment times (RTT) and services were planned to meet the needs of local people
- A new day surgery unit had opened in August 2015 which allowed patients to be treated without requiring them to stay in hospital.
- The trust had opened an emergency theatre in line with national guidance, which meant that emergency surgery did not impact upon surgical patient lists. There was good evidence of learning from complaints and concerns.
- There was a clear vision and strategy for the service and a robust system in place for governance within the surgical division.
- Staff spoke highly of leadership at ward and division level and we saw good examples of innovation with staff acting proactively in support of patient safety.

However:

- Some patients reported frustration with internal and external communication.
- An area identified for improvement within the August 2015 comprehensive inspection report was for a review of awareness of the risk register. Our August 2016 inspection findings showed staff's concerns were not reflective of high grade risks on the divisional risk register.
- Staff said they had a good relationship with the executive team and felt listened to, but concerns were not always acted upon.

Are surgery services safe?

Good



We rated safe as good because:

- Concerns we had identified in August 2015 had been addressed, this included the refurbishment of theatres and the checking of equipment.
- All staff we spoke with were able to report patient safety incidents, and were able to give us examples of lessons learnt from incident investigations which were shared within teams.
- Wards were clean, staff observed appropriate hand hygiene and were bare below the elbows whilst in clinical areas.
- Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients.
- Staff received mandatory training and there was a good level of completion.
- We observed correct use of the World Health Organisation checklist within theatres.
- Patient notes were comprehensively completed, including relevant observations and risk assessments.
- Medicines were stored appropriately and we found regular monitoring of room and fridge temperatures though one medicines room was found to be above the recommended limit.
- There were processes for identifying vulnerable patients and there was an internal safeguarding team available to support the care and treatment where necessary.
- The service was staffed with the appropriate numbers of nursing and medical staff.

Incidents

- Surgical services had three serious incidents reported between December 2015 and May 2016 all of which were grade three hospital acquired pressure ulcers, two of which occurred on surgical ward six and one occurred on surgical ward seven. A review of pressure ulcer trends found that elderly patients were at risk of gaining

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pressure ulcers on their elbows as they moved themselves up their beds. Staff responded by pro-actively providing protective wound dressing on elbows to prevent damage caused by this movement.

- There had been ten hospital acquired pressure ulcers reported between April 2015 and April 2016 though there had been spikes in incidences in September 2015 and February 2016. The number of falls was low with six falls with harm recorded since April 2015.
- All staff were able to report any patient safety incidents including near misses onto the electronic patient incident reporting system 'safeguard'. 7 staff told us they were confident in reporting concerns and incidents.
- Surgical services had not reported any never events between June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
- There was evidence of learning from incidents within surgical services. One incident reviewed showed that staff had correctly recorded the incident an investigation carried out and a change to practice implemented. In this instance it related to the use of different equipment.
- The surgical division held monthly mortality and morbidity meetings to review specific cases which had occurred in the division. . Minutes showed that appropriate cases were discussed, that clinical and other factors considered and any lessons learnt clearly identified. Learning was shared across divisions via the patient safety committee.
- Duty of Candour training was provided to staff on induction. Staff told us that they were encouraged to be open and honest with senior colleagues and patients, and we saw that this was practiced as a member of staff on the urology ward told us about a recent patient fall which had not resulted in any harm, but staff upheld the open culture and apologised to the patient.
- 3 staff we spoke with were aware of their responsibilities under Duty of Candour including giving an apology and offering a meeting with those affected. 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

Safety thermometer

- Surgical wards supplied monthly data to the Patient Safety Thermometer and results were displayed in ward entrances. Between April 2015 and April 2016 the surgical division reported ten grade three pressure ulcers one of which was reported as a serious incident with a root cause analysis investigation completed in February 2016.
- Within the same data period, six falls with harm were reported, the highest occurrences in June 2015.
- At the time of inspection we noted that on ward six the latest infection control data was two months behind (June 2016), demonstrating 94% compliance with standards.
- We noted that the number of Deep Vein Thrombosis (DVT) episodes were not displayed on wards as part of the monthly data. We requested this data from the trust and found that between January and June 2016 there had been between 96% (May 2016) and 98% (June, July 2016) harm-free care for patients with new DVTs.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia in the year before our inspection and the trust was below trajectory with incidents if Clostridium Difficile.
- Surgical site infection surveillance data for January to March 2016 (the last full set of audit results) showed the hospital to be performing better than the England average for surgical site infections in the categories of hip replacement, knee replacement and repair of fractured neck of femur.
- Surgical surveillance data confirmed that within the period January to March 2016 there had been 1 out of 54 inpatient or re-admission cases following surgery at the trust for surgical site infections, equivalent to 1% which was low (positive).
- We observed one member of theatre staff who was not compliant with national best practice standards for the prevention of surgical site infections due to the wearing of jewelry. We raised this at the time with theatre staff and noted that no action had been taken as this was not a substantive member of staff, however we were concerned as this showed disregard of patient safety.

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- We observed appropriate use of personal protective equipment such as gloves and aprons being changed as clinical staff moved between bays on a ward.
- Surgical wards were visibly clean and had sinks for staff to wash their hands in the corridor. Sinks were also available for staff to decontaminate their hands within patient's single side rooms. We observed clinical staff adhering to the bare below the elbows requirement and washing hands appropriately. Hand sanitiser gel was readily available on wards for hand cleaning.
- Environmental audits showed that ward areas consistently scored in excess of 95% for cleanliness and green stickers were affixed to equipment that was cleaned and ready for use.
- The hospital had had an outbreak of Extended Spectrum Beta Lactamase (ESBL). Staff we spoke with confirmed that the single side rooms were used within the Charnwood suite to isolate infectious diseases, and we saw that the hospital had produced patient information leaflets explaining ESBL and effects for patients and their visitors, in April 2015. The trust was working with NHS Improvement and Public Health England to identify any causative reasons for the outbreak and to ensure that actions in place were sufficiently robust.
- The day surgery unit had laminar flow in the theatre area which reduced the risk of patients receiving air-borne infections whilst undergoing surgical procedures.

Environment and equipment

- Resuscitation trolleys were regularly checked. We found the contents to be correct and the medicines to be in-date. August 2016 showed that the equipment was checked on a daily basis and recorded in the logbook. The senior sister confirmed that the wards alternated months for daily review of the trolley to ensure it was safe for use.
- On review of adult and children's resuscitation and emergency intubation trolleys in theatres we found that both were complete with all necessary equipment and medications. Daily check sheets demonstrated that staff had completed checks on both trolleys every day between 01 June 2016 and 17 August 2016.
- During our 2015 inspection we found the environment in some areas of theatres and recovery to be in poor

condition. Significant work had been completed to improve this and the issues previously raised had been addressed through extensive refurbishment of main theatres and recovery.

- There was a laser protection supervisor on site for staff to escalate any safety concerns to for patients receiving laser eye surgery. We observed that details of laser treatment patients received were recorded on one of the electronic hospital systems.
- Curtains used on surgical bays around individual beds were material based (not disposable), and there was a three monthly cleaning schedule for these unless these became contaminated with bodily fluids, and then nursing staff would arrange for immediate removal and replacement. One of the surgical wards we inspected confirmed that they had had a curtain change two days prior to our inspection.
- Records showed that equipment had been properly maintained according to manufacturer's instructions and safety testing had been carried out appropriately.
- Environments in some ward areas were cluttered with trolleys and equipment which we had also found at our previous inspection. On one ward we saw an empty bed to be left blocking a fire exit as other ward beds were moved to make a single sex bay available. The bed was removed from the emergency exit when we raised this concern to the nurse in charge.

Medicines

- A medicines management action plan had been implemented in January 2016 to address the medicine concerns we had previously raised. There was one outstanding action in August 2016 in relation to the decision, and purchase of, automated cabinets for safely storing medication.
- However, medicines were stored securely on wards. We found that medications stored in the fridge were double locked by the fridge and the room door. Controlled drugs were double locked as per national guidance, and we saw that the logbook for recording contents of the cupboard was fully completed so that medication was traceable.
- We found two of the ward medicine fridges had several episodes of elevated temperatures outside of the recommended range. One was due to the fridge being next to an ice machine which expelled heat, we raised this with staff at the time, and the ice machine has now been removed to allow the fridge temperatures to

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remain in range. The other instance was where the medication fridge was being pushed so that the rear of the fridge rested against the wall and stopped air circulation, demonstrating above target readings in July 2016. A notice had been placed on the fridge advising staff not to push the fridge back.

- On the Charnwood Suite the medicines stock room showed the temperature to be high at 28 degrees centigrade on the day of inspection. The temperature monitoring log showed the temperature to be in excess of 25 degrees centigrade frequently.
- Fridge temperature recording in theatres had been completed daily as per trust protocol with no gaps between June 2016 and 17 August 2016, we saw evidence that escalation and appropriate action had been taken when temperatures were outside of acceptable range.
- We reviewed the contents of store rooms on surgical wards and found these to be tidy, clean and well organised with intravenous medication stored appropriately.
- We observed a lunch-time drug round where a nurse checked if a patient had any pain or nausea. The patient's identification was properly checked before the correct administration of medication was completed.
- We looked at the prescription and medicine administration records for 6 patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed with no gaps or omissions.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital. Pharmacy staff visited the wards to arrange medicines to take home, but nursing staff said there was sometimes a delay in getting medication on time.

Records

- A concern raised within the August 2015 comprehensive inspection was that surgical records were not always up to date and reflective of patient's needs. During this inspection, we reviewed five sets of patient notes and found them to be fully completed with clear plans of care with regular observations having been taken where these were needed to ensure that prompt escalation could happen to ensure patient safety.

- Patient notes we reviewed were accurate and complete for example we reviewed a mental capacity assessment and deprivation of liberty application which were appropriately completed. The patient lacked capacity to consent for treatment, and we saw that a doctor had signed this in the patient's best interest.
- Surgical patient records were divided into medical notes stored centrally, and nursing notes stored at the end of patient's beds. Test results and diagnostics, and discharge plans were available on the hospital's electronic system.

Safeguarding

- There were clear processes and procedures in place for safeguarding people at the trust.
- The majority of nursing and medical staff were trained to level 2 safeguarding with over 80% up to date with training.
- Information was available in clinical areas advising staff on which action to take in the event of a suspected safeguarding.
- Staff were supported in reporting safeguarding concerns by the safeguarding team.
- Staff were aware of their responsibilities of safeguarding. Five staff we spoke with were aware of local safeguarding procedures and knew how to make a referral in the event of a safeguarding concern. Most staff we spoke with had completed mandatory training in safeguarding or had the training booked.

Mandatory training

- Mandatory training was provided by a combination of e-learning and face to face training sessions.
- Mandatory training records for staff were kept by team leaders who locally managed compliance with performance targets.
- Theatre staff we spoke with told us that although they often had practical class-room based mandatory training sessions booked in their diaries; these were often cancelled due to staff shortages.
- Senior nursing staff confirmed that theatre staff were 84% compliant with their mandatory training requirements in August 2016.
- Staff we spoke with told us that they had received mandatory training or that it was booked. In ward areas staff reported no concerns in booking mandatory training.

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Assessing and responding to patient risk

- The surgical division used the early warning score system (EWS) to record regular patient observations. This system was designed to provide an early indication if a patient's condition began to deteriorate. This was in line with national best practice guidance to ensure that prompt treatment by either a doctor or the critical care team could be sought to assist acutely ill patients.
- A July 2016 trust wide audit sampling 154 sets of patient records showed that 112/154 (73%) of observations had been correctly calculated to identify the individual patient's risk of deterioration. Audit data showed that 6/18 (33%) of early warning triggered episodes had a clear management plan in place. An action plan had been developed and results shared with senior nurses, ward managers and the critical care outreach team (CCOT). We noted that the CCOT were due to meet with and provide additional education with areas requiring improvement before re-measuring results in November 2016.
- During our inspection we found EWS scores to be properly calculated and patients appropriately escalated for review by critical care outreach or medical staff.
- We saw that wards used a purple sticker as a visual aid to indicate that these patients required prompt action, and the Situation, Background, Assessment and Recommendations (SBAR) sticker was used to escalate medical concerns to doctors for urgent review. Records reviewed showed the SBAR tool to be properly used.
- National guidance was being followed in theatres to ensure safety processes were checked before and after a patient was surgically operated on. Compliance with the World Health Organisation's five steps to safer surgery was 99% for patients treated in April and May 2016.
- At our last inspection we found that there was no dedicated National Confidential Enquiry in Patient Outcomes and Death (NCEPOD) emergency theatre which was not in line with national guidance. At this inspection, following theatre refurbishment, a full 24 hour NCEPOD emergency theatre was now available.
- The trust recognised sepsis as a clinical emergency and there was a clear policy for staff to follow which included guidance and recommendations from NCEPOD. This policy had been reviewed by the critical

care outreach team and an emergency consultant in January 2016. We requested sepsis training dates for surgical staff, but the trust were unable to supply us with this data.

- We saw that there was a joint NHS trust policy with a neighbouring NHS trust for the appropriate fasting of patients before they received surgery, written by consultant anaesthetists from both trusts and an education lead. This was to ensure that patients were safe to receive anaesthetic before having their surgery.
- There were clear procedures and processes in place for the transfer of unwell patients who required specialist treatment at another hospital. There were also contracts in place for additional services such as interventional radiology at a local acute teaching hospital.
- Morning trauma meetings were held daily at 0800 to prioritise patients for surgery according to clinical need.

Nursing staffing

- Nurse staffing levels had been reviewed in early 2015, which had allowed for an increase in the number of nurses used within the trust to maintain safe levels of patient care. At the time of inspection in August 2016 the trust were in the process of ensuring that 100 overseas nurses were adequately skilled to care for patients in the hospital. Surgical ward managers we spoke to stated that they did not know how many of these new staff members would be joining their teams.
- Planned and actual staffing numbers were displayed daily on each surgical ward. Figures showed that on wards visited during our inspection that staffing was maintained in accordance with the planned staffing level.
- We reviewed rotas on two wards and found nurse staffing to be maintained for the preceding two months.
- Senior theatre staff told us that they planned to staff theatres in line with the Association for Perioperative Practice national guidelines with a business case to be considered by the executive team to increase staffing numbers by one full time member of staff.
- Theatre and day surgery unit staff told us that if they experienced unexpected staff shortages on the day, they would attempt to use bank or agency staff to cover gaps in rotas. At the time of inspection agency staff were being used to ensure safe staffing levels to maintain patient safety in the recovery suite.

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- Bank and agency were used on occasion to fill shifts though the frequency of this was declining due to the increase in permanent staff recruitment. We saw local ward inductions were in place for agency staff and that they were completed prior to them commencing work.
- When it was not possible to cover nursing rota gaps with department staff working flexibly to provide cover across different wards and clinical areas.

Surgical staffing

- There was the same number of consultants as the England average at 43% of the medical work force. There were more middle grade staff and less registrar staff than the England average with a similar number of junior doctors.
- Surgical consultants worked a week on call rota with regular morning trauma meetings.
- There were clear on call rotas for consultants and registrars. Orthopaedic wards had a junior doctor dedicated to the wards with more senior cover when required.
- Surgical wards, out of hours, shared a junior doctor who also covered the emergency department. More senior doctors supported them. There were on call consultants always available on the rota.
- We spoke with 3 doctors who told us that they were adequately supported by senior staff. They told us there were no problems in calling for senior help to review patients.
- There were sufficient general surgeons on the rota to cover the new NCEPOD emergency theatre that was now in operation.
- There were a number of vacancies for consultant grade staff including in urology with recruitment under way. Senior managers' mitigated this by block booking locum consultant's to ensure continuity of care. Locum consultants had an induction on commencement of their placement.
- Emergency handovers happened twice daily, lasting half an hour. These were well attended by all levels of staff who were not directly involved in patient care at the time of the meetings, and an electronic list of all emergencies was provided for each meeting.
- We spoke with a second year junior doctor who said that inductions into the hospital were detailed. They added that they were currently working with a more senior member of staff to complete daily surgical ward rounds, and felt well supported by all senior staff.

Major incident awareness and training

- Emergency plans included working with external organisations on a county-wide basis for incidents such as fuel shortages or an incident involving mass casualties.
- We saw evidence of regular training and real incidents forming part of staff's awareness and training for a major incident. Training involved a four wheel drive volunteer response practice to aid with taking emergency patients to hospital in bad weather. Real incidents involved a small fire, flooding, fire brigade strikes and junior doctor strikes. In January 2016 the highest level of emergency planning was put into effect when the hospital reached capacity issues.
- The surgical department had its own detailed emergency plan which provided guidance on all predictable emergency situations, plans included details of how to continue core department functions. Plans were accessible to staff via the staff intranet and in hard copies in three locations across the hospital, and these were updated on an annual basis.
- Staff we spoke with knew where to locate the hospital emergency plan and major incident cards which gave timely prompts for key actions to be completed in the event of an emergency situation.
- We reviewed emergency planning and resilience response meeting minutes from June 2016 and saw that the nurse lead and service manager for the elective division (which the surgical department sits within), had attended to input into hospital planning updates and staff training exercises with other NHS providers.

Are surgery services effective?

Good



We rated effective as good because:

- Staff were supported with learning and development and demonstrated competence in their roles.
- Local clinical audits were used to review and improve services offered to patients.
- Trust policies and procedures used in the surgical division were evidence based.

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- The Mental Capacity Act was appropriately applied and Deprivation of Liberty's applied for in line with legislation.
- Local fluid balance chart audits and early warning score trust wide audits showed that there were areas for improvement and staff had committed to re-audit services once improvements had been embedded.
- Patients had access to 24/7 pain relief with psychological support if required, and received appropriate pain review in line with national guidelines.
- Elective length of stays for patients was generally better than the England average with exception of general surgery.
- The hospital staff were proactive in promoting research for the benefit of patients.

Evidence-based care and treatment

- Staff followed local policies which were based upon national best practice guidelines such as those produced by the National Institute for Health and Care Excellence (NICE). For example the pathway for the management of low back pain was updated in October 2014. This is in line with the current recommendation by NICE for the management of low back pain.
- There were enhanced recovery pathways in place for some surgical procedures including for patients having bowel surgery which incorporated guidance for care of patients' pre and post operatively. There was also a pathway in place for patients with fractured hips.
- Elective patients were assessed for, and given information, relating to deep vein thrombosis (DVT) and pulmonary embolism (PE) at their pre assessment appointment in line with NICE guidance Venous thromboembolism in adults admitted to hospital: reducing the risk CG92. Emergency admissions, including those for trauma orthopaedics were also assessed to this standard.
- There were full year clinical audit plans in place for the division which set out priority areas for audit and the clinician responsible.
- At the time of our last inspection there was no dedicated emergency theatre. Instead, elective operations were planned for the morning in one theatre

and the afternoon used for emergency cases. At this inspection we found that the NCEPOD dedicated emergency theatre had been opened as planned and was in full operation.

- Audiology services were working towards gaining Improving Quality in Physiological Services (IQIPS) accreditation for the Adult and Paediatric Audiology Services which was accredited under the Royal College of Physicians, to demonstrate high quality service provision.
- In 2015 surgical services took part in a national lower gastrointestinal bleed audit. The audit identified some areas for improvement, and as such medical staff re-audited one standard from this original audit, as well as an additional two standards based on best practice national principles between May and July 2016. The 2016 re-audit showed that (13/14) 93% of upper gastrointestinal patients received a digital rectal exam which showed improvement from (24/28) 86% in 2015. Improvements had been made in relation to patients receiving a transfusion who required one from (4/13) 31% in 2015 to (3/7) 43% in 2016. No patients met the criteria for inclusion in the final standard within either audit for clinically significant bleeds.
- A March 2016 local audit on the use of fluid balance charts for surgical patients, recommended that documentation needed to be more accurate with the suggestion of implementing a new fluid balance chart, and re-audit of effectiveness once the chart had been embedded.
- The hospital staff were proactive in promoting research for the benefit of patients. Research staff discussed research programme with patients which may enhance their care and enrolled patients onto relevant research projects in line with patients wishes.

Pain relief

- Pre-operative assessment clinics ran each weekday morning. Clinic nurses told us that they saw on average between 26-31 patients in each clinic, they added that if patients were already using strong pain killers such as morphine before surgery, then these patients were referred to the medically-led chronic pain management team for review before surgery. This team was led by three consultants.

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- A specialist pain nurse attended the wards most days to ensure that patients were receiving enough pain relief whilst they recovered, and they would attend the ward as required, if called by the ward staff to provide support.
- There was a specialist pain team, consisting of three consultants who provided support to patients between the hours of 09:00am to 05:00pm, Monday to Friday. This was in line with national guidelines. Outside of these core hours there was an on-call anaesthetist available.
- Surgical services had an established pain management service for acute and chronic pain that included two Pain Management consultants, one Specialist Doctor, Clinical Nurse Specialists, Nurses, Extended Scope Physiotherapists, an Occupational Therapist and administrative staff.
- There were two Consultant-led pain management ward rounds per week and daily Nurse-led pain management ward rounds.
- There was one Clinical Nurse Specialist provided non-medical prescribing in the inpatient setting to reduce delays in treatment. There were plans to expand this service in the future.
- Psychological patient support for pain management was supported by an occupational therapist with particular skills in Psychological techniques.
- Medicines charts showed that patients were given pain relief in a timely way.
- Post-operative pain relief was managed in a number of ways for surgical patients including patient controlled analgesia.

Nutrition and hydration

- We observed patients receiving fluids via intravenous drips, to provide appropriate hydration on the general surgical wards and ward 6.
- We observed nurses assisting patients with meals in a non-hurried way with plenty of verbal encouragement.
- Patients were risk assessed for malnutrition to ensure that they received the appropriate foods to support their recovery from surgery. We reviewed five records that showed the Malnutrition Universal Screening Tool (MUST) had been completed and action taken where any concerns had been identified.
- Fluid charts were completed for patients in ward areas, and monthly audits were undertaken to ensure completion. Food charts were also in place for patients who required their intake monitored.

- There was a hospital dietician service available which patients could be referred into for nutritional assessments.
- Nutritional requirements were met for patients who were unable to consume food or drink orally or by other means. We saw patients receiving nutrition via percutaneous endoscopic gastrostomy feeds and naso-gastric tubes.
- Patients we spoke with told us that food choices and quality were good, and that they had no complaints.
- We saw that patients had jugs of water available to them for hydration purposes, and observed catering staff providing hot drink refreshments in the afternoon in a positive and encouraging way.

Patient outcomes

- Patient reported outcome measure (PROMS) data released in August 2016 reviewing April 2015 to March 2016 data showed that for hip, knee, groin and varicose vein surgical procedures the trust performed in line with England average for patient reported improvement following surgery.
- Surgical services took part in the following national audits as part of the 2015 programme; national bowel cancer audit, national hip fracture audit, elective surgery, national PROMS, national confidential enquiry into patient outcome and death, national joint registry audit, national falls and fragility fractures audit and the national emergency laparotomy audit.
- Data from the national bowel cancer audit of 2014/15 showed that the trust performed better than the England average for case ascertainment rate and worse than the England average for the number of patients being seen by a clinical nurse specialist. The trust had slightly more people than the England average staying longer than 5 days post operatively.
- Data from the national hip fracture audit of 2015 showed that the trust performed worse than the England average for four of the measures including length of stay, surgery on the day or day after admission and being admitted to an orthopaedic ward in four hours. The trust performed better than the England average for number of patients having a full medical assessment,
- The national emergency laparotomy audit 2015 showed that improvements could be made in recording patient risks before they received surgery, patient's direct access after surgery to critical care when this was required, and

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provision by a specialist in mental crisis in older people assessment for patients of 70 or more years. This data also showed that patients were arriving into theatre appropriate to their clinical urgency, and that upon arrival both consultant surgeons and consultant anaesthetists were present to perform the surgery.

- Data from January to June 2016 showed that the average length of stay for trauma and orthopaedic patients receiving hip or knee replacement surgery was 4.5 days. Comparative figures for five surgeons within this data period ranged from 3.7 days to 5.1 days.
- Between January and December 2015, average length of stay for patients receiving elective surgery was better (lower) than the England average at 2.7 days compared to 3.3 days. Trauma and orthopaedics average length of stay was 3.3 days which was better than the England average of 3.4 days, and ears nose and throat was better than the England average at 0.9 days compared to 1.5 days. However, for general surgery average length of stay was worse (higher) than the England average at 4.4 days in comparison to 3.5 days.
- Average length of stay for patients receiving non-elective surgery for the same period were worse (higher) than the England average at 6.6 days compared to 5.2 days. Trauma and orthopaedics average length of stay was 11.0 days compared to 8.7 days. Urology average length of stay was 3.8 days compared to 3.0 days, and general surgery was 4.9 days compared to the England average of 4.1 days.
- Standardised relative risk of readmission for elective patients were better than expected with the exception urology which was slightly worse than expected. Relative risk of readmission for non elective (emergency) admissions was better than expected for all specialties measured.

Competent staff

- Staff had a full induction prior to commencing work and were assigned a colleague to work with during a supernumerary period.
- The trust had recruited a number of staff from overseas who received a tailored induction programme and 6 weeks supervised practice before working autonomously.
- Many staff took on a clinical champion role in their workplace. For tissue viability, link staff had three monthly meetings where further training was undertaken and competency also considered.

- Ward data showed that the majority of staff had completed appraisals or that they were booked.
- We saw evidence in theatres of annual staff appraisal completion which were carried out to make sure that staff were adequately trained to carry out their job. We noted that development needs were identified within these meetings, but were not always met.
- The General Medical Council held data from December 2012 to June 2016 about the trust's doctor revalidation. This data showed that all doctors employed by the trust had been compliant with providing the necessary documents with just 1% of revalidation cases being deferred which was lower than the England average at 14%.
- We observed that within the theatre environment staff competencies demonstrated that they had read applicable policies and completed training on how to use specific equipment relevant to their role before their managers signed them as being competent.
- A consultant anaesthetist we spoke with told us that junior doctors received regular supervision and both surgical and anaesthetic consultants would be available to support junior staff as and when they were needed.
- Theatre staff told us that they had recently received an annual performance appraisal. As part of our routine inspection, we requested data to confirm the numbers of staff who had been appraised since April 2016, and we were told that just 3/100 (3%) had though almost all staff had an appraisal in 2015/ 16.
- Consultant annual performance appraisals started in May 2016 and had a due date for completion at the end of August 2016. On 17 August 2016 77/83 (93%) had appraisal dates set ahead of the deadline. Staff told us that there were currently some consultants on sick-leave.

Multidisciplinary working

- Daily multi-disciplinary team meetings on the trauma and orthopaedic ward were attended by senior nurses, physiotherapists, occupational therapists, and fractured hip key-workers with medics attending inconsistently. The purpose of these meetings was to combine specialist knowledge to best support individual patient's recovery progress.
- Weekly infection control multi-disciplinary meetings on the trauma and orthopaedic ward were attended by;

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senior nurses, consultant surgeons, microbiologists and Matron to ensure that patients recovering from open surgery were healing appropriately and they were not at risk of contracting infections.

- Anaesthetic staff we spoke with told us that they were involved with multi-disciplinary teams for community dental service provision, autistic children receiving surgery, and patients who were critically ill in the intensive care unit.
- Surgeons worked as a wider multi-disciplinary team for patients requiring treatments not offered by the James Paget Hospital. For example, cardiac surgery and interventional radiology procedures were conducted at another local NHS trust.
- Regional MDT's were held in for a number of conditions to ensure peer review of care and that the most effective treatment was being given.

Seven-day services

- In the afternoon and evenings a first year junior doctor covered acute medicine and surgical support between the hours of 02:00pm to 11:30pm on the twilight shift, and a more experienced second year junior doctor provided orthopaedic and surgical cover between the hours of 08:00pm overnight to 08:30am the following day.
- The on-site pharmacy was open Monday to Thursday 09:00am to 05:00pm, 09:30am to 05:00pm on Fridays and 10:15am to 02:00pm on Saturdays and Sundays. Outside of these core hours and on bank holidays there was on-call pharmacist provision.
- Theatre staff we spoke with confirmed that they had 24 hours a day; seven days a week access to diagnostic imaging, and confirmed that they did not experience any delays in supply of these services.
- A chest physiotherapist was available via the on-call system at weekends, but there was no provision of other types of physiotherapy or occupational therapy outside of core hours.
- Some specialist services were Monday to Friday only including intensive care outreach and the pain management team, however there were arrangements in place to cover these teams for example through the on call anaesthetist.

Access to information

- Patient records were available on wards. Medical notes were kept in notes trolleys, and nursing notes were kept at the end of patient's beds.
- Medical staff had prompt access via secure electronic systems to patient imaging and reports from radiology.
- Blood results were available to staff to access, via secure electronic systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff attended a mental capacity act training day, and to ensure they have understood this training, there was a weekly 'share your care' audit which reviewed 25 members of staff's understanding of this legislation.
- Theatre staff told us that patients living with dementia were identified in outpatient clinics, and a planning meeting was arranged to agree the best course of action for the patient with input from the dementia link nurse.
- The trust used green stickers for mental capacity assessments which guided staff via a two stage process to make a clinical judgement about whether or not a patient had capacity to make decisions at that point in time. These stickers required the date to be added, so that an individual's capacity could be reviewed over a period of time.
- The trust's consent to examination or treatment policy stated that annual consent audits would take place to ensure that staff were following the policy correctly. We noted that this audit was not registered on the 2016/17 audit plan, but that documentation audits were regularly completed by ward managers to ensure the quality of care received by patients, and that staff were accurately recording care and treatment.
- Whilst reviewing patient notes, we found a patient who had fluctuating mental capacity. We saw that regular mental capacity assessments were taking place, and that deprivation of liberty safeguard had been correctly implemented.

Are surgery services caring?

Good



We rated caring as good because:

- Patients we spoke with spoke very highly of the quality and professionalism of care they received.

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- There was an open culture and patients we spoke with told us they felt able to ask consultants questions and were able to raise any concerns they had.
- Specialist nurses and allied health professionals were available to support patient's specific needs.
- Friends and family test data showed between 97% and 100% of patients would recommend the service.
- Patients told us that they felt able to request pain relief as required from staff, and confirmed they had received it.
- Staff were 'dementia aware' and used a radio to aid anxiety of patients living with dementia.

However;

- Some patients reported frustration with internal and external communication.

Compassionate care

- Patients responded positively to the "would you recommend this service to your friends and family" question which was asked following care or treatment received at the hospital. Between the months of April 2015 and April 2016 responses were within the 90% to 100% response range.
- Response rate for the Friends and Family Test (FFT) was 43% which was higher than the England average.
- Between January and April 2016 all wards had scored in excess of 90% for the number of people who would recommend them.
- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. We witnessed people being spoken to with respect at all times.
- Data reviewed on three wards showed positive friends and family test comments and greater than 95% of patients recommending the ward and care in July 2016.
- We observed staff's response to patient's call for help using patient call bells, on the general surgery and urology ward these were answered promptly by staff. There was a longer wait for staff response to patient call bells on ward six which at the time of observation was a busy ward which was running with three rather than the four planned registered nurses, and had a complex mix of patients including confused patients.

- We observed numerous positive staff interactions. On one occasions we observed a patient assisted to mobilise with gentle encouragement given. The staff clearly had a good knowledge of the patient as they discussed things the patient enjoyed doing.
- 11 patients we spoke with told us they had been treated with care and compassion.

Understanding and involvement of patients and those close to them

- Patients told us they had received excellent care and were able to request and receive pain relief as they required it.
- The ward sister on the trauma and orthopaedic ward explained that there were a number of patients living with dementia on the ward, and staff played a radio which played 1940s and 1950s music which patients by could relate to.
- Patients and relatives spoke of frustrations at ineffective communication whilst being an inpatient and understanding timeframes for being seen by medics and discharged home, and also between the hospital and other NHS local trusts.
- Patient visiting times were fixed for each ward, but ward managers and matrons made exception to these in special situations to meet the needs of the individual patient.
- Patient discharges from surgical wards were nurse-led. Staff told us that relevant patient information was supplied along with discharge letters prior to a patient returning home. An example of an elderly patient information pack was an A5 envelope containing information on falls prevention, assessments and what to do if a fall occurred at home, post-surgical wound care including contact details if an infection was suspected, information on how to prevent blood clots and information on stockings to wear at home to help prevent blood clots.

Emotional support

- We observed the caring and professional interaction between a member of ward nursing staff and an anxious patient, the member of staff listened to the patient's concerns about contacting home, and then enabled them to make contact with their family.

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- There was a chaplaincy service available within the hospital which patients could access either by visiting the multi-faith room, or by requesting attendance on the ward. The chaplain was able to provide other faith leaders upon request.
- Counselling services were provided to some patients. Peer support groups, for example for patients requiring bowel surgery were also in place. A number of these groups we were told had arisen informally.

Are surgery services responsive?

Good



We rated responsive as good because:

- Referral to treatment targets (RTT) for surgical services were being met.
- There was evidence that learning from complaints took place and quality reviews and improvements to the complaints process happened.
- There were processes for booking patients in for surgery and reviewing their urgency.
- Systems and processes were in place to ensure patient's individual needs were met.
- Where noise at night was keeping patients awake on wards ear plugs were offered to aid sleep.
- There were support mechanisms in place for victims of domestic abuse.
- Translation services were available to support patients.

Service planning and delivery to meet the needs of local people

- There were development plans in place for specialties in the surgical division that highlighted plans required to meet the health and care needs of local people.
- A new day surgery unit had been opened in late August 2015 to serve the local population and help reduce the waiting list times for patients, as this meant that patients could be treated without the need for waiting for an in-patient bed. New procedures were available in some instances in the day surgery unit including day case nephrectomy.
- Meeting minutes showed that service design was considered along with commissioners so that the local

health economy offered the right services. There was engagement with the formation of the local sustainability and transformation plans and working with other providers across health and social care.

Access and flow

- There were 25,729 surgical episodes of care between January and December 2015. There were 17,886 surgical episodes of care between January and June 2016, 1,928 of these were elective, 9,736 were day case and 6,202 were non-elective.
- The day surgery unit had not had any non-medical cancellations between August 2015 and July 2016.
- Surgical wards' bed occupancy often exceeded 100%, with surgical patients as outliers on other surgical wards. A priority for the surgical wards was to retrieve outliers planned for more than 24 to 48 hour stays back from other wards, so that specialist surgical care is immediately available for patients.
- Referral to treatment times (RTT) had been below the England average at our last inspection and had remained so until March 2016 however since then RTT had been better than the England average.
- Review of April to July 2016 data confirmed that within July 2016 referral to treatment times were being met by specialties including; Ophthalmology (94%), ears nose and throat (94%), urology (95%) and oral surgery (97%), general surgery (90%), and trauma and orthopaedics (94%).
- The percentage of patients whose operation was cancelled and were not treated within 28 days was below the England average. For quarter 4 2015/16, 54 patients received treatment within in 28 days with two patients not receiving treatment in this timeframe.
- Theatre staff told us that medical secretaries booked surgical operating lists and once a week there was a utilisation meeting to agree the scheduling of patients.
- The trust had an electronic discharge system which automatically emailed patient discharge details to the patient's GP. A local audit of general surgical cases completed in June and July 2016, reviewing 75 discharges, showed that the quality of information provided on the patient's discharge summary was good in 46/75 (61%) of cases. Data also demonstrated that the inputting of actions required by the patient's GP were completed in (65/75) 87% of cases.

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- Discharge processes on the day surgery unit were nurse-led (unless they had medical concerns). If following day surgery, patients were admitted to a surgical ward, then the nursing staff visited the patient on the ward and complete the discharge process once they had been assessed as being safe to return home.
- However, senior urology nursing staff said that patients were sometimes sent to the discharge lounge, but this was not always appropriate as they may be awaiting blood test results which may require them to be catheterised.

Meeting people's individual needs

- In patient waiting areas we saw posters promoting flexible visiting times for family carers looking after vulnerable patients, hospital staff contact details were provided for the dementia liaison nurse, the learning disability lead, the family carers lead and the end of life care team.
- The trust provided translation services face-to-face or via the telephone for patients and their relatives to access if required. There was a trust translation policy which stated that only registered professionals bound by a code of conduct may offer translation services to patients, and additional training was available to staff to support this function.
- A finding from the friends and family test on the trauma and orthopaedic ward was that noise at night was keeping patients awake. The ward had responded by providing patients with ear-plugs to allow them to sleep.
- A senior sister on a surgical ward told us about a learning disabilities patient who had attended the ward for surgery within the last six months. The learning disabilities nurse had been involved in this patient's care and preparation for surgery. The anaesthetist had visited the ward to provide the patient with their sedation in the environment they were familiar with. The learning disabilities nurse had provided nursing and medical staff with key information about the patient, so that when the patient was brought back to the ward following their surgery, staff were able to refer to things that the patient could easily identify with, to help put them at ease.
- One of the surgical wards had a side room available to allow family members or carers to stay overnight with patients.
- There was a dementia care team available within the hospital and staff told us that they were very engaged

with supporting dementia patients on wards. Dementia champions were available to support the dementia team and spread awareness of the condition and how staff can best support patients living with dementia.

- Dementia awareness training was provided to staff on induction, and on an annual basis to all relevant staff as detailed in the trust's dementia improvement plan dated 2014/15
- The hospital had a multi-faith room available for patients to access, and the chaplain had the ability to contact specific faith leaders such as Rabi and Imam, if patients requested these services.
- Nursing staff told us that close to the hospital there was a Portuguese population, adding that there were a number of surgical Portuguese nurses who provided basic translation for patients for example, at mealtimes to help with their understanding. Formal translation services were used when clinical detail or consent matters needed to be discussed with medical staff.
- A patient we spoke with said that there was no hospital Wi-Fi for patients to connect to their families and loved ones via social media whilst they were recovering from surgery. They added that being an inpatient for an extended stay could be very isolating and they felt that outside communication for patients should be supported by the hospital.

Learning from complaints and concerns

- Complaint leaflets and posters were available in patient waiting areas on wards, should patients have the need to access these.
- The hospital had a Patient Advice and Liaison Service (PALS) and complaints team to manage written complaints received, patients could access these services via the hospital website. Complaints, trends and learning were discussed within surgical clinical governance meetings. Staff we spoke with told us that they aimed to discuss any patient complaints immediately, to reduce patient distress.
- Hospital data showed that surgical services had received three formal complaints between July 2015 and July 2016. Two complaints were about post-surgery care from theatres, and one was about a patient who developed a burn following a day case procedure. The trust had completed a complaints evaluation survey in 2015 and this showed that nine out of 24 patients and relatives surveyed said that they had found how to

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make a complaint via the patient advice and liaison service, with 22 of the 24 saying that it was easy to make their complaint, and 13 out of 23 responses stating that they were happy with the outcome of their complaint.

Are surgery services well-led?

Good



We rated well led as good because:

- Staff were aware of the trust's vision and values and were passionate about the care they provided to patients.
- Divisional governance structures reviewed learning from incidents, and this information was then shared across divisions to promote patient safety.
- Consultants confirmed that the opening of the new day surgery unit was improving patient flow and reducing waiting times.
- Local ward leadership was good, and staff were enthusiastic and keen to provide a high quality service to patients. Staff reported feeling well supported and that managers were approachable.

However:

- Staff said they had a good relationship with the executive team and felt listened to, but that concerns were not always acted upon.

Leadership of service

- The division was led by a divisional director, lead nurse and divisional manager. Staff told us that they were visible around wards and in clinical areas.
- Staff told us that they felt supported by their line managers, had opportunities for professional development and felt a valued part of the team.
- Senior staff on surgical wards, the day case unit and in theatres, all made themselves accessible to staff and encouraged their staff members to make quality improvement suggestions, or cost saving ideas.
- However, we observed one instance of a locum member of staff in theatres not conforming to the uniform policy and when we raised this with theatre who felt that they had no power of influence to make sure that the member of staff followed policy.

Vision and strategy for this service

- Staff we spoke to on the ward were aware of the ward vision as well as the wider hospital vision and strategy.
- The trust's vision was to deliver excellence in healthcare and high quality education and research. Nursing staff on surgical wards that we spoke with, spoke of the leadership on their wards aiming for the very best care for their patients, and it was clear from these discussions that this was a passion reflected in individual staff members.
- The introduction of a day surgery unit last year had increased the number of day patients whilst allowing the reconfiguration of existing theatre capacity and the introduction of a dedicated emergency theatre. New pathways were being considered and the division was taking on more ambitious day case procedures.
- Staff we spoke with were aware of the vision for their area and the hospital visions and values.
- Theatre staff told us that they have seven key objectives which had recently been presented to them. These were based on the trust objectives and reflected the department's aim to reach 85% theatre utilisation against the trust current median of 77% theatre utilisation.

Governance, risk management and quality measurement

- Regular governance meetings were held within the service. There was a good attendance by staff at divisional board meetings. Key issues were discussed according to agendas and minutes. A divisional action log showed ownership for actions with realistic timescales.
- Lessons learned from when things went wrong with patient care were shared within the surgical division and also in a wider cross-divisional context. We saw evidence of a surgical patient fall discussed in the April 2016 elective division clinical governance meeting minutes, including learning points identified from the root cause analysis report. This learning was later to be shared in the cross-divisional learning meeting later that month.
- Ward level information such as safety thermometer data was discussed at divisional level with appropriate challenge and oversight as shown by meeting minutes.
- Review of the elective division risk register showed that the surgical department had a number of risks documented including a high graded risks about capacity issues in the ophthalmology department

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leading to delays in patient's follow-up appointments. We saw that plans were in place to minimise this risk. Surgical services also had a high risk in relation to ears nose and throat cover for patients at the weekends which had not been formalised with a local NHS trust. We saw that this had been escalated appropriately in February 2016 to minimise the risk level to patients and there was appropriate mitigation in place for ongoing risk.

- A moderate risk had been logged about the governance arrangements for private patients and in May 2016 we saw that this had been escalated appropriately to the private patient committee for review and action.
- There were ongoing peer reviews of ward areas by senior staff from other wards. This highlights areas for improvement and offered peer challenge to staff.
- There was a comprehensive audit plan in place for the division. A member of allied health professional staff told us they were able to add in specific audits (once approved) and had added one for the coming year.

Culture within the service

- Within the 2015 annual staff survey 92% of staff said that they would recommend this trust as a good place to work in terms of the work and treatment they received. Nursing and medical staff spoke positively of the hospital's ability to retain staff either for continuous service, or returning after breaks in service.
- Staff retention was good and we heard examples of staff returning to the trust after receiving their medical training as part of the university teaching hospital programme.
- Surgical ward managers we spoke with all told us that morale was good amongst staff. They added that there was a sense of teamwork and staff supported each other when areas were short of staff.
- There was a positive, open culture within the division.

Public engagement

- The 'would you recommend to your..' friends and family test was carried out across the division and provided positive results in all areas.

- There was a "you said..we did" initiative across the surgical division for example resulting in the use of ear plugs at night for patients who requested them.
- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping of future services.

Staff engagement

- Staff in the day surgery unit showed us a number of thank you cards that they had received from patients, and confirmed that these messages were shared with the team in team meetings.
- At our inspection in August 2015 we saw that the trust had opened a social media 'twitter' account entitled 'proud of the paget' which allowed staff members to share positive messages about the trust. A post on 18 August 2016 had a picture of all the trust's porters ready to keep staff and patient's safe.
- Staff told us that they were encouraged to share their views at team meetings.
- Ward managers spoke of senior managers being 'approachable', adding that they often listened to staff's concerns, but felt they did not always have the capability or authority to address staff's concerns.

Innovation, improvement and sustainability

- Coloured walking frames were used for patients living with dementia on the trauma and orthopaedic ward, staff told us that research had showed this to reduce the number of falls.
- Staff we spoke with in the day surgery unit told us that there were plans to hold some of the day case surgical lists from a neighbouring NHS hospital to help decrease waiting list times for patients. To enable this there were plans to extend the service from Monday to Friday 06:45am to 10:00pm to include Saturdays.
- Managers were mindful that private patient work would need to be affiliated to the Private Healthcare Information Network, but were waiting for official guidance and timeframes for completion.

Maternity and gynaecology

Safe

Good



Overall

Good



Information about the service

James Paget hospital provides maternity and gynaecology services to the populations of Great Yarmouth, Lowestoft and Waveney. Maternity and gynaecology includes all services that relate to pregnancy and women's health. This includes antenatal care, labour and birth, and postnatal care. There were 2070 deliveries at James Paget hospital from April 2015 to March 2016.

The maternity service at James Paget hospital included a 23-bed maternity ward providing antenatal and postnatal care (ward 11), a 10-bed central delivery suite providing consultant-led care and the 3-bed dolphin suite, a midwifery-led birthing unit. The hospital provided an antenatal clinic, Monday to Friday 9am to 5pm and an early pregnancy assessment unit (EPAU) available Monday to Friday 9am to 4.30pm. The hospital also provided community midwifery services through GP surgeries and children's centres.

James Paget hospital provided a gynaecology inpatient service on ward 4. This was a female surgical ward with 28 beds. The number of beds used for gynaecology patients was dependent on demand. At the time of our inspection, three beds on this ward were in use for gynaecology patients. The hospital also has a gynaecology outpatient clinic.

Our inspection team visited the maternity and gynaecology services to observe care. We visited the maternity ward, the central delivery suite, the dolphin suite, EPAU, the antenatal clinic and ward 4. We did not inspect community midwifery services during this inspection. We spoke to seven women and their loved ones. We also spoke to 12 members of staff, including doctors, midwives, nurses, managers, a housekeeper and a support worker. We reviewed nine sets of patient care records and prescription charts.

Summary of findings

Overall maternity and gynaecology service were rated as good. In August 2015 the effective, caring, responsive and well-led key questions were all rated as good. We returned to the hospital to undertake a focused inspection of the safe key question only as in August 2015 safety was rated as requires improvement.

Our findings at this inspection demonstrated that improvement had been made and the safe key question was rated as good. This was because:

- Managers had moved the paediatric clinic away from the antenatal clinic in response to concerns about infection control raised at our last inspection. This meant that pregnant women attending antenatal appointments were not exposed to children with potentially infectious conditions, such as chickenpox.
- Staff consistently completed safety checks for emergency equipment in the maternity and gynaecology services.
- Medicines were stored securely across the maternity and gynaecology services.
- All clinical areas and equipment we saw were visibly clean.
- Managers had responded to midwifery staffing shortages and had recruited 18 midwives to start work from June to September 2016.

However:

- We found three medications that were out of date on the maternity ward. This meant that the efficacy of these medications could not be assured if they were given to women.

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- The midwife to birth ratio was consistently higher than the ratio of 1:29 recommended by the Birthrate plus staffing tool. However, senior staff had recruited 18 new midwives due to start work from June to September 2016 in order to improve this.
- There were no processes in place for gynaecology services to monitor safety outcomes for patients. This was however being planned.
- Staff signatures on prescription charts were not always legible. We looked at nine prescription charts and found that signatures were not easy to read on four of them. This meant that staff could not easily identify the prescriber if there were any questions or concerns about the prescription of medications. The provider took action to mitigate this by introducing electronic prescribing shortly after our inspection.
- The safety checklist for the resuscitation trolley on the maternity ward was not easy to read. This meant that there was a risk of staff not documenting safety checks accurately. The provider took action to address this concern during the inspection.

Are maternity and gynaecology services safe?

Good



We rated safe as good because:

- Clinical areas in maternity and gynaecology were visibly clean. Staff completed hand hygiene and complied with 'bare below the elbows' practices.
- Staff in the maternity and gynaecology services kept equipment clean and consistently completed equipment safety checks.
- Managers had moved the paediatric clinic away from the antenatal clinic, following concerns about infection control raised at our last inspection. This meant that pregnant women attending antenatal appointments were not exposed to children with potentially infectious conditions, such as chickenpox.
- There was a robust process for reporting and learning from incidents.
- Staff understood their responsibilities in relation to the duty of candour (a regulatory duty that relates to openness and transparency). Serious incident investigations showed evidence of staff using the duty of candour and there was a policy outlining expectations about this requirement.
- Staff set targets and collected data on safety outcomes. This included use of the maternity safety thermometer.
- Staff in maternity and gynaecology stored medicines securely and completed records of controlled drugs consistently.
- Records were stored securely and contained appropriate risk assessments.
- Staff were trained in safeguarding children. On ward 4, 95% of staff were trained in safeguarding children, level two. In the maternity service, 93.8% of midwives were trained in safeguarding children, level three. A team of specialist midwives supported staff with safeguarding concerns.

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- Consultant staffing on the labour ward was consistently 40 hours per week. This was in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG).

However:

- We found three medications that were out of date on the maternity ward. This meant that the efficacy of these medications could not be assured if they were given to women. However staff took immediate action and removed these.
- The midwife to birth ratio was consistently higher than the ratio of 1:29 recommended by the Birthrate plus staffing tool. However, senior staff had recruited 18 new midwives due to start work from June to September 2016 in order to improve this.
- There were no processes in place for gynaecology services to monitor safety outcomes for patients. This was however being planned.
- Staff signatures on prescription charts were not always legible. We looked at nine prescription charts and found that signatures were not easy to read on four of them. This meant that staff could not easily identify the prescriber if there were any questions or concerns about the prescription of medications. The provider took action to mitigate this by introducing electronic prescribing shortly after our inspection.
- The safety checklist for the resuscitation trolley on the maternity ward was not easy to read. This meant that there was a risk of staff not completing all of the required safety checks. The provider took action to address this concern during the inspection.

Incidents

- There were no never events in the maternity and gynaecology services from June 2015 to May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no serious incidents in the gynaecology service from June 2015 to May 2016 and four serious

incidents in the maternity service in this period. The number of serious incidents reported was less than the previous year, when there were nine serious incidents reported across maternity and gynaecology.

- Staff at all levels of seniority understood how to report incidents using the electronic reporting system that was in place. There were 1008 incidents reported from July 2015 to June 2016 in maternity and gynaecology. There was a trend of incidents related to medicines management in gynaecology, which senior staff had taken action to address. Senior staff did not identify any other trends in terms of incidents. We asked seven members of staff about the incident reporting process. All of them were able to describe the incident reporting process and told us they had received training in incident reporting.
- Staff in the maternity service completed detailed investigations into serious incidents. We reviewed three serious incident investigations. All three investigations included terms of reference, root cause analysis and plans for sharing learning from the incident with staff. Senior staff told us that all obstetrics and gynaecology consultants were trained in root cause analysis. This meant they had the skills to analyse the cause of serious incidents. The investigations we reviewed showed evidence of learning from serious incidents. For example, managers appointed a bereavement midwife following a recommendation from an incident investigation. After this change, improved support for bereaved parents was highlighted as an area of good practice in a later serious incident investigation.
- There was a robust process for learning from incidents in the maternity service. The risk and governance lead midwives triaged incidents on a daily basis and there was a weekly maternity clinical incident panel where the multidisciplinary team discussed incidents. We spoke to a midwife who confirmed, "The risk management team review all incidents." Managers in the maternity service shared learning with staff via the maternity risk newsletter and staff noticeboards. One midwife we spoke to told us that managers shared learning with staff and gave an example of how staff had learned from an incident by changing documentation.
- Staff in the gynaecology service told us that there was a monthly maternity and gynaecology governance committee where senior staff shared learning between the two services. Senior staff in the gynaecology service

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shared learning from incidents with ward staff via a newsletter. The gynaecology matron gave us an example of an incident where a referral to a specialist hospital for a patient with a molar pregnancy had not occurred. Staff were reminded of the process and importance of making these referrals.

- Staff understood their responsibilities in relation to duty of candour. 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. All three serious incident investigations we reviewed showed evidence of staff meeting duty of candour requirements. We asked five members of staff about duty of candour and all of them were aware of their responsibilities. The trust had a duty of candour policy, which outlined staff members' responsibilities in terms of this regulation and a duty of candour quiz was included as part of mandatory training for all staff. We saw an information poster about duty of candour in the staff resource room on the maternity ward.
- Staff held monthly perinatal morbidity and mortality meetings. We saw six sets of minutes from these meetings dated from June 2015 to May 2016. These showed that meetings were attended by a multidisciplinary team of obstetrics and gynaecology staff and contained discussion of cases in relation to morbidity and mortality.
- The maternity service had a specialist midwife for bereavement, who collected and reported data on all births from 22+0 to 23+6 weeks gestational age who did not survive the neonatal period. This was in line with recommendation eight of the mothers and babies reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) perinatal mortality surveillance report, published in June 2015.
- Senior staff monitored stillbirth and neonatal death rates using the maternity dashboard. This dashboard showed there were seven stillbirths from April 2015 to March 2016. There were no neonatal deaths in this period.
- The MBRRACE-UK perinatal mortality surveillance report for 2014 births was published in May 2016. James Paget hospital reported stillbirth, neonatal and extended perinatal mortality rates that were up to 10% higher than the group average, achieving an amber rating. The

adjusted stillbirth rate was 3.57 per 1000 births, the adjusted neonatal death rate was 1.28 per 1000 births and the extended perinatal death rate was 4.93 per 1000 births.

- MBRRACE-UK recommends that all organisations identified as having an adjusted extended perinatal mortality rate that falls in the red or amber band should conduct a local review, including checking of data quality and review of any local factors that might be responsible for the higher rate. The trust informed us that a local review had occurred. Any case of stillbirth was considered a serious incident and was investigated and presented to the maternity clinical incident panel for multidisciplinary review and learning. This was in line with recommendation two of the MBRRACE-UK report, which recommends that all organisations, irrespective of their extended perinatal mortality rate, should investigate individual stillbirths and neonatal deaths.

Safety thermometer

- Staff in the maternity service collected data on patient safety and set targets for safety outcomes. Data on safety outcomes showed positive results. For example, the maternity dashboard showed that a target of 97% had been set for venous thromboembolism (VTE) assessments. Completion of VTE assessments from April 2015 to March 2016 was 97.1% for the dolphin suite, 97.2% for the central delivery suite and 93.2% for the maternity ward. From April to July 2016 results for the maternity ward had improved: completion was 100% in April and May, 98.6% in June and 97.9% in July.
- Maternity staff collected data for the NHS maternity safety thermometer every month. The NHS maternity safety thermometer was introduced in 2015. It is an improvement tool for measuring, monitoring and analysing patient harm and harm free care. The maternity safety thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. Also included is an Apgar score of less than seven at five minutes, and unexpected admissions to neonatal units. The Apgar score is an assessment of overall newborn well-being, which staff complete at one and five minutes after birth.

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- Results from the maternity safety thermometer showed that from March 2016 to July 2016 there had been three episodes of harm in the maternity department. Two of these related to postpartum haemorrhage of 1000-1999 millilitres and one related to a third degree tear.
- Staff on ward 4 collected data for the NHS safety thermometer. Information was collected on a monthly basis in relation to pressure ulcers, falls, venous thromboembolism and urine infections (in patients with a catheter). However, the matron informed us that the incidents reported did not relate to gynaecology patients who were at less risk for these incidents compared to other patients on the ward. Staff did not collect information on safety outcomes specifically in relation to gynaecology patients. Staff had an action plan in place to create a gynaecology dashboard, however this had not been completed at the time of our inspection.
- Managers presented information on safety outcomes to staff using the maternity dashboard. We saw this dashboard displayed in staff areas on the maternity ward and central delivery suite. We did not see safety thermometer results displayed in any patient areas during our visit. This meant that women using the service did not have access to information on the safety performance of the service.

Cleanliness, infection control and hygiene

- All the clinical areas we visited in maternity and gynaecology were visibly clean. We saw staff completing hand hygiene before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.
- Clinical staff in the maternity and gynaecology services were bare below the elbows and wore uniforms in line with trust policy. For example, on ward 4, we saw five nursing staff, three doctors and one occupational therapist who were bare below the elbows.
- Audit data showed good compliance with hand hygiene procedures. From January 2016 to July 2016, monthly hand hygiene audit scores were consistently between 95-100% on the maternity ward and central delivery suite. On ward 4, audit of hand hygiene procedures showed a 100% score in March 2016. However, we noted that the next audit, due in April 2016, was overdue.

Senior staff responsible for infection control told us that this was due to confusion following a change in responsibility for completing the audit from the infection control team to ward staff. Senior staff told us that steps had been taken to correct this and audit completion would be closely monitored in future.

- A local maternity survey of 10 women in June 2016 showed positive results about cleanliness. In response to the question 'Are the facilities always kept clean?' 90% of women replied 'Yes' and 10% did not answer this question. All seven of the women and their loved ones that we spoke to during our inspection told us that facilities were clean and that staff completed hand hygiene. We saw information posters for visitors about handwashing and infection control in the corridor of the maternity ward.
- Equipment across the maternity and gynaecology services was visibly clean. We checked cardiotocograph machines (machines to monitor foetal heart rate), resuscitation trolleys and a selection of other equipment on all wards across maternity and gynaecology. All the equipment we checked was visibly clean and marked with green 'I am clean' stickers to indicate when the equipment was last cleaned. All of the stickers we saw were dated appropriately. There were three birthing pools on the dolphin suite. A midwife informed us that clinical staff cleaned this daily.
- We saw results from an environmental cleanliness audit on display in the maternity ward. This showed that staff had carried out an environmental audit four times between January and June 2016. Scores were 97% in January, April and May 2016 and 98% in June 2016. Data was missing for February and March 2016.
- We saw that the disposable curtains on the central delivery suite had been renewed in July 2016 and staff told us that they were changed every three months or sooner if they became soiled. On the maternity ward and ward 4, fabric curtains were in situ. There was a cleaning strategy in place for these with clear timeframes and responsibilities for cleaning and replacing these curtains.
- We noted that the paediatric clinic had been moved away from the antenatal clinic in August 2016 in response to concerns about infection control raised during our last inspection. The antenatal clinic now had its own waiting area, which was not shared with the

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paediatric clinic. This meant that pregnant women in the antenatal waiting area were not exposed to children with potentially infectious conditions, such as chickenpox.

- There were no cases of MRSA or norovirus in maternity and gynaecology from April 2015 to March 2016.
- There were no cases of *Clostridium difficile* (C. difficile) in the maternity service from April 2015 to March 2016. There were two cases of C. difficile on ward 4 from April 15 to March 16. The matron informed us that these did not relate to gynaecology patients.
- There were four instances of puerperal sepsis (infections related to giving birth) within 42 days of delivery in the 12 months prior to our inspection. However, staff in the maternity service had not set any targets in terms of puerperal sepsis rates.

Environment and equipment

- The doors to gain entry to the maternity wards were locked in order to ensure the safety of women and their babies. Staff asked visitors who they intended to visit before allowing them entry. During the inspection, staff asked us to present our identification badges when entering the maternity ward.
- Staff monitored equipment for electrical safety. We checked five cardiocotograph machines in the maternity service. We also checked a selection of other equipment across maternity and gynaecology, including six blood pressure monitors, one ECG machine, two sets of suction equipment and one set of scales. All of this equipment was in date for electrical safety testing. We visited the storeroom on central delivery suite and found that all items were stored appropriately on shelves.
- We checked five neonatal resuscitaires across the maternity department. We looked at records for the last 10 days and found that staff had consistently completed all the required safety checks for the four resuscitaires we saw on the central delivery suite and the dolphin suite. The resuscitaire on the maternity ward was safety checked by staff every day, although we found one individual check was not documented on 15 August and one check was not documented on 16 August. We raised this with the ward manager at the time of our inspection.
- We checked the adult resuscitation trolley on ward 4. This was shared with ward 5 and staff from each ward

completed checks on alternate months. The trolley was easily accessible and staff had completed all the required safety checks over the last 10 days. The adult resuscitation trolley on the maternity ward was stored in an easily accessible location. We reviewed the checks that staff had made on the trolley over a period of 16 days and found that safety checks had been completed every day. The checklist contained a large number of checks to be completed each day. Over the 16-day period, three individual checks had not been documented. Two of these related to the availability of spare security seals and one related to the tray being secured with a security seal. We also noted that the checklist was not easy to read due to being a faded photocopy. This meant that there was a risk of staff not documenting all required safety checks. We raised these points with the ward manager and action was taken to address these concerns..

- Staff in the maternity department had developed an action plan to improve checking of equipment following concerns over checking of emergency equipment raised at our last inspection. This included a daily equipment checklist, which was put in the ward coordinator's handover book. We saw this checklist on the maternity ward and the central delivery suite.

Medicines

- We checked access to the medication preparation rooms on the maternity ward, the central delivery suite and ward 4. All three rooms were secured with keypad access and staff kept controlled drugs (CDs) behind two locked doors. This meant that medications were stored securely.
- We saw two members of staff on the maternity ward and ward 4 checking the dosage and date of medicines before administering them. This meant there was less risk of women receiving inappropriate medication.
- We looked at registers of CDs on the maternity ward, central delivery suite and ward 4 for the month of August 2016. These showed that staff regularly checked the register of CDs to ensure that the stock of each drug was monitored and accounted for. On the central delivery suite, the CD book was checked on a daily basis. On the maternity ward and ward 4, the CD book was checked on a weekly basis. Staff on the maternity ward told us that the pharmacist audited the CD book every three months to make sure that these medications were monitored correctly.

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- We checked a sample of four CDs on the maternity ward and four CDs on ward 4. All of these were in date and stored appropriately. On the maternity ward, we checked the emergency post-partum haemorrhage box and the pre-eclampsia emergency box. We checked a selection of five medications within these boxes and all were in date. We looked at records for checking these boxes from March 2016 to August 2016 and saw that these were completed on a weekly basis.
- We saw records of daily refrigerator temperature checks on the central delivery suite. We looked at a sample of these checks from 1 August 2016 to 16 August 2016 and found that all checks were complete and were within the recommended temperature range of two to eight degrees. This meant that medications that needed refrigeration were stored correctly on the central delivery suite.
- During our inspection, we found three medications that were out of date on the maternity ward. We raised this immediately with the ward manager who disposed of the out of date medications and assured us that two members of staff checked all medications before they were given to women. We saw staff checking the date of medications before administration. The ward manager alerted the head of midwifery about the out of date medications. The head of midwifery informed us on the following day that an action plan was being put together to prevent this from happening again.
- Senior staff in the gynaecology service told us they had noted a theme of incidents relating to medicines management. In response to this, they had developed a medicines management newsletter, which they sent to staff to improve processes around medicines management.

Records

- All patient care records were stored securely in staff areas on the maternity ward and ward 4.
- We reviewed nine sets of patient care records across maternity and gynaecology. Pathways of care were clearly documented in all nine sets of notes.
- All nine sets of notes we reviewed contained assessment of pain, which meant that staff monitored women for pain.
- All of the patient care records that we reviewed contained documentation of women's consent to treatment.

- All of the prescription charts we saw were signed and dated and included documentation of allergies. However, we did note that in four maternity prescription charts not all signatures were legible. This meant that staff could not easily identify the prescriber if there were any questions or concerns about the prescription of medications. The provider took action to mitigate this by introducing electronic prescribing shortly after our inspection.

Safeguarding

- Four specialist midwives, known as the Eden team, provided advice on any concerns relating to safeguarding and child protection in the maternity service. The records we reviewed contained evidence of appropriate referrals to the team and staff were aware of the team's role. A named midwife attended the trust safeguarding committee to provide a link for safeguarding between the maternity service and the rest of the trust.
- All staff across maternity and gynaecology completed training in safeguarding adults and safeguarding children (level 2) as part of their mandatory training. On ward 4, 98% of staff were trained in safeguarding adults and 95% of staff were trained in safeguarding children level two. In the maternity service, 93.8% of midwives were trained to level three in safeguarding children due to their direct involvement in the care of children. Midwives and midwifery support workers were required to evidence 12 to 16 hours of safeguarding experience every three years using a participatory log as part of their mandatory training.
- There was a safeguarding children strategy in place. This was version controlled, in date for review and referred to national and local requirements.
- The trust had a guideline for "The Management of Children Under the Age of 16 Years Who Abscond/Go Missing from Children Inpatient Areas" to guide staff in the maternity service how to respond if a child went missing from a ward. This guideline, which was issued in July 2015, was version controlled and was within the stated date for review.
- Staff in the maternity service told us they received training on domestic violence. We saw a flowchart for staff about domestic violence on the central delivery suite. Two midwives told us that they had attended a

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study afternoon about female genital mutilation (FGM). Senior staff in the maternity department told us that FGM was discussed as part of safeguarding training. Staff did not receive training on child sexual exploitation.

- Staff in the service did not have a formal protocol for the management of termination of pregnancy for young people under the age of 13. Senior staff in the service told us that presentation of young people of this age for termination of pregnancy was very rare and that these young women would be admitted to the paediatric ward but overseen by the termination of pregnancy clinic. We saw a patient information leaflet, which contained advice for women under the age of 16 about legal competence to consent to termination of pregnancy and outlined staff members' obligation to report concerns about sexual abuse or harm to social services.

Mandatory training

- All staff in the maternity and gynaecology services were required to complete mandatory training including basic life support, safeguarding, moving and handling and training on mental capacity assessment.
- Staff in the maternity service completed additional mandatory training, which was specific to their speciality. This included emergency skills and drills, cardiotocograph (CTG) training and antenatal screening training.
- In the maternity service, all mandatory training was pre-booked for staff by the practice development midwife, who was responsible for maintaining staff competency. From January to August 2016, 79% of staff had completed their mandatory training, including their specialist maternity training. The remaining staff were scheduled to complete their mandatory training later in the year. The head of midwifery told us that this 'year to date' system of monitoring was used in the maternity service to ensure that all staff had completed their training by the end of the year.
- Staff compliance with mandatory training on ward 4 was 92% for the last year. This was below the trust target of 95%.
- We spoke to two junior doctors who were new to the maternity and gynaecology service and both told us that they had completed their mandatory training.

Assessing and responding to patient risk

- All nine sets of notes we reviewed had early warning scores documented. An early warning score is a tool used to monitor and respond to a deteriorating patient. In four sets of records there was a need to escalate the level of care given to the woman. All four of these records had clear plans for escalation and evidence of action being taken promptly. For example, one set of notes showed evidence of a woman being transferred from the dolphin suite to the central delivery suite following a worsening of her condition.
- The risk and clinical governance midwife had completed an audit of compliance with newborn early warning trigger and track procedures (NEWTT) for the month of June 2016. This audit of 20 patient records, showed positive results in terms of staff monitoring newborn babies and escalating their concerns. The audit showed that 100% of all newborn infants with a NEWTT chart had risk factors documented, 100% of observations were recorded correctly, 100% of concerns were escalated appropriately and 80% of identification was documented accurately on the chart.
- The patient records we saw contained appropriate risk assessments. Eight out of the nine records we reviewed contained assessment for risk of venous thromboembolism (VTE). Staff completed specific risk assessments for women using the maternity service, including assessment of BMI, mental health history and safeguarding concerns.
- Staff in the maternity theatre used the World Health Organisation (WHO) five steps to safer surgery checklist. This is a tool for improving the safety of surgery by reducing complications and deaths. Audit data showed that staff consistently completed these checklists. From May 2015 to May 2016 completion of the checklist for the maternity service ranged from 97.2% to 100%.
- On the maternity ward we saw information displayed for staff about where to find the nearest resuscitation equipment if the ward's own equipment was already in use.
- We spoke to two junior doctors who told us that senior medical staff supported them to ensure the safety of women. One told us that there was always a consultant available and said, "If you call, they come." The doctors we spoke to told us that all women were reviewed by a senior doctor before any decisions about discharge from hospital were made.

Midwifery staffing

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- Senior staff in the maternity department used the Birthrate plus acuity tool to assess the level of midwifery staffing needed. Maternity managers completed the Birthrate plus tool in October 2015 and this showed a recommended midwife to birth ratio of 1:29.
- The actual midwife to birth ratio had been 1:35 on average from April 2015 to March 2016. This was higher than the ratio of 1:29 recommended by the Birthrate plus analysis and the Royal College of Midwives 2010 guidance.
- Senior staff had responded to the shortfall in midwives. They had highlighted midwifery staffing on the maternity risk register and in the maternity unit meetings. Senior staff in the maternity service put forward a business case for staffing levels to be increased in line with recommendations from the Birthrate plus tool. To meet the ratio recommended by the tool, an uplift of 5.14 whole time equivalent midwives and 2.37 whole time equivalent midwifery support workers was agreed in May 2016. Following this, senior staff in the maternity service had successfully recruited 18 midwives due to start work from June to September 2016.
- The service had a good track record for ensuring planned staff were on shift. From May to July 2016 between 94.5% to 97.9% of planned midwifery staff were on shift for day shifts and from 93.9% to 97.3% for night shifts. During the same period, 88.2% to 99.4% of midwifery support workers were on shift for day shifts and from 95.9% to 106.5% for night shifts.
- Senior staff told us that they used an escalation plan when there were staffing problems, which included reallocating community staff to the maternity unit. This meant that the maternity unit had not closed due to staffing since October 2013.
- Agency midwives were used in the maternity service. Senior staff in the maternity service told us that four to five regular agency midwives, who were familiar with the service, were used regularly. Staff told us that agency staff received an induction. Senior managers in the maternity service told us that they planned to stop using agency staff by October 2016, once all the recruited midwives were in post.
- On ward 4, meeting planned staffing for nurses ranged from 88.1% to 95.3% for day shifts and from 94.2% to

97.6% for night shifts from May to July 2016. For non-registered staff, meeting planned staffing ranged from 93.2% to 94.7% and from 99.8% to 102.1% for the same period.

- We saw planned and actual staffing numbers displayed on the maternity ward and the central delivery suite. On the day of our visit, the actual number of staff matched the planned number of staff. We did not see any staffing numbers displayed on ward 4. This meant that patients did not have access to information about staffing levels on the ward.
- The gynaecology matron told us that the matrons completed a daily walk round of wards in order to assess staffing levels and re-allocate staff as required.
- We spoke to two women on the maternity ward who had recently given birth. Both of these women told us that they received one to one care from a midwife during labour and that staff responded quickly if they had a concern. Staff told us that women received one to one care during labour.
- Senior midwifery staff were available to support midwives 24 hours a day, seven days a week via an on-call system.

Medical staffing

- Consultant cover on the labour ward was consistently 40 hours per week from April 2015 to July 2016. This was in line with The Royal College of Obstetricians: safer childbirth: minimum standards for organisations and delivery of care in labour (2007), which states that for a unit with less than 2500 births per year, consultant cover should be 40 hours per week or based on risk assessments.
- The consultant grade staff skill mix was 35%, which is slightly lower than the England average of 40%. There were eight obstetrics and gynaecology consultants in total, including two locum consultants. Senior staff told us that consultants were available on site or on-call 24 hours a day, seven days a week. We spoke to two junior doctors who said that there was always a consultant available and that consultants would regularly come in out of hours when they were needed. The clinical lead for obstetrics and gynaecology was currently acting as lead consultant for the labour ward.

Maternity and gynaecology

- An anaesthetist was available 24 hours a day, seven days a week. This was in line with AAGBI Obstetric Anaesthetic Guidance, which states that a duty anaesthetist must be immediately available 24 hours a day, seven days a week.
- There were eight middle grade doctors and seven junior grade doctors in the maternity and gynaecology service. Out of hours cover was provided on a rota basis. We spoke to two junior doctors who both said that there were no gaps on the junior grade or registrar rotas.
- Both of the junior doctors we spoke to told us that handovers occurred twice a day and were well attended by members of the multidisciplinary team.

- Staff reported a low number of incidents in relation to staffing. There were only three incident forms relating to staffing from April 2015 to March 2016.

Major incident awareness and training

- Staff in the maternity service had an escalation plan in case of disruption to staffing.
- There was a trust-wide business continuity strategy in place. This was last updated in 2014 and was within date for review.

Services for children and young people

Safe

Good



Overall

Good



Information about the service

The James Paget Hospital NHS Foundation Trust provides children and young people's services to a population of approximately 230,000 people throughout Great Yarmouth, Lowestoft and Waveney. Children's services at the trust included a nine cot neonatal unit, a 29 bedded ward (Ward 10) and children's outpatient clinics.

The trust is also responsible for a community paediatric service, which is operated from the Newberry clinic at a separate location. This provides healthcare services to children from infancy to adolescence who are vulnerable due to additional needs.

The neonatal unit (NNU) has one intensive care cot for up to 24 hours, two high dependency cots and six cots for babies requiring special care. The service provides a full range of medical services for babies born at 30 weeks gestation and above. Babies born under 30 weeks gestation or who require longer term ventilation are stabilized and transferred to another hospital that can provide on-going care. The neonatal unit is part of a network of neonatal services throughout the East of England region and the network has a dedicated transport team for when a sick baby needs transferring to another hospital in the region.

Ward 10 is divided into two areas, 10a is the medical end of the ward, which includes a six bedded bay, four side rooms, two high dependency rooms and a paediatric assessment unit. Ward 10b is the surgical end with eight beds as well as a six-bedded young person's unit, which has three single sex rooms with en-suite facilities for two young people aged 13 years or above and its own sitting room. A playroom is located next to the eight bed surgical ward.

Minor procedures such as blood tests, are undertaken in the jungle themed room next to the ward.

Overnight accommodation is provided for parents to stay with their children as well as a parents' kitchen and sitting room.

The service also has a new dedicated children and young person outpatient department with eight consulting rooms and separate waiting areas for adolescents and young children and a new paediatric recovery room with two bed/cot spaces.

During our inspection we visited the neonatal unit, ward 10, children's outpatients and the paediatric recovery area. We spoke to 15 members of staff including nurses, doctors, a play specialist, phlebotomist and housekeeper. We spoke to one parent and reviewed 11 care records and 10 prescription charts.

We did not visit the Newberry Unit on this inspection.

Services for children and young people

Summary of findings

Overall children and young people's services were rated as good. In August 2015 the effective, caring, responsive and well-led key questions were all rated as good. We returned to the hospital to undertake a focused inspection of the safe key question only as in August 2015 safety was rated as requires improvement. Our findings at this inspection demonstrated that improvement had been made and the safe key question was rated as good. This was because:

- The trust has made significant changes to the children's outpatient service, which now has a new dedicated children and young people's outpatient clinic, no longer sharing space with the maternity service.
- The trust has developed a standard operating procedure (SOP) to ensure a senior (band 6 or above) paediatric nurse was available at all times via a rota as per Royal College of Nursing best practice guidance (2013) in relation to nurse staffing levels for children's and young people's services.
- Resuscitation equipment was checked and recorded daily, with full checks undertaken weekly as per trust policy.
- There was a new children and young person flowchart to risk assess those with mental health crises needing a place of safety.
- Safeguarding training had improved with all but one staff trained to level three.

However:

- The paediatric immediate life support refresher training was below trust requirements but we did see evidence of booked dates to rectify this.
- Ward 10 and the NNU had not produced regular data for the hand hygiene and personal protection equipment audit.
- Medicines were not stored appropriately on the NNU with poor management of medicine fridge temperatures and out of date medicine in drug cupboards.

Are services for children and young people safe?

Good



We rated safe as good because:

- Incidents were reported and investigated in a timely manner and there was evidence of learning from incidents.
- Records were kept securely and confidentiality was maintained.
- Safeguarding processes were robust and there was evidence of collaborative working across the paediatric department to protect children and staff were trained appropriately.
- Clinical areas were visibly clean and uncluttered and equipment had dated 'I am clean stickers' in place.
- The previous CQC inspection had identified that shared clinic space with antenatal clinic was not safe and the trust had redressed this with a new dedicated children's outpatient clinic.
- There was a new children and young person flowchart to risk assess those with mental health crises needing a place of safety presenting to the accident and emergency department.

However:

- We could not be assured that medicines were monitored and stored safely as we found out of date medicines and poorly monitored medicine fridge temperatures.
- Staff were not compliant with regular hand hygiene audits, which meant we were not assured that they conformed to trust infection prevention and control policy. We also found that there were no records kept which confirmed cots or resuscitaires had been cleaned.
- Paediatric immediate life support (PILS) training figures were 68%, which was below the trust requirement of 95%. All staff who were out of date had refresher training booked within three months.

Incidents

Services for children and young people

- There were no never events or serious incidents reported at the trust for children or young people for the period June 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. A serious incident is an event leading to a serious level of harm, unexpected death and/or likely to attract public and media interest.
- We reviewed the 294 trust reported incidents from 1 July 2015 to 28 June 2016. These included 130 incidents from the Newberry Unit, 67 from ward 10, 37 from the neonatal unit, 29 from paediatric outpatients and 29 from 'the paediatric department'. There was no common theme for the incidents reported from ward 10 or the neonatal unit and the main theme for the Newberry unit was of missing notes for clinics.
- All of the staff we spoke to were aware of how to report incidents on the trust's electronic reporting system and knew who to escalate them to. Staff told us they received feedback if they completed the relevant tick box on the electronic incident report form. Learning from incidents was delivered via face to face meetings and posted on the wall in the ward 10 seminar room. Incidents were also discussed at monthly risk meetings. We saw minutes from the meeting held on 27 June 2016, which showed two incidents, and their outcomes were discussed. Learning from incidents was evident such as reviewing blood test results and the introduction of a risk assessment proforma for young people presenting with mental health issues.
- We reviewed the root cause analysis (RCA) of an incident and this showed robust investigation. Learning needs were identified and an action plan produced.
- Senior staff had received RCA training to investigate incidents.
- The trust was criticised following the last CQC inspection for not producing minutes of morbidity and mortality meetings (M&M). We saw evidence of the minutes of M&M meetings from March, May and June 2016 and the resulting action plans.
- The staff we spoke to had a good understanding of duty of candour and were able to describe when it would apply. 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.

- We saw evidence of a doctor contacting a baby's parent to explain the outcome and risk of a medication overdose incident.

Safety Thermometer

- The NHS Health and Social Care Information Centre records data on one specific day each month, for a safety thermometer. This nationally collected data provides a snapshot of specific harms. The paediatric safety thermometer reported no episodes of hospital-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections or venous thromboembolisms (VTE) for the period April 2015 to April 2016.

Cleanliness, infection control and hygiene

- Both ward 10 and the neonatal unit were visibly clean and uncluttered. The bins were clean and not overfull, and sharps bins were labelled, dated and not overfilled.
- Clinical areas were clean and well stocked and sluice areas looked clean and tidy. There were 'I Am Clean' stickers on equipment showing the last date of cleaning.
- The children's outpatient area was clean and newly refurbished and had only been occupied for two weeks prior to the inspection. On the day of our visit, a drain had flooded in one of the consulting rooms and we saw evidence of deep cleaning following the flood.
- The play room staff in ward 10 had a rota for cleaning toys and we saw evidence of the daily sign off sheet. This was signed daily since November 2015. The toys were stored in clear plastic boxes and these were marked with last cleaning/check dates.
- The play team also audited the cleanliness and condition of play equipment used in other outpatient areas such as the accident and emergency department and other outpatient clinics where children were seen. We saw the audit findings from 15 August 2016 which showed varying degrees of cleanliness and the actions recommended.
- The housekeeper on the neonatal unit confirmed they thoroughly cleaned the cots and incubators following a

Services for children and young people

baby being discharged, these were then stored on the unit or in a storeroom until needed. We observed equipment being washed and disinfected during the inspection.

- There was no evidence of any rota for cleaning cots and resuscitaires whilst occupied or in storage and when questioned the housekeeper confirmed they would be damp dusted if necessary prior to occupation. Records were kept of the cleaning and previous occupants of cots and resuscitaires. "I am clean" stickers were applied to cots and resuscitaires.
- Staff washed their hands before and after patient contact and adhered to the 'bare below the elbows policy'. There was hand sanitizer available on entering the wards and at multiple locations throughout and staff were seen using it.
- Personal protection equipment (PPE) such as gloves and aprons were readily available and we saw staff using them where appropriate.
- The infection prevention and control (IPC) team audited hand washing fortnightly for areas achieving less than 80%, monthly for 81-90% and bi monthly for those areas achieving over 95%. Both ward 10 and the neonatal unit were overdue in submission of hand hygiene and PPE audit data. Ward 10's last audit information provided was from April 2016 when they scored 100%, the neonatal unit last provided audit data from March 2016 when they also scored 100%. We requested evidence of more recent audit submission but they were unable to provide this. Previous submission of data had also been irregular although both areas consistently showed scores of 100%. We were not assured that hand hygiene audits and PPE were regularly submitted.
- The IPC team performed environmental checks of the neonatal unit and ward 10 in April 2016. High level dust was found on ward 10 and the area was missing 'I am clean' labels for some equipment. We saw that a check on 24 May 2016 showed improvement to 91% with improvements noted on the report. The neonatal unit scored 100%
- The neonatal unit identified seven cases of AmpC *Enterobacter* Species colonisation in babies between February and August 2015. AmpC are enzymes, which convey resistance to commonly used antibiotics. This could make treating babies with AmpC infections very difficult. The unit met with the consultant microbiologist and IPC specialist nurse on three separate occasions to identify how the babies became infected. It was felt that

some babies were probably already colonised when admitted from another unit. The group discussed actions to prevent further cases such as reviewing the isolation room cleaning, further isolation protocol development, discharge screening and staff competencies for swab taking.

- There had been no further cases identified and no MRSA bacteraemia or clostridium difficile (C diff) infections in the previous 12 months.

Environment and equipment

- For security and protection of children and babies, ward 10, the neonatal unit and the new paediatric recovery room were only accessible via a staff electronic security pass or an intercom system. During daytime hours, a reception window was manned by a ward clerk on ward 10 for access. The exit for these locations was also electronically controlled. This meant that the environment was secure to prevent unauthorised visitors or the absconding of children.
- The children's outpatient clinic doors were unlocked during clinic times only if a ward clerk was at the desk with full sight of the doors. The door was locked at all other times. This ensured that children could not wander or be removed from the department without being seen.
- We inspected a range of equipment on ward 10 and the Neonatal unit and found them to be safety tested and serviced within the past 12 months. The previous inspection had reported inconsistencies with the daily checking of resuscitation trolleys and oxygen and suction equipment. On this inspection, we found resuscitation trolleys on ward 10 had been checked and signed daily, with full checks undertaken weekly as per trust policy. There were also lists of all equipment and expiry dates in the trolley folders. The housekeeping staff checked the oxygen and suction equipment daily and we saw that on the days when they were not on duty, the equipment was checked by another member of staff. There were no gaps in the daily logs since August 2015. The children's outpatients department had a new resuscitation trolley with a defibrillator and checks were all recorded as per trust policy.

Medicines

- Medicines were safely stored in locked cupboards and fridges on ward 10, the neonatal unit and the children's outpatients.

Services for children and young people

- Staff told us that both ward 10 and the neonatal unit had dedicated pharmacists who were responsible for restocking regularly used medications.
- We looked at seven medication charts on ward 10 and three on the neonatal unit. All charts had allergies and weight documented and were signed and dated correctly.
- We observed medications being administered with the appropriate name and date of birth checks on name bands.
- Controlled drugs were stored appropriately in locked cupboards and signed out by two nurses and weekly stock checks were recorded.
- Fridge temperatures were recorded daily on ward 10 and the neonatal unit with high and low temperatures recorded (recommended range between two-eight degrees). We reviewed records from January 2016 until August 2016 and noted that although staff checked the fridge daily, no action was taken when the temperature was out of normal range. On ward 10a the log showed two occasions in May 2016 where the fridge temperature exceeded eight degrees with no action or comment. The neonatal unit fridge temperature logs for January to March 2016 showed seven episodes of the temperature being higher than eight degrees. The logs for April to June were missing. July to August showed one missing check and 12 days when the fridge temperature dropped below two degrees or exceeded eight degrees, on one occasion reaching 16.4 degrees. When questioned, staff remarked that it was probably because the fridge had been opened for a while before the check was done. None of these recordings showed a recheck or any action to resolve. The trust policy was to recheck the fridge temperature after one hour and if not within normal range, to report to the pharmacy and the estates department. This meant that staff could not be assured that the medicines stored in the fridges were safe to administer as they had not been stored at the correct temperature. The children's outpatients log had 12 gaps in the daily log between May to August 2016 but no temperature abnormalities recorded.
- We checked a variety of drugs stored in the medicine cupboards and fridges. On the neonatal unit we found gentamycin eye drops that expired at the end of July 2016 and two boxes of medium used for Methicillin Resistant Staphylococcus Aureus (MRSA) swabs in the fridge that expired on 27 July 2016 and 1 August 2016.

The nurse in charge confirmed that no babies were currently prescribed eye drops and the medication and medium was discarded. In the children's outpatients we found chlorpheniramine suspension that expired in May 2016, an Epipen that expired in July 2016 and paracetamol suspension, with no opening date recorded. When brought to the attention of the nurse in charge, they explained that these medications had been brought down from another clinic (dermatology) that morning for an allergy clinic and not yet been checked. They were immediately disposed of.

- The neonatal staff indicated that weekly checks of medication were supposed to take place on night duty but there was no record kept of this.

Records

- Patient care records were stored securely on ward 10, the neonatal unit and children's outpatients.
- The trust used multidisciplinary care records for different ages and we saw that they were completed and updated by all members of the multidisciplinary team. The care record included medical history, person-centred information, care planning, safeguarding information and communication methods.
- We reviewed nine patient care records on ward 10 and two on the neonatal unit. All entries were signed, although signatures were not always legible and bleep numbers were not always shown making it difficult to know who had reviewed the patient. On one care record the date had been incorrectly entered twice as 5 August 2016 instead of 15 August 2016, and on another the entry was not dated.
- The neonatal staff had recently started using the East of England Neonatal Operational Delivery Network first hour of care pathways. These were multidisciplinary documents designed to ensure that babies were risk assessed and received the appropriate care in the first hour of life. There were two separate pathways: for babies who required special care/observation and those who required intensive or high dependency care. We reviewed two pathways, one was correctly completed, the other had several gaps but a member of staff said that as the forms were new, some staff were still not familiar with them. The pathways were in the process of being audited.

Safeguarding

Services for children and young people

- The safeguarding team comprised of a children's safeguarding lead nurse, adult safeguarding lead, both with level four safeguarding training, a named safeguarding midwife and named doctors for both the children's and adult services and a safeguarding business co-ordinator who provided clerical support.
- The children's safeguarding dashboard recorded 126 safeguarding concerns in the period April 2015 to March 2016. There were 164 Multi Agency Safeguarding Hub (MASH) referrals made and 127 incidents of professional information sharing recorded. The MASH is a multi-agency team which co-locates key safeguarding agencies with a view to better identifying risks to children, and improving decision-making, interventions, and outcomes.
- The trust had recently updated (April 2016) their safeguarding children strategy and kept a safeguarding log with evidence of regular updated actions.
- The safeguarding risk register had three medium risk and one high risk entry and there was evidence of regular review and actions to redress risks.
- The safeguarding lead nurse for children worked closely with members of the children and young people's service and had good links with the accident and emergency staff. The trust used a secure nationwide database that gave staff access to community records and social care involvement with vulnerable children.
- Safeguarding supervision was in place for staff that required support.
- The safeguarding nurse checked records daily of children presenting at the accident and emergency department.
- Staff we spoke with were aware of their safeguarding responsibilities and able to describe their actions if they had a safeguarding concern.
- All nursing and nursery nurse staff were trained to level three safeguarding, other than one paediatric nurse in the recovery room who was trained to level two, one nurse who was leaving shortly, and another who had an update booked. The phlebotomist who ran a paediatric clinic twice a week was also level three trained. This is required training for all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

- Medical staff told us they were trained to level three but although requested, we were unable to access their training records to confirm this.
- The trust produced a guideline in July 2015 for "The Management of Children Under the Age of 16 Years Who Abscond/Go Missing from Children Inpatient Areas" to guide staff on how to respond if a child went missing from a ward. This guideline, was version controlled and was within the stated date for review.

Mandatory training

- Mandatory training for nurses was via face to face, workbook and e-learning.
- Nursing and nursery nurse staff confirmed that they were given time to attend mandatory training and that it was delivered in a variety of ways, which "kept it interesting".
- The information supplied by the trust indicated that staff were 94% compliant with mandatory training which was slightly below the 95% rate required by the trust.
- The training encompassed paediatric life support, information governance, consent, safe use of insulin equality and diversity, infection prevention and control and medicines management.
- The paediatric life support training figures (PILS) were of particular concern at 68%. During the inspection, the senior nurse did provide evidence of booked dates for refresher training within the next three months.

Assessing and responding to patient risk

- The neonatal unit had one intensive care cot, which was used for babies up to 24 hours, after which time babies would be transferred to a specialist unit at another hospital if their condition warranted further intensive care. Two cots were high dependency with the other six used as special care cots.
- The neonatal unit was part of the East of England network of neonatal services for the region and the network had a dedicated team from the acute neonatal transfer service (ANTS) for when a sick baby needed transferring to another hospital in the region.
- The neonatal team continually risk assessed staffing levels according to British Association of Perinatal Medicine (BAPM) guidance and closed the unit to non-urgent transfers when staffing levels were low, although they remained open to emergency admissions.

Services for children and young people

- The paediatric service used a paediatric early warning (PEWs) tool to monitor and manage deteriorating patients on ward 10 and the neonatal unit used the neonatal version of the tool (neonatal EWs). Ward 10 took part in a PEWs audit between August and December 2015. The audit results were presented at a governance meeting and showed poor escalation of high PEWs and use of the purple sticker prompt, which indicated a PEWS score of greater than three and requiring medical review. Actions for nursing staff were identified such as indicating the frequency of observations, stating if oxygen saturations were on air or oxygen therapy and if parents or staff had concerns. There were plans to repeat the audit within the next month to assess any changes.
- Senior staff confirmed there was always at least one member of staff, usually the band six or higher, on duty qualified in advanced paediatric (or neonatal) life support.
- Ward 10 had two high dependency rooms which were used for caring for children requiring close supervision and monitoring following surgery, those requiring close observation for mental health problems or with single system problems until the child is fully stable.
- The children's acute transport service (CATS) was used to transfer children needing paediatric intensive care to another hospital within the region.
- All patient care records included risk assessments such as nutritional risk, skin integrity and wound charts and for children and young people between 13-18 years, venous thromboembolism (VTE).
- There was a children and young person's flowchart for those requiring surgery to direct clinical management dependent on type of surgery and whether elective or emergency. This helped assess the care needs post operatively.
- The paediatric recovery area limited the contact with other patients for children's protection.
- The previous CQC inspection commented on the lack of risk assessment for a young person with a mental health crisis being placed on ward 10 as a place of safety. Between April 2016 and June 2016, ward 10 admitted 257 children and young people with mental health concerns. Following that inspection, Ward 10 and the accident and emergency department collaborated to develop a new flowchart to risk assess the suitability of a young person with a mental health crisis up to and including the age of 18 years old being admitted to ward

10 as a place of safety. The flowchart gave clear direction of best management dependent on age, risk and mental health assessment. Also, in a new initiative newly qualified nurses will complete a three day exchange with the local child and adolescent mental health services (CAMHS) team as part of their preceptorship programme. This will enable nursing staff to develop skills for better management of young people with mental health crises.

Nursing staffing

- There were nursing staff vacancies on ward 10 and on the neonatal unit. Ward 10 had 2.4 trained nurse vacancies as a result of a recent safer staffing review. A new member of staff was due to start in November 2016 and a second member of staff relocating to the area starts early 2017 leaving one whole time equivalent (WTE) vacancy.
- The neonatal unit had 2.39 nurse vacancies. A new member of staff was due to start in September 2016 leaving 1.4 WTE vacancies.
- The vacancies were being actively recruited to, using NHS jobs to advertise and manage the recruitment process.
- No agency staff were used on the neonatal or ward 10. Bank staff were used to fill gaps but these were usually staff from the ward or nursery nurses who were very familiar with the ward/unit. Ward 10 and the neonatal unit staff were multi skilled and worked collaboratively to ensure there was appropriate care provided for children, sharing staff where necessary.
- Our previous report had identified that the trust was not following best practice with regard to a senior nurse of band six or above being on duty 24 hours, seven days a week. This is recommended by the Royal College of Nursing, which defines staffing levels for children's and young people's services. The trust had reviewed this and a standard operating procedure (SOP) had been developed to ensure a senior (band six or above) paediatric nurse was available at all times via a rota. We reviewed the rota for August 2016 and saw that there was appropriate senior paediatric nurse cover. Telephone and bleep numbers were used for contact and cover was available 24 hours other than nine occasions between six and seven pm.

The neonatal unit staffing

Services for children and young people

- The neonatal unit was staffed by 12.5 WTE qualified nurses, some of whom had the neonatal specialist qualification: Qualified In Speciality (QIS), and six part time nursery nurses.
- The unit used the British Association of Perinatal Medicine (BAPM) recommendations for staffing.
- The BAPM toolkit recommends that babies with intensive care needs are cared for by a neonatal QIS nurse on a one to one basis. The ratio of neonatal QIS nurses responsible for the care of babies requiring high dependency care should be one nurse: two babies, and for special care, it should be at least one QIS nurse: four babies. BAPM also recommends that the shift leader is supernumerary.
- We saw the staff nursing numbers for May to July 2016. Using the BAPM tool, this showed that on 56 occasions the shift leader was not supernumerary, (as per BAPM recommendation) and acted in a supervisory capacity for junior staff for whole or part of the shift. On six occasions there was a shortage of QIS trained staff, although it is not possible to show on the BAPM tool when staff have come in early or stayed late to assist, or when staff from ward 10 have assisted to provide safe cover.
- We reviewed the staff rota and cot occupancy for the same period and saw that although there were enough staff on the day time shifts (with the ward manager acting as supervisor) there were five night shifts in July where there were insufficient staff to provide safe staffing levels due to a high admission rate. Staff confirmed that they would have had cover from ward 10 but that there was no way of showing this on the electronic register. We checked the ward 10 staffing levels for this period and were assured there were sufficient staff to assist the neonatal unit.
- There was a clear commitment to providing safe staffing levels and staff were proactive in assessing their ability to provide care and had closed to outside transfers four times in the last 12 months due to lack of staff, although they remained open to emergency admissions.
- Staff handed over using a multidisciplinary handover sheet although a handover was not specifically witnessed.

Ward 10 staffing

- Ward 10 (including the two HDU beds) was staffed with 26.6 WTE trained staff, part time nursery nurses and two

play specialists. There were three paediatric nurse practitioners who worked on a rota system, and a band six clinical educator who worked on both ward 10 and the neonatal unit.

- Newly qualified staff rotated for two years spending six months on the neonatal unit, accident and emergency and recovery room as well as ward 10a and 10b to develop skills and experience in all areas.
- The ward used the Shelford Children & Young People's Safer Nursing Care Tool (SNCT) and the Royal College of Nursing (RCN) guidance on paediatric staffing levels to assess staffing requirements. The SNCT recommends staffing numbers based on the Paediatric Intensive Care Society five levels of need, which classify patients according to the degree of support required. The RCN guidance recommends registered nurse to children ratios: children younger than two years should be 1:3 and two years and older 1:4.
- We reviewed the electronic health roster safe care analysis for the period May to August 2016. This analysed the care hours per patient, per day (CHPPD) and the number of staff on duty to indicate safe staffing. We saw that staffing was safe for the majority of this period, with numbers below the levels required for the type of care needed, for less than 20 out of the 2,280 hours. Staff confirmed they would have escalated this to the level six nurse on duty and that assistance would have been sought from other areas but we have no documented evidence to confirm this.
- We reviewed the multidisciplinary shift handover sheets and found them to be informative and comprehensive detailing all changes to condition and treatment within the shift period.

Medical staffing

- There were 15.7 WTE medical staff including nine consultants, 2.5 WTE speciality doctors, six specialist registrars and one foundation year (FY2) junior doctor. The paediatric service had three WTE medical staff vacancies. The medical consultant vacancy was for the community paediatric post, a new consultant had been appointed and was due to take up the role in January 2017 and this role was in the interim, being covered by a long term locum. The 1.3 registrar middle grade posts had been advertised and one successful candidate has been interviewed with a second in communications with medical staffing. A 0.5 WTE speciality consultant post was awaiting interview.

Services for children and young people

- The medical staff skill mix was 50% consultants, 15% middle grade, 31% registrar and 5% junior staff. The England average for consultants was 39%, middle grade 7%, registrar 47% and junior doctors 7%. Overall the trust had a higher (65%) number of highly qualified medical staff compared to junior staff than the England average (46%).
- We reviewed 11 patient care records. The Royal College of Paediatrics and Child Health (RCPCH) revised standards 2015 recommended that all acute medical attenders were reviewed by a paediatrician within 4 hours. We saw that a paediatrician staff grade or registrar had reviewed children during the 4 hour period following admission. Six records also showed a consultant review within 4 hours.
- The RCPH also recommends a consultant or similar grade with appropriate speciality review within 14 hours of admission and all records documented this.
- Out of hours cover was provided on a rota basis and nursing staff confirmed that this worked well with medical staff being supportive and available when

needed. The consultants also worked a 'hot week rota' system where they were also available out of hours and meant that cover was available for 24 hours daily, seven days a week on the neonatal unit and ward 10.

- Medical staff used the multidisciplinary shift handover document which ensured continuity of care and communication.

Major incident awareness and training

- Ward 10 staff had contingency plans for increased staffing during winter months to prepare for higher respiratory admissions.
- The paediatric service had developed a business plan to ensure the sustainability of the paediatric community service as delivered by the trust.
- Senior staff we spoke with knew of the hospital emergency plan and major incident cards, which gave timely prompts for key actions to be completed in the event of an emergency situation, junior staff were less knowledgeable of the actions although they were aware that there was a plan.

End of life care

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

Information about the service

The James Paget University Hospital provided end of life care to patients with progressive life limiting illnesses such as cancer, advanced organ failure, for example heart and renal failure, and neurological conditions. The hospital had 1037 deaths in 2015. There were similar numbers leading up to our inspection, with 702 deaths between 1st January 2016 and 16th August 2016. The specialist palliative care team was an integrated service, providing care within the hospital and across the community. A telephone advice and support service was available seven days a week 9am to 5pm including bank holidays. This service was accessible to patients, carers and professionals. The palliative care team also offered face-to-face holistic needs assessments for patients in all community settings and within the hospital. The team also provided palliative care training to staff on the wards to support them in caring for patients at the end of their lives. End of life care services were supported by the chaplaincy, bereavement and mortuary services.

Staff made 919 referrals to the specialist palliative care team from April 2015 to March 2016. The majority (69%) of these patients had been living with cancer.

There was a lead consultant, nurse and non-executive director for end of life care at this hospital.

This inspection formed part of the hospitals focused inspection following our 2015 inspection report that rated end of life services as 'requires improvement' overall. This was mainly because the hospital did not have a clear end

of life care pathway, the trust performed worse than the England average in national audits and there was no clear leadership for the service. Following our inspection in August 2016, we found improvements in all areas.

We visited ten wards including A&E and intensive care. We visited supporting departments such as the Louise Hamilton palliative care support centre, bereavement, mortuary and chaplaincy. We spoke to 42 members of staff, including doctors, nurses, porters and the mortuary team. We also spoke with seven patients and relatives and looked at 36 patient records. We observed care and attended staff meetings.

End of life care

Summary of findings

We undertook a full review of end of life care which was rated good overall. The safe key question was rated as requires improvement which had not improved from our previous inspection in August 2015 but the effective and well-led key questions had improved from requires improvement to good. Responsive remained as good though caring was now outstanding. This was because:

- Staff worked to clear guidelines and policies. We saw good infection control techniques, such as handwashing and use of gloves.
- There was a much more unified care plan for dying patients and this was well-referenced and accessible to staff.
- Staff were proud of the service they provided and patients gave high praise of the caring support they received. We saw examples of the hospital's teams going beyond their normal duties to be compassionate and supportive and Staff took into account personal preferences to provide outstanding personalised care.
- The mortuary and chaplaincy had well embedded procedures to go the extra step to provide outstanding care and offered a 24 hour service.
- The hospital had access to the Louise Hamilton centre which provided support and resources to cancer and palliative patients.
- There was an improvement in the percentage of patients receiving individualised care and this was above the England average. The hospital provided a fast track discharge and in 2015 73% patients wishing to die at home were discharged.
- We saw evidence of patient's being given options on their care and having a choice of an open ward or side room.
- The service received little complaints but those that were received were acted upon and responded to in line with hospital policy.
- There was now an end of life care strategy for end of life services that reflected the trusts vision and values.

- The leadership structure was clear and following recommendations there was now a clinical lead and a non-executive director for end of life care and we found board level staff to have an understanding of the service and the areas of concern and risk.

However:

- The palliative care team were understaffed and did not provide a seven day nursing service.
- Ward staff had difficulty accessing all palliative care records as a different computer system was used.
- The service had implemented new Clinically Agreed Plans (CAPs) to replace the previously used Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. Internal audits in March 2016 found that they were not always completed though re-audit in late summer 2016 showed improvement in completion.
- We were also unable to assess the long terms effectiveness of improvements, as at the time of our inspection they were not fully embedded throughout the trust.

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Are end of life care services safe?

Requires improvement



We rated safe as requires improvement because:

- We observed two members of staff not following the bare below the elbow policy and one not using gloves at an appropriate time.
- The service had implemented new Clinically Agreed Plans (CAPs) to replace previous Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. We found these were not always located at the front of patient's notes, as they should be which increased the risk of not locating the form in a timely manner.
- We also found gaps in mental capacity assessments for CAPs and some were difficult to read or illegible. The CAPs had a section titled 'Escalation of care'. Staff did not have an understanding of this and its use was inconsistent.
- An internal audit in March 2016 found nineteen blank CAPS forms throughout the trust which presented a risk of resuscitation against a patient's wishes. Re-audit in late summer 2016 showed improvement
- Staffing levels for both hospital based palliative care nurses and palliative consultants was below national recommendations.

However:

- There were no serious incidents reported between June 2015 and May 2016.
- Staff were aware of reporting procedures and the importance of thorough analysis of incidents, duty of candour and sharing lessons learnt.
- Clinical areas were visibly clean and personal protective equipment and hand sanitiser was readily available.
- All staff had completed mandatory training. This included infection control training.
- Equipment was visibly clean, well maintained and documented.
- The mortuary was secured, monitored and had swipe card access for relevant staff. Mortuary records were complete and accurate.
- Syringe driver and anticipatory medicine administration had a clear triage tool and guidelines.
- Patient notes and prescription cards were clear and legible.

- Each patient had a multidisciplinary care record completed on admission, which included a Clinically Agreed Plan form stating resuscitation status.
- All mortuary and palliative care staff had received safeguarding training and staff we spoke to knew the process of raising safeguarding concerns. There had been no safeguarding concerns between June 2015 and June 2016.
- Results from the national care of dying audit were above the England average and there was an improvement on previous results for identifying patients who required end of life support.
- The hospital had systems for identifying deteriorating patients and access to equipment such as resuscitation trolleys to protect patients from harm.

Incidents

- There were no never events reported between June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no serious incidents (those requiring investigation) reported between June 2015 and May 2016 for end of life services. .
- Staff were aware of the procedures for reporting an incident using the hospitals electronic system. They explained the importance of investigating incidents to learn lessons and improve services.
- There were 41 incidents relating to end of life care between August 2015 and June 2016.
- We reviewed a root cause analysis for a recent ward incident. Although not specific to end of life care, we saw that lessons were learnt and shared. New procedures were disseminated to staff by providing education updates.
- Staff were aware of their responsibilities and principles in regard to the duty of candour . 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

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provide reasonable support to that person. Staff explained the importance of being open and honest when making mistakes, apologising and notifying all those involved.

- The specialist palliative care team discussed hospital deaths at weekly multidisciplinary meetings. We confirmed this by attending one of the meetings.

Cleanliness, infection control and hygiene

- The wards and departments were visibly clean, bright and well maintained. All clinical areas had hard flooring to ensure hygiene was maintained. Cleaning schedules were signed and up to date.
- Hand sanitiser was available at the entrance of each ward and sinks were also available for the use of hand washing. We observed staff using hand sanitisers and washing hands in line with World Health Organization guidelines.
- Staff complied with the hospitals infection control policy, including being bare below the elbows in clinical areas. However, we observed two junior doctors wearing watches in clinical areas.
- The mortuary had designated risk of infection areas for uniformed mortuary staff only. All staff followed the trust's infection control and hand hygiene policies. We witnessed staff washing their hands and using hand sanitiser after releasing a deceased patient to funeral staff.
- Gloves were available and used on each ward. We witnessed staff changing these in between each patient, in line with national guidance.
- Mortuary porters stated that all personal protective equipment, such as gloves and aprons, were easily accessible on the wards and within the mortuary. However, one porter transferred a deceased patient without using the available gloves. This increased the risk of transferring infection to clinical areas.
- Mortuary porters had recently worked alongside the infection control team and purchased a portable handwashing station for their department. This was in response to our last inspection and ensured porters had suitable facilities to wash their hands, lowering the risk of transferring infections.
- All fridges and freezers within the mortuary were visibly clean and used for their intended purpose.
- The mortuary manager had produced a 'care of the deceased patient regarding infection control' policy,

with referenced best practice from the Health Service Advisory Committee and five other NHS trusts. Mortuary staff had signed to say they had read and understood the policy, and worked in line with it.

- The palliative care team and mortuary staff had all completed the trust's infection control training.

Environment and equipment

- Patients receiving end of life and palliative care were treated on general wards. Staff informed us that where possible patients would have an option to have a side room, where they had private and quiet surroundings.
- The mortuary was licenced by the Human Tissue Authority to allow post mortem examination and storage of the deceased. The hospitals estates department maintained mortuary equipment. Items of equipment such as fridges and trolleys were visibly clean and had up to date portable appliance testing.
- The trust provided evidence of a robust and detailed mortuary environment audit. This included checks for cleanliness, tidiness of work areas and the availability of stock. We reviewed the most recent audit dated 27 June 2016 and it demonstrated that the environment and equipment were at the required standard.
- All fridge temperatures were within the correct range. Staff undertook temperature checks daily and recorded them for audit purposes. We confirmed these were up to date by reviewing records from 1 June 2016 to 16 August 2016. Switchboard staff monitored fridge alarms 24 hours a day. Switchboard staff would contact the on call mortuary technician with any temperature alarm activation out of hours. We saw an example of when the alarm had been activated. This was noted on the daily check records.
- Facilities were available for a deceased person to stay longer term within the mortuary should there be a reason, such as an on-going police investigation, which would mean there was a delay in releasing them for their funeral. There were also facilities to accommodate deceased patients of different sizes including bariatric patients.
- Access to the mortuary was via swipe card and the entrance was under surveillance by CCTV. Only staff that worked in the mortuary had access.
- Staff told us they did not have any problems accessing equipment such as bed pans, urinals or pressure relieving equipment.

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- The trust provided a list of syringe drivers in use, identified by unique serial numbers, and included the equipment service dates. We noted that this also helped to identify those requiring maintenance, eight out of the 44 were due for a service.
- The palliative care team kept detailed records of the location of syringe drivers, and which patient had been discharged with a syringe driver. We did not see any evidence of tracking the location of those that went home. This increased the risk of mislaying equipment. However, we noted that the care of end of life group discussed this in their April 2016 meeting and had put plans in place to contact care homes and discussed the issue with the medical devices group.

Medicines

- The hospital reported no medication errors relating to end of life care between June 2015 and June 2016.
- The hospital used anticipatory prescribing to control pain for patients who were dying within hours or days. Staff used a triage document that advised on medication doses to control symptoms (for example breathlessness, pain and nausea) for patients in the last days or hours of life. This was considered good practice by the National Institute for Health and Care Excellence (NICE)
- Staff felt there had been an increase in the number of patients going home with anticipatory medication. The hospital did not audit this; however, the hospital had implemented further training in the prescribing of take home medication for those patients at the end of life.
- Staff felt there was a multidisciplinary approach to pain and symptom control. They felt doctors took overall responsibility for medication, nurses administered it in good time and it was readily available. We confirmed this with a patient who said they received their medication in a timely manner.
- The trust used one type of syringe pump for continuous pain relief. Nurses felt these were easily accessible and were confident in using them effectively. Sixty-six registered nurses had received syringe driver training, and the hospital submitted training records to support this.
- We looked at the syringe driver prescription and administration record. This had clear guidelines and instructions for drug management of symptoms of dying

patients. The record also contained pain scoring and the triage tool for different symptoms. Both community and hospital staff used the same administration record, ensuring continuity in patient care.

- At the time of our inspection, we did not see any patients that required this chart, therefore we could not check that it was used correctly or recorded on the patients main prescription chart.
- We looked at four patient's prescription cards. All were legible, complete and comprehensive. They showed evidence of regular administration in accordance with prescription. Ward staff documented and reviewed anticipatory medicine. The consultant stopped non-palliative medication aimed at prolonging life, in the last days and hours of life. This is considered good practice by the National Institute for Health and Care Excellence (NICE)

Records

- We looked at 36 sets of patient records; these were stored in trolleys next to ward reception areas. They were not locked and easily accessible.
- Patient notes were signed, legible and dated. There was evidence of risk assessments having been carried out, these included falls and skin integrity.
- During the 2015 inspection, the hospital had two do not attempt cardiopulmonary resuscitation forms (DNACPR) in use. The second one was being piloted and was now called the Clinically Agreed Plan (CAP). However, on one occasion we found an old DNACPR form still in use, and dated April 2015.
- We reviewed 28 CAPS forms. Two were difficult to read, one of these had writing that was illegible. We asked staff about this, they were also unable to read the writing and identify who had signed the form.
- There was no review date on the forms. We asked a nurse about this who stated that patients are reviewed daily or when the patient's condition changes. They gave an example of when a patient had changed their mind after their health had improved. We saw that this patient's form clearly had 'void' written across it.
- Each CAP form also had a section titled 'Escalation of Care' it had a tick box option for active therapies or comfort care. We asked a senior nurse on ward 5 what this meant, they stated that 'it was very subjective and could mean anything'. We asked nurses on another ward whose understanding was that although one option could be ticked, both may apply. Some staff members

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stated that they found it confusing whilst others found it helpful and would use it as a ceiling of care. This inconsistency in understanding meant there was a risk of inappropriate escalation of care, or not escalating when required.

- The hospital audited CAP forms in March 2016. The audit reviewed 225 patient CAP forms from across the hospital. Nineteen forms were blank and one only had the escalation of care section completed. Nursing staff told us that if a form were blank, they would perform resuscitation. This meant there was a risk of a patient being resuscitated against their or their families, wishes. However, re-audit in late summer 2016 showed an improvement in record completion.
- Compliance for completed sections of the form varied from 23% to 83%. We cannot comment on the effectiveness of this audit as we did not see any evidence of compliance targets or resulting action plans. However these results were compared to the previous type of form and there was an overall improvement in most sections.
- All forms we looked at had a clear cardiopulmonary resuscitation status documented. There was evidence that these had been discussed with patients and their relatives where appropriate. We saw evidence that a patient's wish to be resuscitated was respected, though discussion stated there was likely to be a poor outcome.
- Staff felt there had been improvements in the last six months. Staff felt 'do not attempt cardiopulmonary resuscitation' discussions are now taking place earlier, and feel they can challenge a consultant to complete the form on admission, resulting in all patients having one complete in a timely manner.
- Patient's had a multidisciplinary care record completed on admission, which included the CAP form. They were always located on page 5 of this blue booklet. This meant staff knew where to locate them when required. On two occasions, we found the booklets in the middle of the patient's notes, rather than being at the front. This along with different forms still being used meant that there was the potential of an increased risk in locating the form in a timely manner, resulting in possible delayed or inappropriate treatment.
- We looked at the last days of life care plan for a patient who had just died. There was evidence of discussions with the patient and their relatives, we saw regular consideration of symptoms and pain scoring.

- Mortuary records, including those for admittance and release from the mortuary, were accurate.

Safeguarding

- The hospital reported no safeguarding concerns relating to end of life care between June 2015 and June 2016.
- Ward staff were aware of their role in safeguarding. They were able to describe actions and procedures to report a safeguarding concern.
- The palliative care and mortuary team had completed safeguarding training for both adults and children, and training records submitted by the hospital confirmed staff were up to date and 100% compliant.

Mandatory training

- Mandatory training included dementia awareness, equality and diversity, manual handling and learning disabilities and autism. It also included medicines management, safe use of insulin, falls prevention and safeguarding children and adults.
- Data provided by the trust showed that 90% of the palliative care team and 89% of mortuary staff were up to date with their mandatory training. This did not meet the hospital target of 95%.
- Staff received syringe driver training as part of the hospital's induction training. We looked at training records and confirmed all relevant end of life care staff had completed this training. Staff we spoke with felt competent to use these, and stated additional training and advice was available from both the palliative care team and the manufacturers if they required.
- Porters had received specific training for transferring deceased patients to the mortuary. Mortuary porters had undertaken competencies for equipment within the mortuary 68% of porters had completed the required competencies. 100% of porters that worked within the mortuary had completed this training.

Assessing and responding to patient risk

- The trust used an early warning score (EWS) system in line with national guidance. This was used to determine the degree of illness of a patient. It was based on six cardinal vital signs, respiratory rate, oxygen levels, temperature, blood pressure, heart rate, and observations. We saw that this was used appropriately to alert clinicians to a patient requiring end of life care.

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- The plan of care for the last days of life booklet contained assessments of risks including, falls, wound care, pressure area care and personal hygiene. These were reassessed every three days unless a change occurred which indicated a reassessment.
- Ward staff were aware of the procedures for referring a patient to the specialised palliative care team, and felt this was always done in a timely manner.

Nursing staffing

- The hospitals palliative care team was an integrated service providing care within the hospital and community settings.
- The palliative care team included 10 whole time equivalent nurses. Only one of these nurses was based full time at the hospital whilst the others would split their time between the hospital and the community.
- The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds. The trust had around 460 beds. Based on these recommendations the hospital's staffing level for hospital based palliative care nurses was insufficient.
- The palliative care team felt understaffed as they could not provide a seven day face to face service for patients, or provide advice between 5pm and 9am Monday to Friday.
- Whilst this shortage in staff was recognised by the hospital, filling the role had so far proved unsuccessful. Staffing pressures were also impacted by one palliative care nurse being on long term sick.

Medical staffing

- There were 1.5 whole time equivalent palliative care consultants. This was not in line with the Association for Palliative Medicine in Great Britain and Ireland, and the National Council of Palliative Care, which states there should be a minimum of one consultant per 250 beds. This was highlighted at our last inspection. The trust had advertised this vacancy and been unsuccessful in recruiting.
- Palliative care consultants were available Monday to Friday for face to face reviews. However, there was a lack of this face to face support through the night at weekends and during bank holidays. One junior doctor stated they felt they could still call for consultant advice out of these hours, although they had never needed to.

Major incident awareness and training

- The mortuary had contingency plans for additional storage should it be required. The trust provided us with detailed policies for procedures if the mortuary was full or there was a mechanical breakdown.
- There was space for approximately 78 deceased patients, with additional folding racking to increase this to 100. If required, there was a procedure in place to further increase this capacity, by setting up a cold room.

Are end of life care services effective?

Good



We rated effective as good because:

- The new 'plan of care for the last days of life' was a unified approach to end of life care and was being embedded throughout the hospital. The majority of staff felt this enabled more family involvement.
- Hospital policies and plans were evidence based and referenced national guidance.
- The hospital participated in the recent national 'End of Life Care-audit- dying in hospital' and used material from the National Gold standard Framework centre.
- Patients felt they received pain relief in a timely manner.
- Nutrition and Hydration was adequately assessed and patients felt their needs were met.
- End of life care training was provided by the palliative care team and we found this to be well attended. Each ward had an end of life care link nurse who had received additional training.
- Patient notes and multidisciplinary records were easily accessible.
- The mortuary and chaplaincy services offered a 24-hour service.

However:

- Palliative care multidisciplinary meetings were unstructured and did not address on-going care planning for patients.
- Palliative care advice was not readily available out of hours.
- The palliative care team used a different computer system to that of the hospital. Ward staff had difficulty accessing information on the system.

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Evidence-based care and treatment

- During our inspection in August 2015, we found that the trust had not been proactive in replacing the Liverpool Care Pathway, which the trust phased out of use in 2014. Since July 2015, the hospital replaced the Liverpool Care Pathway, providing a unified approach to end of life care.
- Last year we found that this new plan was in its pilot stage and staff told us that uptake was slow. The new plan of care, called 'Plan of care for the last days of life', had now been embedded across the hospital. Staff were aware of the new care plan and could locate it when requested. The 'One chance to get it right' report, published in 2014, guided the structure of the new care plan, ensuring it contained the five priorities for care; recognise, communicate, involve, support, plan and do.
- Each priority had a separate section within the booklet, and clear explanations of each one on the front. Ward nurses had the five priorities on cards to act as prompts whilst the care plan was in its early stages. A ward nurse was able to show this to us when asked.
- Staff we spoke with felt this care plan focused on family involvement and was evidence based. One nurse we spoke with stated 'It fitted in well with other paperwork and helps to build staff's confidence in end of life care'. Another nurse said 'it is tailored towards patient's needs and helps decision making for nurses'. We saw prompts that encouraged families to be involved and make individualised decisions. However, some staff still felt it was more of a tick box exercise and could be more individualised to the patients care.
- Staff could access local policies and procedures and we noted that the policies were in line with national guidance. Mortuary policies referenced other NHS hospitals and the Health Service Advisory Committee.
- We saw that the Royal College of Physicians SBAR (Situation, Background, Assessment and Recommendation) technique had been considered when communicating deterioration in patients. There was a section with patients' records for these discussions to be documented.
- The mortuary received newsletters from the Human Tissue Authority (HTA) and the Association of Anatomical Pathology Technology (AAPT). The mortuary

manager disseminated HTA and AAPT updates via email and meetings to ensure all staff were aware of latest practice. Mortuary policies were version controlled following any updates.

- Although the trust did not participate, ward staff had access to guidance from the National Gold Standard Framework centre, which is a leading provider of training specific to end of life care.
- The end of life care strategy referenced the national institute of health and care excellence guidance and the national palliative end of life care partnership ambitions. These were used to inform the trust strategy.

Pain relief

- The hospital had a dedicated pain management team, providing services five days a week, which provided advice and support to wards. Staff also told us they would contact the specialist palliative care team for advice about support about appropriate pain relief if required.
- Symptom control was completed as part of a patient's assessment and planning.
- The trust used the abbey pain score for assessing pain for those who were unable to communicate verbally.
- An audit was planned to ensure anticipatory medications are prescribed for the 5 key symptoms of dying, one of which is pain control. The clinical audit plan stated this was due.
- Patients told us they received pain relief in a timely manner and were given an explanation at each stage of pain relief treatment. This was considered good practice by the Royal College of Anaesthetists core standards for pain management.

Nutrition and hydration

- The plan of care for the last days of life contained assessments of the patient's nutrition and hydration needs. There was also a prompt to consider clinically assisted hydration if appropriate.
- Patients had fresh water within reach of them at all times.
- Staff encouraged patients at the end of life to eat for comfort, as well as nutrition. One patient told us that staff would offer many options until they had found a choice that did not cause nausea. All patients we spoke to were pleased with the portion sizes and believed their nutrition and hydration needs were met.

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- Nursing staff gave examples of patients at the end of life receiving intravenous fluids to maintain hydration and comfort. The hospital used the malnutrition universal screening tool (MUST). This enabled the hospital to identify patients that were at risk from malnutrition, so they could assess their needs accordingly.
- The hospital had a team of acute dieticians based on site. Staff knew how to refer a patient for dietetic support when required.

Patient outcomes

- The end of life care audit – dying in hospital, published March 2016, looked at five clinical key performance indicators related to patient outcomes. The hospital scored higher in four of these compared to the national average.
- 86% of patients had documented evidence that they were likely to die in the coming hours or days. This was higher than the England average of 83% and an improvement from our previous inspection in July.
- 88% of patients were found to have had their concerns listened to. This was higher than the England average of 84%
- There was documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care in 96% of cases. This was higher than the national average of 66%.
- The trust provided us with a clinical audit forward plan. These included a care of the dying audit, side room access, palliative care referral times, documentation and telephone advice line. One audit had not started, whilst the remaining audits had begun but were not complete at the time of our inspection.
- The trust had a clinical audit plan for end of life care. We noted that this had an action plan attached, with those accountable recorded. All actions were either completed or in progress.
- The trust had recently started to request permission to contact relatives, after a patient had died. This was being used as part of a bereavement survey to identify areas on which they could improve

Competent staff

- The palliative care team provided training to staff that cared for dying patients. The 'What on earth do I say?' training aimed to give staff confidence to undertake advance care planning discussions. Staff spoke very

highly of this training. We confirmed that 162 members of staff had attended between September 2015 and July 2016. These included nurses, doctors, health care assistants and students.

- The trust had set up end of life link nurses. These nurses attended a three day end of life certificate course, which included care of dying patients, discharge planning and symptom management. This relieved some of the pressures from the onsite palliative care nurse. The palliative care team were passionate about training and encouraged staff to shadow their work for a day. A health care assistant contacted them with an interest in end of life care and they met with them to discuss career development options and offered further training.
- Staff received syringe driver training as part of the hospitals induction training. We looked at training records and confirmed all relevant end of life care staff had completed this training. Staff we spoke with felt competent to use these, and stated additional training and advice was available from both the palliative care team and the manufacturers if they required.
- Porters had received specific training for transferring deceased patients to the mortuary. Mortuary porters had undertaken competencies for equipment within the mortuary. 68% of porters had completed the required competencies. 100% of porters that worked within the mortuary had completed this training.
- End of life care staff were competent and knowledgeable. We saw evidence of nursing journals and newsletters used for updating staff on their profession. Staff felt fully updated with the recent advances and developments in end of life care.
- Staff felt competent, updated and fully trained on changes in the service. For example during the implementation of new care plans.
- 89% of the palliative care team had received appraisals in the last twelve months. This ensured staff received feedback and encouragement to develop and improve their performance.

Multidisciplinary working

- We attended a palliative care multidisciplinary meeting. A palliative lead consultant chaired the meeting and an occupational therapist, social worker, secretary, the hospital based palliative care nurse and four nurses from the community attended.

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- These meetings took place weekly to review all patients referred to the palliative care team. Ward staff had the opportunity to attend if they felt appropriate.
- Discussions took place for each patient and included conversations about accommodation, social needs, pain and medical conditions, mental wellbeing, discharge planning and access. Whilst an update of the patient and their current condition was presented and discussed we noted there was a lack of discussion around on-going care needs. We observed three further examples of multidisciplinary working the first was a consultant reviewing pain control medications. The consultant discussed this with both the ward nurses and the patient. The patient described this approach as 'fantastic' and felt they were included in the conversation and given choices on their treatment.
- The second was for a patient who was going home with a specific oxygen delivery system. This meeting was attended by the respiratory nurses, intensive care team, oncology nurses, the specialised palliative care team and an occupational therapist.
- Another example was for a patient who wished to die at home. Six members of staff, from different departments, contributed to the patients discharge, ensuring a prompt and effective discharge.
- However, some palliative care staff felt that there was a lack of engagement from other trust teams and felt that referrals were a way of transferring responsibility and not taking responsibility of their own delivery of end of life care. Some palliative care staff felt there should be more engagement and handover by ward staff during referrals.
- The hospital worked alongside the national organ and tissue donation team. Staff informed us that the clinical director of intensive care and the A&E team were very proactive with organ donation. We saw examples of meetings where an organ donation speaker attended to increase awareness of the service.

Seven-day services

- The palliative care team provided a telephone support and advice line for patients, families, carers and professionals seven days a week 9am to 5pm. This advice line was unavailable outside of these hours as there was only one member available to provide this service.
- One palliative care nurse was based at the hospital Monday to Friday 9am to 5pm. Telephone advice from

the palliative care team was available at weekends and bank holidays 9am to 5pm. Outside of these hours, an arrangement was in place that meant staff could contact the hospice located in Ipswich for advice.

- The hospital was not commissioned for on-site palliative care contact overnight. An answer machine was used overnight and answered at 9am the following morning.
- A relative said that there was absence of palliative care support at the weekend. The team were aware of this need and understood that they were not commissioned to provide a 24/7 service.
- Access to the mortuary was available Monday to Thursday 8am to 4:30pm and Friday 8am to 4pm. The staff provided a 24 hour on call service to the trust, coroner, patients and their relatives. This allowed them to facilitate viewings and admission of the deceased from the community. We saw many examples of relatives visiting the mortuary in the evening and at weekends.
- The pastoral care team provided daily support for staff, patients and relatives. They also provided an on call service for those with religious needs or those with none who requested support. We looked at the chaplaincy log and noted that those referrals took place seven days a week. They had 100% compliance with seeing a patient within one hour. During working hours, this was often almost immediately.
- The pharmacy provided dispensary services seven days a week including bank holidays. Monday to Thursday 9am to 5pm, Friday 9:30am to 5pm and weekends 10:30am to 12pm.
- Occupational therapy and physiotherapy was available Monday to Friday 8am to 4pm, and the pain management team was available Monday to Friday 9am to 5pm.

Access to information

- Patient's records were easily accessible on wards. We found them to be organised and filed correctly.
- The multidisciplinary records were blue in colour for easy access. This was mostly stored at the front of the patient's notes.
- CAPS forms were an integrated part of the booklet, so was always on the same page.
- Ward staff told us they felt they had sufficient information to support clinical decision making.

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- There were leaflets in both the bereavement office and the mortuary concerned with help for the bereaved and actions to take when someone dies.
- The Louise Hamilton centre was within the hospital grounds, providing resources for patients and their carers, such as guidance and carers support groups.
- The palliative care team used a centralised system for palliative care. This was a different system than that used by the hospital. Therefore, there would be difficulties accessing specific palliative patient information for the ward teams. An example of this was that preferred place of death was only recorded electronically on this system. The team was aware this was an issue, and believed it was due to IT issues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All patients we spoke to agreed they were asked consent before treatment. One patient said they felt fully informed on their treatment, whilst another said staff always asked permission in a caring and friendly manner. We noted that consent was also recorded in the patient's notes.
- All end of life care staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This is the procedure prescribed in law when it is necessary to deprive a patient of their liberty when they lack capacity to consent to their care and treatment in order to keep them safe from harm. Records provided by the trust confirmed staff were up to date and 100% compliant with this training.
- There were no patients receiving end of life care who had a deprivation of liberty safeguards in place at the time of our inspection. However staff we spoke to had an understanding of the principles of DoLS, this was in line with the Deprivation of Liberty Safeguards (DoLS) trust policy dated October 2015.
- Mental capacity assessments took place if a patient was thought to lack capacity to give consent. The assessment forms were adjacent to the CAP forms in the multidisciplinary care records and available as a green sticker to adhere to the notes.
- The front cover of multidisciplinary care records contained contact information for an independent mental capacity advocate should they be required.
- One of the CAPS forms stated that the patient did not have mental capacity; however, the attached mental capacity assessment form was blank.

- We informed the ward sister who was also unable to find an assessment, and said they would address this immediately.

Are end of life care services caring?

Outstanding



We rated caring outstanding because:

- All patients and relatives highly praised their care and had no negative comments.
- Communication between staff and patients was understanding and compassionate.
- Staff were proactive to ensure patients got the support they required.
- We found evidence of staff going beyond their duties to provide outstanding compassionate care.

Compassionate care

- All seven patients and relatives we spoke to highly praised the care they received. They told us of the very caring attitude of staff. One patient stated 'staff were caring and supportive to both patients and relatives'. Another said 'They would recommend the hospital, as the care was second to none'
- No one had any concerns, complaints or negative comments. One patient said they 'couldn't think of any improvements to be made.'
- All ward staff we spoke to were clear on their role regarding end of life care. They were passionate and proactive to ensure patients got the support they required.
- This was reflected in the many thank you cards we saw throughout the departments we visited. One from ward 5 read 'Thank you for being very positive about care and meeting our needs' Another to the bereavement team read 'A very big thank you to all for your help and caring attention'
- We observed discussions between relatives and a palliative care consultant. This was a caring and sympathetic interaction, offering emotional support to relatives through issues. We spoke to the relatives afterwards and they said 'all staff had been excellent, supportive and could not have done more.'
- Staff took extra steps to meet the wishes of patients at the end of life. One patient's dying wish was to see a

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West End show. The palliative care team organised a meeting to ensure the right care and external support was available for her to fulfil her wishes. They organised the transport to London with underground passes, they ensured relatives had adequate knowledge of the support and pain relief required, as well as directions to the show and health services in London they could access. The palliative care team liaised with hospitals in London, so the patient could visit at set times to have their syringe driver changed.

- We also heard of a gentleman approaching the last days of his life whose wish was to die at home. The football World Cup was very important to him. Palliative care staff surprised him by telephoning a television provider and television technician to ensure his home was set up with sport channels showing the world cup.
- Another example was for a patient who missed their pet dog. Staff facilitated a side room; this enabled the family to visit and allowed the patient to fulfil their wishes of spending afternoons sat in a chair with their dog on their lap.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with told us they felt involved in the care the hospital delivered.
- The recently developed 'plan of care for the last days of life' booklets contained assessment and care planning for spiritual, cultural and religious needs. There was also an area to record communications with relatives.
- A family on ward 5 told us they had felt fully informed throughout the care process and were aware of the next stages. The family were also happy with the amount of information provided and the discussions that had taken place.
- The National care of dying audit 2016 has a clinical quality indicator which asked 'Did your Trust seek bereaved relatives' or friends' views'. The Trust scored 'Yes'. This was in line with 80% of other trusts.
- There was evidence that recognition of imminent death had been discussed with someone close to the patient in 84% of cases. This was higher than the England average of 79%
- 45% of cases had documented evidence that the needs of the person(s) important to the patient were asked about. This was slightly lower than the England average of 52%.

Emotional support

- Staff we spoke to were proud that emotional support for patients and their relatives was a priority in their role. They were clearly passionate about end of life care and explained the importance of face to face support in a private room, or in providing information on external support such as the Louise Hamilton centre.
- Patients confirmed that they felt emotional support was available. One patient said they felt very "supported" as there was "always the opportunity for support and discussion."
- The Louise Hamilton centre organises a palliative care support group, to offer emotional support and resources. Invites were sent to all patients on their list. The events regularly saw over 10 patients attend.
- We heard of an example of a daughter sitting and holding her dying mother as she passed away. Ward staff sat beside her and offered immediate emotional support.
- The chaplaincy provided an open door service for emotional, as well as spiritual, support. Staff spoke highly of the caring chaplaincy staff. One member of staff said they could also access emotional support, we heard an example of a nurse going to have tea and a chat with the chaplain following an emotional death on the ward.
- We witnessed caring interactions and support from the chaplaincy team, as a family was organising flowers for a memorial service that the team had help them organise.
- The mortuary manager was a qualified counsellor and used this to offer emotional support to bereaved families.
- The palliative care team helped organise a bereavement Service at the Louise Hamilton centre. This specialised in helping those with unresolved and complicated grief

Are end of life care services responsive?

Good



We rated responsive as good because:

- The Louise Hamilton centre provided resources and supportive services to people with cancer and palliative illness, and was responsive to their and their relative's needs.

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- Wards had open visiting hours, free parking and facilities to stay the night for relatives.
- There was a designated end of life care room for patients and their families.
- Patients were given the option of staying on an open ward or going into a private side room.
- There was an improvement in the number of patients having their individual care needs assessed in their last 24 hours of life. This was also much higher than the England average.
- The trust provided a fast track discharge for patient's wishing to die at home. 73% of patients wishing to die at home were discharged between January 2015 and January 2016.
- Deceased patients were moved to the mortuary in a timely manner.
- The trust received three PALs complaints relating to end of life care between June 2015 and May 2016. There had been no formal complaints made in the same period. We noted the these were all responded to and resolved in line with the trusts complaints policy.

However:

- Fast track discharge times varied, due to community support services. Reasons for delays were not documented in the patient's notes.
- Ward staff's knowledge on how to contact the palliative care team was inconsistent.

Service planning and delivery to meet the needs of local people

- The trust was the primary provider in palliative care for the geographical area.
- Staff made 919 referrals to the specialist palliative care team from April 2015 to March 2016. The majority (69%) of these patients had been living with cancer.
- The palliative care team were based at the Louise Hamilton centre which was used for processing referrals. The team consisted of both hospital and community nurses. We heard examples of community nurses visiting their patients, when they had been admitted to hospital. This provided good continuity of care for the patient.
- The Louise Hamilton centre opened in 2013 and provided services such as drop in support sessions, support groups and relaxation activities for people with cancer and other palliative illness. These services were

designed to support patient's psychological and social needs as well as their physical health. There were facilities available to relatives of hospital patients, for example they were welcome to go in and use showers.

- Relatives had the option of free parking when visiting; they were issued weekly parking passes.
- Staff offered relatives hot drinks throughout the day and pull out beds were available for visitors to stay the night. We also noted that wards allowed open visiting times for relatives of end of life care patients.
- Ward 12 had recently set up a room dedicated to providing compassionate care in a quiet, less clinical environment so that people's needs can be met more sensitively. This contained soft furnishings with drink making facilities. There was an attached area with a bed where families had the option of staying the night. Staff were in the process of ordering items such as books and additional furniture for this room.
- The hospital did not have designated end of life care patient beds. The palliative care team raised this as a concern and were in the process of collecting evidence for a business case to have them. However, side rooms were used, when available, to provide the patients with quiet, private surroundings. We also heard of an example of a patient wishing to remain on a ward being respected. Patients on an open ward had a curtain to maintain their privacy and dignity.

Meeting people's individual needs

- Multidisciplinary care records assessed social history including living, washing and carers requirements. There was also a section on personal preferences and choices. This included concerns about being in hospital, sleep pattern, hobbies and interests.
- Spiritual and religious needs were assessed in the 'plan of care for the last days of life' booklet. Ward staff completing these booklets also had access to end of life spiritual prompts on the hospital computer system.
- The chaplaincy team provided support for all religions and those with none. The chapel had various religious texts and prayer areas. The team performed specific visits to end of life patients on a 'walk round' on a Friday. Ward staff could also refer patients to the chaplaincy team anytime via their computer referral system.
- The team would also walk around on a Saturday informing patients of their services. A list would be given to a hospital porter on a Sunday morning to collect patients for a Sunday service.

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- The hospital used a telephone language line, for those who could not speak English. One member of staff raised the concern that it was at a fixed location and it was not possible to physically transfer an end of life patient to it. However, this situation had not arisen.
- Staff stated that they often allowed personal items from home, such as a personal radio or framed photos if a patient was in a side room.
- The palliative care team recorded preferred place of death on their electrical system, although this was not accessible in the main hospital. The trust carried out an end of life care audit in August 2016 and found that 90% of patients had their preferred place of death documented in the last episode of care. 95% of patients had their preferred place of death met.
- The national care of dying audit 2016 demonstrated that 96% of dying patients had their individual care needs assessed in the last 24 hours of their life. This was an improvement on the previous audit and higher than the England average of 66%.

Access and flow

- The trust no longer had referral targets; instead, the referrals were triaged by the nurse on call, who would decide on the time to see them. Staff felt this worked well and review times were dependent on the patient's needs, therefore for those patients requiring it, were often seen the same day of referral. We confirmed this by noting that patients were being discussed at the weekly MDT meeting that had been referred to them the previous day.
- The trust provided us with data regarding fast track discharge. The fast track discharge process allowed patients whose preferred place of care was not in the hospital setting to achieve a timely discharge. Between December 2014 and December 2015, 73% of patients, wishing to die at home, were discharged before dying. The average time between starting fast track discharge and going home averaged between 1-5 days. Staff felt that delays were often due to ensuring adequate care was facilitated in their home environment.
- We saw one set of notes where the paperwork for fast track discharge was sent 6 days prior. The ward sister told us the incomplete discharge was because the family could not cope; this was not documented within the patients care plan.

- Ward staff had inconsistent knowledge about how to access the palliative care team. Some nurses incorrectly stated they could get advice through the hospital palliative care team at night.
- Porters made patient transfers to the mortuary a priority. These times were not audited but staff felt they were always transferred in a timely manner and in accordance to trust policy. Wards were sometimes flexible on these times if the families wished to remain and spend time with the deceased. We observed porters being called for a mortuary transfer and confirmed this occurred within one hour. This is considered best practice by the National End of Life Care Programme and National Nurse Consultant Group.

Learning from complaints and concerns

- Staff we spoke with understood the complaints procedure; they felt they would do their best to resolve all problems on the ward. If unsuccessful, staff stated they would direct patients or their relatives to the hospitals Patient Advice and Liaison Service (PALS).
- There had been no formal complaints received by the hospital relating to end of life services between August 2015 and August 2016.
- The PALS department supplied us with all non-formal complaints received by them between June 2015 and May 2016. We noted that three were regarding end of life care. One concerned a hospital pathway that was no longer used; one was regarding lack of available side rooms and one about communication of bad news. We noted that all complaints had been responded to and resolved.

Are end of life care services well-led?

Good



We rated well led as good because:

- The trust had recently produced an end of life care strategy. We found this reflected the trust's vision and values. However, it was too early to see this embedded across the hospital.
- The strategy used national guidance and considered priorities for care of the dying.

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- The trust had an end of life care operational group, and end of life strategic group as well as a carer and patient experience group. Minutes to these meetings showed they worked together to improve, discuss and raise issues in end of life care.
- The trust had a risk register for end of life care. These risks matched issues we found on site during our inspection.
- The trust had an executive director for end of life care and had recently appointed a non-executive director.
- The palliative care team and mortuary had a clear leadership structure, staff could identify their line managers, felt supported, and understood their own roles.
- We found discussions to be honest and open, staff were supported and felt end of life care was a priority for the trust following our last inspection.
- Staff were aware of the recent changes in end of life care and felt supported by their managers.
- The trust engaged with the public, they held remembrance services for deceased patients and produced videos for the internet regarding DNACPR.
- The palliative care team was proactive in making improvements to the service

However:

- Senior staff incorrectly stated the palliative care team was in the hospital seven days a week.

Leadership of service

- Although the chief executive had overall lead of end of life care, responsibility was delegated to the director of nursing. They were responsible for providing board level leadership of the service. At the time of our inspection this position was vacant, due to the director of nursing retiring in May 2016. The deputy was currently acting as director of nursing.
- The leadership team had a good understanding of the end of life service and the improvements which were being made. However, when asked they stated that the palliative care team were available on site seven days a week, which was not accurate.
- Following recommendations from our last report, and that of the 'More care, less pathway' audit, the trust had

appointed a non-executive director of end of life care in March 2016. We noted that they played an active part in end of life care, by participating in the care of end of life group meetings.

- The trust also appointed a consultant surgeon to be the medical end of life care lead.
- The specialist palliative care team had a consultant as their medical lead and a Macmillan specialist nurse as their clinical lead. There was also a clinical educator.
- The mortuary also had a clear leadership structure. It was lead overall by the elective divisional manager. Mortuary staff reported to the mortuary and bereavement manager, who was reportable to the Service manager.
- All staff we spoke to were aware of their immediate managers were and understood the roles of senior management.
- Ward, palliative care, mortuary and chaplain staff felt supported by their immediate manager.

Vision and strategy for this service

- The trust's vision was to deliver excellence in healthcare and a high quality education and research environment.
- Trust values were putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly.
- The trust took part in a national programme of work called 'Compassion in Practice' that lays out the vision and strategy using six areas of action: care, compassion, commitment, courage, competence, and communication.
- Following recommendations from our last inspection, the trust had produced an end of life care strategy in January 2016 that reflected the trust wide vision and values.
- The strategy was approved at the board of directors meeting in June 2016. This meant that the hospital was in the early stages of rolling out this strategy.
- Staff we spoke with at ward level were aware of the strategy but did not know the detail or the changes it would bring about.
- The strategy also outlined the five priorities of end of life care as determined by the Leadership Alliance for Care of Dying People. Each priority had trust actions, these were realistic and some had already been implemented, such as the implementation of the CAPs forms and providing additional training to staff.

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Governance, risk management and quality measurement

- The trust had an end of life care operational group, chaired by a corporate lead nurse. The aim of these meetings were to identify risks and resolutions at ward level and aimed to improve patient and carer experiences in end of life care. This group was reportable to the end of life strategic group.
- The acting director of nursing chaired the end of life strategic group. The aim of these meetings were to assure the strategic plan for end of life care was on track and effective in its delivery. They also discussed and resolved issues raised by the operational group.
- The strategic group escalated to the carer & patient experience group, who in turn escalated to a subcommittee of the board, the safety, quality, governance committee.
- We reviewed meeting minutes titled 'Care and End of Life group' these were chaired by the director of nursing. We noted discussion of issues that were highlighted at ward level. The agenda and minutes were clear with attendees, updates, and actions assigned to individuals.
- The trust had a risk register specifically for end of life care and the mortuary. These were comprehensive with principal risks, scoring, control assurance and action plans. We reviewed the register from June 2016 and found the risks matched issues we found on site during the inspection, for example staffing vacancies within the palliative care team.
- Plans were in place to ensure service development and learning from internal auditing of the service. The care at end of life strategy set out plans for a set of quality measures to be developed and reported to the care at end of life group. It also set out that an annual report would be developed for the safety quality governance committee.

Culture within the service

- Staff we spoke to were passionate about providing a high quality service in end of life care. They were patient focused and felt supported by their managers and each other.
- Staff were aware of the recent changes in regarding end of life care in the hospital, and felt it was one of the trusts priorities.

- The palliative care team felt supported by each other and had formed good working relationships within the team. We attended one of their meetings. Discussions were honest and open and it was clear they were passionate about the care of their patients and their careers.

Public and staff engagement

- The trust had produced a short film explaining the importance of the DNA CPR decisions for both staff and patients. There were plans to use this on the intranet and on the internet.
- The chaplaincy continued to organise regular remembrance services for adults, children and staff.
- Staff were aware that they were welcome to attend multidisciplinary meeting they felt relevant.
- A peer support group was led by a palliative care nurse. We saw an example of this being attended by the respiratory and cardiac team to have a debriefing and receive emotional support. Support workers were also available to attend.

Innovation, improvement and sustainability

- The palliative care team had identified the need for specific beds for palliative care patients. In order to build a business case the team were allocating 'virtual' beds. This meant they could identify how many patients they would send to real ones..
- The hospital had recently assessed themselves against the baseline tool for care of the dying adults in the last days of life. As a result they implemented new documentation, increased training and education to nursing and medical staff and ensured that clinical assisted hydration is highlighted and improved to anticipatory medicine prescribing.
- The acute medicine nursing team was taking part in a research project on patient experience. They had recently attended a research event in Oxford and communicating with London hospitals to develop a patient pack. This was to contain earplugs, eye mask, resus information, paper and a pen. This included patients that were receiving end of life care.

Outstanding practice and areas for improvement

Outstanding practice

- Staff within end of life services going above and beyond to show compassion to the patients they were caring for in the last days and weeks of life. We heard of occasions where staff had facilitated and contributed to helping people fulfil their last wishes such as seeing their pets or being supported to take trips.
- The deep sedation list for patients for whom endoscopy procedures may be traumatic such as those who have mental health issues or learning disabilities.

Areas for improvement

Action the hospital SHOULD take to improve

The trust should:

- Review its registered nurse staffing across the emergency and medical divisions to ensure sufficient numbers of registered nurses are on duty to ensure the delivery of safe care.
- Review medical and dental staff participation in mandatory training and increase compliance with required training.
- Ensure all staff have the appropriate up to date paediatric and or neonatal life support training.
- Consider reviewing their medicines management practice to ensure medications are appropriately stock checked so that out of date medicines are disposed of and action is taken when fridge temperatures are recorded outside of accepted ranges.
- Consider reviewing prescription recording to ensure that signatures on prescription charts are legible.
- Consider improving the recording of staff sharing across ward 10 and the neonatal unit to prove safe staffing standards.
- Consider reviewing infection control arrangements within the children and young people's service to ensure effective hand hygiene and equipment cleaning.